Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COMPARING PHARMACY REIMBURSEMENT: MEDICARE PART D TO MEDICAID

Daniel R. Levinson
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EXECUTIVE SUMMARY

OBJECTIVE

1. To compare Medicare Part D and Medicaid pharmacy reimbursement amounts for selected drugs at the national level.
2. To compare the components of Part D and Medicaid pharmacy reimbursement amounts (i.e., ingredient cost and dispensing fee) for selected drugs in five States.

BACKGROUND

This study compares pharmacy reimbursement for two Federal health care programs: Medicare Part D and Medicaid. It does not compare total program expenditures and does not examine the impact of rebates or post-point-of-sale price concessions.

Medicare Part D coverage is provided through private drug plans offered by plan sponsors. Under Federal guidelines, Part D sponsors independently negotiate pharmacy reimbursement and price concessions with manufacturers and pharmacies. Unlike Part D, State Medicaid agencies administer Medicaid and reimburse pharmacies for drugs. States, in conjunction with the Federal Government, determine pharmacy reimbursement under broad Federal guidelines. States also receive federally mandated Medicaid drug rebates and may negotiate with manufacturers for additional rebates.

Beneficiaries enrolled in Medicare's voluntary drug benefit typically obtain drugs from pharmacies. Pharmacy reimbursement under Part D is based on negotiated prices. Negotiated prices are made up of three elements: ingredient cost, dispensing fee, and sales tax. Ingredient costs are usually based on the average wholesale price (AWP) discounted by a specified percentage or maximum allowable cost set by the plan sponsors.

Medicaid beneficiaries also typically receive covered drugs through pharmacies, which are reimbursed for these drugs by State Medicaid agencies. Most States typically calculate reimbursement based upon the AWP discounted by a specified percentage plus a dispensing fee. For certain drugs, States also use the Federal upper limit or State maximum allowable cost programs, which establish ceiling prices for certain multiple-source drugs.

The Deficit Reduction Act of 2005 (DRA) would have (1) expanded the number of drugs subject to Federal upper limit amounts, (2) changed the basis for the calculation of Federal upper limit amounts to average manufacturer prices (AMP), and (3) required the Centers for Medicare & Medicaid Services (CMS) to share AMP data with States. However, an injunction from a Federal district court and the July 2008 passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) delayed the implementation of these new requirements. Therefore, Federal upper limits are calculated using the prior formula based on the lowest published price (i.e., AWP or wholesale acquisition cost), which the Office of Inspector General (OIG) has found to result in inflated payments.

We compared the average unit reimbursement amount (the sum of ingredient costs and dispensing fees) between Part D and Medicaid at the national level (i.e., data from all States). We also compared the individual components of reimbursement amount (i.e., ingredient costs and dispensing fees) between Part D and Medicaid for five selected States. For this review, we selected 40 single-source (i.e., drugs available from one manufacturer) and 39 multiple-source (i.e., drugs available from more than one manufacturer) drugs with high Part D and/or Medicaid expenditures in the third and fourth quarters of 2006.

FINDINGS

Nationally, the average Part D and Medicaid pharmacy reimbursement amounts were similar for most selected single-source drugs. Based on data from all States, there was less than a 5-percent difference between Medicare Part D and Medicaid pharmacy reimbursement amounts for most single-source drugs under review (34 of 40). At the median, the Medicaid reimbursement amount was 0.6 percent less than the Part D amount for the selected drugs.

The average unit ingredient costs of both Medicaid and Part D were also very similar for the single-source drugs in the five States under review. However, Medicaid dispensing fees in each of the five States exceeded the average Part D dispensing fees for these single-source drugs by at least 40 percent.

Nationally, the average Medicaid pharmacy reimbursement amounts typically exceeded the average Part D reimbursement amounts for selected multiple-source drugs. Based on data from all States, Medicaid pharmacy reimbursement amounts exceeded Part D pharmacy reimbursement amounts by at least 10 percent for 28 of the 39 multiple-source drugs under review. Medicaid reimbursed less than Part D, on average, for just three of these drugs. At the median, the Medicaid reimbursement amount was 17 percent greater than the Part D amount for the 39 selected multiple-source drugs.

In all five selected States, the Medicaid ingredient cost exceeded the average Part D ingredient cost for more than half of the multiple-source drugs under review. Some factors that may contribute to the differences between Medicaid and Part D pharmacy reimbursement in the five States include differences in pharmacy reimbursement methodologies and in the use of maximum allowable cost programs.

For all five States, the Medicaid dispensing fee exceeded the average Part D dispensing fee for these multiple-source drugs by at least 55 percent. In two of five States, the Medicaid dispensing fee was more than double the average Part D dispensing fee.

CONCLUSION

We found that Part D and Medicaid pharmacy reimbursement amounts for most of the single-source drugs that we reviewed were similar; however, Medicaid reimbursement amounts for the multiple-source drugs that we reviewed were typically higher than Part D amounts.

Congress took action to reduce reimbursement for multiple-source drugs in the Medicaid program through provisions in the DRA. These provisions would have expanded the number of drugs subject to Federal upper limits and reduced the Federal upper limit amounts for these multiple-source drugs (including 14 under review in this study). The provisions would have also granted States access to AMP data. However, a Federal judge issued an injunction to prevent the implementation of AMP-based Federal upper limits and State access to AMP data. In addition, because of MIPPA, CMS is prohibited from establishing Federal upper limit amounts based on AMPs or sharing AMP data prior to October 1, 2009. As a result, Federal upper limits and Medicaid reimbursement amounts are still based on published prices, which previous OIG work has found to result in inflated payments for multiple-source drugs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS agreed with the methodology and concurred with the findings in this report. CMS reiterated that the DRA mandated that Federal upper limit amounts be based on AMPs and that those AMPs be publicly posted to ensure transparency. CMS stated that it believes that as a result, until the DRA provisions are implemented, Medicaid pharmacy reimbursement will continue to be inflated. However, CMS noted that provisions of MIPPA prohibit it from posting AMPs publicly until October 1, 2009, and require it to continue calculating Federal upper limit amounts based on published prices. In addition, CMS stated that further work by OIG on dispensing fees would be beneficial.

CMS made one technical comment on the report regarding the classification of a single-source drug. Based on this comment, we conducted additional analysis and made revisions to the report, where appropriate.

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Medicare Part D Drug Coverage

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created the Medicare Prescription Drug Program, known as Medicare Part D, to provide an optional drug benefit for all Medicare beneficiaries. Part D sponsors provide drug coverage to the 25 million beneficiaries who had enrolled in the program as of January 2008.[1] Part D expenditures totaled more than $49 billion in 2007, the second year of the benefit.[2]

[1] Part D 2008 Enrollment Information. Available online at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/. Accessed June 3, 2008.

