Option 1: Administrative claiming allotment reform.
Author: President's Budget FY 2006
Savings Generated: $1.1 Billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.
URL: http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf

SUMMARY

The 2006 Budget proposes to establish individual state allotments for Medicaid administrative costs to encourage states to use more cost-effective methods in administering the program.

KEY POINTS/FINDINGS

- Medicaid reimburses administrative claims under an open-ended financing framework, which does not create incentives for states to operate the program as efficiently as possible.
- In addition, states have taken advantage of open-ended funding to cost shift non-Medicaid activities to the Federal government.
- Congressional Research Services (CRS) reports that the federal match rate for administrative services under Medicaid is usually 50 percent, but that CMS provides different federal match for different administrative expenditures. For example, a 100 percent match is provided for implementation and operation of immigration status verification systems, a 90 percent match is provided for Medicaid Management Information Systems (MMIS) and Medicaid fraud control units (MFCU), and a 75 percent match rate is provided for several services.

FINAL CONSIDERATIONS

This proposal encourages program efficiencies and deters inappropriate cost shifting by slowing the rate of growth related to administrative claims.

CRS reports that program administration expenditures have increased at a rate similar to the growth in expenditures for Medicaid services, remaining a steady share of total Medicaid expenditures. In addition, although states are not limited in the amount they can claim in federal match for administrative services, the Federal government has the authority to review and deny claims for administrative expenditures.

This proposal could limit the amount of money states allocate to their administrative activities, which could impact program effectiveness.

CBO has stated that they cannot score this proposal because, "the Administration has not provided enough details for CBO to prepare its own estimates for some of the proposals that deal with restrictions on certain types of above-cost payments by states to health care providers and on payments for various social and rehabilitative services."

Commissioner Valerie Davidson has requested that the following recommendation be considering during the discussion of this reform option:

(1) Do not impose new or more restrictive limits on reimbursement for Medicaid outreach, education, and enrollment activities. (2) Do not limit the extent to which tribal contributions can be used to match federal expenditures for those activities.

OACT has estimated that amending the proposal to include recommendation (1) would result in approximately a 1% loss in the estimated savings overall. They were unable to estimate the impact of recommendation (2).

Option 2: Equalization of the Medicaid administrative match to 50 percent for all administrative expenses.
Author: Congressional Budget Office, *2005 Budget Options*
Savings Generated: 7.14 Billion over 5 years (2006-2010)
Scored By: Congressional Budget Office

The Congressional Budget Office is Congress's budget agency. CBO regularly publishes a book of Budget Options for altering federal spending and revenues. The information below is taken directly from their 2005 Budget Options volume.
URL: http://www.cbo.gov/showdoc.cfm?index=6075&sequence=0

SUMMARY

The Federal government provides funds to match spending that states incur in administering their Medicaid programs. The basic match rate is 50 percent, but certain services are subsidized with an enhanced match. These services include utilization review (75 percent match), obtaining and retaining skilled medical professionals (75 percent match), and developing and operating information systems (90 percent and 75 percent match respectively). This proposal would set all federal administrative match rates at 50 percent.

KEY POINTS/FINDINGS

- The Federal government reimburses certain administrative costs incurred by states at a rate higher than the 50 percent base for administrative costs.
- This enhanced rate was initially designed to subsidize certain functions important to Medicaid operations, but may no longer be warranted.

FINAL CONSIDERATIONS

This proposal may decrease state spending on attracting skilled medical professionals, which may decrease the quality of services provided. Decreasing the match for information systems may also decrease the efficacy or accuracy of program management. However, it does not seem likely that states would significantly lower the quality of services provided because of this proposal.

Option 3: Limit Medicaid administrative costs to a cap on a per-enrollee basis, with a 5 percent annual growth rate based the 2004 claims data.
Author: Congressional Budget Office, *2005 Budget Options*
Savings Generated: 4.23 Billion over 5 years (2006-2010)
Scored By: Congressional Budget Office

The Congressional Budget Office is Congress's budget agency. CBO regularly publishes a book of Budget Options for altering federal spending and revenues. The information below is taken directly from their 2005 Budget Options volume.
URL: http://www.cbo.gov/showdoc.cfm?index=6075&sequence=0

SUMMARY

States are currently reimbursed for approximately 50 percent of their Medicaid administrative expenses. However, administrative costs per enrollee have been growing at approximately 7 percent per year. This proposal would cap the per-enrollee administrative cost at the 2004 level, and this cap would grow by 5 percent per year. States would not be reimbursed for any administrative costs in excess of this cap.

KEY POINTS/FINDINGS

- This proposal would limit reimbursements to the states for administrative expenses by imposing a cap on the growth of per-capita administrative costs.
- This proposal could significantly decrease the effective reimbursement rate for administrative costs, since the projected growth in administrative costs is faster than the growth of the proposed cap.

FINAL CONSIDERATIONS

This proposal may affect states differently, based on the rate of growth of their administrative costs. It could also limit the amount of money states allocate to their administrative activities, which could impact program effectiveness.

Option 4: Elimination of the "double" administrative payment to states by reducing Medicaid administrative costs to the amount not included in their TANF block grant.
Author: Congressional Budget Office, *2005 Budget Options*
Savings Generated: 1.77 Billion over 5 years (2006-2010)
Scored By: Congressional Budget Office

The Congressional Budget Office is Congress's budget agency. CBO regularly publishes a book of Budget Options for altering federal spending and revenues. The information below is taken directly from their 2005 Budget Options volume.
URL: http://www.cbo.gov/showdoc.cfm?index=6075&sequence=0

SUMMARY

States incur administrative costs that are common to Medicaid, TANF, and Food Stamps such as collecting information about family income, assets and demographics. Before welfare reform, states frequently charged these costs to AFDC, and now states receive a TANF block grant that includes these administrative costs. However, states are now required to charge the Medicaid share of these common costs to the Medicaid program. Therefore, some states are being reimbursed twice for at least a portion of these common administrative costs. This proposal would eliminate this double payment by restricting the Medicaid reimbursement to only that part of the common administrative costs that is not included in the TANF grant.

KEY POINTS/FINDINGS

- Some states are receiving dual reimbursement for Medicaid's share of administrative costs that are already included in their TANF payments.
- The payments made to states under the Food Stamp program have been adjusted downward to account for this double reimbursement. Therefore, it may be appropriate to likewise adjust the Medicaid payments.

FINAL CONSIDERATIONS

To the extent that states were using these extra administrative dollars to increase outreach activities for Medicaid, this proposal may decrease outreach and enrollment in the program.

Option 5: Change the start date of the penalty period for persons transferring assets for Medicaid eligibility.
Author: President's Budget FY 2006
Savings Generated: $1.5 Billion over 5 years (2006-2010)/ $1.4 Billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary/Congressional Budget Office

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.
URL: http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf

BACKGROUND (Due to the complexity of this topic, an overview of current law regarding asset transfers is provided.)

Medicaid is the largest payer for long term care services in the county. Medicaid pays for long-term care services for persons who are poor and need long-term care, as well as for those who are made poor through paying privately the high cost of long-term care services. Determining eligibility for this later group presents a different challenge than for other Medicaid eligibility groups.

States determine financial eligibility for Medicaid coverage of nursing home care using a combination of state and federal statue and regulation. Personal income and assets must be below specified levels before eligibility can be established. Personal resources are sorted into two categories: those considered countable (those that must be spent down before eligibility criteria is met) and those considered non-countable (those that applicants can keep and still meet the eligibility criteria such as real estate). Some assets held in trust, annuities and promissory notes are also not counted. If it is determined that the applicant has excess countable assets, these must spent before they can become eligible. Personal income is applied to the cost of care after a personal needs allowance and a community spouse allowance is deducted.

Federal law requires states to review the income and assets of Medicaid applicants for a period of thirty-six months prior to application or sixty months if a trust is involved. This period is known as the "look back period." Financial eligibility screeners look for transfers from personal assets made during the look back period that appear to have been made for the purpose of obtaining Medicaid eligibility. Transfers made before the look back period are not reviewed. Some states and others maintain that thirty-six months is not a long enough time to discourage transfers.

Applicants are prohibited from transferring resources during the look back period for less than fair market value. Some transfers of resources are allowed, such as transfers between spouses. If a state eligibility screener finds a non-allowed transfer, current law (OBRA'93) requires the state to impose a "penalty period" during which Medicaid will not pay for long-term care. The length of the penalty period is calculated by dividing the amount transferred by the monthly private pay rate of nursing homes in the state. The penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care. Some elder law attorneys advise their clients on how to use the penalty period to retain assets.

