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MANAGING MEDICAID PHARMACY BENEFITS: CURRENT ISSUES AND OPTIONS

Prepared by

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September 2011

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kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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We want thank each of the state Medicaid pharmacy administrators who provided information about their programs. Given the challenges they are currently facing, we are truly grateful they were willing to share their expertise on this important topic. Their input was invaluable. We offer special thanks to Mike Sharp, an independent pharmacy consultant who recommended review topics, participated in discussion with state officials, and reviewed preliminary drafts of the report.

EXECUTIVE SUMMARY

Pharmacy is an important component of Medicaid, accounting for $25 billion in spending across all states in FY 2009. The pharmacy component of Medicaid spending continues to be a focus of state policy attention, particularly now when states are feeling fiscal pressure to improve Medicaid program effectiveness, obtain greater value for state dollars, and constrain program spending. In a February 2011 letter to Governors, U.S. Department of Health and Human Services Secretary Kathleen Sebelius indicated that the federal government would help states identify Medicaid cost drivers and provide states with new tools, resources and options to achieve savings. She offered a long list of options, including several related to pharmacy. For pharmacy, recommendations included more effective drug ingredient cost reimbursement; increasing use of generics and mail order; better management of over-prescribed high cost drugs; using health information technology to encourage appropriate prescribing; and cost sharing incentives for cost-effective drugs.[1]

This issue brief focuses on several of the Secretary's recommendations related to reimbursement, pharmacy management, cost sharing and other best practices for achieving pharmacy savings in Medicaid. The brief provides background data and analysis related to these issues. To inform this analysis, a group of Medicaid pharmacy administrators was convened to discuss current Medicaid pharmacy issues. The group included Medicaid pharmacy administrators representing different geographic regions and diverse pharmacy management policies. Participants included officials from Alabama, Minnesota, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, and Texas. Also participating were former pharmacy administrators from California and Indiana[2] and staff from the National Association of Medicaid Directors. The discussion took place by conference call on May 26, 2011.

Pharmacy Spending Trends

For the past three years, U.S. prescription drug spending (including Medicaid) has increased at historically low rates. Spending increased by just 3.1 percent in 2008, the lowest annual growth since 1961, then 5.3 percent in 2009 and 3.6 percent in 2010. In contrast, between 2000 and 2005, pharmacy spending increased annually by over ten percent.[3] Specialty drug spending however grew by 19.6 percent in 2010, five times faster than spending growth for all prescription drugs.[4] By 2016, projections are as many as eight of the top 10 drugs (by plan spending) could be considered specialty.[5]

In the U.S. market for prescribed drugs, Medicaid is one of the largest single purchasers with approximately $25 billion paid to pharmacies, accounting for a 10 percent share of the total $250 billion U.S. market in 2009.[6] [7] Medicaid outlays are offset by manufacturer rebate revenue, including both mandatory federal rebates and supplemental state rebates. These rebates were $9.8 billion or 38 percent of total Medicaid spending in 2009, resulting in spending of $15.7 billion net of rebates.[8] State pharmacy administrators noted that state budget deficits are affecting Medicaid pharmacy programs and various options for obtaining pharmacy savings are currently under consideration in their states.

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[1] *Sebelius Outlines State Flexibility and Federal Support Available for Medicaid*, HHS letter to State Governors sent February 3, 2011, available at http://www.hhs.gov/news/press/2011pres/01/20110203c.html

[2] Mike Sharp R.Ph., an independent pharmacy benefit consultant and former Indiana Medicaid pharmacy director, and Kevin Gorospe, Pharm. D., principal at HMA and former Medi-Cal pharmacy director

[3] Anne Martin, David Lassman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, "Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades," *Health Affairs*, 30, no.1 (2011):11-22.

[4] *Express Scripts 2010 Drug Trend Report, a Market and Behavioral Analysis*, April 2011, available at http://www.express-scripts.com/research/studies/drugtrendreport/2010/dtrFinal.pdf

[5] *2011 Drug Trend Report*, Medco, available at http://www.drugtrendreport.com/

[6] *Ibid.*

[7] Anne Martin, David Lassman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, "Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades," *Health Affairs*, 30, no.1 (2011):11-22.

[8] *Financial Management Report for FY 2002 through FY 2009*, CMS-64 Quarterly Expense Report, available at http://www.cms.gov/MedicaidBudgetExpendSystem/02_CMS64.asp; Note: The federal fiscal year is October 1 through September 30.

Medicaid Pharmacy Reimbursement Issues

States have flexibility in how they reimburse pharmacies for ingredient costs and a fee for dispensing a prescription. A primary focus for states is brand ingredient costs that are nearly 80 percent of all Medicaid pharmacy spending, even though brands are now less than 30 percent of all Medicaid prescriptions.[9] The most frequently used methodology for brand ingredient cost reimbursement relies on discounted Average Wholesaler Price (AWP). The validity of an AWP-based methodology has been challenged in the courts and as a result, two major compendia agreed in 2009 to lower AWPs on about 22,000 National Drug Codes. One source used by many states will no longer publish AWPs after September 2011 which has forced many states to consider alternative reimbursement methodologies for ingredient costs. [10] The Centers for Medicare and Medicaid Services (CMS) is developing a database of National Average Drug Acquisition Costs (NADACs) and is encouraging states to adopt an Average Acquisition Cost (AAC) payment methodology based on this resource. In addition to payments for ingredient costs, Medicaid also pays pharmacies a fee for dispensing a prescription. Dispensing fees typically account for a small share of total Medicaid pharmacy spending.[11] In 2006, CMS advised states that they should re-evaluate dispensing fees whenever ingredient cost payments change.

States are preparing to revise their reimbursement methodologies for ingredient costs. CMS will distribute data on National Average Drug Acquisition Costs (NADACs) at the end of 2011 based on a CMS survey of retail pharmacies. States in this study noted that they need data that is timely and frequently updated, including data for specialty drugs. States are reviewing their current reimbursement model compared to Average Acquisition Cost (AAC) models. Two states (Alabama and Oregon) have implemented AAC reimbursement methodologies. States are interested in flexibility regarding how a Medicaid program might use the new NADAC data from CMS, as current rates are different in each state and what works for one state may not work for another . Some states are planning to continue AWP pricing using new vendors or move to other methods based on Wholesaler Acquisition Cost (WAC) or Suggested Wholesaler Price (SWP).

States are also considering changes to dispensing fees to reflect market pricing, as they review ingredient cost reimbursement. Some states are considering aligning Medicaid dispensing fees with those paid by commercial payers, Medicaid Managed Care Organizations (MCOs), and Medicare Advantage plans. Historically, Medicaid reimbursement for both dispensing fees and ingredient costs has often been higher than other payers.

Medicaid Pharmacy Benefit Management Issues

States have made progress in controlling prescription drug costs by using generic drugs; however, expenditures for specialty drugs continue to rise. A contributing factor to recent slower growth in Medicaid pharmacy spending is a trend toward greater use of generics. The U.S. generic dispensing rate industry-wide rose to 71 percent in 2010, up from 67.5 percent in 2009, and 63 percent in 2008.[12] This is not the case in the specialty drug market. Rapid growth is expected to continue for all payers, with specialty drug spending projected to increase by over 25 percent annually in 2011, 2012 and 2013.[13] Estimates are that 55 percent of specialty drug spending is counted as a medical benefit. Industry analysts predict that by 2014 specialty drugs (including both medical and pharmacy benefits) will comprise 40 percent of U.S. overall drug spending industry-wide.[14]

States are increasing generic utilization to achieve savings. Because generics are typically much less costly than brands, Medicaid can achieve considerable savings without compromising quality of care when generic use is increased. Medicaid generic dispensing rates in some states currently exceed 80 percent. Medicaid approaches to promote

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[9] Most prescriptions are generics and priced with Maximum Allowable Cost (MAC) rates. Brand prescriptions, however, account for most of the spending for prescription drugs and are priced with discounted AWPs.

[10] Medi-Span, Gold Standard, and Micromedex, unlike First DataBank, will continue to publish AWP.

[11] The DHHS Office of Inspector General found Medicaid dispensing fees to account for 2 percent of total cost of selected brand drugs, and 8 percent of selected multiple source drugs. See: USDHHS, OIG, "Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid," February 2009. http://oig.hhs.gov/oei/reports/oei-03-07-00350.pdf

[12] Anne Martin, David Lassman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, "Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades," *Health Affairs*, January 2011, pages 11-22.

[13] *Express Scripts 2010 Drug Trend Report, a Market and Behavioral Analysis*, April 2011, available at http://www.express-scripts.com/research/studies/drugtrendreport/2010/dtrFinal.pdf

[14] Ibid.

generics have included higher copays for brands, higher dispensing fees for generics, and structuring preferred drug lists to increase use of generics.

A current concern of states is how to manage specialty drug costs. As a result, considerable attention is now focused on how to control this area of prescription drug spending. States are looking at a variety of approaches, including contracts with specialty drug vendors, setting Maximum Allowable Cost (MAC) rates or deeper discounts on select specialty drugs.

States are also considering other options to better manage their pharmacy benefits including monitoring programs for mental health drugs and other new management tools. States are using new tools to better manage the pharmacy benefit, including new pharmacy claims processing that integrates pharmacy and medical claims for more sophisticated review at point-of-sale, more automated prior authorization, and new systems to assure that third party coverage is used when it is primary to Medicaid. States are re-evaluating how they handle prescription drugs reimbursed by Medicaid managed care organizations (MCOs). The Affordable Care Act of 2010 allowed states to collect federal Medicaid rebates on drugs reimbursed under capitation arrangements with Medicaid MCOs. Several states that "carved-out" prescription drugs from their MCO contracts and paid for drugs under their fee-for-service programs now have the option to integrate prescribed drugs in the MCO benefit without losing rebate revenue. Some states also impose beneficiary caps on the number of prescription drugs that Medicaid will pay for per month. Drugs above the limit often require prior authorization. States are focusing on appropriate prescribing of mental health drugs, partly due to their high cost, but more importantly because of clinical concerns about over-prescribing, particularly for children.

Medicaid Pharmacy Cost Sharing Issues

Most (39 states and the District of Columbia) require beneficiary copayments or coinsurance payments for prescription drugs. Federal regulations limit the amount of cost sharing that can be charged to beneficiaries and federal law prohibits states from imposing cost sharing on certain populations and services. States, under federal law amended by the Deficit Reduction Act (DRA), may choose whether a provider may deny a Medicaid service when a beneficiary is unable to pay cost sharing amounts. The DRA also allows states to impose higher cost sharing on select Medicaid services.

Some states use differential copayments to encourage generic drug utilization; however, most states have not implemented the new DRA options to increase cost-sharing and make copayments enforceable. Only one state (Kentucky) has implemented components using the DRA coinsurance model using a 5 percent cost sharing on non-preferred drugs up to $20. Most pharmacy administrators agree that the DRA alternative cost sharing model for non-preferred drugs would be extremely complex for states to implement for a number of reasons.

Increasing copayments can negatively affect providers and prescription drug utilization. While some reports show high collection rates for prescription drug copayments, other administrators hear concerns from pharmacies that it is difficult to collect copayments. For pharmacies, this is the equivalent of accepting a lower Medicaid rate of payment. Medicaid pharmacy administrators cited research showing increases in copayments resulting in lower utilization of prescription drugs, which may result in beneficiaries not getting needed prescriptions.

Conclusion

As state budget challenges persist, Medicaid administrators continuously look for new opportunities to reduce spending for prescription drugs through changes to reimbursement methodologies or pharmacy management efforts. States continue to examine reimbursement methodologies, especially as CMS works to develop a new database with National Average Drug Acquisition Cost (NADAC) data. States have made significant progress in increasing utilization of generic drugs, but spending for specialty drugs continues to accelerate and states are looking at new initiatives to help control spending. Some strategies include contracting with specialty drug vendors; better management of mental health drug utilization and re-tooling pharmacy claims processing systems by integrating paid medical claims to allow more sophisticated automated prior authorization processing. While the DRA allows states more flexibility to impose higher cost sharing and make cost sharing enforceable, few states have utilized these options because they are too burdensome and complex to implement or could result in lower utilization of needed drugs and reduced payments to providers. CMS has been working to share data and best practices in an effort to advance pharmacy savings and beneficiary access to needed prescription drugs.

1. Introduction

In a February 2011 letter to Governors, U.S. Department of Health and Human Services Secretary Kathleen Sebelius indicated that the federal government would help states identify Medicaid cost drivers and provide states with new tools, resources, and options to achieve savings. She offered a long list of options, including several related to pharmacy. For pharmacy, recommendations included cost sharing incentives for cost-effective drugs; more effective drug ingredient cost reimbursement; increasing use of generics and mail order; better management of over-prescribed high-cost drugs; and using health information technology to encourage appropriate prescribing.[15]

This issue brief focuses on several of the Secretary's recommendations related to reimbursement, pharmacy management, cost sharing and other best practices for achieving pharmacy savings in Medicaid. The brief provides background data and analysis related to these issues. To inform this analysis, a group of Medicaid pharmacy administrators was convened to discuss current Medicaid pharmacy issues. The group included Medicaid pharmacy administrators representing different geographic regions and diverse pharmacy management policies. Participants included officials from Alabama, Minnesota, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, and Texas. Also participating were former pharmacy administrators from California and Indiana[16] and staff from the National Association of Medicaid Directors. The discussion took place by conference call on May 26, 2011.