[2] "2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," p. 5. Available online at http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf. Accessed April 16, 2008.

Part D sponsors offer benefits through (1) stand-alone prescription drug plans (PDP) and (2) Medicare Advantage prescription drug plans (MA-PD), which provide integrated medical coverage, including drugs, through managed care. See Appendix A for a more detailed description of drug coverage under Medicare Part D.

Medicare Part D Drug Reimbursement

Beneficiaries enrolled in Medicare's voluntary drug benefit typically obtain drugs from pharmacies. Pharmacy reimbursement under Part D is based on negotiated prices. The Centers for Medicare & Medicaid Services (CMS) defines negotiated prices (or point-of-sale prices) as prices for covered Part D drugs that: (1) are available to beneficiaries at the point of sale at network pharmacies; (2) are reduced by those discounts, direct or indirect subsidies, rebates, other price concessions, and direct or indirect remunerations that the Part D sponsor has elected to pass through to Part D enrollees at the point of sale; and (3) include any pharmacy dispensing fees.[3] These prices are typically based on agreements between manufacturers, plan sponsors, and their affiliated contractors.[4] Negotiated prices, or pharmacy reimbursement, include two main elements:[5]

1. Ingredient cost. The ingredient cost is the amount paid to the pharmacy for the drug itself. Dispensing fees or other costs are not to be included in this amount.

2. Dispensing fee. The dispensing fee is the amount paid to the pharmacy for dispensing the drug. This amount includes only those activities related to the transfer of the drug from the pharmacy to the beneficiary, including charges associated with mixing the drug, delivery, and overhead.[6]

The negotiated price that the sponsors and beneficiaries pay pharmacies for the ingredient cost of the drug is usually based on the average wholesale price (AWP) discounted by a specified percentage

[3] 42 CFR § 423.100.

[4] There may be additional price concessions between plan sponsors, manufacturers, and other stakeholders that are not included in the negotiated price (e.g., rebates). These price concessions are not typically shared with the pharmacy.

[5] Negotiated prices for Medicare Part D also include a data element for sales tax. However, we did not include sales tax in our price comparison.

[6] Requirements for Submitting Prescription Drug Event Data. Available online at http://www.cms.hhs.gov/DrugCoverageClaimsData/Downloads/PDEGuidance.pdf. Accessed July 15, 2008.

or maximum allowable cost plus a dispensing fee, according to CMS staff.[7] The portion of the negotiated price paid by the plan sponsor and the portion paid by the beneficiary are determined by the plan's cost-sharing rules.

Medicaid Drug Coverage

Title XIX of the Social Security Act (the Act) established Medicaid, a program administered by States and financed with State and Federal funds. Medicaid pays for medical and health-related assistance for certain vulnerable and needy individuals and families.

All 50 States and the District of Columbia provide coverage for drugs under the Medicaid program. Medicaid expenditures for drugs totaled over $21 billion in 2006.[8]

Medicaid Drug Reimbursement

Medicaid beneficiaries typically receive covered drugs through pharmacies, which are reimbursed for these drugs by State Medicaid agencies. Federal regulations require, with certain exceptions, that each State Medicaid agency's reimbursement for covered outpatient drugs not exceed (in the aggregate) the lower of the estimated acquisition cost for drugs (i.e., the ingredient cost) plus a reasonable dispensing fee or the provider's usual and customary charge to the public for the drugs.[9]

1. Ingredient costs. Medicaid payment for ingredient costs is based on the estimated acquisition cost. Regulations define estimated acquisition cost to be the State's "best estimate" of the price generally and currently paid by providers for the drug.[10] CMS allows States flexibility in determining what constitutes the ingredient cost of drugs covered by their Medicaid programs; therefore, Medicaid reimbursement varies across States. Most States calculate the estimated acquisition cost based on the AWP

[7] AWPs are listed in commercial publications, derived from manufacturer-reported data for both brand and generic drugs, and not defined in law or regulation. Previous Office of Inspector General (OIG) work found that AWPs are often significantly higher than the prices that drug manufacturers, wholesalers, and similar entities actually charge the physicians and suppliers that purchase these drugs.

[8] This amount is calculated using national summary data for 2006 and includes both Federal and State payments. Rebates collected by States under the Medicaid drug rebate program (section 1927 of the Act) were not subtracted from this figure.

[9] 42 CFR § 447.512.

[10] 42 CFR § 447.502.

discounted by a specified percentage.[11] [12] For certain drugs, States also use the Federal upper limit or State maximum allowable cost programs in setting reimbursement amounts.

2. Dispensing fees. State Medicaid agencies also pay "reasonable" dispensing fees to pharmacies for pharmacy services. Each State determines its Medicaid dispensing fees, which range from $1.75 to $12.50 per prescription.[13]

Federal upper limit program. The Federal upper limit program was created to ensure that the Federal Government acts as a prudent buyer of drugs by taking advantage of current market prices for multiple-source drugs (i.e., drugs available from more than one manufacturer).[14] This program establishes a ceiling price that, in the aggregate, limits Medicaid payments. Prior to January 1, 2007, Federal regulation set the Federal upper limit amount at 150 percent of the lowest price published in the national compendia for therapeutically equivalent products that can be purchased by pharmacists in quantities of 100 tablets or capsules, plus a reasonable dispensing fee.[15]

OIG has found that the published prices on which Federal upper limit amounts were based often substantially exceeded the acquisition costs.[16] Based in part on OIG's work, section 6001(a) of the Deficit Reduction Act of 2005 (DRA) required significant changes to the Federal upper limit program, including changes to the calculation of Federal upper limit amounts. In January 2008, Federal upper limit amounts were to be based on 250 percent of the lowest reported

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[11] "Medicaid Prescription Reimbursement Information by State – Quarter Ending December 2006." Available online at http://www.cms.hhs.gov/MedicaidDrugRebateProgram/downloads/RxReimbursementRateDecember2006.pdf. Accessed July 15, 2008.

[12] A small number of States base Medicaid reimbursement on wholesaler acquisition cost plus a markup percentage.

[13] This range excludes dispensing fees for home IV therapy. "Medicaid Prescription Reimbursement Information by State – Quarter Ending December 2006." Available online at http://www.cms.hhs.gov/MedicaidDrugRebateProgram/downloads/RxReimbursementRateDecember2006.pdf. Accessed on July 15, 2008.

[14] Available online at http://www.cms.hhs.gov/FederalUpperLimits. Accessed June 2, 2008.

[15] 42 CFR § 447.332.