The following two proposals suggest ways to change the way Medicaid determines an applicant's financial eligibility for nursing home care. Both proposals alter aspects of the penalty period and one of them goes further to also change the length of the look back period.

SUMMARY

The Administration proposes to move the start date of penalty period from the date of the transfer to the date of application for Medicaid or the nursing home admission date whichever is later. Changing this date extends the time during which Medicaid applicants who made transfers are financially responsible for the cost of their care. Such a change decreases Medicaid expenditures and increases private payment.

KEY POINTS/FINDINGS

- There is concern among states and others that many persons who anticipate needing nursing home care are transferring their assets for less than fair market value in order to reduce private payment for care.
- Current law provides an incentive for such transfers because even if such a transfer is found, the application of the penalty period allows applicants to retain a significant share of their assets that might have been otherwise available to pay for long-term care.
- A cottage industry of elder law attorneys, as well as "half-a-loaf calculator websites", inform consumers about how to time such transfers to maximize retained assets while still qualifying for Medicaid. Not only does this practice cost Medicaid in the near term, it also runs counter to the Department's efforts to encourage consumers to take control of their long-term care and plan ahead for the care they may need. It is difficult to make the case for advance financial planning while such other arrangements are available.

FINAL CONSIDERATIONS

Many consumer advocates fear that changes to the transfer of assets policy will impose hardship on persons needing long term care. In cases in which a transfer is found and a penalty period is imposed they suggest that applicants, unable to pay for services privately, will be forced to go without care. States are required to have hardship provisions in place to assist those unable to make other arrangements; however, little research exists on well such provisions operate.

Commissioners Angus King, Julianne Beckett on behalf of Family Voices, Joseph W. "Chip" Marshall, III, and Douglas Struyk on behalf of the American Association of Homes and Services for the Aging and the American Health Care Association, submitted proposals that endorsed reforms of the asset transfer penalty and the look-back period, but did not provide sufficient detail to score as separate proposals. They did not endorse this specific proposal but are generally in support of reforming this area of Medicaid.

Commissioner Valerie Davidson has requested that the following recommendation be considering during the discussion of this reform option:

At a minimum, all assets of AI/AN individuals described in CMS's State Medicaid Manual, Section 3810.A.7 should be exempt from Medicaid eligibility calculations and estate recovery provisions.

OACT has estimated that amending the proposal to include this recommendation would result in approximately a 1% loss in the estimated savings overall.

State Medicaid Manual Section 3810.A.7:

American Indians and Alaska Natives.—The Federal government has a unique trust responsibility for American Indian (AI) Tribes and Alaska Native (AN) Villages and their members. Section 1917(b)(3) of the Social Security Act gives the Secretary authority to establish standards for hardship. This includes exemptions from estate recovery for certain assets and resources.

a. American Indians and Alaska Natives: Income, Resources and Property Exempt from Medicaid Estate Recovery.—The following AI/AN income, resources, and property are exempt from Medicaid estate recovery:

    1. Certain AI/AN income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
    2. Ownership interest in trust or non-trust property, including real property and improvements:

        a. Located on a reservation (any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
        b. For any federally -recognized Tribe not described in (a), located within the most recent boundaries of a prior Federal reservation.
            c. Protection of non-trust property described in (a) and (b) is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal organization; and/or to one or more Indians;

    3. Income left as a remainder in an estate derived from property protected in 2 above, that was either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
    4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of Federally-protected rights, and income either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and
    5. Ownership interests in or usage rights to items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom.

b. American Indians and Alaska Natives Income, Resources and Property Not Exempt from Medicaid Estate Recovery.—You may recover the following income, resources and property from the estates of American Indians and Alaska Natives:

    1. Ownership interests in assets and property, both real and personal, which are not described in 7.a, items 1-5 above.
    2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources in 7.a, items 1-5.

Option 6: Change the start date of the penalty period for persons transferring assets for Medicaid eligibility.
Author: National Governors Association
Savings Generated: $1.5 Billion over 5 years (2006-2010)/ $1.4 Billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary/Congressional Budget Office

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States should have increased ability to prevent inappropriate transfer of assets by seniors to qualify for Medicaid. To that end, penalty periods should begin at the time of application.

Accordingly, if at any time during the applicable five year look-back period an applicant, the applicant's spouse, or a fiduciary or person acting for the applicant, the applicant's spouse, or both, transfers or sequesters resources or the right to receive resources, income, or both, from any source, and as a result of the transfer or sequestration the funds available to pay for medical assistance are diminished, the applicant shall be ineligible for medical assistance for the period of time that would cause the transferred or sequestered resources, income, or both, to be fully expended at the weighted average nursing facility rate in effect when the transfer or sequestration occurred (either the monthly rate or the daily per diem multiplied by 30.42 and rounded to the nearest dollar). The disqualification period will begin with the date of application for Medicaid long term care services or if the individual is a recipient of Medicaid long term care services at the time of the transfer, the disqualification period shall begin with the month following the month of the transfer.

If the transfer is between spouses this rule does not apply to the extent that the transfer does not cause the transferees' resources and rights to receive income, resources, or both, to exceed the maximum community spouse resource allowance in effect at the time of the transfer. This same exemption also applies to dependent disabled children. Furthermore, if a dependent disabled child is living in their parent(s) home at a time such parent is applying for Medicaid, that child has the right to stay in the home. In the event of death of the child, the state then has the right to recover the asset of the home.

KEY POINTS/FINDINGS

FINAL CONSIDERATIONS

This proposal is consistent with the Administration's rebate reform proposal summarized above (Option 5). Please refer to the above discussion with regard to Valerie Davidson's requested amendments.

Option 7: Extend the asset transfer look back period from three to 5 years.
Author: National Governors Association
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States should have increased ability to prevent inappropriate transfer of assets by seniors to qualify for Medicaid. To that end, the look-back period should be increased from three to five years.

Accordingly, if at any time during the applicable five year look-back period an applicant, the applicant's spouse, or a fiduciary or person acting for the applicant, the applicant's spouse, or both, transfers or sequesters resources or the right to receive resources, income, or both, from any source, and as a result of the transfer or sequestration the funds available to pay for medical assistance are diminished, the applicant shall be ineligible for medical assistance for the period of time that would cause the transferred or sequestered resources, income, or both, to be fully expended at the weighted average nursing facility rate in effect when the transfer or sequestration occurred (either the monthly rate or the daily per diem multiplied by 30.42 and rounded to the nearest dollar).

If the transfer is between spouses this rule does not apply to the extent that the transfer does not cause the transferees' resources and rights to receive income, resources, or both, to exceed the maximum community spouse resource allowance in effect at the time of the transfer. This same exemption also applies to dependent disabled children. Furthermore, if a dependent disabled child is living in their parent(s) home at a time such parent is applying for Medicaid, that child has the right to stay in the home. In the event of death of the child, the state then has the right to recover the asset of the home.

KEY POINTS/FINDINGS

- The CRS Report for Congress Medicaid and SCHIP: The President's FY2006 Budget Proposals, published February 15, 2005 states that Medicaid law includes provisions establishing penalties for individuals who transfer assets for less than fair market value for the purpose of becoming Medicaid-eligible.
- Specifically, Medicaid law requires states to delay Medicaid eligibility for persons needing institutional coverage (including nursing home care) and certain home and community-based services who transfer assets on or before a "look-back date."
- For most assets, this date is 36 months (three years) prior to Medicaid application.

FINAL CONSIDERATIONS

Commissioner Joseph W. "Chip" Marshall, III, endorsed asset transfer reforms consistent with this NGA proposal.

Option 8: Increase co-pays for certain Medicaid services.
Author: Congressional Budget Office, *2005 Budget Options*
Savings Generated: 1.97 Billion over 5 years (2006-2010)
Scored By: Congressional Budget Office

The Congressional Budget Office is Congress's budget agency. CBO regularly publishes a book of Budget Options for altering federal spending and revenues. The information below is taken directly from their 2005 Budget Options volume.
URL: http://www.cbo.gov/showdoc.cfm?index=6075&sequence=0

SUMMARY

Most states have not implemented extensive cost sharing in their Medicaid programs, and federal statutes limit the amount of co-pays that can be charged. In most cases, co-pays of up to $3 can be imposed for prescription drugs, physician visits, and outpatient hospital visits. However, certain categories of beneficiaries, such as children under 18, pregnant women, and the institutionalized cannot be charged co-pays. Co-pays are also prohibited for some services, including emergency care and family planning. This proposal would increase the allowable co-pay limit from $3 to $5 for adults and from $0 to $3 for children. These co-pays would apply to outpatient hospital visits, prescription drugs, non-emergency ER visits, and physician and dental visits.

