



OLR RESEARCH REPORT

October 27, 2011

2011-R-0354

STATE PREFERRED DRUG LISTS, MEDICAID PHARMACY REIMBURSEMENTS, AND P & T COMMITTEES

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You asked a series of questions about state Medicaid preferred drug lists (PDL) and the pharmaceutical and therapeutic (P & T) committees that consult with state Medicaid programs to establish and oversee them.

Specifically, you asked for (1) a legislative summary and history of Connecticut's PDL law, including legislative proposals affecting the P & T Committee or its charge made in the past five years; (2) explanations of how Medicaid programs in Connecticut, New Jersey, and New York reimburse pharmacies for filling drugs on their PDLs and what authority the head of Connecticut's Medicaid program has to set reimbursement rates; and (3) the following information about these states' P & T committees: (a) current membership and whom they represent, (b) their appointing authorities and authorizing statutes; and (c) the executive branch agency that oversees them.

New Jersey officials report that the state does not have a preferred drug list. Hence, we do not address it in this report.

SUMMARY

Many states have established PDLs as a way to (1) control costs in their Medicaid programs and (2) receive additional rebates from drug manufacturers. Connecticut has had a PDL law since 2002, which the legislature has since amended several times. Among other things, the amendments have (1) increased P & T committee membership, (2)

changed which drugs were covered by or exempt from the PDL, and (3) permitted the Department of Social Services (DSS) to hire a contractor to negotiate for the supplemental rebates (i.e., those that are in addition to the rebates federal law requires manufacturers to pay for Medicaid drugs). DSS recently came into compliance with a 2009 law by joining a multi-state PDL as a way to secure even more in supplemental rebates.

Four other legislative proposals did not pass, including one that would have altogether eliminated the exemption for mental health drugs.

In Connecticut and New York, pharmacies are reimbursed for filling Medicaid prescriptions using two formulas, one for brand-name drugs and another for generics. Both take the drug's average wholesale price and reduce it by a fixed percentage (the discount amount). They also pay the pharmacy a statutorily-set dispensing fee for each prescription it fills. The same reimbursement formula applies regardless of whether the prescribed medication is on the PDL, although until this year, New York paid a higher dispensing fee to pharmacists who filled PDL-listed prescriptions for drugs. In New York, but not Connecticut, Medicaid clients are charged co-payments for their drugs.

In Connecticut, the General Assembly sets the reimbursement methodology for brand-name drugs and DSS sets the generic rate. In addition, the legislature historically has given weight to the DSS commissioner's recommendations for changes in the state's Medicaid program, including pharmacy benefits. New York's legislature determines the reimbursement rates for both brand-name and generic drugs. The state's Medicaid agency, the Department of Health, makes recommendations regarding the Medicaid program.

Federal Medicaid law allows states to limit drugs to which Medicaid patients have access by establishing "formularies" or lists of drugs, such as the PDL. When they do so, they must create P & T committees to consult with state Medicaid agencies developing and changing the lists' contents. Committees must include physicians, pharmacists, and representatives of other stakeholders. In Connecticut, the governor appoints the P & T committee members; in New York, the Department of Health commissioner does so.

Connecticut's P & T Committee operates under DSS' jurisdiction. The governor appoints the members and the committee is directed to comply with DSS regulations. In New York, the P & T committee is within the Department of Health and its members are deemed employees of the department. The health commissioner designates a member of his staff to serve as P & T Committee chairperson.

CONNECTICUT'S PDL LAW—CGS § 17B-274d

Summary

The legislature enacted the PDL law in 2002 as a way to control spiraling drug costs in its medical assistance programs. PDLs are designed to save money by limiting clients' access to certain drugs. By increasing the sales volume for PDL-listed drugs, they also give states greater bargaining power when seeking supplemental rebates from the drugs' manufacturers.

Developing the PDL. The law permits DSS, in consultation with the P & T committee, to adopt PDLs for use in the Medicaid and ConnPACE programs. (As the virtual elimination of ConnPACE has rendered the use of a PDL in that program unfeasible, DSS now uses it only for the Medicaid program.)

When developing a PDL, DSS and the committee must consider a drug's clinical efficacy, safety, and cost effectiveness. There is no limit on the number of classes of drugs that can be included on the PDL. (It currently contains 84.) DSS must publish and disseminate the PDL to all Medicaid providers in the state. Medicaid clients can fill prescriptions for drugs that are not on the PDL ("nonpreferred drugs, as well as drugs in classes not on the PDL), so long as the pharmacy receives prior authorization from DSS.