[16] "Comparison of Medicaid Federal Upper Limit Amounts to Average Manufacturer Prices," OEI-03-05-00110, June 2005; "Deficit Reduction Act of 2005: Impact on the Medicaid Federal Upper Limit Program," OEI-03-06-00400, June 2007.

average manufacturer price (AMP) for each drug rather than 150 percent of the lowest price published in national compendia. AMP is a statutorily defined price, which is based on actual sales transactions.[17] Additional provisions in the DRA would have expanded the number of drugs subject to Federal upper limit amounts and required CMS to share AMP data with States.

However, in December 2007, a Federal judge issued a preliminary injunction to prevent the implementation of AMP-based Federal upper limits.[18] Further, on July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), P.L. No. 110-275, was enacted. As a result of this legislation, CMS is prohibited from establishing Federal upper limit amounts based on AMPs or sharing AMP data with States prior to October 1, 2009.

State maximum allowable cost programs. Many States have implemented maximum allowable cost programs to limit reimbursement amounts for certain drugs. A maximum allowable cost is a ceiling price that applies to a group of multiple-source drugs. Individual States determine which drugs are included in their programs and the methods by which the maximum allowable cost for a drug is calculated.

Rebates. For Federal payments to be available for covered outpatient drugs provided under Medicaid, section 1927(a)(1) of the Act requires drug manufacturers to enter into rebate agreements with the Secretary of the Department of Health and Human Services and pay quarterly rebates to State Medicaid agencies. Under these rebate agreements, manufacturers must provide CMS with the AMP for each of their national drug codes. The quarterly rebate for single-source drugs is generally based on the greater of 15.1 percent of the AMP or the difference between the AMP and the best price.[19] The rebate amount for generic drugs is 11 percent of the AMP.

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[17] Section 1927(k)(1) of the Act defines AMP as the average price paid to the manufacturer by wholesalers in the United States for drugs distributed to the retail pharmacy class of trade.

[18] Civil Action No. 1:07cv02017 (RCL).

[19] Pursuant to section 1927(c)(1)(C) of the Act, best price is the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or government entity within the United States, with certain exceptions. Further, the Federal Medicaid rebate formula for brand name drugs also includes an additional calculation using an inflation factor.

Related Office of Inspector General Work

Federal upper limit program. In 2004 and 2005, OIG issued four reports detailing potential problems with the Federal upper limit program.[20] These reports focused on two main concerns: (1) qualified drugs were not being included on the Federal upper limit list in a timely manner and (2) Federal upper limit amounts often greatly exceeded pharmacy acquisition costs. For example, we found that Federal upper limit amounts were five times higher than average AMPs (a figure that we used as an estimate of pharmacy acquisition costs) in the third quarter of 2004. Based in part on this work, the DRA required that Medicaid Federal upper limits be based on 250 percent of the lowest AMP rather than on 150 percent of the lowest price published in the national compendia.

A June 2007 OIG report assessed the potential effect of AMP-based Federal upper limits.[21] According to this report, pre-DRA Federal upper limit amounts substantially exceeded estimated average pharmacy acquisition costs for 25 selected drugs in the second quarter of 2006 and would decrease considerably under the new calculation method established by the DRA.[22]

Part D payment. A January 2008 OIG report (1) analyzed the relationship between Part D payments to pharmacies and the pharmacies' drug acquisition costs and (2) estimated Part D dispensing fees and compared them with Medicaid dispensing fees.[23] This report found that Medicare Part D payments, excluding dispensing fees, exceeded the pharmacies' drug acquisition costs by an estimated 18 percent when including rebates that drug wholesalers paid to pharmacies. In addition, the average Medicaid dispensing fee was $2 more than the average Part D dispensing fee.

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[20] "Omission of Drugs From the Federal Upper Limit List in 2001" (OEI-03-02-00670, February 2004); "Addition of Qualified Drugs to the Federal Upper Limit List" (OEI-03-04-00320, December 2004); "Comparison of Medicaid Federal Upper Limit Amounts to Average Manufacturer Prices" (OEI-03-05-00110, June 2005); and "How Inflated Published Prices Affect Drugs Considered for the Federal Upper Limit List" (OEI-03-05-00350, September 2005).

[21] "Deficit Reduction Act of 2005: Impact on the Medicaid Federal Upper Limit Program" (OEI-03-06-00400, June 2007).

[22] At the time OIG conducted its assessment, CMS had not fully developed its outlier policy. Therefore, for the purposes of OIG's report, Federal upper limit amounts were calculated without regard to outlier AMPs.

[23] "Review of the Relationship Between Medicare Part D Payments to Local, Community Pharmacies and the Pharmacies' Drug Acquisition Costs" (A-06-07-00107), January 2008.

METHODOLOGY

Scope

This study compared Part D and Medicaid pharmacy reimbursement for selected drugs by (1) comparing the average total reimbursement amount (the sum of ingredient costs and dispensing fees) between Part D and Medicaid at the national level (i.e., data from all States[24]) and (2) comparing the individual components of the total reimbursement amount (i.e., ingredient costs and dispensing fees) between Part D and Medicaid for five selected States.

For this review, we selected 25 single-source (i.e., drugs available from one manufacturer) and 25 multiple-source (i.e., drugs available from more than one manufacturer) drugs with the highest Medicare Part D expenditures as well as 25 single-source drugs and 25 multiple-source drugs with the highest Medicaid expenditures in the third and fourth quarters of 2006. Because of overlap in the selected drugs, there were initially 43 single-source and 37 multiple-source drugs to be included in this review.[25] [26] However, after the drugs were selected, it was determined that three drugs identified by the compendium as single-source products actually had generic versions available during most of the review period. Therefore, for this analysis, we considered these to be multiple-source drugs. Similarly, it was determined that one drug identified by the compendium as multiple-source was actually a single-source drug. This particular drug would not have been selected had it been initially classified as single-source and was removed from our

[24] Arizona does not participate in the Medicaid Drug Rebate Program; therefore, there are no Medicaid data from this State included in this analysis. Further, we identified errors in Medicaid utilization data from two additional States. We excluded Medicaid utilization data from these two States from this analysis.

[25] We excluded from this review drugs that could not be identified, could not be identified as single source or multiple source, or did not have utilization in both programs (i.e., they had Part D utilization but no Medicaid utilization).

[26] For our initial selection of single-source and multiple-source drugs, we used drug-type data from Red Book, a national drug compendium that contains drug product and pricing information.

analysis.[27] As a result the final selection included 40 single-source drugs and 39 multiple-source drugs.[28]

We examined Part D reimbursement by PDPs only; we did not examine reimbursement data from MA-PDs and we excluded noncovered drugs.