KEY POINTS/FINDINGS

- Currently states are prohibited from implementing cost sharing above nominal levels (deductible is $2 per family per month; co-payment from $.50 to $3; co-insurance is 5% of the state's payment rate for the item or services) and are prohibited from requiring cost sharing for certain categories of beneficiaries and certain services.
- This proposal would increase the co-pay limits for adults from $3 to $5 and introduce a co-pay limit for children of $3.
- Services excluded from cost sharing under current law would continue to be excluded.
- This proposal would update cost sharing limits that have not changed since the 1980s.

FINAL CONSIDERATIONS

Since the cost sharing limits have not been updated since the 1980s, they may warrant updating. However, increasing cost sharing for the Medicaid population may lead to beneficiaries forgoing needed treatments because of cost.

Commissioner Maggie Brooks also submitted a broad proposal that endorsed reforms of the cost-sharing provisions in the Medicaid program but did not provide sufficient detail to score as a separate proposal. She did not endorse this specific proposal but is generally in support of reforming this area of Medicaid.

One Medicaid enrollee submitted a letter in support of co-pays for all Medicaid beneficiaries.

Option 9: Providing states flexibility in defining cost-sharing requirements for health care services (not including prescription drugs – see Option 10 regarding prescription drug co-pays).
Author: National Governors Association
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States should be given the ability to implement common-sense, enforceable cost sharing throughout the Medicaid program both to increase responsibility of Medicaid beneficiaries for the cost of their health care, and encourage cost-effective care in the most appropriate setting. This new flexibility would be completely at state option, and states could choose to further restrict the types of cost sharing in the program by income level, beneficiary category, or service type.

- *At or Below 100% FPL.* Existing cost sharing limits would remain for beneficiaries at or below the federal poverty level (*with the exception of tiered co-pays for prescription drugs as described below*); however, states would be given the authority to make cost sharing enforceable. No beneficiaries in this group could be charged a premium.
- *Above 100% FPL.* States would be able to increase cost sharing beyond nominal levels for all beneficiaries above the federal poverty level and be given the authority to make cost sharing enforceable. For these beneficiaries, premiums may be appropriate as a cost sharing option for states and states should be given flexibility to experiment with mechanisms to collect these premiums. Beneficiaries will be protected by a 5% cap on the total amount of cost sharing they would be responsible for (5% of total family income). This would increase to 7.5% for those higher income households (defined as above 150% FPL).

Cost sharing would not be implemented on the following categories of beneficiaries or services, as under current law:

- Infants and children under age 18 that are provided "mandatory" coverage (0-5 133% FPL and 6-18 100% FPL)
- Preventive services for all children (well baby, well child care and immunizations);
- Pregnant women with respect to any services related to pregnancy or any other medical condition which may complicate pregnancy;
- Terminally ill individuals receiving hospice care with respect to any service;
- Inpatients in hospitals, nursing facilities, or ICFs/MR who as a condition of eligibility are required to apply most of their income to the cost of care;
- Emergency services, as defined by CMS; and
- Family planning services and supplies

KEY POINTS/FINDINGS

- Currently states are prohibited from implementing cost sharing above nominal levels (deductible is $2 per family per month; co-payment from $.50 to $3; co-insurance is 5% of the state's payment rate for the item or services) and are prohibited from requiring cost sharing for certain categories of beneficiaries and certain services.
- According to a 2004 GAO report, cost sharing is a practice in many states[i]:
    - 25 states currently have some form of cost sharing for a portion of children in SCHIP
    - 9 states currently have Medicaid cost sharing for children.
    - 43 states currently have some form of Medicaid cost sharing for adults
- Co-payments are the predominate form of cost sharing; primarily for prescription drug and physician visits
- Cost sharing can be a mechanism for states to generate cost savings which a state could then apply to support program expansion to low income families.

FINAL CONSIDERATIONS

One Medicaid beneficiary submitted a letter in support of co-pays for all Medicaid beneficiaries.

Commissioner Angus King submitted a broad proposal that endorsed applying graduated co-payments for certain health care services, but did not provide sufficient detail to score as a separate proposal. He does not necessarily endorse this specific proposal but is generally supportive of considerations for reforming this area of Medicaid.

Commissioner Valerie Davidson has requested that the following recommendation be considering during the discussion of this reform option:

The current law provisions regarding the State Children's Health Insurance Program (SCHIP) should be retained and expanded to apply to all AI/ANs who are otherwise eligible to participate in a state's Medicaid program.

OACT has estimated that amending the proposal to include this recommendation would result in approximately a 1% loss in the estimated savings overall.

SCHIP cost-sharing requirements as outlined in a letter to State Health Official's on October 6th, 1999:
Because cost sharing poses a unique financial barrier to care for AI/AN children, states that impose cost sharing on AI/AN children are not in compliance with the access provision of section 2102 (b) (3) (D). Therefore, we will no longer approve any state plans or amendments to state plans that would impose cost sharing on AI/AN children.

Option 10: Providing states flexibility in defining co-payment requirements for prescription drugs requirements.
Author: National Governors Association
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States should be given the ability to develop effective tiered co-pay structures to encourage cost-effective drug utilization where appropriate for all beneficiaries, regardless of income. Although states may currently operate tiered co-pays, Medicaid's current cost sharing rules, with an unenforceable maximum co-pay of $3 per drug is not conducive to encouraging cost-effective utilization. States should be able to increase co-pays on non preferred drugs beyond nominal amounts when a preferred drug is available, to encourage beneficiaries to fill the least costly effective prescription for treatment. Such co-pays must be enforceable to be meaningful.

For beneficiaries at or below the federal poverty level, co-pays for preferred drugs would remain nominal, although they would be enforceable. For this population, states would be able to increase these enforceable co-pays beyond nominal amounts for a non preferred drug. States should be given broad authority to waive these co-pays in cases of true hardship or where failure to take a preferred drug might create serious adverse health effects.

KEY POINTS/FINDINGS

- There are approximately 6.3 million Medicaid beneficiaries who are currently eligible for or receiving benefits through both Medicare and Medicaid. Medicaid will no longer be responsible for providing prescription drug coverage to these beneficiaries beginning January 1, 2006. [ii]
- On average 24% of all eligibles in Medicaid pharmacy benefit management managed care utilize prescription benefits.[iii]

FINAL CONSIDERATIONS

Commissioner Angus King submitted a broad proposal that endorsed applying enforceable co-payments for prescription drugs, but did not provide sufficient detail to score as a separate proposal. He did not necessarily endorse this specific proposal but is generally in support of reforming this area of Medicaid.

Option 11: Convert Medicaid disproportionate share hospital payments into a block grant.
Author: Congressional Budget Office, *Budget Options February 2005*
Savings Generated: $180 Million over 5 years (2006-2010)
Scored By: Congressional Budget Office

The Congressional Budget Office is Congress's budget agency. CBO regularly publishes a book of Budget Options for altering federal spending and revenues. The information below is taken directly from their 2005 Budget Options volume.
URL: http://www.cbo.gov/showdoc.cfm?index=6075&sequence=0

SUMMARY

This option would convert the current Medicaid so-called disproportionate share hospital (DSH) program into a block grant to the states. The grant could be reduced below current-law levels or its future growth limited to a slower rate than that at which Medicaid DSH payments would increase under current law, or both. In exchange for less funding, states could be given greater flexibility to use the funds to meet the needs of their low-income and uninsured populations in more cost-effective ways.

As an illustration of how this option could be structured, the block grant for each state in 2006 could equal 90 percent of the state's Medicaid DSH allotment for 2005. In subsequent years, the block grant could be indexed to the increase in the consumer price index for all urban consumers minus 1 percentage point. The option would increase costs at first because states do not currently spend all of their allotted money as a result of the criteria and conditions that must be met--conditions that would be removed under this option.

KEY POINTS/FINDINGS

- Hospitals that serve a disproportionately large share of low-income patients may receive higher payments from Medicaid than other hospitals do via DSH.
- States have some discretion in determining not only which hospitals receive DSH payments but also the size of those payments--if the hospitals meet certain federal criteria.
- During the late 1980s and early 1990s, many states engaged in funding transfers using the DSH program to obtain increased federal Medicaid funding without raising their net spending on DSH hospitals--effectively boosting the federal matching rate above that specified in law.
- To combat that practice, lawmakers enacted a series of restrictions on Medicaid DSH payments during the 1990s that included setting fixed ceilings on DSH payments to each state.
- The Medicare Modernization Act of 2003 raised those ceilings by $1.2 billion in 2004 and by smaller amounts in later years. The Congressional Budget Office projects that under current law, federal outlays for Medicaid DSH payments, which totaled $8.7 billion in 2004, will rise to $9.8 billion in 2010.

