Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID REBATES FOR PHYSICIAN-ADMINISTERED DRUGS

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‡ ABSTRACT

Under the Medicaid Drug Rebate Program, manufacturers are required to provide rebates on drugs paid for by a State. To receive rebates, States must identify the drugs by their national drug code. Most States, however, use procedure codes to identify physician-administered drugs. The States that match procedure codes to national drug codes do collect rebates on these drugs. We found that in 2001, Medicaid could have saved millions of additional rebate dollars if every State had collected rebates for all single-source physician-administered drugs and 40 multiple-source physician-administered drugs. As of March 2003, 24 States did not collect rebates on any physician-administered drugs. Our study indicates a State's savings in a single year could exceed the one-time cost of implementing system changes needed to collect rebates for these drugs. We recommend that the Centers for Medicare & Medicaid Services (CMS) continue to encourage all States to collect rebates on physician-administered drugs, especially single-source drugs. As part of this effort, CMS should encourage cooperation and the sharing of information between States that collect rebates for these drugs, and States that do not, in order to facilitate rebate collection. CMS concurred with our recommendation and is currently facilitating information sharing.

‡ EXECUTIVE SUMMARY

OBJECTIVES

(1) To determine whether all State Medicaid agencies collect drug manufacturer rebates for all physician-administered drugs.

(2) To estimate the potential savings that would result if all State Medicaid agencies collected drug manufacturer rebates for physician-administered drugs.

BACKGROUND

The Medicaid program, established under Title XIX of the Social Security Act, is administered by States and financed with State and Federal funds. Medicaid pays for medical and health-related assistance for certain vulnerable and needy individuals and families. All 50 States and the District of Columbia provide coverage for prescription drugs under the Medicaid program.

The Medicaid Drug Rebate Program was established in 1990 to reduce State and Federal Medicaid expenditures for prescription drugs. Under the rebate program, manufacturers are required to provide a rebate on drugs paid for by a State. Physician-administered drugs (drugs that a medical professional administers to a patient in a physician's office) are covered under this program. In order to collect the rebates, States must identify the drugs by their national drug codes and provide units-paid data to the drug company. Unlike self-administered drugs, which are typically billed to the State with national drug codes, physician-administered drugs are more often billed with procedure codes. States that use procedure codes to bill physician-administered drugs need a crosswalk to national drug codes in order to collect rebates on these drugs. A crosswalk is the identification of national drug codes for drugs represented by procedure codes.

We asked Medicaid directors from 48 States and the District of Columbia about their coding and rebate policies concerning physician-administered drugs. We also requested financial data, such as total payments and units paid for physician-administered drugs in calendar year 2001. Arizona and Tennessee did not participate in the rebate program that year. We estimated potential savings on all the single-source and 40

multiple-source, physician-administered drugs for which States made payments but did not receive rebates in 2001.

FINDINGS

In 2001, 17 States collected rebates for physician-administered drugs, and 31 States did not. Of the 17 States that collected drug manufacturer rebates for physician-administered drugs in 2001, 3 collected rebates on all physician-administered drugs. These three States use national drug codes for billing. The remaining 14 States use procedure codes. These 14 States crosswalk procedure codes to national drugs codes for single-source drugs and collect rebates on these drugs only. Thirty-one States did not collect rebates on any physician-administered drugs in 2001, and 1 additional State did not respond to our question about rebate collection.

Medicaid could have saved millions of additional rebate dollars on physician-administered drugs in 2001. If all States had collected rebates for all single-source and 40 multiple-source, physician-administered drugs, Medicaid could have added $37 million to its rebate savings for 2001. The majority of additional savings ($30 million) would have been on rebates for single-source drugs alone, and the remainder ($7 million) would have been on 40 multiple-source drugs.

After 2001, 7 of 31 States that had not collected rebates on physician-administered drugs began to do so. Of the 7 States that began collecting rebates after 2001, 6 States collect rebates on single-source, physician-administered drugs, and 1 State collects rebates on all physician-administered drugs billed by a targeted group of providers. (We estimated that the 2001 potential savings for these seven States was $14 million on all single-source and 40 multiple-source physician administered drugs.) As of March 2003, 24 States still did not collect rebates on any physician-administered drugs. These 24 States spent a total of $125 million on physician-administered drugs. Five of these 24 States said they have no plans to collect rebates for physician-administered drugs. While 19 of these 24 States said they plan to collect rebates for these drugs, 13 of the 19 States did not have specific plans to collect rebates.

For States that had data available, rebates either requested or collected in 2001 exceeded the system implementation cost of collecting rebates for physician-administered drugs. Four States provided us with their estimated costs for implementing system changes to collect rebates for physician-administered drugs. For each of these States, rebates in 2001 alone exceeded their one-time implementation costs. The State that spent the most ($642,000) collected $3 million in rebates for all physician-administered drugs in 2001. The State that spent the least ($56,100) collected $3 million in rebates on single-source, physician-administered drugs in 2001.

RECOMMENDATION

Rebates for physician-administered drugs help States reduce prescription drug expenditures, which are rising at a time when State budgets are severely stressed. Federal and State Medicaid expenditures on physician-administered drugs could have been reduced by an estimated $37 million in 2001 if all States collected rebates on those drugs.

Based on cost estimates provided to us from States that have implemented changes in order to collect rebates for physician-administered drugs, the savings from rebates in 1 year can exceed the one-time costs of implementing system changes.

