POLICY PAPER NO.4 • MARCH 2008

STRENGTHENING MEDICAID

Advancing Efficient Management and Purchasing of Prescription Drugs

by Jeffrey S. Crowley, Health Policy Institute, Georgetown University, and Edwin Park, Center on Budget and Policy Priorities

Overview

Prescription drugs are both central to effective health care and a major driver of spending in the Medicaid program, accounting for more than $19 billion in Medicaid spending in 2006.[1] Prescription drugs are broadly recognized as important and effective interventions and are cost effective when they substitute for hospital stays and other costly forms of care. At the same time, the rate of growth in prescription drug spending has been a source of concern across insurers. Many states have been proactive in employing a broad array of strategies in Medicaid to maximize the benefits of prescription drugs, while striving to minimize costs. These efforts have helped slow the rate of growth in Medicaid spending on prescription drugs, and Medicaid drug spending grew more slowly than spending on prescription drugs nationally through 2005, after which Medicare Part D took effect, shifting responsibility for drug coverage for low-income seniors and some people with disabilities from Medicaid to Medicare.[2]

Despite current efforts, not all of the tools available to states and the federal government are being fully employed. This paper offers strategies to manage prescription drugs efficiently and reduce costs, while maintaining access for beneficiaries. The first set of strategies offers ideas to better manage the drugs Medicaid dispenses to beneficiaries. The second set recommends policies to ensure that Medicaid uses its purchasing power to get the best possible price on prescription drugs. Some of these strategies can be carried out entirely at the state level; in other cases, federal action is necessary.

Georgetown University Health Policy Institute
Center for Children and Families

Ensuring Efficient Management of Prescription Drugs

Prescription drug utilization has grown significantly for several years. States have been working to manage this utilization, and the best guide to which approaches states are taking is 2006 data from Avalere and the National Association of State Medicaid Directors.[3] Additionally, practical information for states on how to use certain pharmacy management tools has been provided by a project of the National Academy for State Health Policy and the Georgetown Health Policy Institute.[4] Effective strategies that could be employed by more states include:

Relying on Clinical Evidence to Manage the Pharmacy Benefit

States rely on a number of data sources for conducting evidence-based reviews of the clinical effectiveness of prescription drugs and use the results to design their prescription drug benefits. Some states conduct evidence-based reviews using state staff; others use private contractors or fund local academic institutions to conduct such reviews. Many states rely on a number of these approaches to conduct evidence-based reviews. A number of states have chosen to work together to collaborate—and spread the financial burden—for conducting evidence-based reviews. The Drug Effectiveness Review Project (DERP), a collaboration of about 13 states and non-profit entities coordinated by the Oregon Health Sciences University Center for Evidence-Based Policy, is the largest program for conducting evidence-based reviews of pharmaceuticals. Drug class reviews answer questions posed by DERP members and generally assess if valid clinical research studies demonstrate whether it is safe and/or effective to interchange prescription drugs within a class.

The 13 states that currently participate in DERP are: Arkansas, Idaho, Kansas, Michigan, Minnesota, Missouri, Montana, North Carolina, New York, Oregon, Washington, Wisconsin, and Wyoming.

Source: Oregon Health and Science University, Drug Effectiveness Review Project, February 15, 2008.

For drug classes where interchanges are determined to be safe and effective, states consider whether to place specific drugs from that class on their preferred drug list (PDL). When a state determines that drugs in a particular class are interchangeable, they often negotiate reduced payments (through supplemental rebates or other pricing mechanisms) with pharmaceutical manufacturers for some or all of the drugs within a class. The state's goal is to concentrate drug use on these less expensive drugs. When a pharmacist switches to a preferred drug which is a different chemical entity than the prescribed drug, this is called therapeutic substitution. Substitution should only take place with the involvement of the prescribing physician, but can provide important cost savings for states. Drugs that are not on the PDL can still be covered, generally through a prior authorization process based on individual evidence of need. Other states rely on provider education to encourage use of drugs on the PDL.