Data Collection

Medicare Part D. We first obtained prescription drug event (PDE) records with dates of service in the third and fourth quarters of 2006 from CMS for all States.[29] We then aggregated the data to identify total pharmacy reimbursement by drug. The PDE records contained only final action claims and data for both the ingredient cost and the dispensing fee for each claim. We identified the Part D drugs with the highest expenditures (i.e., the sum of ingredient cost plus dispensing fee) using the PDE data and drug type data from the national drug compendium, known as the Red Book.

Medicaid. We first downloaded State Medicaid payment, utilization, and dispensing fee data for all States with dates of service in the third and fourth quarters of 2006 from CMS's Web site. We then aggregated the data to determine national payment and utilization by drug. We identified the multiple-source drugs with the highest total pharmacy reimbursement (i.e., the sum of ingredient cost plus dispensing fee) using the Medicaid data and drug type data from the Red Book.

Data Analysis

National analysis. We first calculated the average unit reimbursement amount for selected drugs with dates of service in the third and fourth quarters of 2006 based on data from all States. To calculate the national Medicare Part D average unit cost for selected drugs, we divided the total reimbursement (i.e., the sum of ingredient cost plus

[27] This drug would not have been selected because the total expenditure threshold for the 25 single-source drugs was substantially higher than the threshold for multiple-source drugs.

[28] The drugs selected for this report accounted for 37 percent of total Part D expenditures and 30 percent of total Medicaid expenditures during the third and fourth quarters of 2006.

[29] Every time a beneficiary fills a prescription covered under Part D, plans must submit a summary called the PDE record. The PDE record contains drug cost and payment data that enable CMS to administer the Part D benefit. See Appendix A for a more detailed description of PDE data.

dispensing fee) by the number of units dispensed for each drug.[30] We calculated the national average Medicaid unit payment amount for each selected drug (i.e., based on data from all States) by dividing total reimbursement (i.e., the sum of ingredient cost plus dispensing fees) by the number of units dispensed for each drug.

We compared the average Part D and Medicaid drug reimbursement amount for the selected drugs and calculated the percentage difference between programs for each drug. In addition, we calculated the median percentage difference for all single-source and all multiple-source drugs.

State analysis. We calculated the average unit ingredient cost and average dispensing fee for selected drugs based on data from five States: Arkansas, Hawaii, Illinois, New York, and Wyoming. We chose these States because they (1) had relatively straightforward reimbursement methodologies for determining ingredient costs and dispensing fees, (2) represented a range of reimbursement levels for ingredient costs, (3) varied in total Medicaid reimbursement for drugs, and (4) represented different geographic regions.[31] See Appendix B for information on each of these States.

To calculate the average unit ingredient cost and average dispensing fee under Part D, we first identified all PDE data for the selected drugs in the selected States. We then calculated the average unit ingredient cost for Part D drugs in each State by dividing total ingredient cost by total units dispensed for each selected drug. We calculated the average Part D dispensing fee per prescription for each State for single-source and multiple-source drugs by dividing total dispensing fees by total number of prescriptions.[32]

Medicaid utilization data aggregate ingredient cost and dispensing fees but do not provide separate data on each. Therefore, we calculated the total Medicaid ingredient cost for each drug by subtracting total dispensing fees from total expenditures. To

[30] For most drugs in this review, unit refers to a pill (e.g., tablet, capsule).

[31] These States have one reimbursement amount and dispensing fee for all drugs or a small number of reimbursement amounts and dispensing fees based on whether the drug is a brand or generic product. One State has an additional reimbursement amount for drugs dispensed at specialized pharmacies.

[32] For the analysis of PDE data from five States, we excluded all PDE records where the dispensing fee was equal to zero.

calculate total dispensing fees, we multiplied the State's dispensing fee from the fourth quarter of 2006 by the total number of prescriptions for each drug.[33] We calculated the average State Medicaid ingredient cost by dividing total ingredient cost by the total units dispensed for the selected drugs.

We compared average Part D ingredient costs and average dispensing fees for each of the selected drugs to average Medicaid unit ingredient costs and Medicaid dispensing fees for five selected States. We calculated the percentage difference for each amount between the programs.[34] We also examined Part D and Medicaid reimbursement for drugs with Federal upper limit amounts.

Limitations

This study compares pharmacy reimbursement for two Federal health care programs: Medicare Part D and Medicaid. It compares only the amounts paid to pharmacies for selected drugs under both programs. The study does not compare total program expenditures and does not examine the impact of rebates or post-point-of-sale price concessions.

The findings in this report apply only to the 40 single-source and 39 multiple-source drugs we reviewed. The findings are not projectable to all drugs covered under Part D and Medicaid. We did not verify the accuracy or completeness of CMS's data or the accuracy of data in the national compendium. In addition, we analyzed Medicaid data summarized by drug; i.e., we did not analyze claims-level data. Therefore, we were unable to analyze the effect of usual and customary charges in the Medicaid program.

Standards

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

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[33] The Medicaid dispensing fees for the five States included in this review were the same for both the third and fourth quarters of 2006. Further, for the two States with more than one dispensing fee, we used the brand drug dispensing fee for single-source drugs and the generic dispensing fee for multiple-source drugs.

[34] We compared reimbursement only for drugs that had both Part D and Medicaid utilization in all five States (i.e., if one State did not have both Part D and Medicaid utilization for a particular drug, we excluded that drug from all State data in our comparison). As a result, the State comparison included 39 single-source drugs and 34 multiple-source drugs.

Nationally, the average Part D and Medicaid pharmacy reimbursement amounts were similar for most selected single-source drugs

Based on data from all States, there was less than a 5-percent difference between Medicare Part D and Medicaid pharmacy reimbursement amounts for most of the single-source drugs under review in the third and fourth quarters of 2006. At the median, the Medicaid reimbursement amount was 0.6 percent less than the Part D amount for the selected drugs.

For 34 of the 40 single-source drugs under review, the difference between the Medicare Part D and Medicaid reimbursement amount was no more than 5 percent (18 of these had a difference of 1 percent or less). Only 1 of 40 single-source drugs included in our analysis had a difference between Part D and Medicaid reimbursement that exceeded 10 percent. Table 1 illustrates the differences between Part D and Medicaid reimbursement for the 40 single-source drugs that we reviewed. For additional details concerning how pharmacy reimbursement for individual single-source drugs compared in both percentage and dollar terms, please see Appendix C.

Table 1. Comparison of Average Medicare Part D and Medicaid Unit Reimbursement Amounts for the 40 Single-Source Drugs Under Review

Difference in Medicare Part D and Medicaid Reimbursement	Single-Source Drugs
Medicaid > 50% higher than Part D	0
25% < Medicaid ≤ 50% higher than Part D	0
10% < Medicaid ≤ 25% higher than Part D	0
5% < Medicaid ≤ 10% higher than Part D	1
1% < Medicaid ≤ 5% higher than Part D	6
0.01% < Medicaid ≤ 1% higher than Part D	9
Medicaid reimbursement equal to Part D reimbursement*	1
0.01% < Medicaid ≤ 1% lower than Part D	8
1% < Medicaid ≤ 5% lower than Part D	10
5% < Medicaid ≤ 10% lower than Part D	4
10% < Medicaid ≤ 25% lower than Part D	1
Medicaid > 25% lower than Part D	0
Total number of drugs	40

*Difference between Medicaid and Part D pharmacy reimbursement was less than one-tenth of one cent.

