DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date September 29, 1989

From Richard P. Kusserow
Inspector General

Subject OIG Management Advisory Report - The Use of Average Wholesale Prices in Reimbursing Pharmacies Participating in Medicaid and the Medicare Catastrophic Coverage Act Prescription Drug Program (CIN: A-06-89-00037)

To Louis B. Hays
Acting Administrator
Health Care Financing Administration

Per your request, we are providing you with pertinent information gained thus far in our ongoing review of Average Wholesale Price (AWP) for reimbursing pharmacies participating in the Medicaid program and in the new Medicare Catastrophic Coverage Act (MCCA) prescription drug program.

We were pleased to note that in August 1989, HCFA issued a revision to the State Medicaid Manual which points out that there is a preponderance of evidence that demonstrates that AWP overstates the prices that pharmacies actually pay for drugs by as much as 10 to 20 percent. The Manual issuance further provides that, absent valid documentation to the contrary, it will not be acceptable for a State to make reimbursements using AWP without a significant discount.

We fully concur with the observation made in this pronouncement that the preponderance of evidence shows that AWP is heavily discounted. During 1984, we issued a report titled; "Changes to the Medicaid Prescription Drug Program Could Save Millions" (ACN: 06-40216) pointing out that, on the average, pharmacies buy drugs for 15.9 percent below AWP. This was one of the first, if not the first, report to make public the information that drug purchases are heavily discounted. In our 1984 report, which focused on the impact of AWP on Medicaid reimbursement, we recommended that HCFA revise the Medicaid drug program regulations and include language to preclude the general use of AWP in pharmacy reimbursement.

Our current work shows that there have been no changes since our prior audit, except a much wider base of awareness that the discounts occur. Our current review of drug purchase data shows that, on the average, pharmacies buy drugs for 15.5 percent below AWP. We continue to believe that AWP is not a meaningful figure, and that it should not be used for making reimbursements in either the Medicaid or the new Medicare drug program.

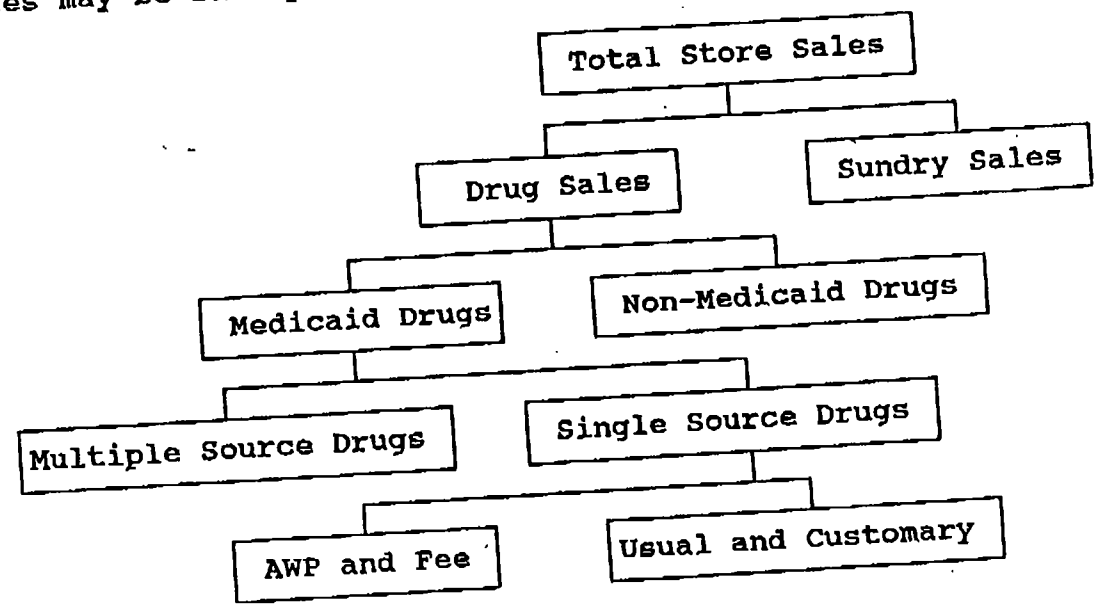
We are recommending that HCFA continue its efforts to require State Medicaid agencies to discount AWP when making program reimbursements. Concerning Medicare, we are recommending that HCFA study the feasibility of other reimbursement methods that do not involve AWP and seek legislative changes to permit either the use of a different method or the discounting of AWP. (We are presently considering alternate methods of Medicare drug reimbursement.)

BACKGROUND

MEDICAID

In our 1984 report, we pointed out that pharmacists were generally paid the lesser of their usual and customary charge to the general public, or AWP plus a dispensing fee (or in some cases a specific maximum amount set either by HCFA or the State). Since the discounted AWP would not be used in making every reimbursement, the full 15.9 percent discount would not be realized as a savings. We estimated that only about 11 percent of the program reimbursement could be saved via discounting AWP.