In addition, many states have promoted or required the use of generic drugs — for example requiring substitution of generic drugs that are chemically equivalent and generally less expensive than brand name drugs.

Demonstrating to stakeholders and the public that a state's evidence-based review process has been thorough, science-driven, and fair — and takes into consideration Medicaid's diverse and vulnerable populations — is essential to improving management of the drug benefit while

maintaining support for state efforts from key stakeholders. Moreover, because conflicts of interest exist throughout the health system, states should enact clear, transparent conflict of interest and disclosure policies for Pharmacy and Therapeutics (P&T) Committees and other entities delegated with authority to set state policy.

While many states have embraced evidence-based reviews, some states could make better use of them. There are some actions states could take on their own. Federal policy changes could also better support state efforts. The following changes could spur broader use of evidence-based reviews:

STATE

States can establish evidence-based pharmacy management programs.

More states should consider developing evidence-based management programs. As of 2005, nearly one-third of states did not have PDLs, and in many states that do, there is considerable room to expand the number of drug classes on the PDL. While states rely on private contractors and others to conduct evidence-based reviews, and DERP publishes its findings on its website, the fact that only 13 states participate in DERP suggests that states could engage in more intensive evidence-based reviews. To enhance effectiveness, evidence-based review processes should adopt standards similar to those employed by DERP, which utilizes internationally accepted criteria for the evaluation of clinical studies.

FEDERAL

Increase federal funding for research on the cost-effectiveness (and comparative effectiveness) of drug therapies.

Evidence-based drug class reviews only add value where evidence on comparative effectiveness exists. Additional objective research on the effectiveness of drug therapies would help states make better decisions about what to cover and how to manage access to some drugs. For some drug classes, the clinical evidence is more definitive than for other classes. The absence of sufficient data and ambiguity in clinical results has been a major challenge to states' efforts to make PDL coverage decisions. In addition, some studies are funded by the pharmaceutical industry, raising questions about the objectivity of the research. When states have conducted drug class reviews for certain classes of drugs, such as anticonvulsants and antipsychotics, controversy has ensued over the reliability and adequacy of existing clinical studies.[5]

The federal government is the appropriate funder of such additional research. It possesses greater resources and can share information across the states. It also may be less susceptible to undue influence by the pharmaceutical lobby. The federal government also now has the capacity to potentially use Medicare Part D claims databases in such research. Even with federal financing and leadership, there is an important role for states in prioritizing which drug classes are reviewed and suggesting key policy questions to be answered.

FEDERAL

Support state efforts to evaluate comparative effectiveness research studies.

The Agency for Healthcare Research and Quality (AHRQ) could help train state staff to increase state capacity to evaluate clinical research studies and assess the veracity of drug class reviews. In addition, AHRQ could develop alternative or expansive approaches to evaluating clinical evidence that consider the results of observational studies and/or respond to issues raised by special needs populations. AHRQ could also help reduce duplication of effort so that more drug classes could be reviewed with available resources.

FEDERAL

Support development of federal standards for observational studies so that these studies are credible complements to randomized-control trials.

Most independent observers believe that randomized controlled trials (RCTs) are the gold standard for assessing clinical evidence. But policy decisions about drug coverage must be made even when RCT data is incomplete. This suggests an expanded role for observational studies. Observational studies could, for example, describe the impact of drugs on populations that are normally excluded from clinical trials. To ensure that observational studies are reliable information sources, however, they must be held to rigorous standards.[6]

Adopting Best Practices for Managing High Cost Patients and High Prescribers

In Medicaid, four percent of beneficiaries are responsible for nearly half of total program spending.[7] Efforts to ensure appropriate access to pharmaceuticals must avoid both under- and over-utilization of prescription drugs. Since spending is so concentrated on a relatively few high-cost beneficiaries, the potential for cost-savings by focusing on the drug costs associated with these beneficiaries is substantial. These beneficiaries, however, often have complicated and overlapping health conditions. Targeting these populations to simply lower use of prescription drugs without taking into account broader clinical goals would be counter-productive and unlikely to either improve health or reduce spending.