Source: OIG analysis of third- and fourth-quarter 2006 Medicaid utilization and Part D PDE data.

Pharmacy reimbursement for ingredient costs was similar for both programs in the five selected States

Overall, the average ingredient cost for both Medicaid and Part D pharmacy reimbursement was similar for single-source drugs under review in the five States. For over four-fifths of the selected single-source drugs in each State, the difference between Medicaid and Part D ingredient costs was less than 10 percent.

However, Medicaid dispensing fees exceeded average Part D dispensing fees in the five selected States

In each of the five States, Medicaid dispensing fees exceeded the average Part D dispensing fees for the selected single-source drugs by at least 40 percent. In two of the five States, the Medicaid dispensing fee was more than double the average Part D dispensing fee. However, because of the relatively high cost of most single-source drugs, dispensing fees typically account for a very small percentage of total cost for these drugs.[35] See Table 2 for a more detailed comparison of Medicaid and Part D dispensing fees for single-source drugs.

Table 2. Dispensing Fees for the Single-Source Drugs Under Review

State	Medicaid Dispensing Fees for Single-Source Drugs	Average Part D Dispensing Fees for Single-Source Drugs	Percentage Difference Between Medicaid and Part D Dispensing Fees
Arkansas	$5.51	$2.54	117%
Hawaii	$4.67	$3.01	55%
Illinois	$3.40	$2.42	40%
New York	$3.50	$2.43	44%
Wyoming	$5.00	$2.20	127%

Source: CMS's Web site and OIG analysis of third- and fourth-quarter 2006 Part D PDE data.

[35] Part D dispensing fees for selected single-source drugs in these five States accounted for only 2 percent of pharmacy reimbursement (i.e., ingredient cost and dispensing fee) for these drugs. Similarly, Medicaid dispensing fees for selected single-source drugs accounted for only 2 percent of pharmacy reimbursement for the five States.

Nationally, the average Medicaid pharmacy reimbursement amounts typically exceeded the average Part D reimbursement amounts for selected multiple-source drugs

Based on data from all States, the average Medicaid pharmacy reimbursement amount exceeded the average Part D pharmacy reimbursement amount by at least 10 percent for 28 of the 39 multiple-source drugs under review. Medicaid reimbursed less than Part D, on average, for just three of these 39 drugs. At the median, the Medicaid reimbursement amount was 17 percent greater than the Part D amount for selected multiple-source drugs. Table 3 illustrates the reimbursement differences for the 39 multiple-source drugs under review. For additional details concerning how pharmacy reimbursement for individual multiple-source drugs compared in both percentage and dollar terms, please see Appendix C.

Fourteen of the thirty-nine multiple-source drugs in this review are included on the Federal upper limit list. The average Medicaid reimbursement amount for all but one of the Federal upper limit drugs exceeded the average Part D reimbursement amount. At the median, the Medicaid reimbursement amount was 32 percent greater than the Part D reimbursement amount for these 14 drugs.

Table 3. Comparison of Average Medicare Part D and Medicaid Unit Reimbursement Amounts for the 39 Multiple-Source Drugs Under Review

Difference in Medicare Part D and Medicaid Reimbursement	Multiple-Source Drugs
Medicaid > 50% higher than Part D	4
25% < Medicaid ≤ 50% higher than Part D	12
10% < Medicaid ≤ 25% higher than Part D	12
5% < Medicaid ≤ 10% higher than Part D	4
1% < Medicaid ≤ 5% higher than Part D	3
0.01% < Medicaid ≤ 1% higher than Part D	1
Medicaid reimbursement equal to Part D reimbursement	0
0.01% < Medicaid ≤ 1% lower than Part D	1
1% < Medicaid ≤ 5% lower than Part D	0
5% < Medicaid ≤ 10% lower than Part D	0
10% < Medicaid ≤ 25% lower than Part D	1
25% < Medicaid ≤ 50% lower than Part D	0
Medicaid > 50% lower than Part D	1
Total number of drugs	39

Source: OIG analysis of third- and fourth-quarter 2006 Medicaid utilization and Part D PDE data.

In all five selected States, Medicaid's ingredient cost was higher than the average Part D ingredient cost for the multiple-source drugs under review

In all five States, the Medicaid ingredient cost for more than half of the multiple-source drugs under review exceeded the average Part D ingredient cost. At the median, the Medicaid ingredient cost in these States was between 2 percent and 29 percent greater than the Part D cost for selected drugs.

Several factors may contribute to the variation across the five States in Part D and Medicaid pharmacy reimbursement for multiple-source drugs. Each State develops its own Medicaid reimbursement formula; therefore, Medicaid reimbursement amounts vary across States. In addition, States have the flexibility to establish maximum allowable cost programs to set a cap on pharmacy reimbursement for certain drugs.

Medicaid dispensing fees for the multiple-source drugs under review exceeded average Part D dispensing fees in all five selected States

In each of the five States, the Medicaid dispensing fee exceeded the average Part D dispensing fee for multiple-source drugs by at least 55 percent. In two of the five States, the Medicaid dispensing fee was more than double the average Part D dispensing fee. Because reimbursement amounts for multiple-source drugs are typically lower than those for single-source drugs, dispensing fees make up a larger percentage of total cost.[36] See Table 4 on the next page for a more detailed comparison of Medicaid and Part D dispensing fees for the multiple-source drugs under review.

[36] Part D dispensing fees for the selected multiple-source drugs in the five selected States accounted for 5 percent of total pharmacy reimbursement (i.e., ingredient cost and dispensing fee). Medicaid dispensing fees for these multiple-source drugs accounted for 8 percent of total pharmacy reimbursement.

Table 4. Dispensing Fees for the Multiple-Source Drugs Under Review

State	Medicaid Dispensing Fees for Multiple-Source Drugs	Average Part D Dispensing Fees for Multiple-Source Drugs	Percentage Difference Between Medicaid and Part D Dispensing Fees
Arkansas	$5.51	$2.66	107%
Hawaii	$4.67	$3.00	56%
Illinois	$4.60	$2.59	78%
New York	$4.50	$2.72	65%
Wyoming	$5.00	$2.43	106%

Source: CMS's Web site and OIG analysis of third- and fourth-quarter 2006 Part D PDE data.

