Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID'S MENTAL HEALTH DRUG EXPENDITURES

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EXECUTIVE SUMMARY

OBJECTIVE

To measure the efficiency and economy of the Medicaid program as a purchaser of mental health drugs by comparing Medicaid to four other Federal payers.

BACKGROUND

Title XIX of the Social Security Act established Medicaid as a jointly-funded, Federal-State health insurance program. Medicaid plays a fundamental role in the provision of prescription drugs to over 42 million low-income and disabled beneficiaries, spending an estimated $20 billion in 2001.

In purchasing mental health drugs, as with all Medicaid expenditures, Title XIX requires States, as part of their State plan, to provide "methods and procedures" to assure that payments are "consistent with efficiency, economy, and quality of care." The Centers for Medicare & Medicaid Services (CMS) exercises this control in two ways: by placing aggregate limits on pharmacy reimbursements and collecting statutorily-defined manufacturer rebates.

Despite efforts to save program dollars, drug costs are the fastest growing component of Medicaid expenditures, growing an average annual rate of 20 percent compared to overall Medicaid expenditure growth of 9 percent from 1998 to 2000. According to a report issued by the United States Surgeon General, spending on drugs used to treat mental disorders are among the fastest rising costs for Medicaid.

Of the $20 billion the Medicaid program spent on prescription drugs, mental health drugs represent an estimated 20 percent, or $4 billion.

Methodology

To assess the efficiency and economy of Medicaid's drug expenditures, this inspection compared Medicaid's average net costs for mental health drugs to four other Federally-discounted prices: 1) Federal Ceiling Prices, 2) 340B Drug Discount Program ceiling prices, 3) Federal Supply Schedule prices, and 4) Big 4 (Department of Defense, Department of Veterans Affairs, Public Health Service and the Coast Guard) prices. These programs' prices serve as criteria by which to assess the economy of Medicaid's drug purchasing, without any judgement as to the appropriateness of different Federal drug purchasing mechanisms.

To calculate Medicaid's net average price, we secured information on 25 mental health drugs from the 10 State Medicaid agencies with the largest reimbursement for prescription drugs. We obtained data on pharmacy payment and rebates for the first two quarters of Federal fiscal year 2001 (October 2000 - March 2001). The Department of Veterans Affairs and the CMS provided the Federal Ceiling Prices, the Federal Supply Schedule prices, the Big 4 prices, and 340B ceiling prices.

FINDINGS

The 10 State Medicaid agencies reviewed paid more than other Government purchasers for the 25 mental health drugs reviewed

Despite Federal and State measures to reduce prescription drug expenditures for the Medicaid program, the 10 State Medicaid agencies' paid more than the other Federal prices reviewed. The complete range of differences between each program's average price to Medicaid's average net price is listed in the chart below.

Average Percent Difference between Medicaid Net Prices and other Federal Drug Purchasers' Prices, FY2001

Federally-Mandated Drug Schedules	Percent More Paid by Medicaid
Federal Ceiling Prices	27%
340B Ceiling Prices	13%
Federal Drug Contract Prices	
Federal Supply Schedule Prices	11%
Big 4 Prices	29%

Source: OIG survey of State Medicaid drug expenditures

As a result of price differences, the 10 State Medicaid agencies paid, on average, between $47 and $126 million more for the 25 mental health drugs than other Federal purchasers

Medicaid would have saved $47 million if it had been able to pay prices equivalent to the Federal Supply Schedule prices and $126 million if it had paid prices equal to the Big 4 prices. In comparison to the Federal Ceiling Prices and the 340B ceiling prices, Medicaid would have saved $116 and $66 million, respectively, for the 25 drugs. The subgroup of nine antipsychotic drugs accounts for over half of the difference between Medicaid and the two ceiling pricing schedules.

CONCLUSION

To safeguard the Medicaid program from excessive payments and capitalize on potential savings, we encourage CMS to reconsider previous OIG recommendations. In past reports, the OIG has recommended that CMS work with States to pursue more efficient means of purchasing pharmaceuticals and initiate a review of the Medicaid rebate program. We also suggest that CMS share this report with the States.