STATE

States could track and monitor high-users of prescription drugs.

Some states conduct periodic reviews of all prescription drugs used by individual beneficiaries across all providers to evaluate whether the prescription drugs the beneficiary is taking are all medically necessary. This can both help address potential waste or fraud and improve patient safety.

Prescribing patterns among physicians also reveal that some providers prescribe significantly more prescription drugs than others, providing another way to target interventions to ensure that prescribing is consistent with best clinical practices. A survey of 37 states in 2005 found that 70 percent of Medicaid programs track high-cost prescription drug users and slightly less than two-thirds of states operate special programs for high cost populations.[8] Additional state efforts to review prescribing patterns and initiate remedial education, where needed, could help control costs and ensure appropriate use of drugs. Some of these efforts are referred to as "counter-detailing" or "academic detailing." Academic detailers are pharmacists and nurse practitioners who provide unbiased educational visits to discuss the most effective and safest available drugs with physicians. Academic detailing has also been shown in the medical literature to reduce costs from inappropriate prescribing.[9]

STATE

States could identify and intervene with high prescribing physicians.

Some states review the prescribing habits of physicians who prescribe an unusually high number of prescription drugs. States intervene with some providers to notify or educate the provider about individual drugs or the number of drugs that are being prescribed. One model for this approach is the Missouri Mental Health Medicaid Pharmacy Partnership Program (see box, page 5).

Missouri's Mental Health Medicaid Pharmacy Partnership Program

In addition to using traditional approaches to pharmacy management for non-psychiatric drugs, Missouri operates a special program, the Mental Health Medicaid Pharmacy Partnership Program, for managing psychotropic drugs for seniors and people with disabilities. Spending on drugs related to mental health is a major spending driver: Nationally, Medicaid spent more on psychotherapeutic drugs than on any other category of prescription drugs in 2002.* According to the state of Missouri, the primary goal of the Partnership program is to improve the quality of care for beneficiaries, but a secondary benefit of saving funds has more than offset the cost of the program. The Partnership program is a state initiative that is funded by a grant from the Eli Lilly Company and operated by a private contractor, Comprehensive Neurosciences, Inc. (CNS).

Roughly one-third of seniors and people with disabilities enrolled in Missouri's Medicaid program are prescribed psychotropic medications, and there are about 8,000 prescribers of these medications in the state. Since 2003, the state has analyzed monthly pharmacy claims against nine clinical quality indicators to flag potentially "questionable" practices. Pharmacy claims for individuals are reviewed for: prescription of three or more antipsychotics, multiple prescribers of antipsychotics, failure to refill an antipsychotic prescription, polypharmacy (i.e. use of multiple drugs) in several therapeutic classes, and unusually high or low doses of antipsychotics.

Missouri sends letters to prescribers with claims that are flagged to inform them that their practices appear inconsistent with current clinical standards. Prescribers are given the opportunity to obtain more information. Persistent prescribing that raises these flags leads to increasing interventions from state officials (starting with a letter from the state Mental Health Director and increasing to personal contacts from leading psychiatrists in the state). The individual prescriber remains free to continue prescribing as they determine is best. The state has found that sending letters is changing prescribing patterns, particularly after multiple letters are sent. The state reports variation in the extent to which prescribers stop engaging in the suspect practice, ranging from 31 to 98 percent success over six months.

This model has garnered positive reactions from a variety of stakeholders. In light of questions over potential conflict of interest that arise from the program's being funded by a pharmaceutical manufacturer, however, states should be mindful of the need to disclose potential conflicts and take actions to minimize the potential for bias.

* Banthin and Miller, "Trends in Prescription Drug Expenditures by Medicaid Enrollees," Medical Care, Volume 44, Number 5 Suppl, May 2006.