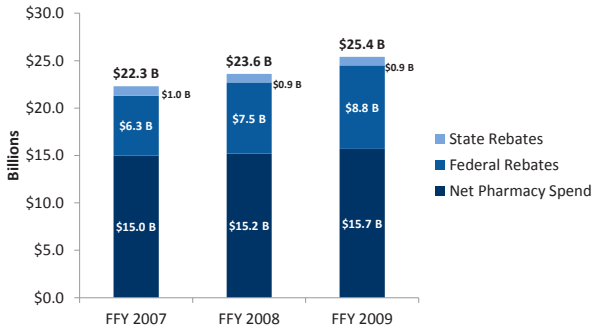
2. Background on Medicaid Pharmacy Trends

For the past three years, U.S. prescription drug spending (including Medicaid) has increased at historically low rates. Growth was just 3.1 percent in 2008, the lowest rate of growth since 1961, then 5.3 percent in 2009 and 3.6 percent in 2010. By comparison, pharmacy spending increased by 18 percent in 1999 and at double-digit rates in the early 2000s.[17] Specialty drug spending grew by 19.6 percent in 2010, five times faster than spending growth for all prescription drugs.[18] By 2016, projections show as many as eight of the top 10 drugs (by plan spending) could be considered specialty.[19]

Medicaid is one of the largest single purchasers of prescription drugs with approximately $25 billion paid to pharmacies, accounting for a 10 percent share of the total $250 billion U.S. market in 2009.[20] Medicaid outlays at both state and federal levels are offset by manufacturer rebate revenue, including both mandatory federal rebates and optional state supplemental rebates. Rebates were $9.8 billion or 38 percent of total Medicaid spending in 2009, resulting in net spending of $15.7 billion. Medicaid pharmacy

FIGURE 1

U.S. Medical Pharmacy Spending & Rebate Revenue Federal Fiscal Years 2007-2009



SOURCE: Financial Management Report for FY 2002 through FY 2009, CMS-64 Quarterly Expense Report, available at http://www.cms.gov/MedicaidBudgetExpendSystem/02_CMS64.asp

[15] *Sebelius Outlines State Flexibility and Federal Support Available for Medicaid*, HHS letter to State Governors sent February 3, 2011, available at http://www.hhs.gov/news/press/2011pres/01/20110203c.html

[16] Mike Sharp R.Ph., an independent pharmacy benefit consultant and former Indiana Medicaid pharmacy director, and Kevin Gorospe, Pharm. D., principal at HMA and former Medi-Cal pharmacy director

[17] Anne Martin, David Lassman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, *Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades*, *Health Affairs*, 30, no.1 (2011):11-22.

[18] *Express Scripts 2010 Drug Trend Report, a Market and Behavioral Analysis*, April 2011, available at http://www.express-scripts.com/research/studies/drugtrendreport/2010/dtrFinal.pdf

[19] *2011 Drug Trend Report*, Medco, available at http://www.drugtrendreport.com/

[20] Anne Martin, David Lassman, Lekha Whittle, Aaron Catlin and the National Health Expenditure Accounts Team, *Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades*, *Health Affairs*, 30, no.1 (2011):11-22.

spending increased by 7.8 percent in FFY 2009. This represents an upward trend compared to the 5.8 percent growth experienced in FFY 2008 (Figure 1).[21] Pharmacy was nearly 7 percent of all Medicaid healthcare payments prior to drug rebate adjustments and about 4 percent after offsets for rebates.[22] Appendix A provides state-by-state spending detail for FFY 2009. Pharmacy administrators noted state budget deficits are affecting Medicaid pharmacy programs and various options for obtaining pharmacy savings are under consideration in their legislatures.

3. Pharmacy Reimbursement Issues

a. Ingredient Cost Reimbursement

Background:

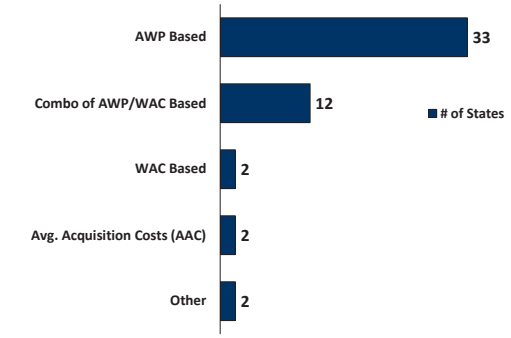
Baseline Requirements for Medicaid Pharmacy Reimbursement. Within criteria outlined in federal regulation, states have considerable flexibility in how they reimburse for drug ingredient costs and for a dispensing fee when a prescription is filled. States must submit changes in their reimbursement methodology for CMS approval in a State Plan amendment.[23] While specific policies vary by state, in general Medicaid reimbursement for prescribed drugs is set on the lowest of:

- *Estimated Acquisition Cost* (EAC) for procuring drug ingredients, plus a *Dispensing Fee*,
- *Federal Upper Limits* (FULs) or *State Maximum Allowable Cost Rates* (MACs), if applicable, set on ingredient costs for multiple source drugs, plus a *Dispensing Fee*, or
- The pharmacy's *Usual and Customary Charge* to the general public for the prescription.

Estimated Acquisition Cost (EAC). Estimated Acquisition Cost (EAC) is a state's best estimate of a drug's price generally and currently paid by pharmacies. EAC applies predominately for pricing brand drugs, which account for about 80 percent of a state's pharmacy spending.[24] Most states base their estimates on Average Wholesale Price (AWP), Wholesale Acquisition Cost (WAC), or Direct Pricing[25] (Figure 2). States (and other payers) approximate procurement costs by applying discounts to AWP or mark-ups on WAC or Direct Price. National compendia such as First DataBank, Medi-Span, Gold Standard, and Micromedex maintain and update the pricing benchmarks that may be used in a state's claims processing system to price ingredient costs.

FIGURE 2

EAC Pricing Benchmarks Used by States, March 2011



SOURCE: Information obtained from individual state and CMS websites reviewed by HMA during March 2011.

As of March 2011, 33 states paid brand ingredient costs based on AWP minus a discount ranging from 10 percent (District of Columbia and South Carolina) to 17.5 percent (New Jersey). Fourteen states used WAC with a markup between zero (Rhode Island) and 12.5 percent (North Dakota). Often states using WAC or

[21] *Financial Management Report for FY 2002 through FY 2009*, CMS-64 Quarterly Expense Report, available at http://www.cms.gov/MedicaidBudgetExpendSystem/02_CMS64.asp; Note: The federal fiscal year is October 1 through September 30.
[22] Total healthcare payments included services provided by inpatient and outpatient hospitals, long-term care facilities, managed care organizations, practitioners, laboratories, and other providers.
[23] 42 CFR §447.50 through §447.518
[24] Federal Upper Limits (FULs) and State Maximum Allowable Cost rates (MACs) are used primarily for pricing multiple source drugs meeting certain criteria for bioequivalence and availability in the marketplace. An in-depth review of FULs and MACs are outside of the scope of the Issue Brief.
[25] An appendix of pharmacy terms at the end of this document provides definitions for EAC pricing benchmarks.

Direct Price combine these benchmarks with AWP, so that EAC is set at the lower of a discounted AWP, marked-up WAC or Direct Price. Two states (New Mexico and Texas) modify their AWP discounts or WAC markups based on pricing data obtained from manufacturer and pharmacy invoices. Attachment B provides state-specific EAC benchmarks.

AWP Changes. AWP-based payments have undergone scrutiny in recent years. Litigation alleged that starting around 2001, First DataBank and Medi-Span arbitrarily changed their AWP calculation from a 1.20 to a 1.25 mark-up of WAC. This change in the "spread" between AWP and WAC increased pharmacy reimbursement amounts for most payers, since AWP-based rates are widely used (Table 1). Pursuant to a settlement agreement, First DataBank and Medi-Span agreed to lower the AWPs on 22,000 National Drug Codes (NDCs) by reverting back to an AWP calculation at 1.20 of WAC. This so-called "AWP roll-back" was effective September 26, 2009. First DataBank, the compendia used by most states, announced it would not publish AWPs after September 26, 2011.[26]

Table 1: Example - First DataBank and Medi-Span Changes to AWP Calculation, before and after 2001

Time Period	WAC	AWP Calculation	AWP	Comments
Before 2000	$100	WAC times 1.20	**$120**	
Starting around 2001	$100	WAC times 1.25	**$125**	First DataBank and Medi-Span increased the spread between AWP and WAC
Starting Sep 26, 2009	$100	WAC times 1.20	**$120**	Back to the pre-2001 AWP calculation and AWP/WAC spread

This announcement forced states using AWP to consider other data sources for AWPs and alternative reimbursement methodologies for ingredient costs.[27] The American Medicaid Pharmacy Administrators Association and the National Association of Medicaid Directors (NAMD) issued a 2010 white paper on ingredient cost reimbursement which recommended a single national benchmark based on actual acquisition cost data.[28] In the meantime, WAC-based payment for brands accompanied by a well-designed Maximum Allowable Cost (MAC) program for generics provides an interim alternative. In response to the NAMD white paper, CMS is developing a database of National Average Drug Acquisition Costs (NADAC) from surveys of pharmacy procurement costs that states *may use* for determining state-specific rates for ingredient costs.[29] The NADACs will be established by drug, strength, and dosage form with two separate rates set for brands and generics. CMS indicates implementation of this new database is targeted for the end of 2011.

Findings:

Ingredient costs account for most Medicaid pharmacy spending. On average, ingredient costs comprise about 90 percent of all Medicaid spending on pharmacy. The share of total costs varies across brand innovator products, multi-source branded products, and generics. One recent Office of Inspector General (OIG) study found ingredient costs to be 98 percent of the total for selected brand products, and 92 percent for selected multi-source products.[30] A high percentage of the total ingredient cost payments (nearly 80 percent) are for brand drugs. Within the discussion group, one participant indicated his state spent about 93 percent on drug ingredient costs with the remainder on dispensing fees. The ratio will differ across states, depending on the dispensing fee and the

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[26] *Update Regarding AWP Litigation – Final Order and Judgment Entered,* March 31, 2009, available at http://www.firstdatabank.com/Support/awp-communications.aspx Note: First DataBank provides states AWP data along with other drug data elements used for claims processing and setting a state's drug benefit design.

[27] Medi-Span, Gold Standard, and Micromedex, unlike First DataBank, will continue to publish AWP.

[28] *Post AWP Pharmacy Pricing and Reimbursement, Executive Summary and White Paper*, the American Medicaid Pharmacy Administrators Association and the National Association of Medicaid Directors, November 2009, available at http://hsd.aphsa.org/home/doc/SummaryofWhitePaper.pdf

[29] *Sebelius Outlines State Flexibility and Federal Support Available for Medicaid*, HHS letter to State Governors sent February 3, 2011, available at http://www.hhs.gov/news/press/2011pres/01/20110203c.html

[30] USDHHS, OIG, "Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid," February 2009. http://oig.hhs.gov/oei/reports/oei-03-07-00350.pdf

mix of generic products. As an example, one participant estimated that for states with high dispensing fees ($10 or higher), the payment ratio would be about 83 percent for ingredient costs and 17 percent for dispensing fees, assuming an average prescription cost of $65.

States are waiting to evaluate the acquisition cost data that CMS will distribute in its planned national database at the end of 2011. Several state pharmacy administrators indicated that their state will likely be interested in implementing an Average Acquisition Cost (AAC) model. A key restraint is the lack of staff and other resources to implement such a change. These states plan to carefully evaluate the national acquisition cost database once it is available from CMS.

Considerable interest is evident in the planned CMS survey of retail pharmacies that will produce the National Average Drug Acquisition Cost (NADAC) data. State officials expressed their views about how the new data it could be most useful to them in their administration of the Medicaid pharmacy benefit. Key issues included:

- *Update Frequency*: To be statistically supportable and defensible, CMS will need to update average acquisition cost data in the national database at least monthly, but *weekly* would be preferred.
- *Time Lag between Collecting and Posting Acquisition Cost Data for State Use*: The data will be useful only if it is timely. Because of ongoing market price increases, the data will be less useful the longer the "lag" between when the pharmacy procurement data is collected and analyzed, and when it is posted in usable form for state use.
- *Pharmacy Compliance with Providing Drug Procurement Data to CMS*: As proposed, pharmacies may "voluntarily" provide drug procurement data to CMS. It was unclear to state pharmacy officials whether pharmacies will comply with such CMS requests and how robust the resulting pool of pharmacies and their geographic distribution will be. In the two states with operational Average Acquisition Cost (AAC) models, pharmacies must participate with the state's requests for procurement data or lose status as a Medicaid pharmacy provider.
- *Statistical Methodologies to Sample Pharmacy Procurement Prices*: Pharmacy administrators in the study raised other questions related to whether data collection algorithms would represent different classes of trade; for example, independent versus chain or mail order pharmacies and how the stratification sampling would work.
- *Specialty Drugs*: Officials were not clear how the process would work for specialty drugs.
- *State Flexibility*: State pharmacy administrators were interested in flexibility regarding how states might use this new pricing source, as current rates are different in each state and what works for one state may not for another. States need the ability to reimburse differently based upon regional considerations (urban vs. rural locations), pharmacy business models (independents vs. chains vs. mail order), or other factors important in individual states.