FINAL CONSIDERATIONS

In addition to budgetary savings, a rationale for a block grant is that the increased latitude provided to the states could result in DSH funds being more appropriately and equitably targeted to facilities and providers that serve low-income populations. For example, states would have greater flexibility to use those funds to support outpatient clinics and other non-hospital providers that treat Medicaid beneficiaries and low-income patients.

State governments, however, might not increase their contributions to make up for the reduction in federal subsidies. As a result, hospitals (and health care providers in general) could receive less in combined federal and state Medicaid subsidies and might not be able to serve as many low-income patients. Another potential drawback is that giving states more flexibility to allocate DSH payments could alter the distribution and amount of assistance among hospitals, possibly resulting in some hospitals receiving less public funding than they do now. Moreover, states may already have enough flexibility under current rules to allocate DSH payments to achieve the maximum benefit.

Option 12: Medicaid federal financial participation payment reform that restricts intergovernmental transfers.
Author: President's Budget FY 2006
Savings Generated: $4.6 billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary
Also submitted by: Grace-Marie Turner, Robert Helms

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.
URL: http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf

SUMMARY

The President's 2006 budget proposes to improve the integrity of the Medicaid matching rate system by requiring the Centers for Medicare and Medicaid Services (CMS) to recover federal funds inappropriately retained by or returned from providers to the state. The proposal would base federal match to states on net expenditures, and would, according to the Congressional Research Service, provide federal matching funds to states only for payments retained by Medicaid providers. This proposal restricts intergovernmental transfers (IGTs).

KEY POINTS/FINDINGS

- States are allowed to finance up to 60 percent of the state share of Medicaid expenditures with local government funds.
- Medicaid's open-ended financing structure encourages states to maximize the amount of Federal matching funds they receive without contributing the legally-determined state share. CRS writes that in some cases, states have required local government providers to use IGTs to transfer back to the state the federal Medicaid funds paid to these providers.
- Through such mechanisms, federal funds intended to pay for health services are either retained by or returned to the state and "recycled" to draw additional federal dollars.
- These financing strategies have led to dramatic increases in federal funding without a corresponding increase in Medicaid services.
- States have a financial incentive to make excessive payments to government providers as part of a strategy to leverage additional federal funds. In many cases, the excessive payments do not remain with the government provider, but are instead transferred back to the state where they can be used for other purposes.

FINAL CONSIDERATIONS

This proposal is intended to reinforce the federal/state partnership while eliminating Medicaid financing arrangements that undermine the program's integrity. It allows states to set adequate rates for Medicaid services and affects funding that does not directly pay for health services. The Federal government remains committed to providing quality services to Medicaid beneficiaries.

In addition, this proposal is consistent with reforms proposed by the HHS Office of the Inspector General (OIG). In past years, the HHS OIG has recommended this proposal as a strategy to curb inappropriate financing mechanisms.

CBO has stated that they cannot score this proposal because, “the Administration has not provided enough details for CBO to prepare its own estimates for some of the proposals that deal with restrictions on certain types of above-cost payments by states to health care providers and on payments for various social and rehabilitative services.”

Commissioners Grace-Marie Turner and Robert Helms endorsed payment reforms consistent with this Administration proposal.

Option 13: Medicaid federal financial participation payment reform limiting government provider payment to actual costs/restricting upper payment limits.
Author: President's Budget FY 2006
Savings Generated: $1.2 billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary
Also submitted by: Grace-Marie Turner, Robert Helms

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.
URL: http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf

SUMMARY

The 2006 Budget also proposes to better align federal reimbursement for government providers to the cost of providing Medicaid services. According to CRS, the proposal would change the permissible upper payment limit (UPL) for government providers from the Medicare payment rate to the cost of providing services.

KEY POINTS/FINDINGS

- CRS writes that aggregate Medicaid payments to specific providers cannot exceed a "reasonable" estimate of what would have been paid under Medicare, called the UPL.
- Because the UPL may exceed the Medicaid rate that would have otherwise been paid to providers, states have been able to require providers to return all or part of the extra payments received back to the state through an IGT.
- Some states have used these excess funds for non-health services or to drawn down additional federal Medicaid matching funds.
- The Government Accountability Office has recommended that HHS address this issue by reimbursing providers on a cost basis.

FINAL CONSIDERATIONS

This proposal is intended to reinforce the federal/state partnership while eliminating Medicaid financing arrangements that undermine the program's integrity. It allows states to set adequate rates for Medicaid services and affects funding that does not directly pay for health services. The Federal government remains committed to providing quality services to Medicaid beneficiaries.

In addition, this proposal is consistent with reforms proposed by the HHS Office of the Inspector General (OIG). In past years, the HHS OIG has recommended this proposal as a strategy to curb inappropriate financing mechanisms.

CBO has stated that they cannot score this proposal because, "the Administration has not provided enough details for CBO to prepare its own estimates for some of the proposals that deal with restrictions on certain types of above-cost payments by states to health care providers and on payments for various social and rehabilitative services."

Commissioners Grace-Marie Turner and Robert Helms endorsed payment reforms consistent with this Administration proposal.

Option 14: Require all states to comply with current UPL regulations by 2006.
Author: Congressional Budget Office, *2005 Budget Options*
Savings Generated: 1.97 Billion over 5 years (2006-2010)
Scored By: Congressional Budget Office

The Congressional Budget Office is Congress's budget agency. CBO regularly publishes a book of Budget Options for altering federal spending and revenues. The information below is taken directly from their 2005 Budget Options volume.
URL: http://www.cbo.gov/showdoc.cfm?index=6075&sequence=0

SUMMARY

Before 2001, Medicaid was prohibited from paying more for hospital and nursing home care than the Medicare program did. This upper bound is known as the Upper Payment Limit (UPL), and applied to services received in both private and local government facilities. Some states, in response, increased their payments to local government facilities, received a federal match, and then recovered the excess payments from the local government facilities. HHS instituted regulations in 2001 that created separate UPLs for facilities run by local governments. However, these regulations are phased in over a longer time period for states that had been using this enhanced-funding mechanism the longest. Some states are not subject to this rule until September 30, 2008. This proposal would require all states to adhere to the new UPL rules starting in 2006.

KEY POINTS/FINDINGS

- This proposal would shorten the time frame for adhering to the new UPL rules so that all states would have to comply starting in 2006.
- Many states are already in compliance with these rules, because they had not used the enhanced-funding mechanism described above.

FINAL CONSIDERATIONS

Enforcing the new Upper Payment Limits for all states would treat all states the same, and would decrease the enhanced match that some states are currently receiving. However, states that did use the funding mechanism described above may require additional time to adjust to the smaller federal payments they will receive under this proposal.

Option 15: Medicaid prescription drug reimbursement formula reform.
Author: President's Budget FY 2006
Savings Generated: $5.4 Billion over 5 Years (2006-2010)/ $5.2 Billion over 5 Years (2006-2010)
Scored By: CMS Office of the Actuary/Congressional Budget Office

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.
URL: http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf

SUMMARY

The Budget proposes to require states to reimburse the Average Sales Price (ASP) of a drug to pharmacies for Medicaid drugs, plus a 6 percent fee for storage, dispensing, and counseling. ASP is the weighted average of all non-Federal sales from manufacturers, and is therefore a sound proxy for pharmacy acquisition cost. This reimbursement scenario aligns pharmacy reimbursement with pharmacy acquisition cost and will create a more sustainable system. Reimbursing ASP + 6 percent is consistent with Medicare reimbursement for Part B-covered drugs as established by the Medicare Modernization Act.

KEY POINTS/FINDINGS

- Currently, most states reimburse pharmacies a percentage discount off the Average Wholesale Price (AWP), a list price set by the drug manufacturer, plus a flat dollar dispensing fee.
- In recent years, the HHS Inspector General has found that pharmacies acquire drugs for a cost that is generally much lower than their reimbursement. The difference between the pharmacy acquisition cost and the reimbursed amount is referred to as the spread. The larger the spread, the more a pharmacy profits on the reimbursement from Medicaid.
- The current system has created an incentive for manufacturers to artificially raise the AWP to make their products more attractive to pharmacies because the profit will be larger with the higher price. As a result, AWP is consistently inflated and therefore a faulty reference price.
- Moving to an ASP-based system creates a more transparent Medicaid pharmacy reimbursement system, which could slow down the rapidly rising costs of Medicaid drugs.