For additional information, see J. Parks and R. Surles, "Best Practices: Using Best Practices to Manage Psychiatric Medications Under Medicaid," Psychiatr Serv 55:1227-1229, November 2004

Enhancing the Effectiveness of Drug Utilization Review (DUR) Efforts

Medicaid law requires states to operate drug utilization review (DUR) programs to protect the health and safety of beneficiaries receiving prescription drugs. These programs hold great promise to reduce spending and improve clinical practices. The law requires states to include three components in their DUR programs: prospective review, retrospective review, and a provider education component. Prospective drug review takes place before a prescription is filled and screens for duplication, contraindications, interactions with other drugs, incor-

rect dosage, and abuse or misuse. Retrospective DUR is based on claims or other data and targets overuse, inappropriate or medically unnecessary care, appropriate use of generics, and fraud and abuse. DUR programs are also required to assess drug use data to determine clinical appropriateness, over or under use, appropriate use of generics, duplication, interactions or contraindications. Based on these reviews, state DUR boards intervene with pharmacists and physicians, and can issue reminders, provide information, suggest changes in practices, engage in face-to-face discussions, and conduct intensive monitoring reviews of some prescribers or dispensers.

It is not clear, however, how many states fully comply with the DUR requirements. Most of the forty-three states that responded to a 2003 survey said they performed key prospective DUR policies, although more than a third of responding states reported that they did not review for diagnostic appropriateness. Nearly one in eight states reported that they did not review for appropriate duration of drug treatment, and seven percent of states reported that they did not review for the correct dosage, even though these measures are required by federal law.[10] The number of states that reported conducting activities consistent with retrospective DUR, like reviewing drugs to determine whether brand name or generics were prescribed, drug costs by disease/condition, or drug costs by eligibility group, was somewhat lower.

New efforts in this area should include:

FEDERAL

Fund research to evaluate current state practices and identify best practices for conducting DUR programs.

These studies could assess compliance with federal law and examine the practices of pharmacy benefit managers (PBMs), which some states contract with to perform DUR.

STATE

Publish state generic dispensing and therapeutic substitution rates on certain drug classes with multi-source drugs.

As of 2005, based on a survey of 37 states, 92 percent of states reported that at least some generic dispensing is required by state law. On average, responding states estimated that 52 percent of prescriptions filled were for generic drugs, and 19 percent of drug spending was for generics.[11] To highlight areas where more progress can be made, states could publish and track their success at shifting prescribing away from brand name drugs to generics. As discussed earlier, clinical evidence reviews are used to determine which drug classes are appropriate for therapeutic substitution. As with generics, states could publish and track over time their success at shifting prescribing away from higher cost drugs to lower cost drugs on the PDL.

STATE

Monitor DUR trends and publish a summary of state DUR efforts.

Since data suggest that not all states are taking full advantage of the DUR tools available to them, states could monitor DUR programs and publicly disseminate summaries of their DUR efforts. The federal government could also monitor DUR programs using the reports that states are required to provide to HHS. Where patterns emerge, in either clinical categories or among individual prescribers, states could develop interventions to respond.

Ensuring Cost-Efficient Prescription Drug Purchasing

It is critical to ensure that state Medicaid programs are getting the best possible price for the prescription drugs they purchase. Most policies that determine the discounts that Medicaid obtains from manufacturers for prescription drugs dispensed to beneficiaries are set at the federal level (while the reimbursement rates at which Medicaid pays pharmacies are generally set at the state level), and some key policies have not been updated in many years. The strategies outlined in this section, many of which are supported by the National Governors' Association, could generate needed savings at both the federal and state levels.

Increase the Medicaid drug rebate

Under federal law, drug manufacturers must pay rebates to the federal and state governments for the prescription drugs that Medicaid dispenses to beneficiaries. These rebates effectively lower the price that Medicaid pays for drugs – the higher the rebate, the lower the price Medicaid ultimately pays. Strengthening the rebate program – by either increasing the amount of the rebate or improving the way in which the program is administered — would reduce both federal and state Medicaid costs without harming beneficiaries. Potential changes to maximize savings from rebate programs include:

FEDERAL

Extend the brand-name rebate inflation adjustment to generic drugs.