Each state will need to closely review its current reimbursement model compared to Average Acquisition Cost (AAC) models. Medicaid pharmacy administrators who had done the analysis found their state would spend more under an AAC model, after running simulation studies using Alabama AAC rates and an assumed $10 dispensing fee. These states currently have EAC benchmarks set in part at AWP minus 14 percent or higher compared to Alabama's previous AWP minus 10 percent/WAC plus 9.2 percent. Officials noted that states with aggressive generic pricing may find moving to AAC less advantageous, because the decrease in ingredient costs may not be enough to counterbalance a substantial increase in the dispensing fee. Given this fiscal possibility, replacing AWP with WAC-based reimbursement may prove to be attractive for some states.

Two states have implemented Average Acquisition Cost (AAC) reimbursement systems. Alabama (in September 2010) and Oregon (in January 2011) implemented AAC reimbursement for ingredient costs.

Ingredient Cost Payment Using Average Acquisition Cost (AAC) — Alabama and Oregon Move Ahead

Alabama Medicaid adopted an average acquisition cost (AAC) model in September 2010, replacing its Estimated Acquisition Cost (EAC) benchmark based on AWP minus 10 percent/WAC plus 9.2 percent.[31] Under the new Alabama plan, an independent contractor performs a random sample of approximately 1,400 enrolled pharmacies twice each year. Selected pharmacies are required to submit one month's invoices. Each Medicaid pharmacy is to be selected once during a two year period. A pharmacy choosing not to participate is no longer eligible to participate in Alabama Medicaid. Pharmacies may submit invoices by mail, fax, or electronically, or may have their wholesalers coordinate submission directly to the state's contractor. The contractor then calculates the average cost per drug and resulting prices are listed online at http://al.mslc.com/AACList.aspx.

The state maintains an exception process if a pharmacy is not able to purchase a drug at the established price. If an AAC price is not established, Alabama's EAC rate for ingredient cost reverts to WAC plus 9.2 percent. AAC prices are updated weekly to reflect fluctuations in the published WAC for a drug. At the same time AAC was implemented, the state (with CMS approval) increased its dispensing fee from $5.40 to $10.64, based on an independent, confidential survey of pharmacies.[32] The Alabama pharmacy administrator indicated that this system more accurately reflects acquisition costs for drugs and the cost of dispensing them.[33] The state estimates that the combined changes to AAC and the dispensing fee resulted in a 6 percent net savings.

Oregon Medicaid implemented AAC-based ingredient cost with a variable dispensing fee on January 1, 2011, replacing its EAC rates of AWP minus 15 percent and dispensing fees of $3.50 (retail pharmacies) or $3.91 (institutional pharmacies).[34] The Oregon approach is similar to Alabama, but when statistically valid pricing observations are unavailable Oregon uses WAC with no markup. The Oregon dispensing fee varies based on annual total prescription volume for each pharmacy. Oregon's variable dispensing fee was originally implemented at $14.01 for fewer than 50,000 prescriptions, $10.14 for up to 70,000 prescriptions, and $9.68 for over 70,000 prescriptions. Effective on August 1, 2011, the dispensing fees were modified to be $9.68 for all chain-affiliated pharmacies, and were set for all independently-owned pharmacies at $14.01 for fewer than 30,000 prescriptions, $10.14 for up to 50,000 prescriptions, and $9.68 for over 50,000 prescriptions.[35]

Other key design and implementation features include:

- Stakeholder engagement began a year in advance of implementation.
- AAC surveys for pharmacy procurement data were designed not to be intrusive or administratively burdensome for the state's 700 enrolled Medicaid pharmacies.
- Oregon worked with its AAC contractor to identify the minimum survey frequency and pharmacy pool that would allow weekly statistically valid and defensible rates representative of chain and independent pharmacies in rural and metropolitan areas. The result was that no individual pharmacy will be surveyed more frequently than once every 18 to 24 months.
- AAC rates for brand and generic drugs are available at http://www.oregon.gov/OHA/pharmacy/reimburse-method/index.shtml.
- Oregon projects $1.6 million annual savings related to the AAC model with its expanded dispensing fees, with an additional $1.3 million annual savings from the dispensing fee adjustment implemented August 1, 2011.

[31] Using AAC as an EAC pricing benchmark is incorporated into both Alabama and Oregon reimbursement methodologies that are based generally on the lowest of (a) EAC rates plus a dispensing fee; (b) Federal Upper Limits (FULs) or State Maximum Allowable Cost rates, if applicable, plus a dispensing fee; or (c) the pharmacy's Usual and Customary Charge.

[32] Steckel, FY 2011 Budget Request Presentation, December 14, 2009, available at http://www.medicaid.state.al.us/documents/News/Special_Presentations/FY11_Budget_Presentation/CHS_FY11_Budget_Presentation_12-14-09_FINALa.pdf

[33] AAC drug pricing, dispense fee increase pending before CMS, May 28, 2010, available at http://www.medicaid.state.al.us/documents/News/MM_Articles/MM_AAC_COD_Update_5-28-10_FINAL.pdf

[34] Proposed changes in pharmacy reimbursement methodologies, September 2010, available at https://apps.state.or.us/cf1/OHP/OHPadmin/files/10-950%20rx%20reimbursement%20methodologies.pdf

[35] The August 1, 2011 dispensing fee change is pending CMS approval of a state plan amendment from Oregon.

Some states find they can replace discounted AWPs with WAC-based EAC benchmarks on a budget neutral basis. To replace (or augment) AWP methodologies, some states are choosing to implement WAC-based benchmarks using a mark-up calculated on the current 1.20 AWP to WAC spread (See Column B on Table 2). Appendix C shows that Michigan, New Hampshire, and North Dakota have taken this approach. As of March 2011, Florida, North Carolina, and Ohio had WAC mark-ups (Column C on Table 2) based on a 1.25 spread.

Table 2: Equivalent WAC Mark-Ups for Sample AWP Discounts Used for Most Brand Drugs

Column A **Current AWP Discount**	Column B **WAC Equivalent Mark-Ups to AWP Discount Using "Current" 1.20 AWP to WAC Spread**	Column C **WAC Equivalent Mark-Ups to AWP Discount Using "Previous" 1.25 AWP to WAC Spread**
-10%	+8.0%	+12.5%
-11%	+6.8%	+11.25%
-12%	+5.6%	+10.0%
-13%	+4.4%	+8.75%
-14%	+3.2%	+7.5%
-15%	+2.0%	6.25%
-16%	+0.8%	+5.0%
-17%	-0.4%	+3.75%
-18%	-1.6%	+3.75%

Some states are planning to continue AWP-based pricing benchmarks using vendors other than First DataBank, or using Suggested Wholesaler Price (SWP). Medicaid pharmacy administrators indicated that AWP data will continue to be available from two other vendors Micromedex and Gold Standard. One state is considering Medi-Span AWP data as a substitute for First DataBank data. One official anticipated his state would adopt the Suggested Wholesaler Price (SWP) benchmark, since First DataBank will continue to support SWP as a substitute for AWP. First DataBank defines SWP as the "manufacturer's suggested price for a drug product from wholesalers to their customers (i.e., retailers, hospitals, physicians, and other buyers) as reported by the manufacturer.[36]

b. Dispensing Fees

Background:

As of March 2011, state dispensing fees for "retail brand" prescriptions varied from a low of $1.75 (New Hampshire) and $1.80 (Ohio) to a high of $26.74 (Alaska). Alaska's in-state pharmacy fee is variable from $12.12 to $26.74 based on a pharmacy's total annual prescription volume. The two states which have implemented AAC pricing had the next highest fees — Oregon between $9.68 and $14.01 based on a pharmacy's annual claims volume and Alabama at a flat $10.64. Texas adds 1.96 percent of a prescription's drug cost (up to $200) to a $7.35 base, resulting in an $8 average fee. California's standard fee was $7.25 with the next highest fee being $5.77 in Louisiana.

Eleven states (Arkansas, Illinois, Maryland, Mississippi, Missouri, New Mexico, New York, Tennessee, Texas, West Virginia, and Wisconsin) include tiered fees that provide incentives to dispense generics. These incentives range between $0.50 (Kentucky, Tennessee, Texas, and Wisconsin) and $2.20 (Illinois). Six states (California, Colorado, Maryland, Michigan, Rhode Island, and Tennessee) have different fees for prescriptions dispensed to beneficiaries residing in long-term care facilities. Most of these institutional fees are higher than standard retail fees with the exception of Colorado and Rhode Island which pay lower fees. Appendix D summarizes these and other state dispensing fee structures.

[36] Drug Pricing Policy, First DataBank, available at http://www.firstdatabank.com/Support/drug-pricing-policy.aspx

In a 2006 Medicaid Drug Rebate Program Release, CMS advised states that when ingredient cost payments change, a state should reevaluate its dispensing fee to ensure that the fee is reasonable.[37] Pharmacy providers have consistently claimed that Medicaid dispensing fees are below actual dispensing costs, although higher ingredient cost payments have cross-subsidized underpayments in dispensing costs.[38] For example, a 2006 Grant Thornton study found the national median dispensing cost was $10.86 per prescription — well above most state fees.[39] The National Community Pharmacists Association has indicated AAC should only be allowed when it is tied to a "higher, more accurate dispensing fee" such as the one Alabama implemented.[40]

States often observe that pharmacies are accepting lower dispensing fee and ingredient cost payments from other payers compared to Medicaid rates. This is shown in the *2010-2011 Prescription Drug Benefit Cost and Plan Design Report* which found the 2010 average commercial payment for retail brand prescriptions was AWP minus 17.5 percent with $1.62 dispensing fee.[41] Several states (Connecticut, Georgia, Massachusetts, and South Carolina) have acted on this differential and implemented "most favored nation" polices. These policies stipulate a pharmacy may bill Medicaid no more than the lowest price reimbursed to the pharmacy by other third party payers and managed care organizations or the lowest price routinely offered to any segment of the general public.

Findings:

The relationship between ingredient costs and dispensing fee reimbursement is important. Ingredient cost payment is not dependent on the dispensing fee or vice versa; however, it is important that both components together reflect the marketplace so that beneficiary access to prescription drugs is not impeded. To illustrate, one pharmacy administrator explained "Even though we have a higher dispensing fee, when we compared our costs with Medicaid MCOs we saw their ingredient costs were higher, so we were paying about the same." Other officials agreed as ingredient cost reimbursement is tightened, states should re-evaluate their dispensing fee. Often a statistically valid cost-of-dispensing fee survey and its findings are posted on the state's website. Still, state officials cautioned that expected CMS regulations on pharmacy reimbursement changes should not be overly burdensome and require states to perform elaborate cost-of-dispensing studies to substantiate changes in fees, particularly when a state's fee aligns with other payers in the state.

Aligning the Medicaid dispensing fee with other payers may be an option for some states. Several state officials indicate they were considering proposals aimed at reducing dispensing fees. One approach would lower the Medicaid dispensing fee to align with commercial payers, Medicaid managed care organizations, and Medicare Advantage plans in the state. As one pharmacy administrator put it, this approach is proposed to prevent "your government paying more than other payers." Where this had been proposed, Pharmacy administrators indicated that CMS questioned whether this reduction would negatively impact beneficiary access to prescription drugs. State post-implementation findings showed no adverse impact on access.

Tiered dispensing fees require careful evaluation. Some states pay a lower dispensing fee for high volume pharmacies because of economies of scale. Medicaid pharmacy administrators suggested that careful modeling needs to be done before adopting such a fee structure. A key factor is whether *a pharmacy's prescription volume* is based *across all books of business*. A state may be at risk for unexpected costs if "you do not know where the

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[37] State Releases, Medicaid Drug Rebate Program, available at http://www.cms.gov/MedicaidDrugRebateProgram

[38] Expert Report of Zachary Dyckman, Ph.D. for the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA) Regarding Cross-Subsidization of Pharmacy Reimbursement Rates in the State of California, October 19, 2009

[39] *National Study to Determine the Cost of Dispensing Prescriptions in Community Retail Pharmacies*, Coalition for Community Pharmacy Action, January 2007, available at http://www.rxaction.org/publications/COD_Study.cfm

[40] National Community Pharmacists Association Letter to Cindy Mann, Director of the Center for Medicaid and State Operations at CMS, June 21, 2010, available at http://www.ncpanet.org/pdf/leg/alabamaspa.pdf

[41] *The 2010-2011 Prescription Drug Benefit Cost and Plan Design Report*, sponsored by Takeda Pharmaceuticals North America, Inc. for the Pharmacy Benefit Management Institute available at http://www.benefitdesignreport.com/PharmacyReimbursement/RetailPharmacyReimbursement/tabid/107/Default.aspx

scatter within the bands will occur." On the other hand, if dispensing fee tiers are based *on only Medicaid claims*, a state risks categorizing a high volume pharmacy inappropriately, if it has a low volume of Medicaid claims.

c. Usual and Customary Policies

States are reviewing their usual and customary policies. In compliance with federal regulations, state reimbursement policies mandate that pharmacies pass their usual and customary charges onto the Medicaid program. Medicaid pharmacy administrators agreed that usual and customary policies and related most favored nations requirements (discussed above under the Dispensing Fees section) can be monitored only on a post-payment basis.

