Analysis of Multi-state Medicaid Drug Purchasing Pool

Pursuant to the 2006-07 General Appropriations Act
(Article II, Health and Human Services Commission,
Rider 56, S.B 1, 79th Legislature,
Regular Session, 2005)

Submitted by the
Health and Human Services Commission

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Introduction

The 2006-07 General Appropriations Act (Article II, Health and Human Services Commission, Rider 56, S.B 1, 79th Legislature, Regular Session, 2005**)** requires the Health and Human Services Commission (HHSC) to conduct an analysis determining the cost-benefit and the feasibility of establishing or joining a multi-state drug purchasing pool. The rider stipulates that the analysis shall include identification of other states with which pooling of Medicaid drug purchasing provides the greatest opportunity to achieve savings in Texas.

HHSC submitted an initial analysis of Multi-State Drug Purchasing in February 2006. This follow-up report contains further evaluation and findings concerning the multi-state drug-purchasing options available to the State including analysis of supplemental rebate levels under the Texas Preferred Drug List (PDL) after the implementation of the Medicare Part D prescription drug program.

Background

The 79th Legislature directed HHSC to examine if Texas could save additional money in the Medicaid program by joining with other states to purchase prescription drugs and negotiate supplemental rebate agreements with drug manufacturers, referred to as a multi-state supplemental rebate agreement. Under a multi-state supplemental rebate agreement, states pool together their Medicaid populations to increase purchasing power and generate larger rebates and discounts from drug manufacturers. While these multi-state agreements may be particularly beneficial to smaller states, it is unclear how much a large state such as Texas would benefit from such an arrangement, since Texas currently receives rebates averaging over 30 percent.

Participation in a multi-state drug-purchasing cooperative requires federal approval for the state to continue to receive the federal funds that match state general revenue expenditures. Currently, there are three operational, multi-state Medicaid drug-purchasing pools that have been approved by the Centers for Medicare and Medicaid Services (CMS). The three pools are the National Medicaid Pooling Initiative (NMPI), the Optimal PDL Solution (TOP$), and the Sovereign States Drug Consortium (SSDC).

National Medicaid Pooling Initiative (NMPI)

The NMPI multi-state pool was first announced in early 2003 with four member states, and as of mid 2006 has grown to a total number of ten pooled states including Alaska, Hawaii, Kentucky, Michigan, Minnesota, Montana, Nevada, New Hampshire, New York, and Tennessee. Vermont was a founding member, but shifted to the SSDC as of January 2006. NMPI is administered by First Health Services, Inc., which serves as the preferred drug list (PDL) contractor for all of the member states.

NMPI currently represents approximately five million member lives and the negotiated rebates are dependent upon the total number of lives in each state that selects a drug for inclusion on their PDL. The supplemental rebate agreements with manufacturers have a two-year price lock

and the rebate amounts are based on reported Wholesale Acquisition Cost (WAC) for each individual drug. Each state maintains its own Pharmaceutical and Therapeutics (P&T) Committee with an annual implementation schedule for changes to the PDL, which occurs each March. Supplemental rebates are not required in order for a drug to be on the PDL.

The Optimal PDL Solution (TOP$)

The current PDL contractor for Texas, Provider Synergies L.L.C., administers the second CMS-approved multi-state purchasing group, which is known as The Optimal PDL Solution, referred to as TOP$. Current member states in TOP$ include Delaware, Idaho, Louisiana, Maryland, Wisconsin, and West Virginia.

TOP$ member states represent approximately 2.1 million recipient lives. Under the TOP$ model, negotiated discounts vary based on the number of states that select a particular drug as a preferred product, rather than the number of recipient lives in each state program. This means that not every state in the consortium has to agree upon every preferred drug product in order to derive a benefit under TOP$. For example, the supplemental rebate amount might be $0.20 per unit if two participating states select Drug A as a preferred drug, but increase to $0.30 per unit if four states select Drug A as a preferred product.

The TOP$ pool implementation schedule is twice a year, with PDL changes made in April and October. Each participating state maintains a separate and individual P&T Committee, and each committee holds meetings in February and August. As in the NMPI pool, supplemental rebate amounts are based on the WAC for each individual drug and supplemental rebates are not required in order for a drug to be placed on the PDL.

The Sovereign States Drug Consortium (SSDC)

The Sovereign States Drug Consortium (SSDC) was founded in October 2005, and as of August 2006 includes Iowa, Vermont, and Maine as operational members. This pool differs from the other two pools in that it is state administered rather than vendor administered. The consortium states negotiate directly with the drug manufacturers, and each state is individually responsible for the clinical input and review required for its P&T Committee.