We recommend that CMS continue to encourage all States to collect rebates on physician-administered drugs, especially single-source drugs. As part of this effort, CMS should encourage cooperation and the sharing of information between States that collect rebates for these drugs, and States that do not, in order to facilitate rebate collection. It would be valuable for States that do not collect rebates for physician-administered drugs to know the details of implementing system changes, such as the what, where, when, and why of resources needed, and how the process unfolded for States that have been down this road. CMS could also issue a letter to State Medicaid Directors informing them about the availability and usefulness of the Medicare crosswalk. States could use this crosswalk, which is on the Internet, to reduce the administrative costs of creating and/or updating their own crosswalk.

AGENCY COMMENTS

CMS concurred with our recommendation and is currently facilitating information sharing. The agency is passing on information to States seeking help to collect rebates on physician-administered drugs and providing contact names in States that have experience in this area. In addition, CMS has asked its Pharmacy Technical Advisory Group to serve as a resource to share this information with States in their consortia.

CMS disagreed with our $37 million estimate of potential savings. As we reported, States provided us their payment and rebate information for physician-administered drugs for calendar year 2001 and told us whether they collected rebates on physician-administered drugs that year. We used the information provided by the States to calculate additional potential savings for each State in 2001. We acknowledge that the savings in future years will depend on rebate amounts and utilization and would likely be different from 2001.

CMS also commented that our report did not break out the States that did not collect rebates in 2001 and that our report did not estimate their potential savings. We wish to point out that in Table 1 in Appendix A, we showed which States did not collect rebates in 2001 and which States told us they began collecting rebates after 2001. We also showed the 2001 potential savings for each State in Table 3 of Appendix A. We have added two sentences to page 10, citing the 2001 potential savings for seven States that began collecting rebates after 2001.

CMS noted that of the 24 States not collecting rebates as of March 2003, 13 States had specific plans to collect rebates for these drugs and 6 States, while not having plans in place, indicated they will collect these rebates in the future. Our study, however, found the opposite for this subset of States. Thirteen States did not have specific plans, and six States did have specific plans (pages 10-11). In Appendix A, Table 1, we have added footnotes 12, 13, and 14 to identify the States that said they do not have specific plans, do have specific plans, and do not plan to collect rebates for these drugs. The full text of CMS comments is in Appendix B.

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(1) To determine whether all State Medicaid agencies collect drug manufacturer rebates for all physician-administered drugs.

(2) To estimate the potential savings that would result if all State Medicaid agencies collected drug manufacturer rebates for physician-administered drugs.

BACKGROUND

The Medicaid program, established under Title XIX of the Social Security Act, is administered by States and financed with State and Federal funds. Medicaid pays for medical and health-related assistance for certain vulnerable and needy individuals and families. All 50 States and the District of Columbia provide coverage for prescription drugs under the Medicaid program.

From 1997 to 2000, Medicaid spending for outpatient prescription drugs grew twice as fast as total Medicaid spending. The total payments for outpatient prescription drugs in fiscal year 2000 were $21 billion.

Drug Manufacturer Rebates

In fiscal year 2000, drug manufacturers paid the Medicaid program $4 billion in rebates. This reduced Medicaid drug expenditures by 19 percent (total payments before rebates, $21 billion; after rebates, $17 billion).

State Medicaid agencies receive manufacturer rebates for drugs under the Medicaid Drug Rebate Program. This program was established by Federal law in 1990 (see section 1927 of the Social Security Act). States cover all prescription drugs produced by manufacturers who have entered into rebate agreements under this program. Physician-administered drugs (drugs that a medical professional administers to a patient in a physician's office) are among the drugs covered by the rebate program. Only two States, Arizona and Tennessee, did not participate in the rebate program at the time of our review.

Under the rebate program, manufacturers are required to provide a rebate on drugs paid for by a State Medicaid agency. In order to collect a rebate, the State is required to identify the drugs by their national drug codes and provide quarterly units-

paid data to the manufacturer. The manufacturer then pays the State a rebate, based on the unit rebate amount per drug multiplied by the number of drug units for which the State made payments.

Codes Used to Bill Physician-Administered Drugs

Self-administered drugs are typically billed by pharmacies in pharmacy claim formats using national drug codes to identify specific drug products. Physician-administered drugs, on the other hand, are more often billed by medical providers on professional service claims. (An example of a physician-administered drug is a prescription drug given by injection in a doctor's office.) Professional service claims identify services, medical equipment, and physician-administered drugs by procedure codes (i.e., the Healthcare Common Procedure Codes).

While it is possible to use either a national drug code or a procedure code to bill for a physician-administered drug, these codes identify different things. The national drug code is an 11-digit numeric code, which is divided into 3 segments identifying (1) the firm that manufactures, distributes, or repacks the drug product; (2) the specific strength, dosage form, and formulation of the product for a particular firm; and (3) the product's package size. The procedure code is a 5-digit alpha-numeric code that identifies a drug by its generic name; route of administration (e.g., oral or injection); and identifies the number of drug units allowed per reimbursement amount for that code.

As mentioned above, States must identify drugs by their national drug code in order to collect rebates. Therefore, if a State requires the use of national drug codes for physician-administered drugs, identifying the drug by its national drug code for rebate collection is not a problem. If a State requires the use of procedure codes for physician-administered drugs, identifying the drug by its drug code can be difficult. For example, if the drug reimbursed by Medicaid has more than one manufacturer, the drug would have more than one national drug code. Therefore, the State would not be able to determine which national drug code matched the procedure code.