Usual and customary definitions vary from to state-to-state and these definitions are necessarily undergoing review with the advent of prescription drug discount clubs and deep discounts such as $4 generic prescriptions. To address issues relating to usual and customary charges, some officials expressed interest in the following definitions used by Connecticut and Michigan.

- *Connecticut*: Effective May 2010, pharmacies must bill Medicaid "the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount program." For purposes of this policy, "savings or discount program" means any program, club or buying group offered by a pharmacy provider to any member of the general public for the purpose of obtaining a lower charge for any good or service than the charge made to any member of the general public who does not participate in such program." Pharmacies are also required to refund any excess payments received for claims billed that do not properly reflect the lowest charge.
- *Michigan*: Usual and customary charge is defined as a pharmacy's charge to the general public. The sum of charges for both the product cost and dispensing fee must not exceed a pharmacy's usual and customary charge for the same or similar service. The usual and charge must reflect all advertised discounts, special promotions, or other programs initiated to reduce prices for product costs available to the general public or to a special population. If a pharmacy discounts prescriptions to an inclusive category of customers (e.g., over 60 years), the pharmacy must reflect this discount in its billings for Medicaid beneficiaries in the same category.

4. Medicaid Pharmacy Management

a. Generic Drugs

Background:

A contributing factor to recent slower growth in prescription drug spending is a trend toward greater use of generics. The U.S. generic dispensing rate rose to 71 percent in 2010, up from 67.5 percent in 2009 and 63 percent in 2008.[42] Estimates show that generic dispensing rates industry-wide could reach 80 percent of retail pharmacy prescriptions in just a few years as new generic entrants are introduced.[43]

Medicaid generic dispensing was 65 percent of all prescriptions in 2009 (Table 3). Nearly 80 percent of pharmacy spending is for brands (single source and multiple source innovator drugs), even though brands are about 30 percent of all prescriptions.[44]

Table 3: Distribution of Medicaid Spending by Drug Type, Calendar Year 2009[45]

Drug Type	Percentage of Total Prescriptions	Percentage of Total Spending	Average Prescription Cost (Before Rebate Adjustments)
Single Source Brand	23%	68%	$231.88
Multiple Source Innovator Brand	8%	11%	$108.75
Non Innovator (Generic)	65%	17%	$20.48
Unknown	4%	3%	$63.72
All Drugs	100%	100%	$78.21

Sources: *State Drug Utilization Data*, CMS, CY 2009, available at http://www.cms.gov/MedicaidDrugRebateProgram/SDUD/list.asp and *Drug Product Data* available at http://www.cms.gov/MedicaidDrugRebateProgram/09_DrugProdData.asp for drug type identifiers

Findings:

States are increasing generic utilization to achieve savings. Most states participating in the discussion have generic dispensing rates at or exceeding 80 percent of fee-for-service prescriptions. Medicaid generic dispensing rates at or higher than 80 percent exceeds industry projections for commercial insurers that were not expected to hit 80 percent generic dispensing rates until mid-2012.[46] One state reported 87 percent generic utilization, excluding prescriptions for mental health drugs. Two states with generic dispensing rates near three-quarters (72 percent and 77 percent) noted that their reimbursement policies incentivize use of the least expensive "net cost" products, whether brand or generic, considering offsets available from federal and state supplemental manufacturer rebates. For example, when a multiple source innovator brand is the least expensive after rebates, these states would require prior authorization on the equivalent generic products. One participant emphasized reverting back to a mandatory generic policy in these cases would result in a multi-million dollar loss for the state. Another Medicaid pharmacy administrator noted the brand-preferred "net cost" arrangements are generally implemented so that states continue to remain compliant with CMS Federal Upper Limit (FUL) requirements.

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[42] *2011 Drug Trend Report*, Medco, available at http://www.drugtrendreport.com/

[43] L Perry, *Pipeline 2011, Watch for a shift to specialties and continued growth in the generic market*, Drug Topics, January 15, 2011, available at http://drugtopics.modernmedicine.com/drugtopics/NEUR/Pipeline-2011/ArticleStandard/Article/detail/703237

[44] An appendix at the end of the Issue Brief defines brand and generic drugs.

[45] Amounts listed include spending on physician-administered drugs and pharmacy-dispensed drugs. Select data from 16 states were not included, because reporting quarters were either missing from the CMS state utilization database or reported data did not meet HMA validity tests.

[46] L. Perry, *Pipeline 2011, Watch for a shift to specialties & continued growth in the generic market*, Drug Topics, January 15, 2011, available at http://drugtopics.modernmedicine.com/drugtopics/NEUR/Pipeline-2011/ArticleStandard/Article/detail/703237

States use preferred drug lists to encourage generic utilization and Maximum Allowable Cost (MAC) rates to reimburse ingredient costs. States typically use preferred drug designations that consider net costs (after rebate adjustments) to encourage appropriate increased generic utilization. As generic use increases, it is important that states employ reimbursement approaches that take into account the competitive forces in the generic market. While federal regulations specify states cannot exceed Federal Upper Limits (FULs) in the aggregate, Medicaid pharmacy administrators agreed that no state should depend solely on the FULs for setting their rates for generic drugs – instead they should be establishing state Maximum Allowable Cost (MAC) rates. The update frequency and breadth of a state's MACs are equally as important and pharmacy administrators recommended updating MACs at least monthly, setting rates down to single-source generics, and basing MACs on pharmacy actual acquisition cost data. The need for ongoing MAC review is reinforced when prices change, for example, due to periodic changes in the availability of specific generic products.

b. Specialty Drugs

Background:

Specialty drugs are generally defined as high-cost injectable, infusion, oral, or inhaled therapies, delivered in non-hospital settings, which require closer supervision, monitoring, special handling, and patient education than conventional therapies. These drugs are often used to treat complex and chronic conditions, including cancer, chronic kidney failure, multiple sclerosis, organ transplants, and rheumatoid arthritis. One national pharmacy benefit manager (PBM) observed in 2010 only 1 percent of members utilized specialty drugs, but this small group accounted for large share of costs since each prescription averaged $2,080. For its Medicaid managed care plans, this PBM estimated specialty drugs were only 1.7 percent of prescriptions but represented about 14 percent of costs in 2010. Estimates show that 55 percent of the specialty drug costs are billed under the medical benefit across all payers. By 2014, industry analysts predict that specialty drugs (including both medical and pharmacy benefits) will comprise 40 percent of the U.S. overall drug spending industry-wide.[47] As a result, considerable attention is being focused on how to control this area of prescription drug spending.

Findings:

Numerous states have implemented specialty drug reimbursement policies aimed at more accurately reflecting pharmacies' drug acquisition costs. Included is setting Maximum Allowable Cost (MAC) rates on specialty drugs or implementing deeper AWP discounts on select specialty drugs, especially for anti-hemophilic factors. However, with the changing market, other approaches may be needed.

Linking specialty drug contracting and care coordination offers significant state savings. One participant noted "With the big tide of generics coming in the traditional market, the money is going to be in the specialty market….Every day I turn round and there's another $50,000 drug coming out. We need to get smarter about how we manage this market." One solution is to contract for specialty drugs using the model such as the one used now in Pennsylvania. (See text box below.) Pennsylvania obtained savings through a combination of payment negotiation, care coordination, and more effective clinical management. The program saved the state 21 percent on overall per member per month (pmpm) expenditures for beneficiaries using specialty drugs, including pmpm reductions of 16 percent on specialty drugs and 56 percent for inpatient hospital costs. States agreed that CMS should streamline the process for obtaining waiver approval for specialty pharmacy contracting. Partnering with a hemophilia thrombosis center to assure appropriate use of anti-hemophilic factors and assay management is one good course of action to reduce expenditures. One state took this approach and saved $150,000 per child, when the state began working for a 340B provider to provide the anti-hemophilic factors and a care coordination model that included outreach and education to local physicians and school nurses.

[47] *Express Scripts 2010 Drug Trend Report, a Market and Behavioral Analysis*, April 2011, available at http://www.express-scripts.com/research/studies/drugtrendreport/2010/dtrFinal.pdf

Contracting for Specialty Drugs and Care Coordination — Pennsylvania Medicaid Case Study

Pennsylvania received CMS approval to implement its Specialty Pharmacy Drug Program under waiver authority at Section 1915(b)(4) of the Social Security Act, that allows a state to require beneficiaries to obtain services from select providers. The state issued a Request for Proposals (RFP) and contracted with two specialty pharmacies to provide services for fee-for-service Medicaid beneficiaries residing in 42 counties across the state where ACCESS Plus primary care case management is operational.

The two vendors provide specialty drugs and related supplies to beneficiaries at physician offices, clinics, treatment centers, or their homes. The vendors also offer beneficiary training on product administration and storage, arrange for nursing services when prescribers determine a specialty drug must be administered by a nurse, staff a 24/7 call center to respond to beneficiary questions, and provide care management services. Twice a year the state negotiates vendor rates on a drug-by-drug basis. Interestingly, there is no additional reimbursement made for dispensing fees or the care management services. Other key features of the program include the following:

- *Case Managers:* Dedicated nurse case managers work hand-in-hand with the specialty pharmacists. For example, the nurse case managers evaluate beneficiaries with multiple sclerosis and if symptoms of depression are assessed, the nurse case manager links identified individuals with behavioral health providers.
- *Included Specialty Drugs*: The current list of specialty products is available at http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/thespecialtypharmacydrugprogram/index.htm. Included classes relate to blood cell deficiency, oncology, chronic renal failure, endocrine disorders, enzyme deficiencies, growth deficiencies, hemophilia, hepatitis B and C, immune deficiencies, inflammatory conditions, iron toxicity, macular degeneration, multiple sclerosis, osteoarthritis, osteoporosis, Parkinson's, pulmonary hypertension, RSV prevention, and other miscellaneous products.
- *Provider-Administration Rates*: The state continues to pay providers for administering specialty drugs in offices, clinics, or other settings.
- *Non-Specialty Drugs*: Beneficiaries served by the program are allowed to obtain non-specialty drugs from any Medicaid participating pharmacy.
- *Prior Authorization*: Even though specialty drugs are available under contract, the state still retains authority to require that prescribers obtain prior authorization on any included product.
- *The Program Excludes Beneficiaries with Other Third Party Coverage*: Beneficiaries with other third party insurance coverage, including Medicare Parts B and D, are excluded from the program, unless these insurers do not cover a prescribed specialty drug.
- *Copayment Exemption for Specialty Drugs*: For beneficiaries, as an added benefit, specialty drugs are *exempt* from Medicaid copayment requirements.

State Evaluation Findings: The program saved the state 21 percent on overall per member per month (pmpm) expenditures for beneficiaries using specialty drugs, including savings of 16 percent on specialty drugs and 56 percent for inpatient hospital costs.

States may need additional authority to negotiate rebates with specialty drug manufacturers. States often use a preferred drug list approach and supplemental rebates to lower costs on traditional prescriptions when there are multiple alternatives in the same therapeutic class. This strategy is not possible for most specialty drugs that do not have generic or clinical competitors. One pharmacy administrator suggested that as the number of expensive specialty and orphan drugs[48] increases in the next 10 years, states may need additional authority to negotiate rebates directly with manufacturers or "have the power to say yes this drug has benefits — but it is not cost effective and the state cannot cover it without additional price concessions from the manufacturer. The way the Social Security Act is written right now, if the manufacturer signs a rebate agreement, states must cover its drug

[48] The Food and Drug Administration (FDA) facilitates the development of orphan drugs to treat rare diseases by offering research grants to manufacturers. The agency defines disease as "rare" when it occurs in less than 200,000 individuals in the United States.

products and pay what the manufacturer is asking. That might have to change in the long run or specialty drug expenditures might be more the system can bear."

States are focusing on mental health drugs and appropriate prescribing. State officials emphasized their focus on this sector is motivated not only by the high costs of mental health drugs, but more importantly by clinical concerns about over-prescribing, particularly for children. Often a state's efforts focus predominately on children receiving inappropriately high doses of mental health drugs. Another state official indicated they review high-cost mental health drugs when they are newly prescribed.

States are seeking additional options to better manage the pharmacy benefit. Several states indicated they are re-tooling pharmacy claims processing systems in a way that integrates paid medical claims with pharmacy claims to allow more sophisticated review and automated prior authorization, and that assures third party coverages are used when they are primary to Medicaid.