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OBJECTIVE

To measure the efficiency and economy of the Medicaid program as a purchaser of mental health drugs by comparing Medicaid to four other Federal payers.

BACKGROUND

Title XIX of the Social Security Act established Medicaid to be a jointly-funded, Federal-State health insurance program. Medicaid plays a fundamental role in the provision of prescription drugs to over 42 million low-income and disabled beneficiaries, spending an estimated $20 billion in 2001.[1] In fact, 12 percent of adults rely on Medicaid to cover their physical and mental health care needs.

In purchasing mental health drugs, as with all Medicaid expenditures, Title XIX requires States, as part of their State plan, to provide "methods and procedures" to assure that payments are "consistent with efficiency, economy, and quality of care."[2] The Centers for Medicare & Medicaid Services (CMS) exercises this control in two ways. In 1987, CMS published a notice of the final rule (52 FR 28648) that limits Medicaid reimbursement to pharmacies. According to the rule, State payments to pharmacies are limited to the agency's "best estimate of the price generally and currently paid [to wholesalers] by providers for the drug." In addition, States are authorized to collect rebates from drug manufacturers for drug purchases made under the Medicaid program.

Medicaid and Mental Health Drugs

Overall expenditures for prescription drugs grew more than twice as fast as total Medicaid spending from fiscal years (FYs) 1998 to 2000. More specifically, expenditures for drugs used for the treatment of mental disorders are among the fastest-rising costs for Medicaid, currently representing an estimated 20 percent of Medicaid's total payment for pharmaceuticals ($4 billion).[3] For 15 States, spending on mental health drugs exceeds 20 percent of the total Medicaid drug expenditures.[4]

For some State Medicaid programs, the costs of treating mental disorders, such as schizophrenia and depression, have surpassed expenditures for medications to treat traditional high-cost ailments, such as high blood pressure, respiratory problems, and diabetes.[5] Among the various categories of mental health drugs, spending on anti-psychotic medications is the highest, accounting for 11 percent of Medicaid's total pharmacy costs for all drugs.[6] Antidepressants and anti-anxieties are also listed among the highest cost medications in Medicaid programs.

Related Work by the Office of Inspector General

The Office of Inspector General (OIG) has issued a significant body of work related to Medicaid drug pricing, including such topics as reimbursement, rebates, and the accuracy of Average Wholesale Price. This report is part of the OIG's continuing work focusing on Medicaid's expenditures for specific classes of pharmaceuticals. In the report entitled "Cost Containment of Medicaid HIV/AIDS Drug Expenditures" (OEI-05-99-00611), OIG found that Medicaid pays up to 33 percent more than other Federal drug discount programs for 16 antiretroviral drugs. Medicaid could have saved $102 million in Federal/State funds in fiscal year 2000, if the 10 sampled States had purchased the 16 antiretrovirals at Federal Ceiling Prices. Based on these findings, OIG recommended that CMS review the current reimbursement methodology and work with States to find a method that more accurately estimates pharmacy acquisition cost. Additionally, OIG recommended that CMS initiate a review of Medicaid rebates. See Appendices B and C for a more complete list of related OIG reports.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective and Scope

The objective of this report was to measure the efficiency and economy of Medicaid's mental health drug purchases. To do this, we compared Medicaid's prices for mental health drugs to those of four other Federal pricing schedules also designed to limit the Government's payments for prescription drugs. In addition to Medicaid's cost containment measures, Federal payments for outpatient drugs are contained through: 1) Federal Ceiling Prices (FCP), 2) 340B Drug Discount Program ceiling prices, 3) Federal Supply Schedule prices (FSS), and 4) Big 4 (Department of Defense (DoD), Department of Veterans Affairs (VA), Public Health Service (PHS), and the Coast Guard) prices. Table A illustrates how each of the discounts operate.