Past OIG Work Found that Few States Collected Rebates for Physician-Administered Drugs

In 1996, the Office of Inspector General (OIG) conducted the study, *Appropriateness of Medicare Prescription Drug Allowances*, (OEI-03-95-00420). It examined Medicare allowances for prescription drugs through a comparison with Medicaid reimbursement mechanisms and Medicaid drug rebates. During the study, OIG found that while most State Medicaid agencies participated in the rebate program, only six were collecting rebates on physician-administered drugs. States' ability to collect rebates for physician-administered drugs was contingent upon their ability to identify the drugs by their national drug codes.

Federal Effort to Encourage States to Collect Rebates for Physician-Administered Drugs

In 2002, the Centers for Medicare & Medicaid Services (CMS) informally gathered information regarding State collection of rebates for physician-administered drugs. This was done through the Pharmacy Technical Advisory Group ? a group composed of CMS and State representatives. From this data collection, it appeared to CMS that States could gain considerable savings if they collected rebates on these drugs. CMS wrote to State Medicaid Directors in March 2003, encouraging them to look into system conversions that would facilitate a crosswalk of procedure codes to national drug codes and make rebate collection possible for these drugs. A crosswalk is the identification of national drug codes for drugs represented by procedure codes.

Availability of Medicare Crosswalk

States that use procedure codes for physician-administered drugs need a crosswalk to national drug codes in order to collect rebates on these drugs. A Medicare crosswalk is available on the Internet. It contains drugs paid by Medicare in a particular quarter and it is updated quarterly. The Internet address is: http://www.cms.hhs.gov/providers/drugs/backgroundsdp.asp.

METHODOLOGY

Preliminary Research

We conducted background research on the Medicaid Drug Rebate Program and code requirements for drug claims, including a review of Federal laws, regulations, manuals, and program memoranda. We reviewed Medicaid expenditures for prescription drugs, and we also reviewed public and private studies addressing the Medicaid prescription drug program and cost controls.

State Medicaid Data

In January 2003, we began collecting a formal set of data from the 49 States (i.e., 48 States and the District of Columbia) that participate in the Medicaid Drug Rebate Program. For the sake of brevity, we use the word "State" in this report as a synonym for both "State Medicaid agency" and "State Medicaid agency representative." We refer to the District of Columbia as a State for the same reason. We sent our data request to State Medicaid directors.

We asked each State whether they collect rebates for physician-administered drugs, the year they began collecting rebates and for what types of drugs, the type of code they use to bill physician-administered drugs, the types of changes they made to their systems in order to collect rebates for physician-administered drugs, and the estimated costs of changing systems for this purpose. We also asked each State to provide us a set of financial data for physician-administered drugs in calendar year 2001, namely, total payments per code, total units paid per code, rebate dollars requested of manufacturers per code, and rebate dollars received from manufacturers per code.

Forty-eight States answered the questions we sent them, and most States provided all or some of the financial data we requested. The State of Nevada provided financial data but did not respond to the questions. We did not verify the data States sent us. Table 1 in the Appendix includes the State financial data.

CMS Data

We used CMS's 2001 list of national Healthcare Common Procedure Codes with complete definitions to identify the

universe of codes that represented physician-administered drugs.

We used calendar year 2001 data from CMS's Medicaid Statistical Information System (MSIS) to identify payments and units paid per code for physician-administered drugs for States that did not send us this information (see Table 1 in Appendix A). Five States did not provide payment and unit data, and an additional two States did not provide unit data. We aggregated the State payment data received directly from States with data retrieved from MSIS to determine total Medicaid payments and utilization for physician-administered drugs.

CMS's Medicaid Drug Rebate Initiative database (hereinafter called rebate database) was used to identify drug unit rebate amounts in calendar year 2001. Since unit rebate amounts are established quarterly, we took the unit rebate amount for each quarter and calculated the average. The average unit rebate amount was then used in our calculation to determine potential savings.

We used the January 1, 2002 update of the Part B Drug Calculation File from CMS's Single Drug Price contractor. The CMS contractor uses this file to establish a national Medicare payment allowance for procedure codes. The file is organized by procedure code. Data in this file for each of the 485 procedure codes for physician-administered drugs included the procedure code description and a list of associated drug products with their national drug codes. The CMS contractor used the 2001 *Red Book*, a national drug-pricing reference, to identify average wholesale prices for drugs in this file.

We used the Part B Drug Calculation File to determine which procedure codes represented single-source drugs and which represented multiple-source drugs on the market in 2001. A single-source drug is a brand name drug that is manufactured under a patent and has no competing products. A multiple-source drug is a drug whose patent has expired and is manufactured by a number of different drug companies under different names. Multiple-source drugs may include generic drugs and brand name drugs.

Single-source drugs are more likely to have only one national drug code and are more easily matched to a procedure code than

multiple-source drugs. If the Part B Drug Calculation File showed only one drug manufacturer for a procedure code, we took that to be an indication the procedure code represented a single-source drug. We then looked up that drug in the October 2001 issue of *Red Book ™ for Windows*® to confirm whether it was indeed a single-source drug. Drugs in the Part B Drug Calculation File that had multiple manufacturers or were not confirmed as single-source drugs in *Red Book* were put in the multiple-source drug category.

We also used the Part B Drug Calculation File to identify the national drug codes for single-source and multiple-source drugs that corresponded to each procedure code.