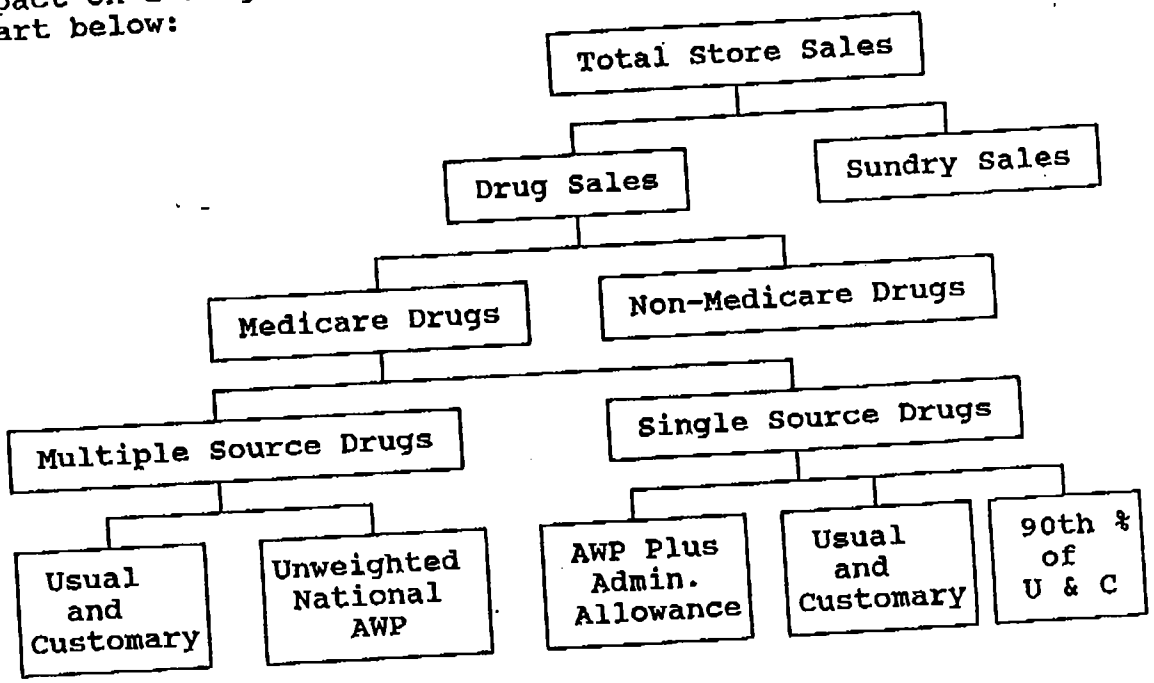
Since that time, the Medicaid regulations have been revised with different payment methods applying depending on whether single source or multiple source drugs are involved. The discounting of AWP would only affect reimbursements for single source drugs and then only in those instances when that amount was less the pharmacies usual and customary charge to the public. We believe that the overall impact of discounting AWP on total drug store sales may be fairly small as shown in the chart below:



MEDICARE

The drug portion of MCCA is scheduled to become operational, for the most part, in January 1991. The MCCA legislation calls for the use of non-discounted AWP, plus an administrative allowance, as one of the reimbursement limits for prescription drugs. It should be noted that during the period that beneficiaries are building their deductible amounts, no program reimbursements are involved and the pharmacists are supposed to charge usual and customary amounts. After the beneficiaries' deductible have been met, the program reimbursement method would vary depending on whether single source or multiple source drugs are involved.

For single source drugs, reimbursement would be limited to the lessor of the pharmacy's usual and customary charge to the general public, the 90th percentile of usual and customary charges for a geography area, or AWP plus an administrative allowance. For multiple source drugs, the reimbursement would be limited to the lessor of the pharmacy's usual and customary charge, or the unweighted median of the AWP on a national basis plus an administrative allowance. Since AWP would be used for only some of the reimbursements, the discounting of AWP for Medicare (if permitted by the legislation) would have less than the full effect of the discounts. At this time there is no information available regarding the frequency that each of the payment methods will be used in making reimbursements. However, since both multiple source and single source drugs have a method that involves AWP, we believe that the impact of discounting AWP would be somewhat greater for Medicare than for Medicaid. The impact on a drug store's sales is fairly small as shown in the chart below:



METHODOLOGY

Our 1984 review included 38 high volume drug items and covered 2,086 purchases made in Arkansas, and 1,383 purchases made in 5 additional states--for a total of 3,469 purchases of the sample drug items. Our data was gathered by visiting pharmacies and reviewing copies of purchase invoices.

Our current review included 55 high volume drug products, most of which are frequently used by the elderly. We relied on pricing information gathered from four different sources. The primary source of our pricing information came from one of the Nation's largest drug wholesalers. We visited the wholesaler and reviewed 4,089 pharmacy invoices for May 1989 covering Texas and Louisiana. A representative for the wholesaler confirmed that the same prices were in effect in Kansas, Oklahoma, and Nebraska. We also obtained 71 national prices for our sample drug items from that same wholesaler's pricing catalog. Further, we obtained 242 invoice prices for our sample drug items from a study conducted by a CPA firm under contract with the Arkansas State Medicaid agency. Finally, we obtained 20 invoice prices from a study conducted in pharmacies by HCFA's Region VI office in the State of Louisiana. These various sources of pricing information gave us a total 4,723 prices on which to base our estimates.