FINAL CONSIDERATIONS

Julianne Beckett of Family Voices, the National Council on Independent Living, Bill Vaughan of Consumers Union, Chris Hilderbrant from the Center for Disability Rights, and Kathryn L. Kuhmerker, the New York State Medicaid director also submitted proposals that endorsed reforms of the payment system for pharmaceuticals but did not provide sufficient detail to score as a separate proposal. They did not endorse this specific proposal but are generally in support of reforming this area of Medicaid. In addition, Commissioners Carol Berkowitz, John Kemp, and Joseph W. "Chip" Marshall, III endorsed pharmacy reimbursement reforms consistent with this Administration proposal.

Commissioner Valerie Davidson has requested that the following recommendation be considering during the discussion of this reform option:

(1) If the basis of reimbursement is changed, provide for flexibility in the dispensing fee to assure that states can protect access in rural and remote locations. (2) Provide expressly that pharmacies of the Indian health system may continue to be reimbursed on the basis of AWP less a percentage plus a dispensing fee (with neither the percentage or dispensing fee to be smaller than tat paid in FY 2005), unless and until the infrastructure foe determining the average cost of acquisition, pharmacy program administration, and dispensing (including patient counseling) on an ongoing basis is developed by HIS and made available to tribal health programs. (Note: Many smaller tribal pharmacy programs lack even the capacity for electronic claims processing, let alone complex cost accounting.)

OACT has estimated that amending the proposal to include recommendation (2) would result in approximately a 1% loss in the estimated savings overall. They were unable to estimate the impact of recommendation (1).

Option 16: Medicaid prescription drug reimbursement formula reform.
Author: National Governors Association
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

States negotiate prices on prescription drugs according to the published average wholesale price (AWP). There is widespread acceptance that AWP is inflated and does not reflect a valid benchmark for pricing. A different reference price should be established and made available to the states that more accurately reflects the actual price for drugs. The Average Manufacturer Price (AMP) should be used for this purpose.

KEY POINTS/FINDINGS

If AMP replaces AWP in pricing, reforms need to be made to ensure that manufacturers are appropriately reporting pricing data. Such improvements should include reforms to ensure: 1) clear guidance from CMS on manufacturer price determination methods and the definition of AMP; 2) manufacturer-reported prices are easily auditable so that systematic oversight of the price determination can be done by HHS; 3) manufacturer-reported prices and rebates should be provided to states monthly rather than the current quarterly reporting; and 4) new penalties are implemented to discourage manufacturers from reporting inaccurate pricing information.

FINAL CONSIDERATIONS

Recent reports by the General Accounting Office (GAO) and the Office of Inspector General (OIG) concluded that improvements in manufacturer price determination methods and reporting, and increased oversight by CMS are essential to ensure that AMP is a reliable and accurate reference price for states if AMP is to be used for the pharmacy reimbursement formula.

Option 17: Medicaid prescription drug reimbursement formula reform.
Author: Governor Angus King
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

Governor King is the Medicaid Commission's Vice-Chair and the former Governor of Maine.

SUMMARY

This option would require states to reimburse the Average Sales Price (ASP) of a drug to pharmacies for Medicaid drugs, plus a flat fee of $9 for storage, dispensing, and counseling.

KEY POINTS/FINDINGS

- Currently, most states reimburse pharmacies a percentage discount off the Average Wholesale Price (AWP), a list price set by the drug manufacturer, plus a flat dollar dispensing fee.
- In recent years, the HHS Inspector General has found that pharmacies acquire drugs for a cost that is generally much lower than their reimbursement. The difference between the pharmacy acquisition cost and the reimbursed amount is referred to as the spread. The larger the spread, the more a pharmacy profits on the reimbursement from Medicaid.

FINAL CONSIDERATIONS

Option 18: Increase the flat rebate paid by brand-name drug manufacturers by increasing the minimum rebate percentage.
Author: Congressional Budget Office, *2005 Budget Options*
Savings Generated: 3.22 Billion over 5 years (2006-2010)
Scored By: Congressional Budget Office

The Congressional Budget Office is Congress's budget agency. CBO regularly publishes a book of Budget Options for altering federal spending and revenues. The information below is taken directly from their 2005 Budget Options volume.
URL: http://www.cbo.gov/showdoc.cfm?index=6075&sequence=0

SUMMARY

All states provide prescription drug coverage to at least some of their Medicaid enrollees. In return for their drugs being covered by Medicaid, drug manufacturers must enter into an agreement with Medicaid to refund a portion of their payments back to the Medicaid program. The amount of the rebate for brand-name drugs is based on two prices, the average manufacturer's price (AMP) and the "best price", the lowest price that the manufacturer sells to any buyer.

The rebate is calculated as a percentage of AMP multiplied by the total number of Medicaid prescriptions for each specific drug. This percentage of AMP is the maximum of 15.1 percent or the percentage difference between the AMP and the best price. Therefore, if a manufacturer offers a steep discount to certain buyers, they will be required to pay back a higher rebate to Medicaid than a manufacturer who does not. On average, Medicaid receives rebates from manufacturers that are approximately 20 percent of the AMP. There is also a secondary rebate that applies if the cost of the drug rises faster than inflation. This proposal would change the minimum percentage of the rebate from 15.1 percent to 20 percent.

KEY POINTS/FINDINGS

- This proposal would increase the minimum percentage applied to drug manufacturers in exchange for covering their drugs from 15.1 percent to 20 percent.
- Changing the floor percentage from 15.1 percent to 20 percent would increase the average rebate percentage received from manufacturers from 20 percent to 23 percent.

FINAL CONSIDERATIONS

This proposal may reduce the cost of drugs slightly to non-Medicaid enrollees, since it will remove some of the penalty that drug companies face in offering deep discounts to some buyers. It will also decrease revenues to drug manufacturing companies, however, which could decrease Research & Development activity.

Julianne Beckett of Family Voices, Joseph W. “Chip” Marshall, III, the National Council on Independent Living, Bill Vaughan of Consumers Union, Chris Hilderbrant from the Center for Disability Rights, and Kathryn L. Kuhmerker, the New York State Medicaid director also submitted proposals that endorsed reforms of the payment system for pharmaceuticals but did not provide sufficient detail to score as a separate proposal. They did not necessarily endorse this specific proposal but are generally in support of reforming this area of Medicaid. In addition, the Association of University Centers on Disabilities and Commissioners Carol Berkowitz and John Kemp endorsed pharmacy rebate reforms consistent with this CBO proposal.

Option 19: Increase the flat rebate paid by brand-name drug manufacturers by increasing the minimum rebate percentage.
Author: National Governors Association
Savings Generated: $3.22 Billion over 5 years (2006-2010)
Scored By: Congressional Budget Office

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

The minimum rebates that states collect on brand name drugs should be increased to 20% (from 15.1%) to ensure lower total costs that would not solely impact pharmacists. Medicaid's "Best Price" provision should not be eliminated in exchange for this.

KEY POINTS/FINDINGS

- This proposal would increase the minimum percentage applied to drug manufacturers in exchange for covering their drugs from 15.1% to 20%.
- Changing the floor percentage from 15.1% to 20% would increase the average rebate percentage received from manufacturers from 20% to 23%.

FINAL CONSIDERATIONS

This proposal is consistent with the Congressional Budget Office's rebate reform proposal summarized above (Option 18).

Option 20: Extension of the Medicaid drug rebate program to Medicaid managed care.
Author: National Governors Association
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

As more and more states utilize managed care to help administer their program, managed care companies should be able to directly access rebates for prescription drugs purchased for their Medicaid population. States should have the option of collecting these rebates directly or allowing plans to access them in exchange for lower capitation payments.

KEY POINTS/FINDINGS

- A Center for Health Care Strategies (CHCS) report concluded that MCOs are able to reduce their average per member per month (PMPM) drug costs for families in Medicaid managed care to $17.36 compared to $20.46 in the state FFS programs.
- The Lewin report concluded that Arizona's managed care program was able to achieve the lowest pharmacy costs in the nation at the time of the study, 38% below the national Medicaid average.
- Support for this reform proposal from includes the following organizations: National Association of State Medicaid Directors, Medicaid Health Plans of America.

FINAL CONSIDERATIONS

Because managed care penetration varies widely by state, the fiscal impact of a reform of this nature would vary considerably across states. Therefore, while it may achieve overall savings for the Federal government, not all states would experience measurable savings.

Option 21: Extension of the Medicaid drug rebate program to Medicaid managed care.
Author: Association for Community Affiliated Plans (formerly Association for Health Center Affiliated Health Plans)
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

The Association for Community Affiliated Plans (ACAP) is a national trade association representing "safety net health plans" that are Medicaid-focused and are non-profit or owned by non-profit entities like public hospitals or community health centers. As of July 2005, ACAP represents 19 plans serving 2.1 million Medicaid beneficiaries in 12 states. ACAP plans serve one of every six Medicaid managed care enrollees.