The law requires the P & T committee to ensure that manufacturers that have agreed to provide supplemental rebates get an opportunity to present evidence as to why one or more of their drug products should be included on the PDL.

The law also requires DSS, upon timely notice, to ensure that the P & T Committee reviews, at its next meeting, any new drug that the federal Food and Drug Administration (FDA) approves, or approves for a particular use, under its priority review process for possible inclusion on the PDL. Likewise, DSS must try to do the same thing when a manufacturer notifies it of any new product.

Negotiating Supplemental Rebates. The PDL law permits DSS to negotiate supplemental rebate agreements with drug manufacturers whose drugs are on the department's PDL. DSS can alternatively contract with a pharmacy benefits organization or a single entity qualified to negotiate with manufacturers for these rebates. Connecticut

has selected the latter option. DSS’ fiscal intermediary, EDS, works with Provider Synergies, a leader in drug rebate negotiations, to negotiate the supplemental rebates on DSS’ behalf.

PDL on DSS Website. DSS maintains the [PDL](#) on its website.

Impact of State Joining a Multi-State PDL—The Optimal PDL Solution (TOPS). The 2009 legislature mandated that the DSS commissioner and other state officials develop a plan for buying pharmaceuticals in bulk. The plan had to include a provision directing DSS to join an existing multi-state Medicaid drug purchasing pool (PA 09-206, not codified). The department met this condition by joining TOPS earlier this year.

Because of the size of its purchasing pool (about four million covered lives), TOPS gives member states more leverage when negotiating with drug manufacturers for supplemental Medicaid rebates. Connecticut, like the other member states, contracts with Provider Synergies to conduct the negotiations and it does so by taking advantage of the states’ combined Medicaid purchasing power.

Connecticut does not have to adopt TOPS’ PDL to join the pool, but it benefits from TOPS’ superior bargaining power when drugs on its PDL are also on TOPS’. For drugs that are not on the TOPS PDL, DSS, through its contractor (also Provider Synergies) negotiates with the drug manufacturers for supplemental rebates.

Legislative History

The state first enacted a PDL law in 2002. Since then, it has been amended 11 times. Table 1 shows the changes made since 2002.

Table 1: Legislative History of Connecticut PDL

Year/PA #	Change
2003	
PA 03-2	<ul style="list-style-type: none"> • specified that the P & T Committee convene by March 31, 2003 • required DSS to adopt the PDL by July 1, 2003 • required DSS to adopt PDL in consultation with committee instead of upon the committee’s

Table 1 (continued)

Year/PA #	Change
	<ul style="list-style-type: none"> recommendations; • required DSS, instead of committee, to review the list at least once a year • required DSS as well as committee to consider certain factors when choosing the drugs for the PDL
PA 03-3, June Special Session	<ul style="list-style-type: none"> • increased size of P & T Committee from 11 to 14 members • specified professional qualifications for committee members • allowed committee to seek participation of other state agencies and interested parties • directed committee to meet after gubernatorial appointments made • specifically applied PDL to Medicaid, ConnPACE, and SAGA programs • limited PDL to proton pump inhibitors and two other classes of drugs that the DSS commissioner determined and required the department to notify the legislative committees of cognizance • required P & T committee's prior authorization (PA)-related recommendation to comport with existing PA law and plan
2004	
PA 04-258	<ul style="list-style-type: none"> • required different PDLs for medical assistance programs instead of just one list applicable to all • required DSS to use list for HUSKY A and B programs

Table 1 (continued)

Year/PA #	Change
	<ul style="list-style-type: none"> • required DSS, in consultation with P & T Committee, to expand the list of drugs covered by the PDL to achieve savings in budget • exempted certain drugs from PDL (e.g., drugs to treat cancer) but PA 04-2, May Special Session, eliminated the exemption • allowed DSS commissioner to contract with pharmacy benefits organization or single entity to negotiate supplemental Medicaid rebates
2005	
PA 05-280	<ul style="list-style-type: none"> • allowed instead of required DSS to adopt PDLs • required P & T Committee to include physicians with experience serving medical assistance recipients instead of just Medicaid population • specified that nonpreferred drugs would be subject to PA and made such PA valid for one year from when prescription first filled • exempted classes of antiretroviral drugs, rather than individual drugs, from PDL • specified that DSS could negotiate any supplemental rebates, not just those tied to Medicaid
2009	
PA 09-5, September Special Session	<ul style="list-style-type: none"> • removed mental health drugs' blanket exemption from PA requirements; instead specified that PA not required for such drugs when they had been filled