C. Other Pharmacy Management Issues

Some states are considering carving prescription drugs into managed care plans due to the change in the ACA to access rebates. The Affordable Care Act of 2010 allowed states to collect federal Medicaid rebates on drugs reimbursed under capitation arrangements starting March 2010. Previous Medicaid law prohibited rebate collection for this sector. To obtain rebate revenue, a number of states chose to exclude (or carve-out) prescription drugs from their managed care organization (MCO) contracts and provide reimbursement under their fee-for-service program.[49]

Given the change in the Affordable Care Act, two of the participating Medicaid pharmacy administrators indicated their states are proposing to reverse pharmacy carve-out policies and pay for all (or most) drugs within the MCO capitation rates. In one case, the proposal under consideration would mandate that MCOs use the state's fee-for-service formulary and preferred drug list instead of customized coverage developed by individual plans. The goal is "to reduce the potential risk of provider confusion from having to be knowledgeable about several Medicaid formularies in one service area, to maintain beneficiary continuity of care, and to ensure minimal impact on manufacturer drug rebate revenue." Another official confirmed that, with CMS approval of a State Plan amendment, his state is obtaining manufacturer agreements to pay state supplemental rebates on MCO prescriptions above the federal rebate levels. These rebates are being provided regardless of individual MCO preferred drug designations. Other officials noted a potential issue that MCOs do not have an incentive to maximize federal and state supplemental rebates, although this fiscal concern may be offset by the opportunity to better coordinate pharmacy services with other care provided through the MCOs.

One state in our study is considering a statewide preferred drug list. Most states have implemented a preferred drug list of covered drugs. States use pharmaceutical and therapeutics (P&T) committees to make recommendations on the preferred and non-preferred status of drug products. This approach is designed to encourage physicians to prescribe products that are safe and clinically effective but yet cost-effective. Products identified as "non-preferred" are typically available only with prior authorization and a prescriber's justification of medical necessity. One state pharmacy administrator indicated that a proposal was being considered in the legislature to replace the current Medicaid Drug Utilization Review Board with a new Pharmacy and Therapeutics Committee that would have primary responsibility to create a statewide preferred drug list. This new preferred drug list, as proposed, may potentially be used for public employees, university employees, teachers, and law enforcement along with Medicaid beneficiaries. This approach was mentioned as a possible strategy that would benefit Medicaid and other payers, providers and beneficiaries.

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[49] Effective Oct 2011, 11 states fully carved drugs out of managed care and 9 states had partial carve-outs. Full Carve-Out States: CT, DE, IL, IN, MO, NE, TN, TX, UT, WV, WI (11 states). Partial Carve-Out States: CA, FL, KS, MD, MI, NJ, NY, OR, and WA (9 states). NY and OH moved from a full carve-out to a carve-in effective October 2011. NY is keeping clotting factor products as a Medicaid fee-for-service benefit for a limited period of time. Also, TX is implementing a "carve-in" planned for March 2012.

Some states are considering beneficiary prescription caps. Another policy being considered involves limiting the number of prescriptions that Medicaid will pay for. Beneficiary prescription caps limit the number of prescriptions allowed for a beneficiary during a month or year. Pharmacy administrators observed that in calculation of potential savings, it was important to account for the fact that caps encourage pharmacies to dispense the most expensive drugs first, although this incentive can be diminished by including brand limits within the cap. For example, one state allows six prescriptions per beneficiary in a month, but now only two of the six can be for brands. Before January 2010, that policy had allowed three brands. Projections for the fiscal year when the change was made showed that per member per month pharmacy spending was "going down a little" compared to the previous year. Overall spending was expected to decrease about 7 percent, although the number of prescriptions increased.

States using prescription caps often offset negative impacts on beneficiaries by exempting select drug classes or beneficiary groups from the limit or by using prior authorization of additional prescriptions above the limits. Another approach to limit the impact on beneficiaries is to allow payment for greater than a one month supply on a prescription, so that savings accrue predominately from reduced dispensing fees paid to pharmacies and not from limiting beneficiary access to prescription drugs. Savings can accrue even with a risk of paying for drugs that may be used at a future time when the beneficiary may have lost eligibility for Medicaid. One participant indicated that his state policies have allowed a 102-day supply on maintenance prescriptions for some time and believed this approach is more cost-effective than mandating a one month supply. Another state that is considering a prescription cap, is proposing to pay pharmacies a share of the savings to encourage dispensing prescriptions with 90-day supply. Other pharmacy administrators indicated this approach may not be desirable for states with transient fee-for-service enrollment, e.g., a month or two of fee-for-service coverage before transitioning to a Medicaid managed care organization.

States are facing many other issues managing the pharmacy benefit. Medicaid pharmacy administrators identified other priority issues that they are confronting or considering in their states, including the following:

- 340B drug requirements and state shared saving models with 340B providers;
- Best practices for pricing generics through Maximum Allowable Cost (MAC) programs;
- Automation strategies for prior authorization and other claims processing innovations;
- Management of provider-administered drugs; and
- Medicaid pharmacy in an Accountable Care Organization (ACO) model.

5. Medicaid Pharmacy Cost Sharing

Background:

Eleven states (Arizona, Connecticut, Florida, Hawaii, Idaho, Nevada, New Jersey, New Mexico, Rhode Island, Texas, and Washington) had no beneficiary cost sharing for pharmacy services in March 2011 (Appendix E). The other 39 states and the District of Columbia required beneficiary copayments or coinsurance payments. Federal regulations limit the amount of cost sharing that can be charged to beneficiaries. Federal law prohibits states from imposing cost sharing on children, pregnant women, and institutionalized beneficiaries; family planning services; hospice services; emergencies; and for Native Americans served by an Indian healthcare provider (Appendix F).[50] States, under federal law amended by the Deficit Reduction Act (DRA), may choose whether a provider may deny a Medicaid service when a beneficiary is unable to pay cost sharing amounts.

[50] Sections 1916(e) and 1916A(d)(2) of the Social Security Act and 42 CFR §447.53

Standard Nominal Model: Cost sharing for states choosing the standard nominal model cannot exceed the amounts established by CMS (current amounts are listed in Table 4) or a coinsurance rate above 5 percent of a state's payment for the prescription.[51] After passage of the DRA, CMS may increase the nominal amounts annually, based on increases in the medical component of Consumer Price Index-Urban. States have flexibility to apply a flat nominal amount across all prescriptions or tiered copayments based on whether a prescription is brand or generic, or preferred or non-preferred.

As of March 2011, two states (Oklahoma and South Carolina) had adopted copayments using the higher post-DRA nominal amounts (Table 4). One state (Montana) had implemented a coinsurance approach. Montana uses a 5 percent coinsurance with a $1 minimum and $5 maximum cost sharing. Eight states (Alabama, Arkansas, Delaware, Georgia, Missouri, Louisiana, Vermont, and West Virginia) had variable cost sharing based on a prescription's cost. Other states have opted for tiered copayments using brand/generic or preferred /non-preferred drug structures.

Seven states also set caps on a beneficiary's cost sharing liability. Included are monthly limits of $12 in Wisconsin, $15 in Delaware and Vermont, $25 in Montana, and $30 in Maine and yearly limits of $200 in Massachusetts and New York. Typically, these caps are based only on pharmacy copayments, but New York applies its cap across healthcare services, e.g., pharmacy, clinic visits, laboratory tests, radiographs, medical supplies, etc.

Table 4: Medicaid Fee-For-Service Nominal Copayment Amounts

State Payment for the Service	Maximum Nominal Copayment Amounts	
	Pre-DRA	Post-DRA for FFY 2011
$10 or less	$0.50	$0.65
$10.01 to $25	$1.00	$1.25
$25.01 to $50	$2.00	$2.45
$50.01 or more	$3.00	$3.65

Deficit Reduction Act of 2005 (DRA) Alternative Model: The DRA alternative cost sharing model allows states to impose *up to a 20 percent coinsurance* on select Medicaid services. However, there is a prohibition of imposing the coinsurance on many health services and on select Medicaid beneficiaries based on an individual's family income as a percentage of the Federal Poverty Level (FPL). Requirements of this model are significantly more complex than nominal cost sharing (Appendix G provides details). Noteworthy for pharmacy services is that the 20 percent coinsurance is limited to only non-preferred drugs – unless the prescriber determines the preferred drug would be less effective or would have adverse effects for a beneficiary. Only one state (Kentucky) has implemented components of this model using a 5 percent cost sharing on non-preferred drugs up to $20.

Findings:

Incentivizing generic utilization with copayment differentials has been successful for some states; others have used preferred drug list approaches to increase generics. One pharmacy administrator described implementing brand-generic differentials on both beneficiary copayments and dispensing fees. Almost immediately after implementation, the state's generic dispensing rate increased 5 percent. Of course, as another participant indicated, implementation of the copayment differential occurred at the same time that more generics were becoming available on the market, and generic rates were increasing for all payers. Other state pharmacy administrators indicated that in their experience using their preferred drug lists was the most effective tool to increase generics.

[51] 42 CFR §447.54, updated by HMA correspondence with CMS staff

The DRA alternative cost sharing model is extremely complex to implement. Across participating Medicaid pharmacy administrators there was general agreement that the DRA alternative cost sharing model for non-preferred drugs would be extremely complex for states to implement for a number of reasons. First, the provisions require different cost sharing amounts based on family incomes; information on family income is usually not available within the pharmacy claims processing system. Next, states are prohibited from imposing the higher and allowable cost sharing on non-preferred drugs, when a prescriber justifies the non-preferred drug as medically necessary. This would be the case for nearly all non-preferred drugs, since states normally cover these products only with prior authorization and justification of medical necessity. One participant summarized that the DRA non-preferred drug cost sharing allowance was pointless, because of this exception process. Another respondent said, "A system like ours couldn't even come close to handling all the requirements that the feds have on it. It would be extremely complex collecting the income for each family. It's not even potentially possible that we could do it without some serious upgrades to eligibility and claims systems."

Most states have "not" adopted the Deficit Reduction Act provision that allows providers to deny a Medicaid service because of a beneficiary's inability to pay a copayment. Most state policies stipulate beneficiaries may receive prescriptions even if they are unable to pay copayments, pursuant to federal regulation. Even in these states, providers may have the flexibility to deny a beneficiary's service when a continued pattern of non-payment occurs. Only a few states have adopted a policy of "enforceable copays," meaning that a provider is authorized to deny a service, including the dispensing of a prescription, if the beneficiary is unable to pay the copayment amount.

Provider complaints about beneficiaries not paying copayments vary by state. Most Medicaid pharmacy administrators mentioned rarely hearing about provider problems collecting copayments. In fact, one participant related that a major national pharmacy chain had reported that it was collecting Medicaid copayments 90 percent of the time in his state. Interestingly, a 2001 survey of 543 community pharmacies in Maryland, Pennsylvania, and West Virginia also found that beneficiaries paid Medicaid pharmacy copayments over 90 percent of the times a copayment was required.[52] On the other hand, as might be expected even if one beneficiary failed to pay a copayment, another pharmacy administrator reported that some providers had complained about collecting copayments, since not collecting a copayment is equivalent to accepting a lower rate of payment.

Increasing copayments can negatively impact prescription drug utilization. Medicaid pharmacy administrators were aware of Oregon State University research that showed copayment increases *reduce* prescription drug utilization. In January 1, 2003, Oregon Medicaid changed its copayments to $2 (generics) and $3 (brands) but exempting HIV/AIDS drugs, oncology, and mail order prescriptions along with other federally-required exemptions. Also, the state applied $3 copayments at the same time on outpatient services, including office visits, home visits, outpatient hospital services, outpatient surgery, outpatient treatment of chemical dependency, outpatient treatment for mental health, occupational and physical therapy, speech therapy, restorative dental work, and vision examinations. Analysis showed the copayment policy was associated with a 17 percent reduction in overall prescription drugs use (measured on a per member per month basis), without significant changes in office visits, emergency department visits, or hospitalizations. Generic utilization increased from 52 percent to 59 percent of all prescriptions. A reduction in utilization was observed in all studied drug classes.[53]

As a matter of consistency and simplicity, Medicaid pharmacy administrators saw the value of aligning Medicaid copayment policies with Medicare since the implementation of Medicare Part D in 2006. Medicare/Medicaid dual

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[52] C Fahlman, B Stuart, and C Zacker, Community Pharmacist Knowledge and Behavior in Collecting Drug Copayments from Medicaid Recipients, America Journal of Health-System Pharmacy, February 15, 2001, available at http://www.ajhp.org/content/58/5/389.short

[53] Dan Hartung, Pharm.D, *Impact of a Prescription Drug Copayment policy on Prescription Drug and Health Services Utilization in an Oregon Medicaid Populatio*n, June 30, 2006, available at www.oregon.gov/OHA/OHPR/OHREC/Docs/ohrecpresent061306.pdf
Oregon Health Plan Drug Copay Analysis: Executive Summary, Oregon State University, available at http://pharmacy.oregonstate.edu/drug_policy/pages/dur_board/evaluations/articles/Copay_Analysis.pdf

eligible individuals now have Medicare Part D prescription drug coverage and pay copayments currently set at $1.10 (generics) and $3.30 (brands) in 2011.[54]

6. Conclusion

Medicaid is a large and important purchaser of prescription drugs and its coverage and reimbursement policies are influential in the marketplace. Driven by ongoing budget constraints, states are designing and implementing new initiatives for generating pharmacy savings. Many strategies used by states were included among the recommendations offered by Secretary Sebelius in her February 2011 letter to Governors.