SUMMARY

ACAP proposes giving Medicaid managed care health plans access to the existing pharmaceutical manufacturer rebate program. Currently, the Medicaid Drug Rebate Program requires drug manufacturers to have rebate agreements for outpatient drugs dispensed to Medicaid patients as part of their fee-for-service programs. Even though managed care plans pay higher prices for drugs due to the inequities of the drug rebate, they still pay less on a PMPM basis because of better utilization management techniques. Equalizing access to the drug rebate would allow a plan to pay even less for drugs on a PMPM basis. Because the Medicaid fee-for-service program is required by law to get the best and lowest price via the drug rebate mechanism, Medicaid managed care plans end up paying higher prices for the drugs even though they are also serving Medicaid beneficiaries.

KEY POINTS/FINDINGS

- A Center for Health Care Strategies (CHCS) report concluded that MCOs are able to reduce their average per member per month (PMPM) drug costs for families in Medicaid managed care to $17.36 compared to $20.46 in the state FFS programs.
- The Lewin report concluded that Arizona's managed care program was able to achieve the lowest pharmacy costs in the nation at the time of the study, 38 percent below the national Medicaid average.
- The Lewin study also concluded that giving health plans access to the drug rebate could save the Federal and State governments up to $2 billion in Medicaid savings over 10 years. ACAP actually believes that the savings could exceed $2 billion because more states are turning to managed care.
- ACAP cites support for this reform proposal from the following organizations: National Association of State Medicaid Directors, Medicaid Health Plans of America, and the National Association of Community Health Plans.

FINAL CONSIDERATIONS

This proposal is consistent with the NGA rebate proposal summarized above (Option 20).

Option 22: "Authorized generics" should be included in calculations of best price for the brand name drug.
Author: National Governors Association
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

For those states that continue to rely on the Medicaid drug rebate and "best price" provisions, reforms should be made to ensure that all drugs be included in these calculations. "Authorized generics" should be included in calculations of best price for the brand name drug. In addition, an "authorized generic" should qualify a particular drug for having a CMS set federal upper limit (FUL). Currently, if at least three versions of the drug are rated as therapeutically equivalent by the FDA and the drug has at least three suppliers listed in current editions of national compendia, an FUL should be set by CMS.

KEY POINTS/FINDINGS

- "Best price" is the lowest price at which the manufacturer sells the covered patient drug to any purchaser in the United States in any pricing structure, in the same quarter for which the AMP is computed.
- Best Price includes prices to wholesalers, retailers, nonprofit entities, or governmental entities within the United States. It also includes cash discounts, free goods contingent on another purchase, volume discounts, and rebates (other than rebates under Section 1927 of the Act).

FINAL CONSIDERATIONS

Option 23: Modification of the calculation for and use of the federal upper limit reimbursement amount for certain generic drugs.
Author: National Governors Association
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

To ensure that states do not pay too much for prescription drugs, a new federal reimbursement ceiling for all drugs should be established based on the AMP. In addition, the current practice of applying a Federal Upper Limit (FUL) to classes of drugs with three therapeutically equivalent products should be maintained; however, the current FUL in this instance is based on 150% of the AWP of the least costly therapeutically equivalent product, and should be revised to reflect 150% of the AMP of the least costly therapeutically equivalent product.

KEY POINTS/FINDINGS

- Currently, CMS sets FUL for drugs with generic equivalents, when there are three therapeutically equivalent drug products.
- The FUL is set at 150% of the published AWP price for the least costly therapeutically equivalent product.
- A recent OIG report found that Medicaid could save hundreds of millions of dollars per year by basing FUL amounts on reported AMPs. According to the report, if Medicaid based FUL amounts on 150% of the lowest reported AMP rather than 150 percent of the lowest published price (AWP), the program may have saved up to $300 million in just one quarter of 2004; an estimated $650 million per year of savings. (http://oig.hhs.gov/oei/reports/oei-03-05-00110.pdf.)
- Previous reports by the OIG in 2004 found that CMS does not effectively add qualified drugs to the FUL list (e.g. OIG found that 90 drug products were not included on the FUL list in 2001 that met the criteria and had they been they could have saved $123 million in 2001).
- CMS should ensure that a FUL is set for qualifying drugs in a timely manner.

FINAL CONSIDERATIONS

Option 24: Require greater use of generic drugs.
Author: National Association of Chain Drug Stores (NACDS)
Savings Generated: *The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See "Criteria for Considering Submissions" in Tab 4.*
Scored By: *N/A*

Founded in 1933, the National Association of Chain Drug Stores works to provide the chain drug industry with a unified voice necessary for growth and success. The chief purpose of NACDS is to represent the views and policy positions of member chain drug companies.

SUMMARY

The Federal government should require greater use of generic drugs where therapeutically equivalent generics are available, and standardizing rules governing generic substitution to eliminate conflicting state and federal requirements. This could be achieved through:

- Maximizing generic substitution by requiring the use of equivalent generic products in place of off-patent brand-name products whenever possible and prudent;
- Requiring that a strong federal generic substitution requirement should preempt state generic substitution laws to avoid conflicting requirements;
- Adopting other policies to encourage use of generic drugs as alternatives to more expensive patented brand-name drugs, where appropriate for a particular patient; and
- Including reimbursement incentives for pharmacies to dispense generics.

See NACDS submission for full proposal details.

KEY POINTS/FINDINGS

- Generic dispensing rates vary widely among states. During the first three months of 2005, the median generic dispensing rate among state Medicaid programs was 53.3 percent. Washington had the highest generic dispensing rate (60.7%) while New Jersey had the lowest (43.1%). Several factors contribute to this variation including population differences and regional prescribing practices, but state policies play a significant role.
- While generic use has increased in Medicaid in recent years, there are still many opportunities to increase generic use. Mandatory substitution of generics for off-patent brands is one option, although exceptions should be permitted to protect patients' health, for example if a particular patient is allergic to inactive ingredients in a generic formulation or does not respond to treatment with the generic.
- Potential savings from mandatory generic substitution represent a small percentage of overall costs because generic substitution rates in Medicaid are already high.
- Generally state laws allow pharmacists to fill a prescription with a generic unless the physician indicates in writing on the prescription "no substitution" or "brand medically necessary." In some states, the law mandates that pharmacists substitute the generic. In most states, the patient must consent or at least be informed when a generic drug is substituted. However, there are cases where Medicaid generic substitution laws conflict with state pharmacy practice

regulations. Federal Medicaid states for generic substitution that preempt state laws would alleviate such conflicts.

- Possible savings from generic substitution should significantly increase when several high volume brand-name drugs come off patent between now and the end of 2007.

FINAL CONSIDERATIONS

NACDS estimates that each one percentage point increase in generic dispensing rates nationally could save Medicaid between $130 million and $283 million in 2006, depending on the mix of patented/off-patented brand products replaced by generics. Over the period from October 2005 to December 2010, total savings could range from $940 million to $2.07 billion.

Option 25: Encourage the implementation of step therapy programs and approved therapeutic interchanges.
Author: National Association of Chain Drug Stores (NACDS)
Savings Generated: *The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See "Criteria for Considering Submissions" in Tab 4.*
Scored By: *N/A*

Founded in 1933, the National Association of Chain Drug Stores works to provide the chain drug industry with a unified voice necessary for growth and success. The chief purpose of NACDS is to represent the views and policy positions of member chain drug companies.

SUMMARY OF PROPOSAL

The Federal government should enhance the use of lower cost drugs by encouraging the implementation of step therapy programs and approved therapeutic interchanges. This could be achieved through:

- Conducting or assisting with cost-effective comparisons of products in the same drug class as well as products in different drug classes that provide similar therapeutic benefit or outcomes, and using the results to establish guidelines and protocols to help increase generic use through approved therapeutic interventions, and
- Initiating step therapy to achieve savings by requiring the use of lower-cost treatments that would be expected to work before using more expensive products.

See NACDS submission for full proposal details.

KEY POINTS/FINDINGS

- Step therapy is a cost containment tool that (1) influences providers to first prescribe a lower-cost therapy that should provide a safe and effective treatment, and (2) allows providers to sequentially prescribe more costly therapies if the initial therapy turns out to be ineffective or causes (or is known to cause) an adverse reaction for a particular patient. Step therapy procedures can be applied to individual drugs, an entire class of drugs, or even span multiple drug classes.
- Step therapy currently used in at least 15 Medicaid or senior drug programs, including programs in Nevada, Pennsylvania, and Tennessee. According to one employer survey, step therapy is also used by about 28 percent of employers.[iv]

FINAL CONSIDERATIONS

NACDS estimates that Medicaid could save about $260 million in 2006 and $1.9 billion from October 2005 to December 2010, if step therapy was used in just three high-use, high cost drug classes (proton pump inhibitors [ulcer medication], statins [cholesterol], and nasal steroids [allergies]).

