A fact sheet from THE PEW CHARITABLE TRUSTS | July 2018

Better Data Could Help Medicaid Programs Cut Drug Spending

Manufacturer information can help states increase rebates, limit overpayment

State Medicaid programs could curb overpayment and secure bigger rebates by requiring drug manufacturers to provide additional pricing information in exchange for preferred coverage.

Medicaid spending on prescription drugs is offset by manufacturer rebates required by federal law and supplemental rebates that states negotiate with manufacturers. Mandatory federal rebates are calculated as a percentage of a drug's average manufacturer price ("federal AMP"). This calculation is based on a statutory formula intended to reflect average drug prices in the commercial market, to ensure that Medicaid is not overpaying for drugs relative to commercial payers.[1] In 2016, manufacturer rebates cut Medicaid spending by 51 percent, from $61 billion to $30 billion.[2]

The federal AMP formula, amended in 2010, is now based on the average price retail community pharmacies pay manufacturers for a drug, including sales to these pharmacies either directly from the manufacturer or through a wholesaler.[3] The calculation excludes any manufacturer discounts or rebates that are not given to retail community pharmacies ("off-invoice discounts"), such as rebates to pharmacy benefit managers (PBMs), hospitals, governmental bodies, or outpatient clinics.

In 2017, manufacturers reduced list prices by 28 percent, or $128 billion in off-invoice discounts and rebates from $453 billion in drug sales.[4] The majority of these discounts and rebates are given to PBMs and are excluded from the federal AMP calculation by statute; for drugs not primarily dispensed through retail settings, however, manufacturers are required to incorporate these discounts in their calculations.[5] Including these discounts and rebates in the AMP formula for all drugs would more accurately reflect the prices paid in the commercial market.

Medicaid reimbursement to pharmacies consists of a flat dispensing fee plus the ingredient cost, which is based on the actual acquisition cost.[6] To calculate the actual acquisition cost, states may use AMP or another metric that reflects the prices pharmacies pay wholesalers; however, these metrics do not reflect true market prices for prescription drugs after accounting for off-invoice discounts.[7]

Changes to pricing calculations

To determine the market prices of prescription drugs, net of all discounts and rebates, state Medicaid programs could require manufacturers to submit pricing information not included in AMP. With this information, a state could establish its own version of AMP ("modified AMP") that includes additional discounts and rebates, and then calculate a supplemental rebate payment that ensures the state's Medicaid program is not overpaying relative to commercial payers.[8]

A state could also establish its own version of the Medicaid best price ("modified BP"), which reflects the lowest price paid by any single commercial customer but excludes the same discounts and rebates as AMP.[9] Modified BP could include these discounts and rebates and would be used as part of the supplemental rebate calculation.

While most states have entered into single-state and/or multistate rebate agreements with manufacturers to reduce prescription drug expenditures, states are negotiating without insight into the drugs' net prices, likely diminishing their savings.[10] One Medicaid PBM negotiated state supplemental rebates that reduced spending by 3 to 6 percent in 2016.[11]

Medicaid preferred drug lists (PDLs) provide states with leverage to require manufacturers to provide additional information on net prices. Putting a drug on the PDL could be made contingent on manufacturer submission of the additional pricing data. States could then require that manufacturers offer rebates based on these new calculations, as described below.

Existing state and national policies support this approach. At the national level, the Medicaid program requires manufacturers to report AMP for all of their drugs in order for any single drug to be covered.[12] Texas previously required manufacturers to report non-AMP information on drug pricing in order to be included on the PDL.[13] And states negotiate further supplemental rebates with manufacturers when determining PDL placement.[14]

To implement this policy, a state would require manufacturers to report the modified AMP and BP, as well as the supplemental rebate amount. The required supplemental rebate based on the modified AMP would be equal to the state's net costs under the current policy (taking into account pharmacy reimbursement and existing mandatory and supplemental rebates) minus the state's hypothetical net costs if it were reimbursing pharmacies at modified AMP and receiving a statutory rebate on that amount. Under this policy, the net cost to the state, after mandatory and supplemental rebates, would equal what its net cost would be if it were reimbursing pharmacies at modified AMP, reflecting true market prices, minus the statutory rebate applied to that figure.

Table 1

Sample State Rebates and Savings Under a Modified AMP System

	Item	Current policy	Proposed policy	Description
A	**Medicaid reimbursement to pharmacy**	$110	$110	The amount Medicaid pays a pharmacy, including ingredient costs and dispensing fees*
B	**Federal average manufacturer price (AMP)**	$100		Based on statutory formula
C	**Statutory rebate**	-$23		23.1% of federal AMP (B) for brand drugs
D	**Existing state supplemental rebate**	-$4		Based on average rebates of 3-6%†
E	**Net price after federal AMP discount**	$83		(A minus C minus D)
F	**Modified AMP**	NA	$72	Assuming a 28% discount from federal AMP (B), based on average manufacturer discounts and rebates‡
G	**Modified AMP state supplemental rebate**	NA	-$17	23.1% of modified AMP (F) for brand drugs
H	**Net price after modified AMP state supplemental discount**	NA	$55	(F minus G)
I	**Modified AMP state supplemental rebate**	NA	$28	(A minus H minus C minus D)
	Net cost	$83	$55	
	Savings		$28	

Note: In this example, brand drug data are for illustration purposes only, and Pew assumes that there are no interactions with best price.