The rebate for brand-name drugs is currently equal to the higher of 15.1 percent of the Average Manufacturer Price (AMP, the price at which manufacturers sell to wholesalers) or the difference between that price and the lowest price (the "best price") at which the manufacturer sells the drug to private purchasers. (The minimum rebate for generic drugs is 11 percent of the AMP.) This rebate amount has not been updated since 1996. Enacting these provisions would produce significant savings for both the federal and state governments.

FEDERAL

Extend the brand-name rebate inflation adjustment to generic drugs.

Manufacturers of brand-name drugs must pay an additional rebate if the Average Manufacturer Price of their product climbs at a faster annual growth rate than the Consumer Price Index. This additional rebate creates incentives that limit annual brand-name drug price increases. Requiring a similar rebate adjustment for generic drugs would reduce Medicaid costs for prescription drugs by limiting generic drug price increases and was recently recommended by the HHS Office of Inspector General.[12]

FEDERAL

Extend the Medicaid drug rebate to drugs dispensed through Medicaid managed care plans.

Drug manufacturers are not required to pay rebates on drugs dispensed to beneficiaries enrolled in Medicaid managed care plans. This exception was based on an assumption that managed care plans could negotiate discounted drug prices as favorable as those available under the rebate system. Recent evidence shows that this is likely not the case.[13] Applying the rebate to drugs dispensed through managed care plans would ensure that these plans get the best drug prices available and would allow states to achieve corresponding savings in their managed care capitation rates.[14]

FEDERAL/STATE

Improve compliance with the drug rebate program.

The federal government could take a more active role to ensure that manufacturers are paying the correct rebate amounts. For example, some drug manufacturers have misused a "nominal price" exception whereby drugs provided at deep discounts to some organizations are inappropriately excluded from their drug rebate calculations.[15] In addition, states could increase their commitment to working with the federal government to ensure manufacturer compliance with the drug rebate. For example states could, both independently and in cooperation with the federal government, devote greater resources to pursuing litigation against manufacturers for violations of the rebate agreement and other drug pricing abuses through the federal False Claims Act (and similar state false claims acts) or improve the transparency of drug pricing, as discussed below.[16] Ensuring compliance with rebate requirements would lessen Medicaid drug costs and any resulting legal settlements could be reinvested in the Medicaid program.

STATE

Obtain supplemental rebates for prescription drugs as part of maintaining clinically sound preferred drug lists.

Many states have been able to obtain supplemental rebates over and above the required federal drug rebate as part of their decisions about what drugs to cover on their Medicaid preferred drug lists. More states could use supplemental rebates though only as part of efforts to develop preferred drug lists that are clinically sound and based on evidence-based reviews. [17] In 2005, less than half of all states reported that supplemental rebates were a criterion that the state takes into account in deciding whether to include a drug on its preferred drug list.

Increase price transparency in prescription drug purchasing

To help states accurately set Medicaid pharmacy reimbursement rates, a 2005 law required the federal government to provide manufacturers' AMP information to states on a monthly basis.[18] The federal government, however, was not required to provide information to states about the "best price" that manufacturers provide private purchasers, which helps determine the rebates that manufacturers ultimately pay. States and the federal government could improve the transparency of information on prescription drug pricing:

FEDERAL

The federal government could provide states with "best price" information on a confidential basis.

Providing this information would enhance states' efforts to set appropriate prescription drug payment rates and enforce rebate compliance.

STATE

Require entities to report drug acquisition costs.

More states could require that drug manufacturers, pharmacies, wholesalers and pharmacy benefit managers report their actual sales prices and/or acquisition costs on a confidential basis to state Medicaid agencies. State-specific pricing information would help improve rebate compliance efforts. It would also help ensure that states are neither underpaying nor overpaying for drugs dispensed to Medicaid beneficiaries. For example, inadequate reimbursement to community pharmacies could reduce beneficiary access or insufficient payments for certain generic drugs could discourage use of more affordable generic drugs. Conversely, ending large overpayments to pharmacies (and other providers) for certain drugs, particularly brand-name drugs, would produce essential savings for the Medicaid program.