Option 26: Expansion of preferred drug lists and prior authorization requirements.
Author: National Association of Chain Drug Stores (NACDS)
Savings Generated: *The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See "Criteria for Considering Submissions" in Tab 4.*
Scored By: *N/A*

Founded in 1933, the National Association of Chain Drug Stores works to provide the chain drug industry with a unified voice necessary for growth and success. The chief purpose of NACDS is to represent the views and policy positions of member chain drug companies.

SUMMARY

The Federal government should maintain and enhance existing state preferred drug list (PDL) and prior authorization procedures by requiring that all drug categories be included, and enhancing the opportunity to earn additional rebates through the development of multi-state purchasing or negotiating pools for prescription drugs. This could be achieved through:

- Requiring that state Medicaid programs develop and implement preferred drug lists (PDL);
- Encouraging and approving multi-state purchasing or negotiating pools among states; and
- Considering all drug categories, including mental health/central nervous system classes, when developing these PDLs.

See NACDS submission for full proposal details.

KEY POINTS/FINDINGS

- Most private employers use "incented" formularies that use financial incentives such as tiered co-payments to steer beneficiaries to lower cost and preferred drugs. Incented formularies are not feasible for Medicaid due to federal limitations on the size and scope of cost sharing allowed by federal law and federal requirements that pharmacies must provide drug products to Medicaid beneficiaries even if they do not pay their co-payments(s).
- Federal law also requires that Medicaid programs maintain open formularies, but states can use a preferred drug list (PDL) to steer use toward particular products. At least 43 states either have implemented or are developing PDLs that encourage the use of more cost-effective drugs. Drugs not on the PDL must still be made available through prior authorization. Manufacturers of drugs are often encouraged to pay rebates supplemental to those required under federal law in order for their drugs to be considered for inclusion on the PDL.
- Medicaid officials have expressed concern that states will lose some of their negotiating leverage with pharmaceuticals manufactures after the Medicare Part D benefit begins in 2006. The "dual eligible" population accounts for roughly half of all prescription drug expenditures in Medicaid nationwide. Part D will eliminate Medicaid prescription drug coverage for dual eligibles, significantly reducing drug utilization and expenditures in state Medicaid programs. Several states have already entered into pooled purchasing arrangements, approved by CMS, which should help those states maintain negotiating leverage with pharmaceutical manufactures.

FINAL CONSIDERATIONS

First Health Services, a pharmacy benefits administrator that helps manage Medicaid drug benefits in several states, estimates that preferred drug lists could reduce Medicaid prescription drug costs by about 10 to 15 percent. NACDS estimates that this proposal could save over $450 million in 2006 and more than $3.3 billion over 5 years.

Option 27: Improve drug utilization review.
Author: National Association of Chain Drug Stores
Savings Generated: *The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See "Criteria for Considering Submissions" in Tab 4.*
Scored By: *N/A*

Founded in 1933, the National Association of Chain Drug Stores works to provide the chain drug industry with a unified voice necessary for growth and success. The chief purpose of NACDS is to represent the views and policy positions of member chain drug companies.

SUMMARY

The Federal government should provide greater resources to states to improve their drug utilization review (DUR) procedures, and making utilization review more effective through such follow-up measures as prescriber profiling and counter-detailing.

Prescription profiling programs attempt to reduce medication errors and inappropriate prescribing practices by focusing on individual prescribers. For example, profiling may identify doctors whose prescribing practices vary dramatically from their peers or show drug-specific variations.

"Counter-detailing" or "academic detailing" is the practice of providing alternative information to physicians to offset "detailing," which is education and marketing provided by drug manufacturers to increase awareness and use of their company's drugs.

KEY POINTS/FINDINGS

- DUR refers to a wide range of systems for monitoring and managing use of drugs.
- Generally, DUR programs observe patterns of drug utilization and costs, compare the results to peer-reviewed standards, and then provide information to physicians, pharmacists, and/or health plan sponsors with the goals of correcting drug utilization problems and minimizing the likelihood of adverse patient health outcomes.
- By federal law, all state Medicaid programs are required to have DUR programs. These include prospective programs that screen for such issues as drug-drug interaction and drug allergies, as well as retrospective programs that review claims data to identify fraud, abuse, or inappropriate or medically unnecessary care among physician prescribing patterns.

FINAL CONSIDERATIONS

NACDS estimates that reductions of up to two percent of total Medicaid drug spending might be attainable. A two-percent decrease in Medicaid drug spending would achieve $470 million in savings in 2006 and $3.44 billion in savings between October 2005 and December 2010.

Option 28: Implementation of grants or enhanced Medicaid match for the adoption of expansion of electronic prescribing (e-prescribing) and related technologies.
Author: National Association of Chain Drug Stores
Savings Generated: *The CMS Office of the Actuary was unable to score this proposal; therefore, it is no longer a possible option for the September 1 report. See "Criteria for Considering Submissions" in Tab 4.*
Scored By: *N/A*

Founded in 1933, the National Association of Chain Drug Stores works to provide the chain drug industry with a unified voice necessary for growth and success. The chief purpose of NACDS is to represent the views and policy positions of member chain drug companies.

SUMMARY

The Federal government should provide grants or enhanced Medicaid match for the adoption of expansion of electronic prescribing (e-prescribing) and related technologies.

This proposal recommends that Medicaid adopt a program similar to a program implemented by Florida Medicaid in January 2005, which supplied handheld, wireless devices, containing the Medicaid preferred drug list, 60-day patient specific prescription history, and drug utilization reports, to 1,000 high-volume prescribers.

KEY POINTS/FINDINGS

- The Federal government already provides 90 percent match for upgrades to Medicaid Management Information Systems (MMIS).
- E-prescribing is the use of electronic systems to generate prescriptions and transmit prescription information between prescribers, pharmacists and Medicaid programs.
- Basic e-prescribing systems typically provide physicians with a drug database for prescribing, check prescriptions against a formulary, and screen for drug-drug interactions with other drugs prescribed using the system.
- More extensive e-technology may include patient profiles that associate diagnoses with prescriptions, screen for allergies or drug-disease warnings, and offer additional drug reference capabilities.
- Benefits to Medicaid programs may include:
  - Increased accuracy, patient safety due to computer generation of legible, consistently-formatted prescriptions, and screening for potential interactions;
  - More efficient methods for drug utilization review and monitoring patient and physician compliance as well as potential fraud and abuse;
  - More efficient communication with pharmacies; and
  - Improved patient satisfaction because prescriptions can be filled faster with fewer errors.

FINAL CONSIDERATIONS

NACDS estimates that Medicaid could save at least $88 nationwide in 2006 and $650 million from October 2005 to December 2010 by adopting a program similar to Florida's pilot program. This projection assumes that states give similar technology to the same percentage of physicians as in Florida (about 2.6 percent), and those physicians achieve similar savings ($700 per month). By comparison, assuming that 10 percent of physicians in each state use the technology and they achieve slightly lower savings of $500 per prescriber per month, we estimate that Medicaid could save $241 million in 2006 and $1.77 billion between October 2005 and December 2010.

Option 29: Reduce the allowable Medicaid provider tax from 6 percent to 3 percent.
Author: President's Budget FY 2006
Savings Generated: $2.8 Billion over 5 years (2006-2010)/ $4.5 Billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary/Congressional Budget Office
Also submitted by: Grace-Marie Turner, Robert Helms

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.
URL: http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf

SUMMARY

The 2006 Budget proposes to phase down the allowable tax rate states can charge providers from six percent to three percent.

KEY POINTS/FINDINGS

- Provider taxes are a financing mechanism states have used to generate state funds needed to obtain federal Medicaid matching payments.
- During the mid 1980s, states began using provider taxes as a mechanism to leverage additional federal funds and cost shift Medicaid expenses to the Federal government. After the taxes were matched with federal funds and paid to the providers, the providers did not keep the payments. Instead, the providers returned most of the federal monies to the states, where the funds could be used for other purposes.
- In 1991, the Congress passed legislation to limit states' use of provider taxes. CRS reports that states were limited from guaranteeing that provider taxes would be returned to the providers.
- While Congress limited the use of this creative financing mechanism, the previous Administration created a "safe harbor" for provider taxes. The safe harbor allows states to tax providers up to six percent of revenues, under certain circumstances.
- CRS reports that the safe harbor allows states to promise to return the tax revenues to the providers if the taxes returned equal less than 6 percent of the provider's revenues.
- The tax must be applied uniformly across all health care providers in the same class (e.g., all hospitals).
- Recently, use of this financing mechanism began to expand.