Factors for Consideration

Texas does not have access to confidential rebate information for the newest multi-state pool, the SSDC, or to information from individual states, such as Florida or California. However, Provider Synergies has compared the savings from the current Texas PDL to the potential savings in the NMPI and TOP$ multi-state cooperatives. This analysis estimates that Texas could realize an additional annual savings of $3.8 million to $4.2 million (general revenue) by joining a multi-state pool. The savings estimate assumes that the Texas P&T Committee would recommend, and HHSC would adopt, a PDL essentially the same as the other member states. States' PDLs may vary, however, and savings would be reduced to the extent the Texas P&T Committee recommendations and the resulting PDL differ from the other member states.

There are several differences between Texas' and other states' PDL processes that need to be considered when evaluating whether to join a multi-state pool. One significant difference is that Texas law requires that a supplemental rebate be in place in order for a product to be on the PDL. Other states do not have this requirement, which could lead to PDL differences between Texas and other states.

In addition, Texas law requires that supplemental rebates be based on the Average Manufacturer Price (AMP) for each specific drug. Both NMPI and TOP$ have supplemental rebate agreements that are based on WAC. AMP is defined in Section 1396r-8(k)(1) of the Omnibus Budget Reconciliation Act of 1990 as "the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts". WAC represents a manufacturer's list price for a drug to wholesalers or direct purchasers, as reported in wholesale price guides or other publications of drug pricing data. WAC does not represent an actual transaction price and does not include prompt pay or other discounts, rebates, or reductions in price. Because WAC may not reflect available pricing discounts and is not restricted to the retail class of trade, the AMP may be a more appropriate and consistent determination of drug cost across manufacturers.

Another consideration is the timing and frequency of P&T committee meetings. The current TOP$ rebate agreements are renegotiated and considered by state P&T committees twice yearly, and NMPI agreements are negotiated every two years. NMPI states all have one multi-day P&T Committee meeting prior to their annual PDL implementation. In 2005, Texas went from a quarterly update cycle to a yearly PDL update cycle at the request of the Texas Medical Association (TMA), and will soon be moving to a twice-yearly cycle. Texas law requires the P&T Committee to hold quarterly meetings, regardless of the implementation schedule for the new PDL arrangement.

Impact of Medicare Rx on Texas Medicaid PDL

Effective January 1, 2006, approximately 340,000 Medicaid recipients who are also eligible for Medicare became eligible for drug coverage through the Medicare Part D prescription drug program, Medicare Rx. These dual-eligible recipients no longer receive prescription drug coverage under Texas Medicaid's Vendor Drug Program, except for a very limited number of drugs excluded from the Medicare Rx program. HHSC estimates that drug expenditures will be reduced by $749,031,300 (all funds) in calendar year 2006 as a result of Medicare assuming drug coverage for this client population. The associated loss of PDL supplemental rebates is estimated to total about $56.2 million (all funds) in state fiscal year 2006 over 8 months and about $74.9 million (all funds) in state fiscal year 2007 over 12 months.

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Medicare Rx Impact on PDL Rebate Revenues
(Dollars in Millions)

	FY 2006 (8 Months)	FY 2007 (12 Months)
Projected PDL Rebates Including Dual Eligibles (All Funds)	$202.00	$181.70
Projected PDL Rebates Without the Dual Eligibles (All Funds)	$145.80	$106.80
Decrease in PDL Rebates Due to Medicare Rx (All Funds)	($56.20)	($74.90)
Percent Decrease in PDL Rebates	27.82%	41.22%
State Match Percent	39.32	39.23
Decrease in PDL Rebates – State General Revenue Dollars	($18.20)	($19.60)

When Medicare drug coverage began January 1, 2006, initial implementation issues at the federal level delayed full federal drug coverage for some of the dual-eligible population until April 1, 2006. As a result of these delays, it may be several months before accurate projections of costs and savings can be prepared based on actual utilization data.

The current PDL classes expected to be most impacted by loss of the dual eligibles are listed below.

- Alzheimer's agents – Drugs used in the treatment of Alzheimer's disease.
- Bone resorption suppression and related agents – Drugs to treat osteoporosis (thinning bones).
- Hypoglycemics, Meglitinides – Drugs used in the treatment of Type II diabetes.
- Ophthalmics, Glaucoma agents - Drugs used to treat glaucoma.
- Platelet aggregation inhibitors – Drugs used to prevent platelets in the blood from sticking together and forming clots.

Since the Medicare Rx program is expected to decrease Texas' PDL rebates by over 41 percent in fiscal year 2007, potential savings to Texas from joining an existing multi-state pool may decrease as a result of Medicare Rx.

Conclusion

HHSC recommends that Texas continue examining the feasibility of joining a multi-state purchasing group and will consider this option as we continue to analyze the trends associated with the PDL supplemental rebates and the pharmaceutical manufacturers' competition for market share within Texas.

The feasibility of Texas joining one of the currently existing multi-state drug pools is limited at this time by the Texas statutory requirement to base supplemental rebates on AMP. The federal

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Deficit Reduction Act of 2005 requires CMS to begin reporting AMP pricing to all states in January 2007, which may impact the pools that now base rebates on WAC and may also facilitate the creation of a new pool with rebates based on AMP.