FOR MORE INFORMATION

• Using Clinical Evidence to Manage Pharmacy Benefits, **National Academy for State Health Policy**, March 2006. Four issue briefs discuss state experiences with the Drug Effectiveness Review Project, prior authorization, pharmaceutical and therapeutics committees, and managing the behavioral health pharmaceutical benefit. http://www.nashp.org/_docdisp_page.cfm?LID=341D7DA7-A140-4A10-A9AB4F82C47F8850.

• 2007 State Perspectives on Emerging Medicaid Pharmacy Policies and Practices, **National Association of State Medicaid Directors and Avalere Health LLC.** http://www.nasmd.org/resources/docs/state_Perspectives-Emerging_Medicaid_Pharmacy_PP.pdf .

• State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update. **Henry J. Kaiser Family Foundation**, October 2005 http://www.kff.org/medicaid/7381.cfm.

• **The Prescription Project, Community Catalyst.** Develops state and national solutions around prescription drug issues across insurance programs, including Medicaid. http://www.prescriptionproject.org/

• **National Legislative Association on Prescription Drug Prices,** http://www.reducedrugprices.org

ENDNOTES

1. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *National Health Expenditure Historical Data, 1960-2006*.

2. U.S. Department of Health and Human Services, ibid. The implementation of prescription drug coverage under Medicare in 2006 was a major change in policy that shifted significant Medicaid pharmacy volume related to seniors and some people with disabilities (and a portion of states' costs related to these populations) onto the Medicare Part D program. Most comprehensive data of Medicaid pharmacy spending does not yet fully reflect this change. Consequently, the rate of growth of prescription drug spending was computed from these data for the years 1999-2005.

3. *State Perspectives on Emerging Medicaid Pharmacy Policies and Practices*, Avalere Health, LLC and National Association of State Medicaid Directors, November 2006, available at http://www.avalerehealth.net/research/docs/Emerging_Medicaid_Pharmacy_Policies_and_Practices.pdf

4. For a series of four briefs, go to http://www.nashp.org/_docdisp_page.cfm?LID=341D7DA7-A140-4A10-A9AB4F82C47F8850.

5. This is particularly important with respect to narrow therapeutic index drugs, which is a Food and Drug Administration (FDA) classification for drugs in which small changes in the dose and/or blood concentration could potentially result in clinically important changes in drug efficacy or safety.

6. Hoadley, J., Crowley, J., Bergman, D, and Kaye, N. *Understanding Key Features of the Drug Effectiveness Review Project (DERP) and Lessons for State Policy Makers*, National Academy for State Health Policy, March 2006, available at http://www.nashp.org/Files/Issue_brief_3_DERP.pdf

7. Sommers, A., and Cohen, M. *Medicaid's High-Cost Enrollees: How Much Do They Drive Program Spending?* Kaiser Commission on Medicaid and the Uninsured, March 2006.

8. Crowley, J. and Ashner, D. *State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update*. Henry J. Kaiser Family Foundation, October 2005.

9. For additional information about academic detailing, Pennsylvania's PACE program is often cited as a model approach. Information about this program can be found at the Prescription Project at http://www.prescriptionproject.org/solutions/casestudies?id=0007. Additionally, the National Legislative Association on Prescription Drug Pricing recently held a meeting on academic detailing. Materials from this meeting are available on their website at http://www.reducedrugprices.org/read.asp?news=1100.

10. Crowley, J., Ashner, D., Elam, L., *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003,* Kaiser Commission on Medicaid and the Uninsured, January 2004.

11. Crowley, et al. 2005.

12. Levinson, D., *Review of Generic Drug Price Increases*, Department of Health and Human Services Office of Inspector General, October 2007, A-06 07 00042.

13. Center for Health Care Strategies Inc., "*Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Setting,"* January 2003 and The Lewin Group, "*Extending the Federal Drug Rebate Program to Medicaid MCOs: Analysis of Impacts,"* May 2003.

14. In 2005, the Congressional Budget Office estimated that applying the drug rebate to managed care plans would save the federal government $800 million annually. This would generate roughly $600 million in state savings.