Table A: Federal Discount Formulas

Drug Purchasing Program	Eligible Purchasers	Discount Mechanism
Medicaid	State Medicaid Agencies	→Aggregate limits on pharmacy reimbursement →Approximately 15.1% off manufacturer prices
Federal Ceiling Prices	the Big 4 agencies *(DoD, VA, PHS, and Coast Guard)*	*At least* 24% off manufacturer prices
340B Drug Discount Program	certain Federally-qualified groups and grantees	Approximately 15.1% off manufacturer prices
Federal Supply Schedule	specified agencies	Contracts negotiated with manufacturers capped by "most favorable customer prices"
Big 4 prices (Represents the 4 agencies' "actual" price)	Big 4 agencies	Contracts negotiated with manufacturers capped by the Federal Ceiling Prices, but the lowest of several possible prices including the FSS

The four Federal pricing mechanisms used in our comparisons offer a robust picture of the prices available across Federal programs. Comparing Medicaid prices to theoretical upper limits represented by the FCP and the 340B ceiling prices provided a means to assess Medicaid in relation to other programs with statutorily-defined manufacturer discounts. Comparing Medicaid to FSS and the Big 4 provided an opportunity to evaluate the actual prices paid by Medicaid to the actual negotiated prices paid by other Federal agencies.

In this inspection, we focused on differences in drug acquisition costs. For Medicaid, we defined acquisition costs as the net costs to Medicaid for mental health drugs. To calculate this, we subtracted the manufacturer rebates Medicaid received from the reimbursement rates Medicaid paid to pharmacies. For the other Federal prices used as points of comparison, drug acquisition cost equals the discounted price they pay for the drug.

We did not attempt to factor in the cost of administrative overhead, drug distribution, and storage expenses. These expenses differ considerably depending on the drug purchasing and distribution systems employed by various pharmaceutical purchasers. Including these costs in our comparisons would result in a discussion of the cost-effectiveness of particular purchasing and distribution systems, and a discussion of that magnitude is beyond the scope of this report.

Methodology

Based on data from the National Pharmaceutical Council's 1999 guide to State pharmaceutical benefits, we purposively selected State Medicaid agencies representing the top 10 States in terms of the highest amount of Medicaid reimbursement for prescription drugs. The States are: California, New York, Florida, Texas, Ohio, Illinois, Pennsylvania, Massachusetts, North Carolina, and New Jersey. These 10 States accounted for 58 percent of the total Medicaid drug payment amount ($7.9 billion out of $13.7 billion).

We identified mental health drug classes using the Food and Drug Administration (FDA) list of therapeutic classes. We examined three of the four FDA-classified groups of mental health drugs: anti-anxiety, antidepressant, and antipsychotic/anti-maniac. We did not look at the fourth class, sedatives/hypnotics, because most of the drugs in this category are prescribed as sleep aids rather than for mental disorders. From each of these three classes, we selected the 10 National Drug Codes (NDCs)[1] with the greatest total national reimbursement, including all doses and package sizes of each NDC, based on an analysis of the calendar year 2000 Drug Utilization Files. After discovering generic versions were available for 5 of the NDCs[2], our net sample was 25 brand-name drugs, representing 63 percent of the total national Medicaid payment for the 3 categories of mental health drugs in 2000.

To gather data on State Medicaid agencies' actual expenditures, we collected fee-for-service pricing data from each of the 10 sampled States in November 2001. The States reported their drug reimbursements, rebates and dispensing fees for the first 2 quarters of

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1 Each drug manufactured in the United States has a unique National Drug Code (NDC) which identifies the drug's manufacturer, product dosage form, and packet size.

2 Clozaril 100 mg, Wellbutrin 150 mg, and Xanax .5 mg, 1 mg, 2 mg

Federal fiscal year 2001 (October 2000 - March 2001). Due to a variety of data issues regarding the rebates, we assumed 100 percent collection of rebates for all 10 States. This estimation consisted of multiplying each State's total units by the Medicaid unit rebate amount.

The State of California negotiated additional rebate amounts with the pharmaceutical manufacturers of each of the drugs in our sample. Therefore, to approximate California's net cost, we subtracted an additional amount using a rough estimate of the rebate formula, per the State's direction. The State did not submit any pricing data relating to the specific calculation or net amount of the supplemental rebates, as this information is proprietary.

In addition to the pricing information, we conducted telephone interviews with the 10 State Medicaid pharmacy directors. We interviewed the directors to gain further understanding of State-specific program operations and to explore any cost containment efforts surrounding mental health drugs. The interviews were conducted between November 2001, and January 2002.