CONCLUSION

This study compares pharmacy reimbursement for two Federal health care programs: Medicare Part D and Medicaid. It compares only the amount paid to pharmacies for selected drugs under both programs. This study does not compare total program expenditures and does not examine the impact of rebates or post-point-of-sale price concessions.

We compared total reimbursement (ingredient cost plus dispensing fee) between Medicare Part D and Medicaid based on data from all States. We also compared Part D and Medicaid ingredient costs and dispensing fees for five selected States. We found that Part D and Medicaid pharmacy reimbursement amounts for most single-source drugs that we reviewed were similar; however, Medicaid reimbursement amounts for multiple-source drugs that we reviewed were typically higher than Part D amounts. In all five States under review, the average Medicaid ingredient costs of most multiple-source drugs under review exceeded the average Part D ingredient costs. In addition, we found that Medicaid dispensing fees were substantially higher than the average Part D dispensing fee for the single and multiple-source drugs under review in all five States.

Congress took action to reduce multiple-source drug prices in the Medicaid program through provisions in the DRA. These provisions would have expanded the number of drugs subject to Federal upper limits and reduced the Federal upper limit amounts for these multiple-source drugs (including 14 under review in this study). These provisions would have also granted States access to AMP data which, in turn, would have allowed States to base Medicaid drug reimbursement on AMPs. However, a Federal judge issued a preliminary injunction to prevent the implementation of AMP-based Federal upper limits and AMP-based Medicaid reimbursement amounts. In addition, because of MIPPA, CMS is prohibited from establishing Federal upper limit amounts based on AMPs or sharing AMP data with States prior to October 1, 2009. As a result, Federal upper limits and Medicaid reimbursement amounts are still based on published prices, which previous OIG work has found to result in inflated payments for multiple-source drugs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS agreed with the methodology and concurred with the findings in this report. CMS reiterated that the DRA mandated that Federal upper limit amounts be based on AMPs and that those AMPs be publicly posted to ensure transparency. CMS stated that it believes that as a result, until the DRA provisions are implemented, Medicaid pharmacy reimbursement will continue to be inflated. However, CMS noted that provisions of MIPPA prohibit it from posting AMPs publicly until October 1, 2009, and require it to continue calculating Federal upper limit amounts based on published prices. In addition, CMS stated that further work by OIG on dispensing fees would be beneficial.

CMS made one technical comment on the report regarding the classification of a single-source drug. Based on this comment, we conducted additional analysis and made revisions to the report, where appropriate.

The full text of CMS's comments is provided in Appendix D.

Medicare Part D Drug Coverage

Part D sponsors are required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to offer, at a minimum, a basic prescription drug benefit that is either the standard prescription drug benefit (described below) or is actuarially equivalent to the standard benefit.[37] Most beneficiaries who elect Part D coverage are responsible for certain costs, which may include a monthly premium, an annual deductible, and coinsurance.

In 2008, the standard drug benefit had a beneficiary deductible of $275. In the initial phase of the Part D benefit, after beneficiaries pay the deductible, they contribute 25-percent coinsurance toward their drug costs and the plan pays the remaining 75 percent until combined beneficiary and plan payments reach $2,510. After combined payments reach $2,510, beneficiaries enter the coverage gap phase of the benefit in which they are responsible for 100 percent of their drug costs. The catastrophic coverage phase begins when a beneficiary's out-of-pocket costs reach $4,050. This amount includes a beneficiary's deductible and coinsurance payments. Once beneficiaries reach $4,050 in out-of-pocket costs, they contribute approximately 5 percent in coinsurance toward their drug costs. Of the remaining 95 percent of drug costs, the Part D sponsors are responsible for approximately 15 percent and Medicare pays 80 percent.

Part D plans may also offer enhanced plan benefit packages. Enhanced plans include benefits such as lower (or no) deductibles and coverage during the coverage gap phase.

Plan Bids and Subsidy Payments

Before the beginning of the plan year, sponsors are required to submit a bid for each plan that they intend to offer.[38] The bid is an estimate of the average costs to provide the basic benefit per beneficiary.

Throughout the year, the Centers for Medicare & Medicaid Services (CMS) makes prospective payments to sponsors for three subsidies based on sponsors' approved bids. These subsidies are: (1) the direct

[37] "Actuarially equivalent" means that the plan's benefit must be at least of a dollar value equivalent to that of the standard benefit.

[38] 42 CFR § 423.265.

subsidy, (2) the reinsurance subsidy, and (3) the low-income cost-sharing subsidy.

Direct subsidy. The direct subsidy, together with beneficiary premiums, is designed to cover the sponsor's cost of providing the benefit to each beneficiary.

Reinsurance subsidy. The reinsurance subsidy covers the Federal Government's share of drug costs for beneficiaries who have reached catastrophic coverage.

Low-income cost-sharing subsidy. The low-income cost-sharing subsidy covers the Federal Government's portion of the cost-sharing payments for certain low-income beneficiaries.

At the end of the plan year, CMS reconciles these prospective payments with the actual costs incurred by the plan sponsors.[39]

Prescription Drug Event Data

As a condition of payment, all Part D plan sponsors submit data and information necessary for CMS to determine and make payment.[40] Every time a beneficiary fills a prescription covered under Part D, plans must submit a summary called the prescription drug event (PDE) record. The PDE record contains drug cost and payment data that enable CMS to administer the Part D benefit.[41] Part D plan sponsors submit one PDE record each time a Part D covered drug is dispensed to its enrollees, including those events in which enrollees have 100 percent cost sharing (i.e., they are in the coverage gap or deductible phase).

CMS uses the National Council for Prescription Drug Programs industry standard for collecting PDE data. The PDE data contain information on the beneficiary, plan, pharmacy, and prescribing physician, as well as information about the event including the date, quantity dispensed, number of days supplied, national drug code, control number, and the amount reimbursed to the pharmacy by the plan. The amount reimbursed to the pharmacy (i.e., negotiated price)

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[39] 42 CFR § 423.343.

[40] Social Security Act, §§ 1860D-15(c)(1)(C) and (d)(2), 42 CFR § 423.322.

[41] "Requirements for Submitting Prescription Drug Event Data." Available online at http://www.cms.hhs.gov/DrugCoverageClaimsData/Downloads/PDEGuidance.pdf. Accessed May 29, 2008.

consists of three fields: ingredient cost paid, dispensing fee paid, and total amount attributed to sales tax.

Dual Eligibles

In 2006, more than 6 million Medicare beneficiaries were full-benefit dual eligibles, i.e., beneficiaries enrolled in both Medicare and Medicaid. Until December 31, 2005, dual eligibles received outpatient drug benefits through Medicaid. However, on January 1, 2006, Federal financial participation ended for Medicaid drug coverage for dual eligibles.[42] Instead, dual eligibles now receive drug coverage under Part D through either a prescription drug plan or a Medicare Advantage Prescription Drug Plan.