Analysis of Payments for Physician-Administered Drugs

Using State financial data, we identified payments for single-source and multiple-source, physician-administered drugs per State. Single-source drug payments for 46 States ranged from $43,000 to $20 million, for a national total of $148 million. Multiple-source drug payments for 46 States ranged from $12,000 to $18 million, for a national total of $152 million. Because California and Nevada use local codes (codes used by the individual States), and Massachusetts uses non-specific codes for physician-administered drugs, we did not identify payments for single-source and multiple-source drugs for these three States. We did, however, aggregate total payments for these three States with total payments for other States. Total national payments for physician-administered drugs in 2001 were $364 million. A summary of payments is provided in Table 1 of Appendix A.

Potential Savings Analysis

Drugs Used to Calculate Savings. We reviewed all physician-administered, single-source drugs and 40 multiple-source drugs for which States made payments in 2001 but did not request a rebate, and for which a unit rebate amount was available in the rebate database. The number of single-source drugs reimbursed by each State ranged from 17 to 149. Of the 40 multiple-source drugs reviewed, the number reimbursed by each State ranged from 5 to 39. We reviewed drugs billed with national procedure codes only. We did not review any drugs billed with local codes. Nor did we review vaccines or immunizations because these products are not covered under the rebate program.

We selected the 40 multiple-source drugs in the following way. We took the State-reported payment data for physician-administered drugs billed with procedure codes and removed payments for codes that received rebates in 2001. We then aggregated the payments nationally by code. We arrayed the aggregated payments from high to low and selected 40 codes for multiple-source drugs having the highest payments. These 40 drugs represented $71 million in total Medicaid payments. Table 2 in Appendix A lists the 40 drugs.

In order to separate single-source drugs from multiple-source drugs, we matched the State's procedure codes with procedure codes in our crosswalk of single-source drugs. If the procedure code paid by the State did not match a procedure code in the single-source crosswalk, we included it in the multiple-source category.

For States that collected rebates on single-source, physician-administered drugs, we removed those codes from our analysis of the State's potential savings.

Identifying Unit Rebate Amounts. Unit rebate amounts for drugs are stored in the rebate database under the national drug code. Having completed a crosswalk for single-source drugs and selected multiple-source drugs, we compiled a list of national drug codes for the drugs under review in the single-source and multiple-source categories. We then obtained the unit rebate amount from the rebate database for each national drug code and calculated the average of the unit rebate amount for all quarters in 2001 for each national drug code. When more than one drug product was on the market for a particular procedure code, and therefore, had more than one national drug code and unit rebate amount in the rebate database, we identified the median unit rebate amount.

In instances where the strength of the national drug code did not exactly match the strength of the procedure code, we applied a conversion factor to calculate the correct unit rebate amount for the procedure code. The unit rebate amount per procedure code was then used to calculate potential savings for each procedure code in each State.

Potential Savings Calculation. We used the following steps to determine potential savings:

Step 1. For each procedure code, we multiplied the total number of drug units paid for the procedure code in 2001 by the unit rebate amount per procedure code. The product of this calculation was the potential savings for the procedure code.

Step 2. We calculated each State's total potential savings by adding the potential savings for each procedure code.

Step 3. In order to determine total Medicaid potential savings, we summed the potential savings from each of the States.

We noticed that in Step 1, savings for some procedure codes exceeded payments. This might have been the result of a State's units-paid data not accurately representing paid claim units. In any State where potential savings for a procedure code exceeded the payments for that code, we removed the code from our savings calculations.

Reporting the Potential Savings. Table 3 in Appendix A contains potential Federal and State savings per State. These savings were calculated on physician-administered drug payments of $169 million. This was the subset of payments for single-source and 40 multiple-source drugs for which the States did not request rebates in 2001. In addition, these payments do not include vaccines or immunizations, drugs billed with local codes or non-specific codes, and codes deleted because savings calculations exceeded payments.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

In 2001, 17 States collected rebates on physician-administered drugs, and 31 States did not.

Of the 17 States that collected drug manufacturer rebates on physician-administered drugs in 2001, 3 States collected rebates on all such drugs, and 14 collected rebates on single-source drugs only.

Three States that use national drug codes for billing were able to collect rebates on all physician-administered drugs.

Only three States use national drug codes to bill physician-administered drugs (Hawaii, Missouri, and Pennsylvania). They were able to collect rebates for physician-administered drugs regardless of whether the drugs were single-source or multiple-source. Two of the three States sent us their data on total rebates collected in 2001. These two States collected $3 million in rebates or 30 percent of their total payments ($10 million) for physician-administered drugs.

Fourteen States were only able to collect rebates on single-source, physician-administered drugs.

Fourteen States that use procedure codes instead of national drug codes to bill physician-administered drugs were able to collect rebates for single-source drugs only. The four States that provided data collected $14 million in rebates on these drugs.

In order to collect rebates for single-source drugs, these 14 States developed a crosswalk to link procedure codes to national drug codes; developed conversion factors for codes where the description of procedure code units differed from rebate units; performed regularly scheduled system maintenance (e.g., to verify that the drug code is still active); identified claims with procedure codes that were, or could be, crosswalked; and changed the rebate invoicing procedure to merge physician services and pharmacy claims.

Medicaid could have saved millions of additional rebate dollars on physician-administered drugs in 2001.

Medicaid could have added an estimated $37 million to its rebate savings in 2001 if all States had collected rebates on single-source and 40 multiple-source, physician-administered drugs. Individual State payments and potential savings are in Tables 1 and 3 of Appendix A.

Medicaid would have obtained the majority of these rebate savings from single-source drugs.

States that did not collect rebates for single-source, physician-administered drugs had payments totaling $99 million for this subset of drugs. These States could have reduced 2001 expenditures on these drugs by an estimated 30 percent or $30 million if rebates had been collected.