* Centers for Medicare & Medicaid Services, "Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State: Quarter Ending March 2018," https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/drug-reimbursement-information/index.html.

† Magellan Rx Management, "Medicaid Pharmacy Trend Report: 2017 Second Edition" (August 2017), https://www1.magellanrx.com/media/671872/2017-mrx-medicaid-pharmacy-trend-report.pdf.

‡ IQVIA Institute for Human Data Science, "Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022" (April 2018), https://www.iqvia.com/institute/reports/medicine-use-and-spending-in-the-us-review-of-2017-outlook-to-2022.

Considerations for state policymakers

Modified AMP reporting may require additional staff to manage and audit price data from manufacturers. Savings from generic drugs may also be minimal, because few rebates are offered for these drugs. Finally, manufacturers may forgo PDL inclusion to avoid reporting modified AMP and payment of supplemental rebates, which may reduce the state's ability to manage drug use or negotiate other voluntary rebates for preferring a particular drug.

To reduce these burdens, states could adopt modified AMP reporting and supplemental rebates only for drugs in certain classes, targeting high-cost drugs, for which savings may be greater. Modified AMP reporting and calculated supplemental rebates should not replace existing state supplemental rebate negotiations; instead, these data can support the state negotiations, forming a new floor from which to negotiate rebates. Using a formula to establish rebate amounts would reduce states' administrative duties in the long run, and manufacturers would not be unduly burdened because, for certain drugs, they already report the price after discounts and rebates.

To further reduce administrative burdens, several states could establish a uniform PDL with modified AMP reporting and calculated supplemental rebates. Existing multistate supplemental rebate negotiating pools could help initiate the process, putting more pressure on manufacturers to participate while sharing administrative costs. This amended AMP would better reflect true commercial prices and reduce, but not eliminate, the state's burden in negotiating supplemental rebates.

Endnotes

1 42 C.F.R. § 447.504.

2 Medicaid and CHIP Payment and Access Commission, "Medicaid Gross Spending and Rebates for Drugs by Delivery System, FY 2016 (Millions)" (2017), https://www.macpac.gov/wp-content/uploads/2015/11/EXHIBIT-28.-Medicaid-Gross-Spending-and-Rebates-for-Drugs-by-Delivery-System-FY-2016-millions.pdf.

3 Patient Protection and Affordable Care Act, § 2503.

4 IQVIA Institute for Human Data Science, "Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022" (April 2018), https://www.iqvia.com/institute/reports/medicine-use-and-spending-in-the-us-review-of-2017-outlook-to-2022.

5 For 5i drugs—medications that are inhaled, infused, instilled, implanted, or injected—an alternate AMP calculation (5i AMP) is used if at least 70 percent of units are not sold through retail community pharmacies. 5i AMP includes sales and associated discounts and rebates to many entities excluded from the standard AMP—including physicians, pharmacy benefit managers, insurers, hospitals, outpatient clinics, and mail-order pharmacies. AMP and 5i AMP are confidential prices, calculated monthly and quarterly. Because these discounts and rebates are included in the AMP calculation, states reimburse for these drugs at lower rates than if they were using the standard AMP. However, states do not benefit from these lower payments because AMP is reduced relative to reimbursement.

6 42 C.F.R. § 447.518(a)(2).

7 Medicaid Program, Covered Outpatient Drugs, Final Rule, 81 Fed. Reg. 5170 (Feb. 1, 2018), https://www.gpo.gov/fdsys/pkg/FR-2016-02-01/pdf/2016-01274.pdf.

8 States could implement this policy through legislation or regulations, depending on how a state has designed its preferred drug list and where the changes fit into existing statutory and regulatory frameworks. States may also need to resubmit their Medicaid State Plan Amendment to make changes to their PDL.

9 42 C.F.R. § 447.505.

10 Centers for Medicare & Medicaid Services, "Medicaid Pharmacy Supplemental Rebate Agreements (SRA) as of March 2018," accessed June 19, 2018, https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/xxxsupplemental-rebates-chart-current-qtr.pdf. Three multistate supplemental agreements serve 30 state Medicaid programs: the National Medicaid Pooling Initiative (11 states), TOP$ (seven states), and Sovereign States Drug Consortium (12 states). Thirty states participate in single-state supplemental rebate agreements.

11 Magellan Rx Management, "Medicaid Pharmacy Trend Report, 2017 Second Edition" (August 2017), https://www1.magellanrx.com/media/671872/2017-mrx-medicaid-pharmacy-trend-report.pdf.

12 Medicaid Drug Rebate Program, created under the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508.

13 Texas Administrative Code § 354.1921. Historically, Texas required manufacturers to report a variety of average pricing metrics, including average wholesale price; AMP; and average prices to wholesalers, pharmacies, and long-term care pharmacies. Texas no longer requires this price reporting and now uses the national average drug acquisition cost to establish pharmacy reimbursement.

14 Centers for Medicare & Medicaid Services, "Medicaid Pharmacy Supplemental Rebate Agreements."

For further information, please visit:

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