The most significant recent change in Medicaid pharmacy reimbursement relates to pricing for ingredient costs using an Average Acquisition Cost (AAC) model. To date, the AAC model is currently operational in two states (Alabama and Oregon.) CMS also is developing a survey of retail prices and a new database of National Average Drug Acquisition Cost (NADAC) data that will be derived from procurement of information supplied by pharmacies across the nation. The database is scheduled to be released late 2011. States are awaiting the opportunity to evaluate the sampling methodology that CMS will use to build the database and to compare resulting acquisition cost data to their current pricing benchmarks for ingredient costs.

When changes are contemplated to the Medicaid pharmacy program, each state assesses a proposed change in light of a state's unique fiscal climate and the dynamics of its current policies and procedures, pharmacy network, and needs of beneficiaries. States that already have lower reimbursement rates for ingredient costs and that have high generic dispensing rates are examining strategies to manage the benefit more effectively to obtain additional savings. Strategies being considered include the following:

- Obtaining a CMS waiver to contract with select specialty drug vendors, who may also provide care coordination services for beneficiaries receiving specialty drugs;
- Aligning state dispensing fees with commercial payers, Medicaid MCOs, and Medicare Advantage plans;
- Better managing utilization of mental health drugs, particularly for children and for new starts of high cost mental health drugs;
- Re-tooling pharmacy claims processing systems by integrating paid medical claims to allow more sophisticated data analysis and automated prior authorization processing; and
- Re-evaluating policies and procedures to assure resources available from other third-party coverage are used before Medicaid.

Lastly, state Medicaid pharmacy administrators were supportive of CMS efforts to foster sharing of data and best practices and to support dialogue with states to help advance pharmacy savings and beneficiary access to needed prescription drugs.

[54] Higher Medicare Part D copayments, currently set at $2.50 (generics) and $6.30 (brands) in 2011, apply for dual eligibles with incomes over 100 percent of the Federal Poverty Limit. Dual eligibles residing in long-term care facilities have no Part D copayments.

Appendix A – Medicaid Pharmacy Spending, Federal Fiscal Year 2009

States	Rx Drug Spending	Manufacturer Drug Rebate Revenue Federal		State Supplemental		Total Rebates		Net Spending
Alabama*	$471,046,450	-$142,571,821	-30%	-$13,078,315	-3%	-$155,650,136	-33%	$315,396,314
Alaska	$76,114,625	-$28,566,225	-38%	$0	0%	-$28,566,225	-38%	$47,548,400
Arizona	$6,928,441	$0	0%	$0	0%	$0	0%	$6,928,441
Arkansas	$309,712,354	-$113,489,328	-37%	$0	0%	-$113,489,328	-37%	$196,223,026
California	$3,125,813,464	-$1,134,674,493	-36%	-$298,333,558	-10%	-$1,433,008,051	-46%	$1,692,805,413
Colorado	$238,732,148	-$78,731,783	-33%	$0	0%	-$78,731,783	-33%	$160,000,365
Connecticut	$451,323,473	-$133,766,763	-30%	-$13,768,888	-3%	-$147,535,651	-33%	$303,787,822
Delaware	$120,837,228	-$53,022,444	-44%	$0	0%	-$53,022,444	-44%	$67,814,784
Dist of Columbia	$89,298,404	-$22,474,607	-25%	-$3,007,011	-3%	-$25,481,618	-29%	$63,816,786
Florida	$1,066,195,847	-$443,812,303	-42%	-$78,903,110	-7%	-$522,715,413	-49%	$543,480,434
Georgia	$490,900,032	-$202,317,758	-41%	-$5,022,612	-1%	-$207,340,370	-42%	$283,559,662
Hawaii	$27,206,978	-$12,140,012	-45%	-$1,472,194	-5%	-$13,612,206	-50%	$13,594,772
Idaho	$110,206,538	-$40,359,116	-37%	-$4,537,052	-4%	-$44,896,168	-41%	$65,310,370
Illinois	$1,082,312,561	-$310,807,340	-29%	-$62,087,016	-6%	-$372,894,356	-34%	$709,418,205
Indiana	$307,132,045	-$134,684,509	-44%	-$7,281,317	-2%	-$141,965,826	-46%	$165,166,219
Iowa	$249,328,608	-$100,207,940	-40%	-$15,009,298	-6%	-$115,217,238	-46%	$134,111,370
Kansas	$163,526,455	-$55,694,381	-34%	-$4,500,150	-3%	-$60,194,531	-37%	$103,331,924
Kentucky	$547,477,058	-$176,010,312	-32%	-$25,759,634	-5%	-$201,769,946	-37%	$345,707,112
Louisiana	$933,256,824	-$233,682,328	-25%	-$41,186,955	-4%	-$274,869,283	-29%	$658,387,541
Maine	$200,355,133	-$88,041,440	-44%	-$13,204,867	-7%	-$101,246,307	-51%	$99,108,826
Maryland	$279,334,190	-$97,235,874	-35%	$0	0%	-$97,235,874	-35%	$182,098,316
Massachusetts	$473,013,677	-$97,348,031	-21%	-$39,166,403	-8%	-$136,514,434	-29%	$336,499,243
Michigan	$481,575,402	-$205,958,538	-43%	-$11,028,103	-2%	-$216,986,641	-45%	$264,588,761
Minnesota	$247,745,878	-$97,233,997	-39%	-$9,841,944	-4%	-$107,075,941	-43%	$140,669,937
Mississippi	$336,490,651	-$97,561,491	-29%	-$14,484,830	-4%	-$112,046,321	-33%	$224,444,330
Missouri	$686,621,041	-$223,365,157	-33%	$0	0%	-$223,365,157	-33%	$463,255,884
Montana	$66,066,107	-$23,142,117	-35%	$0	0%	-$23,142,117	-35%	$42,923,990
Nebraska	$149,570,610	-$57,987,493	-39%	$0	0%	-$57,987,493	-39%	$91,583,117
Nevada	$95,631,331	-$36,554,720	-38%	-$2,094,127	-2%	-$38,648,847	-40%	$56,982,484
New Hampshire	$84,891,769	-$31,454,676	-37%	-$3,055,148	-4%	-$34,509,824	-41%	$50,381,945
New Jersey	$575,841,194	-$170,268,896	-30%	$0	0%	-$170,268,896	-30%	$405,572,298
New Mexico	$27,613,747	-$3,939,062	-14%	$0	0%	-$3,939,062	-14%	$23,674,685
New York	$4,136,679,115	-$1,300,976,364	-31%	-$161,588,242	-4%	-$1,462,564,606	-35%	$2,674,114,509
North Carolina	$1,114,610,687	-$361,104,541	-32%	$0	0%	-$361,104,541	-32%	$753,506,146
North Dakota	$31,215,301	-$12,072,043	-39%	$0	0%	-$12,072,043	-39%	$19,143,258
Ohio	$536,687,097	-$207,949,737	-39%	-$24,007,946	-4%	-$231,957,683	-43%	$304,729,414
Oklahoma	$383,544,463	-$101,456,581	-26%	$0	0%	-$101,456,581	-26%	$282,087,882
Oregon	$150,290,579	-$38,230,448	-25%	$0	0%	-$38,230,448	-25%	$112,060,131
Pennsylvania	$422,982,587	-$169,416,182	-40%	-$13,642,728	-3%	-$183,058,910	-43%	$239,923,677
Rhode Island	$37,382,011	-$21,599,855	-58%	$0	0%	-$21,599,855	-58%	$15,782,156
South Carolina	$290,678,098	-$143,620,865	-49%	$0	0%	-$143,620,865	-49%	$147,057,233
South Dakota	$48,462,762	-$21,313,811	-44%	$0	0%	-$21,313,811	-44%	$27,148,951
Tennessee	$714,863,457	-$246,171,418	-34%	-$36,968,406	-5%	-$283,139,824	-40%	$431,723,633
Texas	$2,133,122,165	-$793,354,143	-37%	$0	0%	-$793,354,143	-37%	$1,339,768,022
Utah	$145,751,014	-$54,519,244	-37%	$0	0%	-$54,519,244	-37%	$91,231,770
Vermont	$3,030,359	-$937,621	-31%	-$164,848	-5%	-$1,102,469	-36%	$1,927,890
Virginia	$231,877,055	-$92,273,414	-40%	-$4,476,231	-2%	-$96,749,645	-42%	$135,127,410
Washington	$421,153,309	-$154,181,470	-37%	-$7,377,984	-2%	-$161,559,454	-38%	$259,593,855
West Virginia	$341,224,331	-$137,976,939	-40%	-$31,845,522	-9%	-$169,822,461	-50%	$171,401,870
Wisconsin	$616,111,128	-$257,665,622	-42%	-$885,181	0%	-$258,550,803	-42%	$357,560,325
Wyoming	$39,891,767	-$11,787,208	-30%	$0	0%	-$11,787,208	-30%	$28,104,559
United States	**$25,371,657,548**	**-$8,773,712,461**	**-35%**	**-$947,779,620**	**-4%**	**-$9,721,492,081**	**-38%**	**$15,650,165,467**

SOURCE/NOTES: Financial Management Report, CMS-64 Quarterly Expense Report, Federal Fiscal Year 2009 (Oct 1 through Sep 30), January 26, 2011, available at http://www.cms.gov/MedicaidBudgetExpendSystem/02_CMS64.asp. All figures represent both federal and state funding. With the exception of Alabama, all states figures have been finalized by CMS staff. Rebate revenue includes rebates for physician-administered drugs; however, for some states the corresponding physician-administered drug expenditures may not necessarily be reported under Rx Drug Spending.

Appendix B – Medicaid Estimated Acquisition Cost (EAC) Benchmarks, Dispensing Fees, and Cost Sharing

State	EAC Benchmark	Dispensing Fee	Cost Sharing
AL	Average Acquisition Cost (AAC), if not available WAC+9.2%	$10.64	$.50 to $3
AK	WAC+8% (in-state); WAC+1% (out-state)	$12.12-$26.74; $3.45(out-state)	$2
AZ	AWP-15% **	$2.00	$0
AR	AWP-14% (brand); AWP -20% (generic)	$5.51	$.50 to $3*
CA	AWP-17%	$7.25 (retail); $8.00 (LTC)	$1
CO	AWP-14.5%/Direct +18% (brand); AWP-12%(rural); AWP-45% (generic)*	$4.00 (retail); $1.89 (LTC)	$1/$3*
CT	AWP-14% (brand); AWP-50% (generic)	$2.90	$0
DE	AWP-14.5% (retail); AWP-18% (LTC)	$3.65	$.50 to $3 *
DC	AWP-10%	$4.50	$1
FL	AWP-15.4; WAC+5.75%	$4.23 (retail); $7.50 (340B)	$0
GA	AWP-11%	$4.63 (retail); $4.33 (non-profit)	$.50 to $3*
HI	AWP-10.5%	$4.67	$0
ID	AWP-12%	$4.94	$0
IL	AWP-12% (brand); AWP-25% (generic)	$3.40 (brand); $4.60 (generic)	$3*
IN	AWP-16%(brand); AWP-20% (generic)	$4.90	$3
IA	AWP-12%; AWP-17% (specialty)	$4.34	$1/$2/$3*
KA	AWP-13% (brand); AWP-27% (generic); AWP-30% (antihemophilia)	$3.40	$3
KY	AWP-15% (brand); AWP-14% (generic)	$4.50 (brand)/$5.00 (generic)	$1/$2/5%*
LA	AWP-13.5% (independents); AWP-15% (chains)	$5.77	$.50 to $3
ME	AWP-15% (brand); AWP-13% (generic); AWP-17% (specialty); mail*	$3.35 (retail); $1.00 (mail)*	$3; $0 for mail*
MD	AWP-12%; WAC+8%; Direct+8%	$2.69 to $3.69*	$1/$3*
MA	WAC+5%	$3.00; $10.00 (340B)	$1/$3*
MI	AWP-13.5%/WAC+3.8% (independent);AWP-15.1%/WAC+1.88% (chain)	$2.50 (retail);$2.75 (LTC)	$1/$3*
MN	AWP-15%; AWP-30% (antihemophilia); AWP-15.5% to 17% (specialty)	$3.65	$1/$3*
MS	AWP-12%/WAC+9% (brand); AWP-25% (generic)	$3.91 (brand); $5.50 (generic)	$3
MO	AWP-10.43%; WAC+10%	$8.91 (brand); $12.91 (generic)*	$.50 to $2*
MT	AWP-15%	$5.04; $3.50 (out-of-state)	5% ($1 min./$5 max.)*
NE	AWP-11%	$3.27 to $5.00*	$2
NV	AWP-15%	$4.76	$0
NH	AWP-16%; WAC+0.8%	$1.75	$1/$2*
NJ	AWP-17.5%	$3.73 to $3.99*	$0
NM	AWP-14%; manufacturer submitted pricing, as available	$2.50; $3.65 (select generics)*	$0
NY	AWP-16.25% (brand); AWP-12% (HIV/AIDS drugs); AWP-25% (generic)	$3.50/$4.50*	$.50/$1/$3*
NC	WAC+7%, if WAC not available AWP-14.5%	$4.00 (brand); $5.60 (generic)	$3
ND	AWP-10%; WAC+8%	$4.60 (brand); $5.60 (generic)	$0 /$3*
OH	WAC+7%, if WAC not available AWP-14.4%	$1.80	$2.00/$3*
OK	AWP-12%	$4.02	$0 to $3.50*
OR	Average Acquisition Cost (AAC), if not available WAC with no markup**	$9.68 to $14.01*	$0/$1/$3*
PA	AWP-14%/WAC+7% (brand); AWP-25%/WAC+66% (generic)	$4.00	$1/$3*
RI	WAC with no markup	$3.40; $2.85 (LTC)	$0
SC	AWP-10%	$4.05	$3.40 (Apr 2011)
SD	AWP-13%	$4.75	$3
TN	AWP-13%; AWP-16% (national PBM Network and specialty)	$1.50 to $6.00*	$0/$3*
TX	AWP-15%; WAC+12%: manufacturer submitted pricing, as available	$7.35+1.96% of drug up to $200*	$0
UT	AWP-17.4%	$3.90 (urban); $4.40 (rural)*	$3*
VT	AWP-14.2%	$4.75; $2.50 (out-of-state)	$1 to $3*
VA	AWP-10.25%; AWP-25% (antihemophilia); WAC+4.75 (specialty)	$3.75	$1/$3*
WA	AWP-16% (brand); AWP-16%/AWP-50% (generic)	$4.24 to $5.25*	$0
WV	AWP-15% (brand); AWP-30% (generic)	$2.50 (brand); $5.30 (generic); $8.25 (340B)	$.50 to $3*
WI	AWP-14%	$3.44 (brand); $3.94 (generic)	$.50/$1/$3*
WY	AWP-11%	$5.00	$1/$3*

* Additional detail on the state's policies is available in other appendices.