[42] 42 U.S.C. § 1396u-5 (2003).

APPENDIX ~ B

Medicaid Pharmacy Reimbursement and Dispensing Fees for Selected States				
State	**Basis for State Medicaid Reimbursement***	**Dispensing Fee**	**Maximum Allowable Cost Program**	**State Rank by Total Medicaid Drug Expenditures****
Arkansas	Average wholesale price (AWP)-20% (generic) AWP-14% (brand)	$5.51	Yes	21
Hawaii	AWP-10.5%	$4.67	Yes	42
Illinois	AWP-25% (generic) AWP-12% (brand)	$4.60 (generic) $3.40 (brand)	Yes	7
New York	AWP-12.75% (brand) AWP-16.5% (generic) AWP-12% (specialized HIV pharmacies)	$4.50 (generic) $3.50 (brand)	No	1
Wyoming	AWP-11%	$5.00	Yes	45

Sources: Centers for Medicare & Medicaid Services Web site and Office of Inspector General (OIG) analysis of State Medicaid expenditures for drugs.

*This is the method that each State uses to calculate the ingredient cost portion for Medicaid reimbursement.

**Denotes State rank by total Medicaid expenditures for drugs in the third and fourth quarters of 2006 according to OIG analysis.

APPENDIX ~ C

Differences in Pharmacy Reimbursement for Selected Single-Source Drugs*		
Drug	**Percentage Difference per Unit Between Medicaid and Part D Pharmacy Reimbursement****	**Dollar Difference per Unit Between Medicaid and Part D Pharmacy Reimbursement****
Alendronate Sodium 70 mg	0.85%	$0.153
Amlodipine Besylate 5 mg	0.16%	$0.002
Amlodipine Besylate 10 mg	1.96%	$0.041
Aripiprazole 5 mg	-5.03%	-$0.555
Aripiprazole 10 mg	-3.40%	-$0.374
Aripiprazole 15 mg	-2.23%	-$0.245
Atorvastatin Calcium 20 mg	0.39%	$0.014
Atorvastatin Calcium 40 mg	0.41%	$0.014
Atorvastatin Calcium 10 mg	0.44%	$0.011
Celecoxib 200 mg	1.13%	$0.034
***Clopidogrel Bisulfate 75 mg	8.08%	$0.302
Divalproex Sodium 500 mg	-3.47%	-$0.083
Divalproex Sodium 500 mg (extended release)	-2.72%	-$0.062
Donepezil Hydrochloride 10 mg	-8.23%	-$0.412
Emtricitabine/Tenofovir Disoproxil Fumarate 200 mg-300 mg	1.19%	$0.308
Esomeprazole Magnesium 40 mg	1.78%	$0.080
Ezetimibe 10 mg	0.68%	$0.018
Fluticasone Propionate/Salmeterol Xinafoate	0.49%	$0.013
Insulin Glargine, Recombinant 100 U/mL	-0.10%	-$0.007
Lansoprazole 30 mg	-0.39%	-$0.018
Lopinavir/Ritonavir 200 mg-50 mg	3.54%	$0.197
Memantine Hydrochloride 10 mg	-9.33%	-$0.217
Montelukast Sodium 5 mg	0.19%	$0.006
Montelukast Sodium 10 mg	1.27%	$0.039
Olanzapine 10 mg	-0.98%	-$0.102
Olanzapine 15 mg	-0.82%	-$0.127
Olanzapine 20 mg	0.00%	-$0.001
Palivizumab 100 mg/mL	-15.49%	-$216.212
Pantoprazole Sodium 40 mg	-0.82%	-$0.030
Quetiapine Fumarate 100 mg	-1.93%	-$0.061
Quetiapine Fumarate 200 mg	-1.10%	-$0.065
Quetiapine Fumarate 300 mg	-0.58%	-$0.045
Risedronate Sodium 35 mg	-2.26%	-$0.409
Risperidone 1 mg	-4.64%	-$0.178
Risperidone 2 mg	-1.23%	-$0.077
Risperidone 3 mg	-0.91%	-$0.067
Rosiglitazone Maleate 4 mg	0.49%	$0.015
Tamsulosin Hydrochloride 0.4 mg	-0.70%	-$0.015
Topiramate 100 mg	-5.69%	-$0.270
Zolpidem Tartrate 10 mg	-1.18%	-$0.043

*Some of the selected single-source products had generic versions become available after the time period under review.
**For most drugs in this review, unit refers to one pill. Negative numbers indicate that Part D pharmacy reimbursement exceeded Medicaid pharmacy reimbursement.
***Clopidogrel bisulfate had a generic version approved in January 2006. The manufacturer marketed the generic version of this drug beginning on August 8, 2006. However, litigation between the brand and generic manufacturers resulted in an injunction on August 31, 2006, barring additional sales by the manufacturer of the generic drug. Because the generic drug was sold by the manufacturer for less than 1 out of the 6 months under review, it is classified as a single-source drug for the period under review.
Source: Office of Inspector General analysis of third- and fourth-quarter 2006 Medicaid utilization data and Part D prescription drug event data.