Table 1 (continued)

Year/PA #	Change
	or refilled at least once in the one-year period before the client presented a prescription for them at the pharmacy
PA 09-14	<ul style="list-style-type: none"> refined PA 05-280 by permitting DSS to enter into contracts for supplemental rebates for any drugs on the PDL, not just Medicaid-covered drugs
PA 09-206	<ul style="list-style-type: none"> required DSS, administrative services commissioner, and comptroller, in consultation with other commissioners, to develop a pharmaceutical bulk purchasing plan that required DSS to join an existing multi-state Medicaid drug purchasing pool; plan had to include a feasibility study of using PDL for all DSS pharmacy programs
2010	
PA 10-72	<ul style="list-style-type: none"> required P & T Committee to ensure that its meeting included opportunity for public comment (in practice, this was already occurring)
PA 10-179	<ul style="list-style-type: none"> deleted requirement that PDL include HUSKY program
2011	
PA 11-44	<ul style="list-style-type: none"> made technical change to reflect repeal of SAGA medical assistance program

Bills That Did Not Pass

While the legislature has passed some PDL bills, within the last five year, others failed. Table 2 lists these bills, by year, provides brief summaries, and indicates their final disposition.

Table 2: PDL Legislation That Failed to Pass

Year/Bill	Summary	Disposition
2007		
SB 147	required DSS to contract with entity to survey and detect access problems resulting from PDL	died in Appropriations
2009		
SB 990	removed mental health drugs from those exempt from PDL	vote to hold
SB 68	increased membership of P & T Committee from 14 to 16, adding (1) a psychiatrist and specifying that one psychiatrist treat adults and the other, children and adolescents and (2) a clinician that the DCF commissioner designated	passed Senate, died on House calendar
2010		
SB 32 (governor's bill to implement budget)	eliminated any exemption for mental health drugs	died on Senate calendar

REIMBURSEMENTS FOR PDL DRUGS

Connecticut

In Connecticut, DSS reimburses pharmacies for drugs they dispense to Medicaid patients based on whether the drug is a brand-name or a generic, not whether the drug is on the PDL. Also, the state maintains a “most favored nations” status,” which generally means that pharmacies may not bill DSS more for prescriptions under Medicaid than they would routinely charge the general public (CGS § [17b-226a](#)).

By law, DSS must reimburse pharmacies for dispensing prescription drugs to Medicaid-enrolled individuals at the lower of (1) the rate the federal Centers for Medicare and Medicaid Services establishes as the federal acquisition cost, (2) the drug's average wholesale price (AWP) less a specified discount, or (3) an equivalent percentage established in the Medicaid state plan. Additionally, the law requires the DSS commissioner to set a professional dispensing fee for each prescription a pharmacist fills, but the legislature actually sets the fee amount (CGS § [17b-280](#)).

Connecticut has opted to set its reimbursement rates using the AWP formula. This year, the legislature lowered the brand-name reimbursement rate from AWP minus 14% plus a \$2.90 dispensing fee to AWP minus 16% plus a \$2.00 dispensing fee (PA 11-44).

While the legislature establishes the reimbursement formula for brand-name drugs, DSS sets them for generics. Beginning in FY 2012, the rate DSS reimburses pharmacies for filling generics was reduced substantially: from AWP minus 50% plus the dispensing fee to AWP minus 72%. The FY 11-12 budget adjustments assume a savings to reflect this reduction. Pharmacists also receive the \$2.00 fee for dispensing generics.

New York

New York's Medicaid statute likewise sets the amount the state pays pharmacists. Currently, the state pays AWP minus 17% for brand name drugs and, generally, AWP minus 25% for generics. Pharmacists also receive a \$3.50 dispensing fee for each Medicaid prescription they fill.

Until 2011, the state used a "tiered" dispensing fee. For brand-name drugs, it paid pharmacies a dispensing fee of \$3.50. For generics and preferred drugs (i.e., those on the PDL), it paid \$ 4.50. This year the New York Assembly established a standard \$3.50 dispensing fee for all Medicaid-covered drugs (New York Elder Law, § 250 (McKinney 2011)).

PHARMACEUTICAL AND THERAPEUTICS (P & T) COMMITTEE

Connecticut State Law

State law requires the governor to appoint Connecticut's P & T Committee. It consists of 14 members, as illustrated in Table 3.