** Arizona and Oregon are the only states that have not implemented State Maximum Allowable Cost (MAC) programs for generic drugs.

SOURCES/NOTES: *Medicaid Prescription Reimbursement Information by State – Quarter Ending March 2011*, available at http://www.cms.gov/Reimbursement updated by information from individual state websites reviewed by HMA during March 2011. Listed information is a snapshot and may not represent current state policies. Reporting excludes supplies, 340B drug costs, compounded drugs, infusion therapy, physician-administered injectables, and pharmacy-administered vaccines. AWP means Average Wholesale Price; WAC means Wholesale Acquisition Cost Direct means Manufacturer Direct Price; and AAC means Average Acquisition Cost. LTC means long-term care or institutional. Antihemophilia means anti-clotting factors used for hemophilia. Specialty means specialty drugs.

Appendix C – Medicaid Estimated Acquisition Cost (EAC) Benchmarks for "Brand" Drugs, March 2011

State	AWP	WAC	Direct	AAC	State MAC	Comments
AL		+9.2%		Yes	Yes	
AK		+8%/+1%			Yes	8% for in-state pharmacies; 1% for out-of-state pharmacies
AZ	-15%				No	
AR	-14%				Yes	
CA	-17%				Yes	
CO	-12% /-14.5%		+18%		Yes	AWP-12% for approved rural pharmacies; AWP-14.5% for others
CT	-14%				Yes	
DE	-14.5% /-18%				Yes	AWP-14.5% for retail; AWP-18% for long-term care and specialty pharmacies
DC	-10%				Yes	
FL	-15.4%	+5.75%			Yes	
GA	-11%				Yes	
HI	-10.5%				Yes	
ID	-12%				Yes	
IL	-12%				Yes	
IN	-16%				Yes	
IA	-12% /-17%				Yes	AWP-17% for specialty drugs; AWP-12% for other brands
KA	-13%				Yes	Lower of state contract price of AWP-30% (antihemophilic factors)
KY	-15%				Yes	
LA	-13.5%/-15%				Yes	AWP-13.5% for independents; AWP-15% for chains
ME	-15% -17% -20%				Yes	For retail pharmacies For specialty pharmacies For mail order pharmacies
MD	-12%	+8%	+8%		Yes	
MA		+5%			Yes	
MI	-13.5% -15.1%	+1.88% +3.80%			Yes	For independents with 4 or fewer stores For chains with 5 or more stores
MN	-15%				Yes	AWP-30% for anti-hemophilic factors AWP-15.5% to 17% for other specialty drugs
MS	-12%	+9%			Yes	
MO	-10.43%	+10%			Yes	
MT	-15%				Yes	
NE	-11%				Yes	
NV	-15%				Yes	
NH	-16%	+0.8%			Yes	
NJ	-17.5%				Yes	
NM	-14%				Yes	Also, uses audited Rx invoices, wholesaler average cost available under state law, widely available mark prices as published by the General Accounting Office
NY	-16.25%				Yes	AWP-12% for specialized HIV pharmacies
NC	-14.5%	+7%			Yes	
ND	-10%	+8%			Yes	
OH	-14.4%	+7%			Yes	
OK	-12%				Yes	
OR		0%		Yes	No	No markup on WAC
PA	-14%	+7%			Yes	
RI		0%			Yes	No markup on WAC
SC	-10%				Yes	
SD	-13%				Yes	
TN	-13% -16%				Yes	For state's network For specialty pharmacies and national PBM network
TX	-15%	+12%			Yes	Uses Net Wholesaler Cost which is similar to WAC but not identical For select drugs, uses direct price & other pricing collected from manufacturers
UT	-17.4%				Yes	
VT	-14.2%				Yes	
VA	-10.25%				Yes	AWP-25% for antihemophilia factors; WAC+4.75% for other specialty drugs
WA	-16%				Yes	
WV	-15%				Yes	
WI	-14%				Yes	
WY	-11%				Yes	

SOURCES/NOTES: *Medicaid Prescription Reimbursement Information by State – Quarter Ending March 2011*, available at http://www.cms.gov/Reimbursement updated by information from individual state websites reviewed by HMA during March 2011. Listed information is a snapshot and may not represent current state policies. Reporting excludes generic pricing, supplies, 340B drugs, physician-administered injectables, and pharmacy-administered vaccines. AWP means Average Wholesale Price; WAC means Wholesale Acquisition Cost; Direct means Manufacturer Direct Price; and AAC means Average Acquisition Cost.

Appendix D – Medicaid Pharmacy Dispensing Fees, March 2011

State	Standard	Institutional	Tiered Fee by: Brand	Tiered Fee by: Generic	Other Fees and Comments
AL	$10.64				
AK	$3.50 $12.12- $26.74				$3.50 (out-of-state) Based on a pharmacy's volume using a 3-tiered system
AZ	$2.00				
AR	$5.51*			*	$2 extra dispensing fee paid on generics not limited by a MAC or FUL
CA	$7.25	$8.00			$8.00 for residents in skilled nursing or intermediate care facilities
CO	$4.00	$1.89			$1.89 for institutional "pharmacies;" $4 for mail order pharmacies
CT	$2.90				
DE	$3.65				
DC	$4.50				
FL	$4.23				$7.50 (340B drugs)
GA	$4.63				$4.33 (not-for-profit pharmacies)
HI	$4.67				
ID	$4.94				
IL			$3.40	$4.60	
IN	$4.90				
IA	$4.34				
KA	$3.40				
KY			$4.50	$5.00	
LA	$5.77				
ME	$3.35				$1 for mail order; also applies quarterly rural dispensing fee adjuster
MD		*	$2.69*	$3.69	*Preferred brands are paid the same fees as generics non-preferred are at $2.69; for LTC pharmacies, $3.66 (brands) and $4.69 (generics)
MA	$3.00				$10 for 340B drugs
MI	$2.50	$2.75			$2.75 for residents in long-term care facilities
MN	$3.65				
MS			$3.91	$5.50	$3.91 for residents long-term care facilities (brand & generics)
MO			$8.91*	$12.91*	Includes $4.82 enhanced fee (provider tax) added on all prescriptions
MT	$5.04				$3.50 (out-of-state pharmacies)
NE	$3.27 - $5.00				Based on service delivery, unit dose, or third party payers
NV	$4.76				
NH	$1.75				
NJ	$3.73 - $3.99				Based on availability of 24-hour emergency service & location
NM			$2.50	$3.65	$3.65 fee given only if pharmacists use product selection
NY			$3.50 /$4.50	$4.50	$4.50 fee for generics and select preferred brands $0.20 pharmacy & $0.80 prescriber incentive for e-prescribing
NC			$4.00	$5.60	
ND			$4.60	$5.60	$0.15 per tablet for "pill splitting"
OH	$1.80				
OK	$4.02				
OR	$9.68 - $14.01				Based on a pharmacy's annual claims using a 3-tiered system
PA	$4.00				
RI	$3.40	$2.85			For hospital outpatient pharmacies, fees are based on a 25% mark-up or $2.85, whichever is lower
SC	$4.05				
SD	$4.75				
TN		*	$2.50	$3.00	For LTC pharmacies, $5 (brands) and $6 (generics) For national Pharmacy Benefits Manager contract, $1.50 $1.50 specialty fee, if on Specialty Pricing List – otherwise $0
TX	$7.35 + 1.96% of drug to $200			*	$8 is the average dispensing fee A $0.50 incentive fee is allowed on "premium preferred generics"
UT	$3.90/$4.40				$3.90 (urban); $4.40 (rural); $1 (oral contraceptives)
VT	$4.75				$2.50 for out-of-state pharmacies
VA	$3.75				
WA	$4.24 to $5.25				Based on pharmacy volume using a 3-tiered system
WV			$2.50	$5.30	$8.25 (340B drugs)
WI			$3.44	$3.94	
WY	$5.00				

* = See Comments; SOURCES/NOTES: *Medicaid Prescription Reimbursement Information by State – Quarter Ending March 2011*, available at http://www.cms.gov/Reimbursement updated by information from individual state websites reviewed by HMA during March 2011. Listed information is a snapshot and may not represent current state policies. Reporting excludes supplies, unit dose, pharmacy-administered vaccines, compounded drugs, and infusion therapy. LTC means long-term care.

Appendix E - Medicaid Prescription Drug Copayments from March 2011

State	OTC	Generic		Brand		Beneficiary Copay Cap	Comments
		Preferred	Non-Preferred	Preferred	Non-Preferred		
AL		$.50-$3	$.50-$3	$.50-$3	$.50-$3		See Notes following
AK		$2	$2	$2	$2		
AZ		$0	$0	$0	$0		
AR		$.50-$3	$.50-$3	$.50-$3	$.50-$3		See Notes following for AR details
CA		$1	$1	$1	$1		Copays are not deducted from payments
CO		$1	$1	$3	$3		
CT		$0	$0	$0	$0		
DE		$.50-$3	$.50-$3	$.50-$3	$.50-$3	$15/month	See Notes following
DC		$1	$1	$1	$1		
FL		$0	$0	$0	$0		
GA		$0.50	$.50-$3	$.50	$.50-$3		See Notes following
HI		$0	$0	$0	$0		
ID		$0	$0	$0	$0		
IL		$0	$0	$3	$3		
IN		$3	$3	$3	$3		
IA		$1	$1	$1	$1-$3		See Notes following
KA		$3	$3	$3	$3		
KY		$1	$1	$2	5% up to $20	$225/year	$1 for atypical anti-psychotics The KY cap is set only on Rx
LA		$.50-$3	$.50-$3	$.50-$3	$.50-$3		See Notes following
ME		$3	$3	$3	$3	$30/month	$0 for mail-order prescriptions
MD		$1	$1	$1	$3		$1 for HIV/AIDS drugs (generic & brand)
MA	$1/$3	$1/$3	$1/$3	$3	$3	$200/year	See Notes following
MI		$1	$1	$3	$3		
MN		$1	$1	$3	$3		
MS		$3	$3	$3	$3		
MO		$.50-$2	$.50-$2	$.50-$2	$.50-$2		See Notes following; MO copays are not deducted from Rx payments
MT		5% up to $5	5% up to $5	5% up to $5	5% up to $5	$25/month	$1 minimum up to $5 maximum The MT copay cap is set only on Rx
NE		$2	$2	$2	$2		
NV		$0	$0	$0	$0		
NH		$1	$1	$2	$2		
NJ		$0	$0	$0	$0		
NM		$0	$0	$0	$0		
NY	$.50	$1	$1	$1	$3	$200/year	The NY copay cap is set on multiple healthcare services not just Rx
NC		$3	$3	$3	$3		
ND		$0	$0	$3	$3		
OH		$0	$0	$2	$3		$3 for drugs requiring prior authorization
OK		$0	$.65-$3.50	$.65-$3.50	$.65-$3.50		See Notes following
OR		$0	$0-$1	$0	$1-$3		See Notes following
PA		$1	$1	$3	$3		
RI		$0	$0	$0	$0		
SC		$3.40	$3.40	$3.40	$3.40		Effective April 1, 2011
SD		$3	$3	$3	$3		
TN		$0	$0	$3	$3		
TX		$0	$0	$0	$0		
UT		$3	$3	$3	$3	$15/month	The UT copay cap is set only on Rx
VT		$1-$3	$1-$3	$1-$3	$1-$3		See Notes following
VA		$1	$1	$3	$3		
WA		$0	$0	$0	$0		
WV		$.50-$3	$.50-$3	$.50-$3	$.50-$3		See Notes following
WI	$.50	$1	$1	$3	$3	$12/month	The WI copay cap is set only on Rx but does not include OTC copays
WY		$1	$1	$3	$3		

SOURCES/NOTES: *Medicaid Prescription Reimbursement Information by State – Quarter Ending March 2011*, available at http://www.cms.gov/Reimbursement updated by information from individual state websites reviewed by HMA during March 2011. Listed information is a snapshot and may not represent current state policies. Reporting excludes supplies, physician-administered injectables, and pharmacy-administered vaccines. OTC means over-the-counter drug. Cost sharing does not apply to certain *statutory exemptions*, such as children, pregnant women, institutionalized individuals, family planning supplies, hospice services, etc. and to state-specific policy exemptions (Appendices F and G).