Differences in Pharmacy Reimbursement for Selected Multiple-Source Drugs		
Drug	**Percentage Difference per Unit Between Medicaid and Part D Pharmacy Reimbursement***	**Dollar Difference per Unit Between Medicaid and Part D Pharmacy Reimbursement***
Acetaminophen/Oxycodone Hydrochloride 325 mg-10 mg	13.68%	$0.137
Albuterol 0.09 mg/Actuation	25.69%	$0.210
Albuterol Sulfate 0.083%	-21.85%	-$0.028
Amoxicillin/Clavulanate Potassium 600 mg/5 mL-42.9 mg/5 mL	14.04%	$0.051
Amoxicillin/Clavulanate Potassium 875 mg-125 mg	33.44%	$0.778
Azithromycin 250 mg	38.82%	$1.784
Bupropion Hydrochloride 150 mg	17.12%	$0.198
Clozapine 100 mg	14.47%	$0.295
Desmopressin Acetate 0.2 mg	0.33%	$0.011
Diltiazem Hydrochloride 240 mg	7.85%	$0.095
Ethinyl Estradiol/Norgestimate	15.55%	$0.158
Fentanyl 75 mcg/HR	29.67%	$8.270
Fentanyl 100 mcg/HR	30.39%	$10.992
Fentanyl 50 mcg/HR	32.50%	$5.813
Fexofenadine Hydrochloride 180 mg	16.27%	$0.282
Fluticasone Propionate 0.05 mg/Actuation	20.64%	$0.722
Gabapentin 600 mg	63.33%	$0.602
Gabapentin 300 mg	123.25%	$0.465
Immune Globulin 100 mg/mL	36.35%	$3.270
Insulin Human Isophane (NPH) 100 U/mL	2.99%	$0.101
Insulin Human Isophane/Insulin Human Regular 70 U/mL-30 U/mL	3.62%	$0.123
Lisinopril 20 mg	39.25%	$0.119
Loratadine 10 mg	-83.77%	-$2.245
Lorazepam 1 mg	13.13%	$0.038
Lovastatin 40 mg	39.72%	$0.379
Megestrol Acetate 40 mg/mL	5.87%	$0.023
Metformin Hydrochloride 500 mg	56.74%	$0.104
Nifedipine 60 mg	19.46%	$0.312
Omeprazole 20 mg	44.64%	$0.525
Oxycodone Hydrochloride 40 mg	5.75%	$0.177
Oxycodone Hydrochloride 80 mg	10.03%	$0.597
Paroxetine Hydrochloride 20 mg	81.70%	$0.728
Phenytoin Sodium, Extended 100 mg	3.18%	$0.009
Polyethylene Glycol 3350 17 GM/Dose	-0.92%	-$0.001
Potassium Chloride 20 MEQ	24.88%	$0.073
Sertraline Hydrochloride 100 mg	9.01%	$0.204
Simvastatin 20 mg	25.96%	$0.916
Simvastatin 40 mg	27.16%	$0.955
Warfarin Sodium 5 mg	12.67%	$0.054

*For most drugs in this review, unit refers to one pill. Negative numbers indicate that Part D pharmacy reimbursement exceeded Medicaid pharmacy reimbursement.
Source: Office of Inspector General analysis of third- and fourth-quarter 2006 Medicaid utilization data and Part D prescription drug event data.

APPENDIX ~ D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Service

200 Independence Avenue SW
Washington, DC 20201

DATE: DEC 0 8 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid" (OEI-03-07-00350)

Thank you for the opportunity to review and comment on the OIG draft report evaluating pharmacy reimbursement in Medicare and Medicaid. This OIG report provides the findings of the comparison between Medicare Part D and Medicaid pharmacy reimbursement for 25 single-source and 25 multiple-source drugs with the highest Medicaid and Medicare Part D expenditures for the third and fourth quarters of 2006.

The OIG compared Medicare Part D and Medicaid pharmacy reimbursement amounts for selected drugs at the national level, and further compared the components of Medicare Part D and Medicaid pharmacy reimbursement amounts (namely, ingredient cost and dispensing fee) for selected drugs in five States.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established Medicare Part D drug coverage for Medicare beneficiaries. Medicare Part D coverage is provided through private drug plans offered by plan sponsors. Medicare Part D sponsors independently negotiate pharmacy reimbursement and price concessions with manufacturers and pharmacies. Drug reimbursement methodologies under the Medicaid program are based on State estimated acquisition cost plus a reasonable dispensing fee. States also use the Federal upper limit (FUL) or State maximum allowable cost programs which establish ceiling prices for certain multiple source drugs.

OIG Findings

The OIG found that there was less than a 5 percent difference between Medicare Part D and Medicaid pharmacy reimbursement amounts for most single-source drugs under review. At the median, the Medicaid reimbursement amount was 0.4 percent less than the Medicare Part D amount for the selected drugs. In addition, the average unit ingredient cost of both Medicaid and Medicare Part D were very similar for the single-source drugs in the five States reviewed. However, Medicaid dispensing fees in each of the five States exceeded the average Medicare Part D dispensing fees for these single-source drugs by at least 40 percent.

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The study also compared Medicaid pharmacy reimbursement amounts to Medicare Part D reimbursement amounts for selected multiple-source drugs. The OIG found that Medicaid reimbursement amounts exceeded Medicare Part D pharmacy reimbursement amounts by at least 10 percent for 26 of the 37 multiple-source drugs under review. At the median, the Medicaid reimbursement amount was 16 percent greater than the Medicare Part D amount for the 37 selected multiple-source drugs. Fourteen of the 37 multiple source drugs in this review are included on the FUL limit list. The average Medicaid reimbursement amount for all but one of the Federal upper limit drugs exceeded the average Medicare Part D reimbursement amount. At the median, the Medicaid reimbursement amount was 32 percent greater than the Medicare Part D reimbursement amount for these 14 drugs.

The OIG also found that in four of the five States, the Medicaid ingredient cost for more than half of the multiple-source drugs under review exceeded the average Medicare Part D ingredient costs. Furthermore, for all 5 States, the Medicaid dispensing fee exceeded the average Medicare Part D dispensing fee for these multiple-source drugs by at least 50 percent. In two of the five States, the Medicaid dispensing fee was more than double the average Medicare Part D dispensing fee.

CMS Response

In general, the Centers for Medicare & Medicaid Services (CMS) agrees with the methodology used in this study and concurs with the findings in this report.

As the OIG noted, in order to align reimbursement for multiple source drugs in the Medicaid program with pharmacy acquisition cost, the Deficit Reduction Act of 2005 (DRA) mandated that the FUL be calculated based on 250 percent of the average manufacturer price (AMP) for the lowest priced therapeutically equivalent drug, without regard to customary prompt pay discounts. The DRA also mandated that these AMPs be publicly posted to ensure transparency.

In accordance with section 203 of the Medicare Improvements for Patients and Providers Act of 2008, CMS is prohibited from posting AMPs publicly until October 1, 2009, and must calculate the FUL using the methodology established previously in CFR 447.332. (Please see our State Medicaid Director (SMD) letter on these issues at http://www.cms.hhs.gov/SMDL/downloads/SMD110308.pdf.). Until the DRA provisions are implemented, we believe Medicaid pharmacy reimbursement will continue to be inflated, since CMS and the States cannot use the AMP data necessary to compute such prices.

In regard to the OIG finding concerning Medicaid dispensing fees, we believe additional work by the OIG on what it costs to dispense drugs would be beneficial to us. We would also be interested in further work for Medicaid on what parts of the current dispensing costs are hidden in inflated ingredient costs.

We appreciate the work that the OIG did and the findings that came out of this report and hope that the findings of this report will help substantiate the need to align reimbursement amounts to pharmacy acquisition cost plus a reasonable dispensing fee.

ACKNOWLEDGMENTS

This report was prepared under the direction of Robert A. Vito, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and David E. Tawes, Director, Prescription Drug Pricing Unit.

Edward K. Burley served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Philadelphia regional office who contributed to the report include Eric M. Biersmith; other central office staff who contributed include Eddie Baker, Jr., Dave J. Graf, Kevin Manley, Matthew S. McMullen, and Cynthia Thomas.