We also gathered information regarding pharmaceutical pricing from CMS and the Department of Veterans Affairs (VA). The CMS supplied us with the Average Manufacturer's Prices, the Best Prices, the Medicaid Unit Rebate Amounts, and the 340B ceiling prices. The VA provided us with data on FCP and FSS contract prices.

To represent Medicaid's average net price, we calculated an average unit price per drug, per State for the two quarters worth of data collected. Each State's average unit price per drug was then averaged to represent the average unit price Medicaid paid for each of the 25 drugs. We used this average per drug unit price as the point of comparison to the unit price per drug for the other Governmental programs. We also calculated and utilized average FCPs because our study spanned a time period in which the FCP was refigured. The median difference between the calculated average FCP and any given FCP for the 25 drugs is 2 cents.

This report reveals no specific drug pricing information because of the proprietary nature of this data. Toward this end, most estimates are averages and all estimates have been rounded. All savings estimates based on this information have been aggregated and rounded down for conservative estimates.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

To measure Medicaid's efficiency as a Government purchaser of pharmaceuticals, this study compared 10 State Medicaid programs' net costs for 25 mental health drugs to four other Federal pricing schedules. Our review revealed that Medicaid's net costs for the 25 mental health drugs were the highest among all of the Government purchasers. Medicaid could have saved between $47 and $126 million, on average, if they had been able to achieve the lower prices paid by the other Federal purchasers for these 25 mental health drugs.

The 10 State Medicaid agencies paid more than other Government purchasers for the 25 mental health drugs reviewed

Despite Federal and State measures to reduce prescription drug expenditures for the Medicaid program, the 10 State Medicaid agencies' average net price was between 11 and 29 percent more for the 25 sampled drugs than the other Federal programs. Table B demonstrates the complete range of differences between each programs' average price and Medicaid's average net price. See Appendix A for a breakdown of the percent differences between Medicaid and each of the other Federal purchasers by drug.

Table B: Average Difference Between Medicaid Prices and Other Federal Prices

Federally-Mandated Drug Schedules	Percent More Paid by Medicaid
Federal Ceiling Prices	27%
340B Ceiling Prices	13%
Federal Drug Contract Prices	
Federal Supply Schedule Prices	11%
Big 4 Prices	29%

Source: OIG survey of State Medicaid drug expenditures

Medicaid pays more than other programs with statutorily-defined discounts

On average, the net cost to the Medicaid program for the 25 mental health drugs reviewed was 13 percent higher than the 340B ceiling prices, ranging from 9 to 28 percent. Medicaid paid an average 26 cents more per pill than the 340B ceiling price. The difference ranged from 6 cents more per pill for Buspar (5 mg, 500 units) to 65 cents more for Zyprexa (10 mg, 60 units).

On average, Medicaid paid 27 percent more than the FCP. The differences between Medicaid's average net price and the FCP ranged from Medicaid paying 7 percent more for Buspar (10 mg, 500 units) to 50 percent more for Effexor (75 mg, 100 units). For over half of the sampled drugs, Medicaid paid at least 25 percent more than the FCP. Translated into actual dollar differences, Medicaid paid 48 cents more, on average, than the FCP. This difference ranged from 4 cents more per pill for Buspar (5 mg, 500 units) and $1.30 more for Zyprexa (10 mg, 60 units).

It is important to remember that these two pricing schedules - the FCP and the 340B - are computed ceiling prices. The actual prices paid by entities covered by these programs can be, and typically are, below the mandated ceiling prices. For example, the Big 4 prices represent the actual prices paid by agencies benefiting from the FCP. When Medicaid's prices are compared to the theoretical upper limit set by the FCPs, there is a 27 percent gap. However, this discrepancy grows to 29 percent when Medicaid's prices are compared to the actual prices paid by the agencies benefitting from the FCPs.

Medicaid also pays more in comparison to Federally-contracted prices

In addition to comparing Medicaid's net prices to other statutorily-defined prices, we compared Medicaid's prices to the Federally-contracted prices of the FSS. This comparison involved both direct FSS prices as well as the prices actually paid by the Big 4 (VA, DOD, PHS and Coast Guard).