Medicaid could have obtained further savings in rebates for 40 multiple-source drugs.

The States that did not collect rebates for 40 multiple-source, physician-administered drugs paid $70 million for these drugs in 2001. These States could have lowered payments by an estimated $7 million or 10 percent by collecting the rebates.

After 2001, 7 of 31 States that had not collected rebates on physician-administered drugs began to do so.

After 2001, 7 of 31 States that had not collected rebates on any physician-administered drugs began collecting rebates for some of these drugs. Six of these seven States implemented changes (e.g., developed a crosswalk) to collect rebates for single-source, physician-administered drugs. The remaining State reported that it targets the eight highest paid providers who bill physician-administered drugs and asks them to provide the national drug code from the product dispensed for the paid claim. Once the State has the drug code, rebate invoices can be sent to manufacturers.

The 2001 potential savings for these 7 States was $14 million on all single-source and 40 multiple-source, physician-administered drugs. This $14 million represents 38 percent of the total $37 million in potential savings for 2001.

As of March 2003, 24 States still did not collect rebates on any physician-administered drugs.

The 24 States that did not collect rebates on physician-administered drugs as of March 2003, reported spending $125 million for these drugs in 2001. Nineteen of these 24 States said they plan to collect rebates for physician-administered drugs. However, 13 of 19 have no specific plans to change their systems. Some of these 13 States said that they were aware of changes that are needed, and others said they did not know what changes are needed. Four of the 19 States indicated they have begun the process of making changes to their systems,

such as ordering a change to their Medicaid Management Information System, developing a crosswalk, building a new claims management system to accommodate national drug codes on professional service claims, and changing policies and billing instructions to require national drug codes. The remaining 2 of 19 States responded that they have created crosswalks for single-source drugs.

Five of 24 States that currently do not collect rebates on physician-administered drugs said they do not have plans to collect rebates for these drugs. These 5 States had $25 million in expenditures for physician-administered drugs.

For States that had data available, rebates requested or collected in 2001 exceeded the system implementation cost of collecting rebates for physician-administered drugs.

Of the States currently collecting rebates on physician-administered drugs, four were able to provide system implementation costs for collecting rebates for these drugs. Costs ranged from a high of $642,000 to a low of $56,100.

- The State that reported the highest implementation cost estimate ($642,000) is a State that now collects rebates for all physician-administered drugs. This State implemented a policy change in 1992 that required physician-administered drugs be billed on pharmacy claims forms. Then, in 1994, they spent an estimated $642,000 to integrate the pharmacy rebate system into their Medicaid Management Information System. In 2001, they collected $3 million in rebates for physician-administered drugs.
- A State that began collecting rebates in 2001 for single-source, physician-administered drugs spent an estimated $220,000. They made modifications to their Medicaid Management Information System, including creating a crosswalk and tables to store physician-administered drug claims, and merging physician services and pharmacy claims for rebate invoicing. In 2001, this State requested $2 million in rebates from drug manufacturers for single-source, physician-administered drugs.

- Another State estimated spending $110,000 for personnel needed to make system changes to collect rebates for single-source, physician-administered drugs. This State began collecting rebates for these drugs after 2001, but in 2001 the State invoiced manufacturers $1 million for rebates on these drugs.
- The State that had the lowest implementation costs ($56,100) collected $3 million for single-source, physician-administered drugs in 2001. This State began collecting the rebates in 1998. This State's implementation costs were for a system engineer to create a link between procedure codes and national drug codes, add programming that automatically relates procedure-code billing to drug-code billing, merge physician and pharmacy claims for invoicing, and test the system.

Three additional States said they plan to collect rebates for single-source, physician-administered drugs. These States estimated the costs for system changes would range from $10,008 to $150,000. In addition to these one-time expenditures, 1 State planning to make changes said it would cost approximately $1,500 per year to maintain the new system.

RECOMMENDATION

Rebates for physician-administered drugs help States reduce prescription drug expenditures, which are rising at a time when State budgets are severely stressed. Federal and State Medicaid expenditures on physician-administered drugs could have been reduced by an estimated $37 million in 2001 if all States collected rebates on those drugs.

Based on cost estimates provided to us from States that have implemented changes in order to collect rebates for physician-administered drugs, the savings from rebates in 1 year can exceed the one-time costs of implementing system changes.

We recommend that CMS continue to encourage all States to collect rebates on physician-administered drugs, especially single-source drugs. As part of this effort, CMS should encourage cooperation and the sharing of information between States that collect rebates for these drugs and States that do not, in order to facilitate rebate collection. It would be valuable for States that do not collect rebates for physician-administered drugs to know the details of implementing system changes, such as the what, where, when, and why of resources needed, and how the process unfolded for States that have been down this road. CMS could also issue a letter to State Medicaid Directors informing them about the availability and usefulness of the Medicare crosswalk. States could use this crosswalk, which is on the Internet, to reduce the administrative costs of creating and/or updating their own crosswalk.

AGENCY COMMENTS

CMS concurred with our recommendation and is currently facilitating information sharing. The agency is passing on information to States seeking help to collect rebates on physician-administered drugs and providing contact names in States that have experience in this area. In addition, CMS has asked its Pharmacy Technical Advisory Group to serve as a resource to share this information with States in their consortia.

CMS disagreed with our $37 million estimate of potential savings. As we reported, States provided us their payment and

rebate information for physician-administered drugs for calendar year 2001 and told us whether they collected rebates on physician-administered drugs that year. We used the information provided by the States to calculate additional potential savings for each State in 2001. We acknowledge that the savings in future years will depend on rebate amounts and utilization and would likely be different from 2001.

