Hepatitis C Medicaid Affinity Group

HCV Medicaid Drug Pricing

When a Medicaid beneficiary fills an outpatient prescription at a pharmacy, the state Medicaid program pays the pharmacy for the ingredient cost and a dispensing fee. States have some flexibility in how they set each of these payment levels and must develop a method of paying ingredient costs based on Actual Acquisition Cost, or AAC. This document discusses ways in which states might manage these costs.

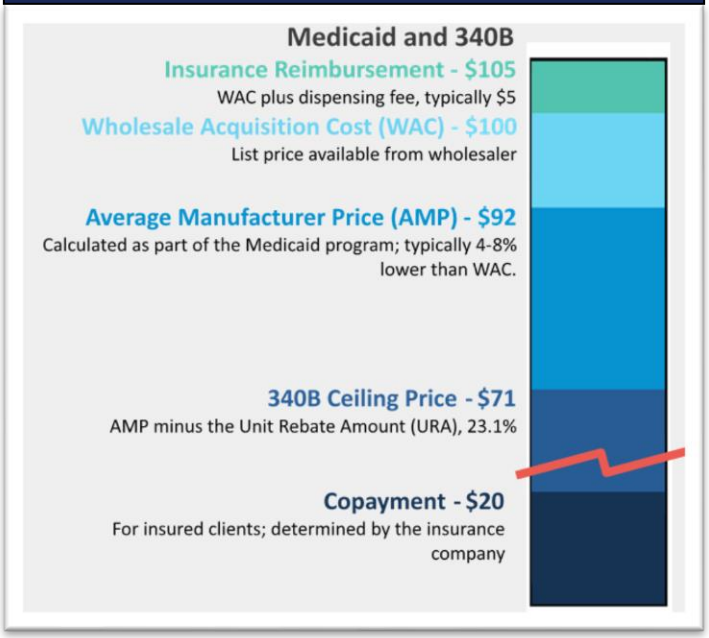
$31.7 billion
2015 Medicaid expenditures on prescription drugs

The Medicaid Drug Rebate Program

Under the Medicaid Drug Rebate Program (MDRP), a drug manufacturer enters into a national-level rebate agreement with the Secretary of Health and Human Services. In turn, states are required to cover most of the manufacturer's drugs.

In a rebate agreement, manufacturers agree to give states rebates on drug purchases. Rebates are based upon the Average Manufacturer Price (AMP), or "the average price paid to the manufacturer for the drug in the US by wholesalers for drugs distributed to retail community pharmacies and retail community pharmacies that purchase drugs directly from the manufacturer." Rebates are calculated differently based on drug status and incorporate an inflation adjustment to protect budgets from manufacturer price inflation:

Who Pays What? A $100 Drug



Source: NASTAD

- For brand-name ("innovator") drugs the rebate is the greater of 23.1% of AMP, or AMP minus best price (i.e. the lowest price paid by any other wholesaler, retailer, or provider, excluding government entities and "nominal" prices paid by certain entities such as 340B providers).
- For generics, the rebate is 13% of AMP. Specific rebate formulas apply to exclusively pediatric drug formulations; blood clotting factors; and new formulations (i.e. "line extensions").

Generally, state Medicaid programs purchase drugs from pharmacies, and then receive the applicable rebate from manufacturers quarterly. These rebates are then shared with the Federal government based on each state's Federal Medical Assistance Percentage (FMAP).

While all state Medicaid programs must cover their drugs once a manufacturer joins the MDRP, state programs retain some flexibility around the conditions of coverage. States may maintain preferred drug

lists (setting higher cost sharing for non-preferred drugs); require prior authorization; set limits on use (e.g. quantity limits); or decline to cover off-label uses.

Medicaid Supplemental Rebates

In addition to the MDRP, states may negotiate supplemental rebates (rebates) with drug manufacturers. States may negotiate on their own, or together with other states. States usually only have the leverage to negotiate rebates when there is more than one drug with the same clinical effect and safety profile. To prompt a manufacturer to offer a rebate, states can propose placing a drug on the "preferred" list, which increases utilization of the medication over competitors. States must continue to cover the manufacturer's drugs under the MDRP.

Often, these supplemental discounts are calculated by subtracting Federal rebates and any other price guarantees from the Wholesale Acquisition Cost (WAC), which is the price paid for by wholesalers.

Beneficiary Cost Share

Medicaid law allows states to charge beneficiaries a "nominal" amount of cost sharing for prescription drugs. These amounts vary based on brand/generic status and other factors but are capped based on the enrollee's income level. For enrollees under 150% of the federal poverty level (FPL), states may impose cost sharing of up to $4 for preferred drugs and up to $8 for non-preferred drugs. For enrollees over 150% of the FPL, states may impose cost sharing of up to 20% of the cost of the drug.

Other Strategies to Control Drug Costs

States have considered or implemented additional strategies to reduce the growth in Medicaid drug spending. In August 2018, the National Governors Association released an article, Public Health Crises and Pharmaceutical Interventions: Improving Access While Ensuring Fiscal Sustainability, which describes these strategies. Some efforts include:

- Subscription Model: This model, which has recently gained traction with states, involves an agreement between a state and a drug manufacturer where the manufacturer agrees to provide a certain volume of drugs at a pre-set, recurring price. States can hit the target volume by pooling consumers across health care delivery systems, such as Medicaid and correctional settings.
- Drug Growth Caps: These caps establish a target for expenditures on a drug in a given year, and trigger additional supplemental negotiation or utilization controls spending is projected to exceed the target (currently being used by NY);
- Closed Formularies: A state would need to receive an 1115 waiver of the requirement that its Medicaid program cover every FDA approved-drug. This would give states increased leverage in their negotiations with manufacturers for better supplemental rebate rates. However, a closed-formulary component of a waiver proposal from a state was recently rejected by CMS, and advocates may be concerned about how closed formularies might affect access to medications.

Outpatient Prescription Drugs in Medicaid Managed Care

The majority of Medicaid enrollees are in Medicaid Managed Care Organizations, or MCOs. All states include outpatient prescription drugs as part of the contracted services that MCOs must cover under their capitation rate. MCO-purchased drug reimbursement is based on formulas that differ somewhat from fee-for-service reimbursement, but MCOs must follow MDRP rules and cover all drugs that are part of the MDRP.