Medicaid's net cost, on average, was 11 percent higher than the FSS prices. This translates into an average of 23 cents more per pill. Overall, Medicaid paid more for all the drugs in the sample except the four versions of Risperdal (1 mg, 2 mg, 3 mg, and 4 mg). In these four instances, the 10 State Medicaid agencies paid an average of 13 percent less than the FSS contract prices, or 47 cents less per pill. With the exception of Risperdal, State Medicaid agencies paid between 1 cent more to $1.02 more per pill than the FSS, averaging 36 cents more per pill than the FSS contract.

Comparing Medicaid's average net prices to the Big 4 prices, we found that Medicaid's price was 29 percent higher. Medicaid's prices ranged from 6 percent to 67 percent higher than the prices paid by the Big 4. For 4 of the drugs, Medicaid paid approximately 50 percent more than the Big 4 prices. On average, States paid anywhere from 4 cents to $1.28 more per pill than the Big 4 agencies, averaging 51 cents more per pill.

As a result of price differences, the 10 State Medicaid agencies paid, on average, between $47 and $126 million more than other Federal purchasers for the 25 mental health drugs

The 10 State Medicaid agencies would have saved, on average, between $47 and $126 million during the first 2 quarters of FY 2001 if they were able to obtain the lower prices of the other Federal drug purchasers for the 25 mental health drugs. The States would have saved a total of $116 million in the 2 quarters if their drug prices equalled the FCPs. This savings represents approximately 20 percent of the 10 States' net costs for this time period. The Federal share of this savings is over $62 million. The 10 States would also have saved over $66 million if their prices for the 25 mental health drugs had equalled the 340B ceiling price.

We additionally analyzed the potential savings for the Medicaid program if they were able to obtain prices comparable to FSS and Big 4 prices. While State Medicaid agencies do not currently negotiate directly with pharmaceutical manufacturers, these comparisons demonstrate the potential savings negotiations might be able to offer the Medicaid program. In fact, faced with dramatic increases in drug prices, more than 20 States are exploring the creation of purchasing coalitions with the intention of wielding aggregate purchasing power to negotiate lower prices.[7]

The difference between FSS prices and Medicaid prices translates into potential Medicaid savings of $47 million semiannually. If the 10 State Medicaid agencies received prices similar to those negotiated for the Big 4, they would have saved $126 million during the same time period. Table C illustrates the potential savings in comparison to each Federal pricing program.

Table C: Average Medicaid Savings

Federally-Mandated Drug Schedules	Savings (millions)
Federal Ceiling Prices	$116
340B Ceiling Prices	$66
Federal Drug Contract Prices	
Federal Supply Schedule Prices	$47
Big 4 Prices	$126

Source: OIG survey of State Medicaid drug expenditures

The nine antipsychotic drugs reviewed constitute more than half of the potential savings between Medicaid and the other ceiling prices

The 25 mental health drugs in our sample can be broken down into three drug classes: anti-anxieties, antidepressants, and antipsychotics. The savings potential for the anti-psychotic drugs far exceeds the saving potential for the other two classes of drugs. The savings for the 9 drugs in this class represents 68 percent of the total the 10 States would save if their prices equalled FCP and 58 percent of the total if the States' prices equalled the 340B ceiling price. Table D illustrates Medicaid's average unit difference and savings potential by class.

Table D: Medicaid's Average Unit Difference and Savings Potential by Drug Classification

Drug Class	Unit Difference to FCP	Savings Estimate	Unit Difference to 340B	Savings Estimate
antipsychotic	79 cents	$79 M	37 cents	$38 M
antidepressant	37 cents	$31 M	23 cents	$22 M
anti-anxiety	21 cents	$5 M	16 cents	$5 M

Source: OIG survey of State Medicaid drug figures, all expenditures have been rounded down

The antipsychotics in our sample represent the greatest savings because of their higher costs and their higher utilization than drugs from the other classes. In fact, the 5 drugs with the greatest gap in unit price between Medicaid and the FCP are all antipsychotics: Zyprexa (10 mg), Risperdal (4 mg), Seroquel (200 mg), Zyprexa (5 mg), and Zyprexa (2.5 mg). Medicaid would have saved $60 million semiannually if the net prices for just these 5 antipsychotics equalled the FCP, accounting for 52 percent of the total savings estimated for all 25 drugs in our sample. Antipsychotics are also heavily prescribed. In fact, just 2 of these antipsychotics represent almost 20 percent of all of the prescriptions for the 10 States.