CMS also commented that our report did not break out the States that did not collect rebates in 2001 and that our report did not estimate their potential savings. We wish to point out that in Table 1 in Appendix A, we showed which States did not collect rebates in 2001 and which States told us they began collecting rebates after 2001. We also showed the 2001 potential savings for each State in Table 3 of Appendix A. We have added a sentence to page 10, citing the 2001 potential savings for seven States that began collecting rebates after 2001.

CMS noted that of the 24 States not collecting rebates as of March 2003, 13 States had specific plans to collect rebates for these drugs and 6 States, while not having plans in place, indicated they will collect these rebates in the future. Our study, however, found the opposite for this subset of States. Thirteen States did not have specific plans, and six States did have specific plans (pages 10-11). In Appendix A, Table 1, we have added footnotes 12, 13, and 14 to identify the States that said they do not have specific plans, do have specific plans, and do not plan to collect rebates for these drugs. The full text of CMS comments is in Appendix B.

APPENDIX ~ A

Table 1. Summary of 2001 State Medicaid Data for Physician-Administered Drugs

This table incorporates the States' responses to our information request. From January through March 2003, we collected a formal set of data from the 49 States (i.e., 48 States and the District of Columbia) that participate in the Medicaid Drug Rebate Program. We specifically asked States to provide us with financial data for physician-administered drugs only, and not to include crossover drug claims from Medicare. A number of States included vaccines and immunizations in the financial data they sent us. However, these products are not covered under the Medicaid Drug Rebate Program. Therefore, we excluded vaccine and immunization data from our analysis of payments and potential savings and from this table.

State	Physician-Administered Drug Payments in 2001	Physician-Administered Drugs for which States Collected Rebates in 2001	Rebates Requested of Drug Manufacturers for Physician-Administered Drugs in 2001	Rebates Collected from Drug Manufacturers for Physician-Administered Drugs in 2001
Alabama	$13,196,168 [8]	None[1]		
Alaska	$2,229,910	None[13]		
Arkansas	$4,159,582	None[13]		
California[6]	$59,278,322	Single-Source	$6,417,891	$5,445,273
Colorado	$3,211,272 [3]	None[14]		
Connecticut	$3,776,003 [8]	Single-Source	Not Available	Not Available
Delaware	$55,008	Single-Source	Not Available	Not Available
District of Columbia	$995,166	None[12]		
Florida	$22,037,705	None[1]		
Georgia	$13,205,614 [4]	Single-Source	$2,465,042 [4]	$3,627,956 [4]
Hawaii	$479,692	All	$237,295	$135,872
Idaho	$1,830,202	None[12]		
Illinois[9]	$1,612,548	None[12]		
Indiana	$9,806,848	Single-Source	$2,280,000 [3]	Not Available
Iowa	$5,407,563 [8]	None[14]		
Kansas	$4,170,742 [8]	Single-Source	Not Available	Not Available
Kentucky	$1,995,578	None[1]		
Louisiana	$3,723,133	None[1]		
Maine	$1,840,082	None[12]		
Maryland	$25,235,109	None[1]		
Massachusetts[6]	$190,676	None[13]		
Michigan	$6,625,762 [7]	Single-Source	$1,964,919 [7]	$1,193,894 [7]
Minnesota	$5,451,191	None[13]		
Mississippi	$5,606,025	None[12]		
Missouri	$9,979,292	All	$2,887,966	$2,875,550
Montana	$1,896,598 [3]	None[12]		
Nebraska[9]	$3,174,260 [5]	None[12]		
Nevada	$4,510,532	Not Available[10]		
New Hampshire	$621,931	Single-Source	$78,914	Not Available
New Jersey	$2,274,470	None[14]		
New Mexico	$563,289	None[12]		
New York	$23,301,898	None[12]		
North Carolina	$14,817,041	Single-Source	$3,522,962	$3,285,105

North Dakota	$367,185	None[12]		
Ohio	$13,344,648	None[14]		
Oklahoma	$3,880,609	None[12]		
Oregon	$8,569,989	Single-Source	$1,437,366	Not Available
Pennsylvania	$772,931	All	Not Available	Not Available
Rhode Island	$527,412 [8]	Single-Source	Not Available	Not Available
South Carolina	$10,277,645	Single-Source	Not Available	Not Available
South Dakota	$591,771	None[13]		
Texas	$35,534,137	None[13]		
Utah	$1,095,075	None[12]		
Vermont	$1,247,256	None[1]		
Virginia	$2,597,819	Single-Source	$612,957	Not Available
Washington	$17,740,284	None[2]		
West Virginia	$6,529,169 [3]	None[12]		
Wisconsin	$3,548,728	Single-Source	$634,259	Not Available
Wyoming	$269,851	None[14]		
49[11]	**$364,153,722**		**$22,539,571**	**$16,563,651**

Sources: State Medicaid agency data provided to OIG January-March 2003, and CMS's Medicaid Statistical Information System

[1] After 2001, State began to collect rebates on single-source drugs.

[2] After 2001, State began collecting rebates for drugs billed by the 8 highest paid providers.

[3] Fiscal year data.

[4] Eleven months of data.

[5] Based on service (not payment) dates.

[6] This State's data is represented entirely by local codes or non-specific codes.

[7] Includes crossover drug claims from Medicare.

[8] State did not provide financial data to us. Therefore, we used data from CMS's Medicaid Statistical Information System.