15. See, for example, *Letter to Acting CMS Administrator Leslie Norwalk* from Senators Max Baucus and Charles Grassley, January 31, 2007, available at http://finance.senate.gov/press/Bpress/2007press/prb020107a.pdf; see also "FY 2007 Top Management and Performance Challenges Identified by the Office of Inspector General" in U.S. Department of Health and Human Services, "*Agency Financial Report, Fiscal Year 2007*," November 15, 2007.

16. See, for example, Testimony of Ronald Tenpas, Associate Deputy Attorney General, U.S. Department of Justice before the House Committee on Oversight and Government Reform, February 9, 2007; Testimony of Patrick O'Connell, Chief, Civil Medicaid Fraud Section, Office of the Attorney General of Texas, before the House Committee on Oversight and Government Reform, February 9, 2007; Testimony of Lewis Morris, Chief Counsel to the Inspector General, U.S. Department of Health and Human Services, before the House Committee on Oversight and Government Reform, February 9, 2007; and Testimony of James Moorman, President and CEO, Taxpayers Against Fraud, before the House Committee on Oversight and Government Reform, February 9, 2007.

17.The use of supplemental rebates, while important as a cost-saving tool, has the potential to be disruptive and confusing to individuals and physicians. Because states negotiate different rebate agreements from year to year, a state may change the preferred drug within a class. Physicians and consumers need to be informed of why these changes are being made; when, and how individuals can try to continue accessing a drug they are currently taking. One important option is an automatic right to continue on a specific drug, without prior authorization, in cases where the specific preferred drug(s) within a class changes.

18. Government Accountability Office, "*Medicaid Outpatient Drugs: Estimated 2007 Federal Upper Limits for Reimbursement Compared with Retail Pharmacy Acquisition Costs*," December 22, 2006.

About this Project

The Center for Children and Families (CCF) at the Georgetown University Health Policy Institute, working with health policy consultant Vikki Wachino, is initiating a project, **"Strengthening Medicaid"** designed to develop fresh ideas to strengthen the Medicaid program and to engage policymakers and stakeholders at the state and federal levels in discussion about how these ideas might be translated into policies. These approaches will focus on (1) promoting access to high-quality, cost effective care that meets beneficiaries' needs; (2) improving coverage options; and (3) assuring sustainable financing while ensuring that available resources are used in the most efficient way. These approaches, which will be presented through a series of short policy papers, will represent some of the best ideas from a number of experts in different areas, including some who will bring their expertise from outside of Medicaid to the Medicaid context. The policy papers are edited by Joan Alker, Deputy Executive Director of CCF and consultant Vikki Wachino.

To visit our project website, please go to http://ccf.georgetown.edu/index/strengthening-medicaid/

About the Authors

Jeffrey S. Crowley, M.P.H. is a Senior Research Scholar at the Health Policy Institute. His primary areas of focus involve Medicaid and Medicare policy issues as they impact people with disabilities and chronic conditions (including people with HIV/AIDS). His research has included studying state Medicaid pharmacy policies. Mr. Crowley is a member of the National Academy for Social Insurance (NASI).

Edwin Park is a Senior Fellow at the Center on Budget and Policy Priorities. His work focuses on Medicaid, SCHIP, and approaches to expand coverage to the uninsured at the federal level. He also analyzes federal tax policies related to health care, state regulation of the private health insurance market, and issues related to low-income Medicare beneficiaries and prescription drugs. He has served as the health policy advisor for the National Economic Council, as a Medicaid professional staff member for the U.S. Senate Finance Committee and as an attorney in private practice specializing in health law.

Georgetown University Health Policy Institute
Center for Children and Families

GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE
CENTER FOR CHILDREN AND FAMILIES

BOX 571444 ■ 3300 WHITEHAVEN STREET, N.W., SUITE 5000
WASHINGTON, DC 20057-1485
(202) 687-0880 ■ FAX (202) 687-3110
CCF.GEORGETOWN.EDU