Our analysis specifies that one drug, Zyprexa (10 mg), contributes significantly to the high cost and utilization of antipsychotics. Medicaid paid $1.30 more than the FCP for Zyprexa (10 mg), compared to 72 cents more, on average, for the other antipsychotics. Zyprexa (10 mg) also leads in savings for the Medicaid program when prices are compared to the 340B, FSS, and Big 4 price. Further, the number of prescriptions dispensed for Zyprexa (10 mg) lead all other NDCs sampled by far with 371,823 prescriptions filled in 6 months. The drug with the second highest number of prescriptions is Risperdal (1 mg), but it falls behind Zyprexa (10 mg) by a significant 105,000 bottles with 267,247 prescriptions filled. Because of this, Zyprexa (10 mg)

is the top drug for savings for all 10 States and all 25 drugs at $58 million a year compared to the FCP and $14 million a year compared to the 340B price.

Antipsychotics represent the largest potential for savings in relation to the other drug classes, and also comprise a significant portion of the total Medicaid drug budget. In FY 2001, the 10 State Medicaid agencies in our sample spent $562 million on all 25 drugs selected, 67 percent of that expenditure, $378 million, purchased the 9 antipsychotics represented in our sample. These same nine antipsychotics represent 4 percent of the $20 billion Medicaid spent on all prescription drugs for FY 2001.

The rapid growth in expenditures for antipsychotics has raised concerns in the State Medicaid programs as they struggle to contain program costs. States are concerned with finding strategies for maximizing cost-effectiveness while maintaining current access. Since Medicaid is the main provider of care for persons with schizophrenia, an illness that typically requires long-term drug therapy with these drugs, consistent, if not increasing, demand seems likely.

Program savings through reducing drug costs represent a powerful means of maintaining current levels of service in the face of tightening budgets. For example, saving $79 million in drug acquisition costs for antipsychotics could help avoid restricting coverage of these crucial drugs. Alternate cost containment strategies, such as preferred drug lists and prior authorization, often exempt mental health drugs, making price containment strategies even more crucial for this set of drugs.

CONCLUSION

The law directs the Medicaid program to establish payment methods that are efficient and economical. We found that Medicaid agencies in 10 States spent between $47 and $126 million more for 25 mental health drugs in 6 months than they would have had they obtained the lower prices used by the other Federal programs reviewed.

To safeguard the Medicaid program from excessive payments for mental health drugs and capitalize on potential savings, we encourage CMS to reconsider the OIG recommendations made in previous reports. While these past reports focus on reducing Medicaid's costs for various classes of drugs, the analysis of each demonstrates the need for CMS to address the broader issues Medicaid faces in purchasing all drugs. For a listing of these reports, please refer to Appendices B and C. Given that this report provides further evidence of the problems plaguing the Medicaid prescription drug benefit program, it supports recommendations previously set forth by the OIG which have not yet been implemented. We also suggest that CMS share this report with the States.

In particular, we continue to believe that CMS should implement the recommendations outlined in our report entitled, "Cost Containment of Medicaid HIV/AIDS Drug Expenditures" (OEI-05-99-00611). These recommendations are summarized below. For each of the recommendations, we offer CMS options for implementation, which are listed in Appendix B.

- CMS should review the current reimbursement methodology and work with States to find a method that more accurately estimates pharmacy acquisition cost.

- CMS should initiate a review of Medicaid rebates.