[9] State provided us with payments but not units. Therefore, we used units from CMS's Medicaid Statistical Information System to calculate potential savings. Potential savings are in Table 3.

[10] State provided us with financial data but did not respond to the questions.

[11] Arizona and Tennessee did not participate in the Medicaid Drug Rebate Program at the time of our study.

[12] State said it planned to collect rebates for physician-administered drugs in the future, but the plans were not specific.

[13] State said it had specific plans underway to collect rebates for physician-administered drugs.

[14] State did not plan to collect rebates for physician-administered drugs.

Table 2. Selected Physician-Administered Multiple-Source Drugs (n=40)

Procedure Code	Description
J0640	INJECTION, LEUCOVORIN CALCIUM, PER 50 MG
J1040	INJECTION, METHYLPREDNISOLONE ACETATE, 80 MG
J1100	INJECTION, DEXAMETHASONE SODIUM PHOSPHATE, 1MG
J1245	INJECTION, DIPYRIDAMOLE, PER 10 MG
J1561	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, 500 MG
J1562	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, 5 GMS
J1563	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, 1G
J1631	INJECTION, HALOPERIDOL DECANOATE, PER 50 MG
J1642	INJECTION, HEPARIN SODIUM, (HEPARIN LOCK FLUSH), PER 10 UNITS
J1644	INJECTION, HEPARIN SODIUM, PER 1000 UNITS
J1750	INJECTION, IRON DEXTRAN, 50 MG
J1885	INJECTION, KETOROLAC TROMETHAMINE, PER 15 MG
J2000	INJECTION, LIDOCAINE HCL, 50 CC
J2275	INJECTION, MORPHINE SULFATE (PRESERVATIVE-FREE STERILE SOLUTION), PER 10 MG
J2550	INJECTION, PROMETHAZINE HCL, UP TO 50 MG
J2680	INJECTION, FLUPHENAZINE DECANOATE, UP TO 25 MG
J2912	INJECTION, SODIUM CHLORIDE, 0.9%, PER 2 ML
J3370	INJECTION, VANCOMYCIN HCL, 500 MG
J7050	INFUSION, NORMAL SALINE SOLUTION, 250 CC
J7190	FACTOR VIII (ANTIHEMOPHILIC FACTOR, HUMAN) PER I.U.
J7192	FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) PER I.U.
J7194	FACTOR IX, COMPLEX, PER I.U.
J7619	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER 1 MG
J9000	DOXORUBICIN HCL, 10 MG
J9040	BLEOMYCIN SULFATE, 15 UNITS
J9060	CISPLATIN, POWDER OR SOLUTION, PER 10 MG
J9062	CISPLATIN, 50 MG
J9181	ETOPOSIDE, 10 MG
J9182	ETOPOSIDE, 100 MG
J9190	FLUOROURACIL, 500 MG
J9209	MESNA, 200 MG
J9265	PACLITAXEL, 30 MG
J9370	VINCRISTINE SULFATE, 1 MG
Q0136	INJECTION, EPOETIN ALPHA, (FOR NON ESRD USE), PER 1000 UNITS
Q9930	INJECTION OF EPO, PER 1000 UNITS, AT PATIENT HCT OF 30
Q9932	INJECTION OF EPO, PER 1000 UNITS, AT PATIENT HCT OF 32
Q9933	INJECTION OF EPO, PER 1000 UNITS, AT PATIENT HCT OF 33
Q9934	INJECTION OF EPO, PER 1000 UNITS, AT PATIENT HCT OF 34
Q9935	INJECTION OF EPO, PER 1000 UNITS, AT PATIENT HCT OF 35
Q9936	INJECTION OF EPO, PER 1000 UNITS, AT PATIENT HCT OF 36

Source: CMS's 2001 list of Healthcare Common Procedure Codes

Table 3. Potential Medicaid Savings on Rebates for Physician-Administered Drugs in 2001

State	Potential Savings for All Single-Source Physician-Administered Drugs	Potential Savings for Selected Multiple-Source Physician-Administered Drugs (n=40)	Number of Selected Multiple-Source Drugs With State Payments in 2001 (n=40)	Total Potential Savings[4]
Florida[1]	$5,528,662	$1,391,713	27	$6,920,375
Texas	$5,322,837	$750,305	30	$6,073,142
Washington[1]	$2,271,591	$259,842	20	$2,531,432
Alabama[1]	$1,341,721	$978,014	38	$2,319,735
Ohio	$2,007,335	$271,809	28	$2,279,144
New York	$1,238,323	$347,384	30	$1,585,707
Mississippi	$1,412,029	$83,198	24	$1,495,227
West Virginia	$1,296,469	$197,225	29	$1,493,694
Maryland[1]	$1,254,053	$140,015	29	$1,394,069
Minnesota	$936,016	$143,601	32	$1,079,617
Iowa	$823,714	$223,213	38	$1,046,927
Arkansas	$999,389	$71,679	23	$1,071,068
Nebraska	$832,833	$153,363	26	$986,195
Oklahoma	$797,371	$44,944	25	$842,315
New Jersey	$455,750	$44,965	30	$500,715
Montana	$433,828	$44,894	30	$478,722
Kentucky[1]	$440,601	$30,568	10	$471,169
Colorado	$367,984	$45,422	28	$413,406
Louisiana[1]	$241,741	$159,806	23	$401,547
Alaska	$359,894	$41,153	21	$401,047
Idaho	$243,772	$75,102	36	$318,874
North Carolina[2]		$307,865	30	$307,865
Vermont[1]	$275,045	$25,902	22	$300,947
Maine	$247,267	$25,778	27	$273,045
Utah	$211,677	$13,203	27	$224,880
Indiana[2]		$210,665	32	$210,665
Michigan[2]		$181,748	28	$181,748
South Carolina[2]		$175,382	27	$175,382
District of Columbia	$127,635	$5,107	25	$132,742
Connecticut[2]		$132,157	37	$132,157
Kansas[2]		$112,065	31	$112,065
South Dakota	$102,510	$6,605	25	$109,115
North Dakota	$74,405	$2,897	15	$77,302
Illinois	$59,909	$4,954	30	$64,862
Wyoming	$37,194	$5,008	13	$42,202
Wisconsin[2]		$42,289	26	$42,289
Georgia[2]		$39,815	16	$39,815
Rhode Island[2]		$19,063	22	$19,063
Oregon[2]		$18,152	18	$18,152
New Mexico	$12,055	$1,598	22	$13,653
Virginia[2]		$9,938	5	$9,938
New Hampshire[2]		$6,042	18	$6,042
Delaware[2]		$361	13	$361
43[3]	**$29,753,610**	**$6,844,810**		**$36,598,420**