Notes for Appendix E:

1. **Alabama**, **Arkansas**, **Delaware**, **Georgia**, **Missouri, Louisiana**, and **West Virginia** base their copayment, solely or in part, on the nominal amounts allowed by federal regulations, prior to passage of the Deficit Reduction Act of 2005 (DRA).

Pre-DRA Nominal Copayment	Prescription Costs	Comments
$0.50	$10.00 or less	Exceptions to the listed Pre-DRA Nominal Copayment Amounts: a. **Georgia** has flat $0.50 copayments for *preferred generics* and *preferred brands*, but follows the pre-DRA nominal amounts for other drugs b. **Iowa** has flat $1 copayments for *all generics*, *preferred brands*, and when *non-preferred brands are paid $25 or less*, but follows the pre-DRA nominal amounts for *other non-preferred brands* (i.e., $2 if between $25.01 and $50 and $3 if $50 or more) c. **Missouri** caps its copayments at $2 instead of the $3 maximum used by Alabama, Arkansas, Delaware, Georgia, Iowa, Louisiana, and West Virginia
$1.00	$10.01 to $25.00	
$2.00	$25.01 to $50.00	
$3.00	$50.01 or more	

2. **Kentucky** bases its copayments, as follows. In addition to the $225 calendar year copayment cap per beneficiary, the maximum amount of cost sharing will not exceed 5 percent of a family's total income for a quarter.

Copayment Amount	Drug Type
$1.00	Generics and atypical anti-psychotics
$2.00	Preferred brands with available state supplemental rebates
5% coinsurance up to $20 per prescription	Non-preferred brands

3. **Massachusetts** bases its copayments at: (a) $1 for generics and over-the-counter drugs that antihyperglycemics, antihypertensives, and antihyperlipidemics; (b) $3 for generics and over-the-counter drugs in other classes; and (c) $3 for other drugs.

4. For **New York**, the maximum "annual" copayment ($200 per beneficiary) is set based on copayments for pharmacy and for clinic visits, laboratory tests, radiographs, medical supplies, inpatient hospital stays, and emergency room visits.

5. **Oklahoma** bases its copayment on the amounts allowing federal regulations, after DRA's passage.

Post- DRA Nominal Copay	Prescription Costs	Drug Type/Comments
$0	---	Preferred generics
$0.65	$10.00 or less	Non-preferred generics, preferred brands, and non-preferred brands have copayments based on prescription costs, using post-DRA nominal amounts.
$1.20	$10.01 to $25.00	
$2.40	$25.01 to $50.00	
$3.50	$50.01 or more	

6. For **Oregon**, beneficiary copayments are based on:

Copayment Amount	Prescription Costs	Drug Type
$0.00	---	Preferred generics and preferred brands on the Preferred Drug List
$0.00	$10.00 or less	Generics not on the Preferred Drug List
$1.00	$10.01 or more	Generics not on the Preferred Drug List
$1.00	---	Non-preferred brands on the Preferred Drug List
$3.00	---	Brands not on the Preferred Drug List

7. For **Vermont**, beneficiary copayments are based on prescription payments as follows:

Copayment Amount	Prescription Costs	Comments
$1.00	$29.99 or less	Copayments are lower than the standard nominal amounts (prior DRA's passage), because of the breakout of prescription costs used by the state
$2.00	$30.01 to $50.00	
$3.00	$50.01 or more	

Appendix F – Standard Medicaid Cost Sharing Exemptions

Standard Nominal Cost Sharing Model

States are prohibited from imposing Medicaid cost sharing on the following beneficiaries or in the following circumstances:[55]

- *Children* – Services furnished to individuals under age 18 (and, at the option of a state, individuals under age 21, 20, or 19, or any reasonable category of individuals age 18 years or over)
- *Pregnant Women* – Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women. These services include routine prenatal care, labor and delivery, routine postpartum care, family planning services, complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, and urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy.
- *Institutionalized* – Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his income required for personal needs.
- *Emergency Services* – Emergency services means covered inpatient and outpatient services that are furnished by a qualified provider needed to evaluate or stabilize an emergency medical condition.
- *Family Planning* – Both family planning services and supplies.
- *Hospice Services* – Services furnished to an individual who is receiving hospice care.
- *Indians* – Items and services furnished to an Indian directly by an Indian health care provider or through referral under contract health services.

State-Specific Cost Sharing Exemptions

Individual states may implement cost sharing exemptions in addition to the federal exemptions above. For example, Pennsylvania has applied state-specific copayment exclusions on numerous drug classes, including antihypertensive agents, anticonvulsants, antineoplastic agents, antiglaucoma agents, antidiabetic agents, cardiovascular agents, HIV/AIDS drugs, antiparkinson drugs, and antipsychotic agents except those that are also Schedule IV antianxiety agents.

HMA research also identified the following other state exemptions on cost sharing requirements:

- Beneficiaries with chronic renal disease (Delaware);
- Medicare/Medicaid dual eligibles (Georgia and Missouri);
- Beneficiaries enrolled in breast and cervical cancer programs (Georgia and Kansas);
- Foster care children (Kansas);
- Beneficiaries receiving home- and community-based services (Nebraska, New Hampshire, and New York);
- Residents in adult care homes (Kansas, Nebraska, and New York);
- Beneficiaries in case management programs (New York);
- Beneficiaries with traumatic brain injury (New York);
- Clozapine used to treat schizophrenia (Montana and New Hampshire);
- Antipsychotics (Minnesota); and
- Drugs to tuberculosis and mental illness (New York).

[55] Sections 1916(e) and 1916A(d)(2) of the Social Security Act and 42 CFR §447.53

Appendix G – Deficit Reduction Act of 2005 (DRA) Alternative Cost Sharing Model

The Deficit Reduction Act of 2005 (DRA) alternative cost sharing model allows states to impose up to a 20 percent coinsurance on select Medicaid services. Requirements of this model are significantly more complex than the standard nominal cost sharing approach.

- *Pharmacy alternative cost sharing only applies to non-preferred drugs*. Copayments cannot exceed the nominal amounts on Table 4 for a drug identified as preferred or not identified as a non-preferred.
- *No alternative cost sharing on non-preferred drugs is "not" allowed, if these products are determined more effective than preferred drugs*. If a prescriber determines the preferred drug for treatment of the same condition either would be less effective for a beneficiary or would have adverse effects, the copayment for a non-preferred drug is limited to the same amount as the preferred drug.
- *Numerous mandated exemptions apply to alternative cost sharing.* The statutory exemptions for the nominal copayments also apply to the alternative cost sharing, plus exemptions for beneficiaries in foster care receiving Medicaid benefits under Section 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Social Security Act and beneficiaries enrolled in the Breast and Cervical Cancer Program receiving Medicaid under Section 1902(a)(1)(A)(ii)(XVIII) of the Social Security Act.
- *Pharmacy alternative cost sharing amounts are capped and limited based on family income*. Table G-1 lists maximum alternative cost sharing amounts that states may impose on fee-for-service non-preferred drugs. These amounts vary based on an individual's family income and the Federal Poverty Level (FPL). Also, the alternative cost sharing is capped so that total aggregate cost sharing on any health care service for all individuals in a family may not exceed five percent of the family's income. This limit may be applied on either a monthly or a quarterly period, at a state's discretion. Other requirements apply when a state imposes alternative cost sharing on beneficiaries enrolled in managed care organizations.

Table G-1: Fee-For-Service Alternative Cost Sharing for Non-Preferred Drugs

Federal Poverty Level (FPL)	Maximum Alternative Cost Sharing on Non-Preferred Drugs	Alternative Cost Sharing Caps Applicable Across All Individuals in a Family
At or Below 100% FPL	Standard Nominal Amounts $0.65 to $3.65 based on service cost	Total aggregate cost sharing on any service for all individuals in a family may not exceed 5% of the family's income
Above 100% FPL but At or Below 150% FPL	Standard Nominal Amounts $0.65 to $3.65 based on service cost	Total aggregate amounts for *both premiums (if applied) and other cost sharing* on any service for all individuals in a family may not exceed 5% of the family's income
Above 150% FPL	Coinsurance of 20% on payments	[Same as above]

Note: Alternative cost sharing on pharmacy services is restricted to "non-preferred drugs" under federal law.

Appendix H – Pharmacy Terms

Term	Meaning	Legal Reference
Terms Describing General Types of Drugs:		
Ingredient Costs	Means the drug product cost portion of a prescription	Not defined in federal Medicaid law or regulation
Estimated Acquisition Cost (EAC)	Means the agency's best estimate of the price generally and currently paid by providers [for ingredient costs] for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers.	42 CFR 447.502
Dispensing Fee	Means reimbursement for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed. It includes pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid recipient. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filling the container, beneficiary counseling, physically providing the completed prescription to the Medicaid beneficiary, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy.	42 CFR §447.502
Single Source Drug	Means a drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application. One product is approved on the market for the active ingredient, strength, and dosage form (e.g., tablet, capsule, vial, etc.).	Sec 1927(k) of the Social Security Act and 42 CFR §447.502
Multiple Source Drug	Means a drug for which multiple manufacturers distribute a drug, each providing a pharmaceutical equivalent having the same active ingredient(s), strength, and dosage form. These drugs include ***noninnovator products (often called generics)*** and the ***innovator drug*** that was originally marketed under an original new drug application approved by the Food and Drug Administration (FDA).	Sec 1927(k)(7) of the Social Security Act provides requirements relating to multiple source drugs as used in the Federal Upper Limit process
Innovator Multiple Source Drug	Means a multiple source drug that was originally marketed under an original new drug application (NDA) approved by the Food and Drug Administration (FDA). A Single Source Drug becomes an Innovator Multiple Source Drug as it loses its patent protection.	42 CFR §447.502
Noninnovator (Generic) Multiple Source Drug	Means a drug which is a multiple source drug that is not (1) an innovator multiple source drug or (2) a single source drug. Noninnovator Multiple Source Drugs are often referred to as generics.	42 CFR §447.502
Generic Drug	See Noninnovator (Generic) Multiple Source Drug	
Brand Drug	Means a Single Source Drug or Innovator Multiple Source Drug	42 CFR §447.502
Specialty Drug	Means generally high-cost injectable, infusion, oral, or inhaled therapies, delivered in non-hospital settings, which require closer supervision, monitoring, special handling, and patient education than conventional therapies	Not defined in federal Medicaid law or regulation

Term	Meaning	Legal Reference
Drug Pricing Benchmarks:		
AWP (Average Wholesale Price)	Means the list price from a wholesaler to a pharmacy. AWP is not the price paid, as pharmacies negotiate discounts. Payers typically discount AWP to estimate a pharmacy's acquisition costs.	Not defined in federal Medicaid law or regulation
SWP (Suggested Wholesale Price)	Represents the manufacturer's suggested price for a drug product from wholesalers to their customers (i.e., retailers, hospitals, physicians and other buying entities) as reported by the manufacturer. SWP, like AWP, is a suggested price and does not represent actual transaction prices.	Not defined in federal Medicaid law or regulation
WAC (Wholesale Acquisition Cost)	Means the manufacturer's list price to wholesalers or other direct purchasers. WAC is not the price paid, as manufacturers offer discounts. Payers typically markup WAC to estimate a pharmacy's acquisition costs. WAC has also been referred to as Net Wholesale Price.	Defined in Medicare law at Sec 1847A (c)(6)(B) of the Social Security Act, but not Medicaid law
DP (Direct Price)	Represents the manufacturer's published catalog or list price for a drug product to non-wholesalers as reported to by the manufacturer. Direct Price does not represent actual transaction prices and does not include prompt pay or other discounts, rebates or reductions.	Not defined in federal Medicaid law or regulation
FUL (Federal Upper Limit)	As revised by the Affordable Care Act of 2010, means a federal upper reimbursement limit set for a multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit. FULs are set as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly Average Manufacturer Price (AMP) for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis.	Sec 1927(e) of the Social Security Act
MAC (Maximum Allowable Cost)	Means payment ceilings on multiple source drugs and select other drugs set by states and other payers. A state may implement its own MAC rates – as long as MAC payments, in aggregate, do not exceed what would have been paid using the FULs.	Not defined in federal Medicaid law or regulation

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