APPENDIX A

Sampled Mental Health Drugs

Anti-Anxieties					
Drug Name	**NDC**	**Medicaid/340B Difference**	**Medicaid/FCP Difference**	**Medicaid/ Big4 Difference**	**Medicaid/FSS Difference**
Buspar	00087081841	22%	12%	11%	11%
Buspar	00087081844	17%	11%	11%	11%
Buspar	00087081941	23%	8%	7%	7%
Buspar	00087081944	18%	7%	7%	7%
Buspar	00087082232	14%	28%	28%	28%
Buspar	00087082233	12%	28%	27%	27%
Buspar	00087082481	13%	28%	28%	28%

Antidepressants					
Drug Name	**NDC**	**Medicaid/340B Difference**	**Medicaid/FCP Difference**	**Medicaid/ Big4 Difference**	**Medicaid/FSS Difference**
Prozac	00777310502	28%	11%	23%	.6%
Zoloft	00049490066	15%	37%	55%	38%
Zoloft	00049491066	14%	36%	54%	36%
Celexa	00456402001	13%	32%	67%	35%
Paxil	00029321013	14%	22%	22%	22%
Paxil	00029321113	15%	22%	30%	30%
Paxil	00029321213	15%	25%	34%	34%
Effexor XR	00008083301	9%	50%	50%	50%
Remeron	00052010530	20%	30%	31%	31%

Antipsychotics					
Drug Name	**NDC**	**Medicaid/340B Difference**	**Medicaid/FCP Difference**	**Medicaid/ Big4 Difference**	**Medicaid/FSS Difference**
Zyprexa	00002411260	11%	26%	26%	10%
Zyprexa	00002411560	10%	27%	27%	10%
Zyprexa	00002411760	10%	24%	24%	8%
Risperdal	50458030006	12%	19%	19%	-17%
Risperdal	50458032006	12%	21%	20%	-16%
Risperdal	50458033006	11%	28%	27%	-11%
Risperdal	50458035006	11%	26%	25%	-10%
Seroquel	00310027110	11%	41%	42%	42%
Seroquel	00310027210	10%	39%	41%	41%

APPENDIX B

Related Office of Inspector General Report Summaries

"Cost Containment of Medicaid HIV/AIDS Drug Expenditures" (OEI-05-99-00611)	
Findings	**Recommendations**
Medicaid pays up to 33 percent more than other Federal Government drug discount programs for HIV/AIDS Drugs.	For the 16 HIV/AIDS drugs examined, CMS should review the current reimbursement methodology and work with States to find a method that more accurately estimates pharmacy acquisition cost. ▸ *Option 1*: Develop safeguards to protect Medicaid from Average Wholesale Price manipulations, or ▸ *Option 2*: Create national estimated acquisition cost for the States based upon the Average Manufacturers Price, or ▸ *Option 3*: Share Average Manufacturer Price data with States so that they can accurately set Medicaid reimbursement amounts.
Differences in Federal drug pricing formulas are partially responsible for cost discrepancies.	CMS should initiate a review of the Medicaid rebates for the 16 HIV/AIDS drugs examined. Two options include increasing the rebate percentage off AMP or basing the rebates on AWP. ▸ *Option 1:* Increase the rebate percentage off of Average Manufacturer Price, or ▸ *Option 2:* Base the rebates on Average Wholesale Price rather than Average Manufacturer Price so that it is linked to the reimbursement methodology.
State reimbursement formulas affect the magnitude of the gap between Medicaid and other Government drug purchasers.	
Medicaid could have saved $102 million if the 10 sampled States purchased the 16 antiretrovirals at Federal Ceiling prices.	

"Medicaid Pharmacy: Actual Acquisition Cost of Prescription Drug Products for Brand Name Drugs" (A-06-00-00023) & Review of Pharmacy Acquisition Costs for Drugs Reimbursed Under the Medicaid Prescription Drug Program of _____" (A-06-01-00001 through A-06-01-00008) **(This nationwide audit resulted in 8 separate, State-specific reports. The States are: TX, FL, WI, CO, MO, WA, WV, IN)**	
Findings	**Recommendations**
The actual acquisition cost for brand name drugs is estimated to be a national average of 21.84 percent below AWP.	CMS should require the States to bring pharmacy reimbursement more in line with the actual acquisition cost of these drugs being realized by pharmacies.
If reimbursement had been based on the estimates of this report, Medicaid could have saved $1.08 billion for 100 drugs in calendar year 1999.	