FINAL CONSIDERATIONS

These proposals are intended to strengthen requirements and ensure the fiscal integrity of the Medicaid program.

Commissioners Grace-Marie Turner and Robert Helms endorsed payment reforms consistent with this Administration proposal.

Option 30: Reform of Medicaid Managed Care Organization provider tax requirements.
Author: President's Budget FY 2006
Savings Generated: $399 Million over 5 years (2006-2010)/ $1.2 Billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary/Congressional Budget Office
Also submitted by: Grace-Marie Turner, Robert Helms

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.
URL: http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf

SUMMARY

The 2006 Budget proposes to require that managed care organizations (MCOs) be treated the same as other classes of health care providers with respect to uniformity requirements. Under this proposal, states would be prevented from guaranteeing that tax revenues paid to states by MCOs would be returned.

KEY POINTS/FINDINGS

- Provider taxes are a financing mechanism states have used to generate state funds needed to obtain federal Medicaid matching payments.
- During the mid 1980s, states began using provider taxes as a mechanism to leverage additional federal funds and cost shift Medicaid expenses to the Federal government. After the taxes were matched with federal funds and paid to the providers, the providers did not keep the payments. Instead, the providers returned most of the federal monies to the states, where the funds could be used for other purposes.
- In 1991, the Congress passed legislation to limit states' use of provider taxes.
- CRS reports that under current law, Medicaid MCOs are treated differently than other providers regarding provider taxes.
- As a result, states currently may tax Medicaid MCOs and provide a guarantee that the tax revenues will be returned to the MCOs. States may receive the full federal match for the tax funds that are returned.

FINAL CONSIDERATIONS

These proposals are intended to strengthen requirements and ensure the fiscal integrity of the Medicaid program.

CRS states that this proposal will pertain to both Medicaid and non-Medicaid MCOs.

Commissioners Grace-Marie Turner and Robert Helms endorsed payment reforms consistent with this Administration proposal.

Option 31: Reduce Targeted Case Management reimbursement matching rate to 50 percent.
Author: President's Budget FY 2006
Savings Generated: $1 billion over 5 years (2006-2010)/ $1.5 billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary/Congressional Budget Office

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.
URL: http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf

SUMMARY

The 2006 Budget proposes to reduce the federal matching rate for targeted case management services from state-specific federal medical assistance percentages (FMAP). FMAP currently averages 57 percent. The Budget would reduce this to 50 percent.

KEY POINTS/FINDINGS

- Targeted case management is largely an administrative activity. Therefore, it may be appropriate to reimburse it at 50 percent, similar to other Medicaid administrative activities.
- The proposal would align reimbursement for TCM services with other federal programs, such as Foster Care.
- This proposal does not affect the amount of reimbursement that states will receive for other Medicaid services to which an individual may be referred by a case manager.
- This proposal only affects states whose federal matching rate for medical services is above 50 percent.

FINAL CONSIDERATIONS

Some states have been using targeted case management dollars in their child welfare systems. The budget expresses the Administration concern that states are shifting costs in Medicaid that are the obligation of other programs and using expanded definitions. As an administrative cost, targeted case management would then be subject to the Medicaid proposal's administrative cost containment requirements.

Option 32: Clarification of reimbursement policies for targeted case management and rehabilitation services.
Author: President's Budget FY 2006
Savings Generated: $2 Billion over 5 years (2006-2010)
Scored By: CMS Office of the Actuary

This option is among the eight savings proposals specific to the Medicaid program included in the President's 2006 Budget, presented to the public February 11, 2005.
URL: http://www.whitehouse.gov/omb/budget/fy2006/pdf/budget/hhs.pdf

SUMMARY

The 2006 Budget proposes to clarify reimbursement policies for targeted case management (TCM) services and rehabilitation services by specifying that payment is excluded for services furnished without charge, not billed under a fee schedule or not provided to a specific individual.

The Federal government would continue to pay for TCM and rehabilitation services, but this proposal tightens the definitions of what would be reimbursable under these services. The rehabilitation definition clarifies the purpose of rehabilitation services, specifies who may prescribe and provide the services, and specifically precludes payment for services or administrative functions under any other Federal, State or local program. The targeted case management definition clarifies that targeted case management services are distinct from medical, social, education and other services to which an individual is referred and are used to achieve specific, measurable outcomes. The targeted case management definition also specifically precludes payment for services or administrative functions under any other Federal, State or local program.

KEY POINTS/FINDINGS

- A majority of states offer rehabilitation and targeted case management services.
- However, reimbursement policies for these services are not well articulated.
- This ambiguity has resulted in questionable cost-shifting of services onto Medicaid from other programs, which increases costs.

FINAL CONSIDERATIONS

Clarifying these policies ensures the integrity of Medicaid payments.

CBO has stated that they cannot score this proposal because, "the Administration has not provided enough details for CBO to prepare its own estimates for some of the proposals that deal with restrictions on certain types of above-cost payments by states to health care providers and on payments for various social and rehabilitative services."

Option 33: Increased flexibility to tailor benefits to beneficiary health care needs.
Author: National Governors Association
Savings Generated: Score Pending
Scored By: CMS Office of the Actuary

The National Governors Association (NGA) is the bipartisan organization of the nation's Governors. The savings option presented below is a summary interpretation based upon the NGA's draft working paper on Medicaid reform, provided to the Medicaid Commission in August 2005. The estimation of the savings generated is also based on the interpretation of the option presented.

SUMMARY

The Medicaid population is very diverse and includes medically frail individuals as well as relatively healthy individuals that Medicaid serves as a traditional health insurance program. Currently "comparability" requirements limit states' ability to tailor benefit packages to meet different health care needs of beneficiaries. Reforms are necessary to allow states to design programs to support the health care needs of the diverse Medicaid population in their state.

For relatively healthy individuals, flexibility as is afforded states in the State Children's Health Insurance Program would allow states to design an appropriate benefit package for these beneficiaries. This flexibility includes the ability to choose to provide the set Medicaid benefit package or to provide a tailored benefit package with four options for coverage:

1. *Benchmark coverage*: This is a coverage package that is substantially equal to either the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; or a health benefits plan that the state offers and makes generally available to its own employees; or a plan offered by a Health Maintenance Organization that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.
2. *Benchmark equivalent coverage*: In this instance, the state must provide coverage with an aggregate actuarial value at least equal to one of the benchmark plans. States must cover inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, include age-appropriate immunizations.
3. *Existing state-based comprehensive coverage*: In the states where existing state-based comprehensive coverage exists (e.g. state-only funded programs; or waiver populations), the existing health benefits package is deemed to be meeting the coverage requirements.
4. *Secretary approved coverage*: This may include coverage that is the same as the state's Medicaid program; coverage provided in a Medicaid demonstration project approved by the Secretary; or coverage purchased by the state that is substantially equal to coverage under one of the benchmark plans through the use of benefit-by-benefit comparison.

KEY POINTS/FINDINGS

SCHIP-like benefits flexibility is not being proposed for the following categories of beneficiaries and services:

- Pregnant women, infants and children under age 18 that are provided "mandatory" coverage (0-5 133% FPL and 6-18 100% FPL);
- SSI recipients;
- Dual eligibles;
- Terminally ill individuals receiving hospice care;
- Inpatients in hospitals, nursing facilities, or ICFs/MR;
- Medically frail and special needs populations; and
- Individuals eligible for long term care services.

FINAL CONSIDERATIONS

[i] General Accounting Office, March, 2004. *States' Premium and Cost Sharing Requirements for Beneficiaries* (GAO-04-491). Available online at: http://www.gao.gov/new.items/d04491.pdf.

[ii] Medicare Modernization Act, Pharmacy MMA Information, Medicare Help at the Counter: Medicare Rx Update June 10, 2005. Available online at: http://www.cms.hhs.gov/medicarereform/pharmacy/update061005.asp.

[iii] Pharmaceutical Care Network, April 2004. *Pharmacy Benchmark Study for Managed Medicaid Health Plans*. Available online at: http://www.pharmcarenet.com/pdf/benchmarks_medicaid_2004.pdf.

[iv] Pharmacy Benefit Management Institute (PBMI), 2003. *The Prescription Drug Benefit Cost and Plan Design Survey Report* (Provided by Takeda Pharmaceuticals).