We obtained our AWP information from national drug pricing authorities including "Blue Book" and Medi-Span".

In addition to the pricing study, we interviewed the Director of the Texas Medicaid Drug Program regarding the State's implementation of a policy to discount AWP reimbursement to Medicaid pharmacies.

RESULTS

Our 1984 review showed an average discount below AWP of 15.7 percent in Arkansas, and 15.9 percent for 5 additional states. Our current work shows that there has been very little change from the last audit since the overall discount rate is about 15.5 percent.

Our study of prices actually paid by pharmacies for high volume sample drug items resulted in 3,320 prices for single source items and a weighted average price below AWP of 14.39 percent. For multiple source drugs, our sample of 1,403 prices showed a weighted average price below AWP of 18.20 percent. The combined rate for both single source and multiple source drugs is 15.52 percent.

The following table summarizes the sources of our prices for our current study.

	Single Source		Multiple Source	
Prices From	No. of Prices	Discount Percent	No. of Prices	Discount Percent
Wholesaler	3,077	14.47	1,312	17.85
Wholesaler's Catalog	25	13.24	46	31.51
C.P.A.'s - Arkansas	200	13.34	43	14.70
HCFA - Louisiana	18	14.15	2	17.27
Totals	3,320	14.39	1,403	18.20

As shown above, we obtained the pricing information for our current study primarily from drug wholesalers, rather than from pharmacies. We contacted four of the Nation's largest wholesalers and inquired about their actual selling prices to pharmacies. While officials of all four wholesalers acknowledged that drugs are sold to pharmacies at discounts below AWP, only one of the wholesalers would agree to show us their actual pharmacy invoices. However, the other three wholesalers made the following comments to us with regard to AWP :

Wholesaler	Comments
A	"Overall selling price would be about 12 percent off AWP."
B	"AWP is a meaningless figure."
	"Most of...pricing is based on cost plus a percentage markup."
	"This computed selling price would be less than the AWP."
C	"...it is recognized in the industry that there are discounts off AWP...selling price is based on AWP less a discount or...cost plus a markup."

The only significant change since our prior audit is that all facets of the industry are willing to admit that the discounts exist. For example, consider the following comments by pharmaceutical officials:

> Rugby Laboratories' Director of Regulatory Affairs was recently quoted in the Lexington Herald-Leader as saying:
>
> > "The (Average Wholesale Price) is a joke...it has largely become a farce because many companies have abused it and continue to abuse it."
>
> Also, a top Pennsylvania Medicaid official was quoted in the same publication as saying the average wholesale price:
>
> > "...just doesn't mean anything. It has no connection to what pharmacies really purchase the drug for."

There is a growing trend to discount AWP when it is used as a basis for making drug reimbursements. After our 1984 report was issued, the Texas State Medicaid Agency changed its reimbursement method to reduce AWP by 10.49 percent, which has saved millions of dollars. The Director of the Texas Medicaid drug program in a recent interview, advised us that Texas experienced no decline in pharmacy participation when the discount provision was instituted--in fact, participation has since gone up. This official informed us that, in Texas, the Medicaid business represents about 8 to 10 percent of the prescription drug sales in the typical pharmacy and that there are only a handful of high volume Medicaid pharmacies (over 50 percent Medicaid business). Further, this official pointed out that since drug stores sell many sundry items besides drugs, the impact on total sales resulting from discounting AWP on Medicaid prescription was very small--too small to adversely affect pharmacy participation in the program.

The Texas Director explained that sometimes pharmacists benefit from selling prescriptions, even at no profit, because it provided a broader based over which to spread overhead costs. He pointed out that about 60 percent of the Medicaid prescriptions are filled with generic drugs, which was advantageous to the pharmacist because generic drugs can be purchased at a greater discount than brand name drugs--the discounted AWP has less impact on generic drugs.

A recent survey conducted by the Texas Medicaid agency of 18 third party programs in Texas showed that each program used AWP in the reimbursement formula; however, in 4 of the programs the AWP was discounted from 10 to 15 percent.

CONCLUSIONS AND RECOMMENDATIONS

We conclude that there has been little change in the practice of discounting AWP since our prior audit. Based on our work then and our current ongoing efforts, we continue to believe that AWP is not a reliable price to be used as a basis for making reimbursements for either the Medicaid or Medicare programs. When AWP is used, we believe that it should be discounted.

We recommend that HFCA continue its efforts in the Medicaid program to require State agencies to discount AWP when making program reimbursements. Concerning the Medicare program, we recommend that alternate reimbursement methods be studied and that consideration be given to seeking a legislative change to either use a different reimbursement method or to discount AWP.