APPENDIX C

Related Office of Inspector General Reports

"Cost Containment of Medicaid's HIV/AIDS Drug Expenditures" (OEI-05-99-00611)

"Medicare Reimbursement of Albuterol" (OEI-03-00-00311)

"Medicare Reimbursement of End Stage Renal Disease Drugs" (OEI-03-00-00020)

"Medicaid Pharmacy: Actual Acquisition Cost of Generic Prescription Drug Products" (A-06-01-00053)

"Medicaid Pharmacy: Actual Acquisition Cost of Generic Prescription Drug Products" (A-06-97-00011)

"Medicaid Pharmacy: Actual Acquisition Cost of Prescription Drug Products for Brand Name Drugs" (A-06-00-00023)

Review of Pharmacy Acquisition Costs for Drugs Reimbursed Under the Medicaid Prescription Drug Program of _____ (all included in the 2001 reports)
Texas Health and Human Services Commission (A-06-01-00001)
Florida Agency for Health Care Administration (A-06-01-00002)
Wisconsin Department of Health and Family Services (A-06-01-00003)
Colorado Department of Health Care Policy and Financing (A-06-01-00004)
Montana Department of Public Health and Human Services (A-06-01-00005)
Washington Department of Social and Health Services (A-06-01-00006)
West Virginia Department of Health and Human Services (A-06-01-00007)
Indiana Family and Social Services Administration (A-06-01-00008)

"Medicaid Pharmacy: Actual Acquisition Cost of Prescription Drug Products for Brand Name Drugs" (A-06-96-00030)

Review of Pharmacy Acquisition Costs for Drugs Reimbursed Under the Medicaid Prescription Drug Program of _____ (all included in the 1996 review)
California Department of Health Services" (A-06-95-00062)
Montana Department of Public Health and Human Services" (A-06-95-00068)
Florida Agency for Health Care Administration" (A-06-95-00065)
North Carolina Department of Human Resources" (A-06-95-00071)
Delaware Department of Health and Social Services" (A-06-95-00063)
Virginia Department of Medical Assistance" (A-06-95-00072)

New Jersey Department of Human Services" (A-06-95-00070)
Nebraska Department of Social Services" (A-06-95-00069)
Missouri Department of Social Services" (A-06-95-00067)
District of Columbia Department of Human Services" (A-06-95-00064)
Maryland Department of Health and Mental Hygiene" (A-06-95-00066)

"Excessive Medicare Payments for Prescription Drugs" (OEI-03-97-00290)

"Need to Establish Connection Between the Calculation of Medicaid Drug Rebates and Reimbursement for Medicaid Drugs" (A-06-97-00052)

"Medicaid Managed Care and HIV/AIDS" (OEI-05-97-00210)

"Medicaid Drug Rebates: The Health Care Financing Administration Needs to Provide Additional Guidance to Drug Manufacturers to Better Implement the Program" (A-06-91-00092)

"Medicaid Drug Rebates: Inaccurate Reporting of Medicaid Drug Data by Pharmacies" (A-06-91-00056)

"Medicaid Drug Rebates: Improvements Needed in the Health Care Financing Administration's Procedures to implement the Medicaid Drug Rebate Program" (A-06-91-00102)

APPENDIX D

Endnotes

1. Centers for Medicare & Medicaid Services, Health Care Industry Market Update: Pharmaceuticals. January 10, 2003.

2. Section 1902(a)(30)(A) of the Social Security Act.

3. U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Washington, DC & Centers for Medicare & Medicaid Services. (2000). State Drug Utilization Data.

4. "Pharmaceutical Benefits Under State Medical Assistance Programs", 1999 National Pharmaceutical Council. The 15 States are: ID, IN, IA, ME, MD, MA, MN, NH, ND, OR, RI, UT, VT, WA, WI.

5. Mental Illness Drugs Top State List. (2001, February 9). The Dallas Morning News.

6. Centers for Medicare & Medicaid Services. (2000). State Drug Utilization Data.

7. National Council of State Legislatures. 2002 Prescription Drug Discount, Bulk Purchasing & Price-Related Legislation. www.ncls.org/programs/health/drugdisc02.htm,.

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