Sources: State Medicaid agency data provided to the OIG January-March 2003, CMS's Medicaid Statistical Information System, Medicaid Drug Rebate Initiative database, and Single Drug Price contractor's Part B Drug Calculation File

[1] These States began collecting rebates on physician-administered drugs after 2001.

[2] These States collected rebates on single-source drugs in 2001. We did not estimate potential savings on single-source drugs if a State collected rebates on these drugs. California collects rebates for single-source drugs but is not in this table because they use local codes.

[3] Arizona and Tennessee did not participate in the Medicaid Drug Rebate Program at the time of our study. California and Massachusetts are not in this table because they use local and non-specific codes,respectively. Hawaii, Missouri, and Pennsylvania are not in this table because they use national drug codes and collect rebates on all physician-administered drugs. Nevada is not in this table because they did not respond to our questions asking if they collect rebates for physician-administered drugs.

[4] The sum of potential savings for single-source and multiple-source drugs may not exactly equal total potential savings due to rounding.

APPENDIX ~ B

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: FEB 12 2004

TO: Dara Corrigan
Acting Principal Deputy Inspector General
Office of Inspector General

FROM: Dennis G. Smith
Acting Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *"Medicaid Rebates for Physician-Administered Drugs"* (OEI-03-02-00660)

Thank you for the opportunity to review and comment on the above OIG draft report, which determined whether all state Medicaid agencies collect drug manufacturer rebates for all physician-administered drugs, and estimated the potential savings that would result if all state Medicaid agencies collected drug manufacturer rebates for physician-administered drugs.

Many state Medicaid programs have not collected rebates on physician-administered drugs, resulting in millions of dollars in uncollected rebates. This is generally a result of the lack, in many states, of the capability to link the Healthcare Common Procedure Coding System codes assigned to these drugs to the National Drug Code necessary for billing rebates to manufacturers. In Fiscal Year 2001, Medicaid spent $364 million for all physician-administered drugs. The Centers for Medicare & Medicaid Services (CMS) strongly encourages states to take the necessary steps to collect rebates for all physician-administered drugs.

OIG Recommendation

The CMS should continue to encourage all states to collect rebates on physician-administered drugs, especially single-source drugs by:

- Encouraging cooperation and the sharing of information between states that collect rebates for these drugs and states that do not, in order to facilitate rebate collection.
- Providing information to states that do not collect rebates for physician-administered drugs on how to implement system changes necessary to bill for rebates.
- Informing State Medicaid Directors about the availability and usefulness of the Medicare crosswalk, which is accessible on our CMS Web site.

Agency Comments

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CMS Response

We concur with the recommendation that CMS continue to encourage all states to collect rebates on physician-administered drugs. As noted in your report, in March 2003, CMS sent a letter to the State Medicaid Directors encouraging states to explore available system conversions that would facilitate a crosswalk of procedure codes to national drug codes in order to identify the drug dispensed and bill the manufacturer for rebates. The March 2003 letter generated much interest among states that had not begun to collect rebates for these drugs.

We are currently facilitating information-sharing among states by passing on information that we have collected to states seeking help to collect rebates on physician-administered drugs and providing contact names in states that have experience in this area. We have also asked our Pharmacy Technical Advisory Group to serve as a resource to share this information with states in their consortia.

However, while we agree with the recommendation to encourage and assist states to collect rebates on these drugs, we disagree with the finding of the projected savings of $37 million cited by the report.

We note that the report acknowledges that certain states have made significant progress in collecting rebates on these drugs. However, it fails to identify these states and provide estimates of their savings. While only 17 states collected rebates in 2001, 7 additional states now collect rebates, 13 more have specific plans to begin collections, and 6 others, while not having plans in place, indicate that they will collect these rebates in the future. This leaves only 5 states that have yet to commit to collecting rebates on these drugs.

The report does not break out the states that did not collect rebates in 2001. However, it does note that the 24 states not collecting rebates spent only 34 percent ($125 million) of the $364 million spent nationally on physician-administered drugs in 2001. Using the assumption in the OIG report of an average 19 percent rebate collection, the lost rebates in these states would be less than $24 million. This implies that the 7 states that began collections after 2001 account for $13 million in savings.

We believe that the report should display data on these states and estimate the resulting savings. While we believe that additional state efforts to collect rebates for all physician-administered drugs will result in further savings to the Federal government and the states, more analysis should be done to quantify the savings estimates in this report.

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