Table 3: P & T Committee Membership (Statutory)

<i>Group Represented</i>	<i>Number</i>
Physician	Five, including (1) general practitioner, (2) pediatrician, (3) geriatrician, (4) psychiatrist, (5) family planning specialist
Pharmacist	Four
Visiting nurses	Two, one specializing in adult care and one specializing in psychiatric care
Clinician	One that the Department of Mental Health and Addiction Services (DMHAS) designates
Pharmaceutical manufacturer	One
Consumer	One

The law further requires the governor to ensure that the committee includes physicians and pharmacists who serve Medicaid recipients. Committee members serve two-year terms and can be reappointed. DSS administrative staff serves as the committee’s staff and assist with all administrative duties.

Committee members select a chairperson and vice-chairperson from the membership each year. The committee must meet at least quarterly. According to its bylaws, at these meetings the committee reviews and evaluates medical criteria, standards, and educational intervention methods concerning the PDL. It also allows drug manufacturers and other stakeholders to present evidence supporting inclusion of their drugs on the PDL. And it listens to concerns expressed by members of the public. The committee also makes recommendations concerning PA requirements. It must ensure that each meeting include an opportunity for public comment, and comply with DSS regulations, including public meeting notice requirements (CGS § [17b-274d](#)(b); Bylaws of the Pharmaceutical and Therapeutics Committee, pp. 1-2).

Current Membership

Table 4 lists the current P & T Committee’s members and the constituencies they represent. Two of the positions are presently unfilled.

**Table 4: Connecticut’s P & T Committee —
Current Members and Affiliations**

<i>Name</i>	<i>Representing</i>
Tsampika Apostolidis	Practicing visiting nurse, adults
Stella Cretella	Consumer
Richard Carbray, Jr., R. Ph.	Pharmacist, practicing
Vacancy	Practicing pharmacist
Eric Einstein, M.D.	Physician, geriatrician
Charles Thompson, M.D.	Manufacturer representative
Carl Sherter, M.D., chairperson	Physician, general practitioner
Lawrence Sobel, R. Ph.	Pharmacist, practicing
Hilda Slivka, M.D.	Physician, pediatrician
Emmett Sullivan, R. Ph.	Pharmacist, practicing
Manage Nissanka, M.D.	Physician, psychiatrist
Ezra Griffith, M.D.	Clinician, Department of Mental Health and Addiction Services
Vacancy	Physician, family planning specialist
Elizabeth Rodriguez, R.N.	Visiting nurse, psychiatric

Source: DSS website

New York P & T Committee

New York’s PDL has been in place since 2006. Its P & T Committee consists of 18 members (increased from 17 in 2011). The commissioner of the Department of Health appoints the members and, as a result of 2011 legislation, designates a member of his department to serve as chairperson of the committee. (Under prior law, the committee members chose the chairperson from among themselves.) Members serve for three years and can be reappointed (New York Public Health Law, § 271, et. seq. (McKinney 2011)).

Table 5 lists the committee members and the constituencies they represent. Five positions are presently unfilled.

Table 5: New York’s P & T Committee—Current Members and Affiliations

<i>Member</i>	<i>Representing</i>
Mary Lee Wong, MD	Internal and pediatric medicine, allergy and immunology
Vacancy	Physician
Andrew Cheng, MD	Private practice, otolaryngology, head and neck surgery
Glenn Martin, MD	Psychiatry/neurology
David Lehmann, MD, Pharm. D	Professor of Medicine and Pharmacology at SUNY Upstate Medical University
Vacancy	Physician
Andrew Flynn, R. Ph.	Community Practice Coordinator
William Scheer, R. Ph.	Independent pharmacy owner
Roxanne Hall Richardson, R. Ph.	Oswego Hospital
Vacancy	Pharmacist
Donna Chiefari, Pharm. D.	Empire/Wellpoint
Jeffrey Dubitsky, R. Ph.	NYC Health and Hospital Corporation
Nancy Balkon, Ph.D., NP	Assistant professor, Stony Brook School of Nursing
Tamara Goldberg, Pharm. D.	Assistant Professor of Pharmacy Practice, Arnold and Marie Schwartz College of Pharmacy and Health Sciences
Maria Suzan Eglowston, M.D.	National Multiple Sclerosis Society
Vacancy	Consumer
Vacancy	Consumer
Jason A. Helgersen	Office of Health Insurance Programs

Source: New York Department of Health website

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