Testimony of:
Robert A. Vito
Regional Inspector General for Evaluation and Inspections, Philadelphia
Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Mr. Chairman and members of the committee. I am Robert Vito, Regional Inspector General for Evaluation and Inspections in Philadelphia at the U.S. Department of Health and Human Services' Office of Inspector General (OIG). I appreciate the opportunity to appear before you today to present information regarding fraud and abuse in Medicaid prescription drug pricing.

In short, the Medicaid program is vulnerable to abuse and continues to pay too much for prescription drugs compared to prices available in the marketplace. My testimony begins by describing efforts to identify fraud and abuse involving prescription drugs in the Medicaid program, followed by an overview of OIG's work related to prescription drug pricing. This will include a discussion of new work, released today, which further reinforces our belief that Medicaid is paying too much for prescription drugs.

IDENTIFYING FRAUD AND ABUSE INVOLVING PRESCRIPTION DRUGS

OIG continues to place high priority on identifying and preventing fraud and abuse in Federal health care programs. One area of focus involves Medicare and Medicaid reimbursements for prescription drugs, where we have played a key role in rooting out fraud and abuse. Working closely with our many Federal and State partners, OIG has assisted in investigations that have resulted in significant civil and criminal monetary settlements.

Identifying and pursuing perpetrators of fraud and abuse depends on effective cooperation among a number of Federal and State agencies, as well as other partners. As you heard in testimony delivered yesterday, our office oversees the operations of the State Medicaid Fraud Control Units, which identify and develop cases of potential fraud and abuse.

Private citizens, whistleblowers, and other industry insiders are instrumental in identifying issues and assisting in investigations. They are often among the most knowledgeable sources of fraudulent or abusive activities. A notable example is a recent case initiated as a False Claims Act suit filed by three former employees of a Schering-Plough subsidiary. This case concluded when Schering-Plough Corporation agreed to pay almost $345.5 million as part of a global settlement with the Government to resolve administrative, civil, and criminal liabilities and entered into a corporate integrity agreement[1] with OIG. These liabilities occurred in connection with the alleged payment of kickbacks and the alleged failure to include the value of certain incentives offered to two HMOs in the company's determination of best price reported for purposes of the Medicaid drug rebate program, thereby resulting in the underpayment of rebates due to States and overcharges to health care entities, such as community health centers, that purchased drugs at ceiling prices based on Medicaid drug

[1] A provider or other entity that enters into a corporate integrity agreement commits to establish a compliance program and take other specified steps to ensure its future compliance with Federal health care program requirements.

rebate prices. Appendix A contains a list of False Claims Act settlements with pharmaceutical manufacturers.

MEDICAID PRESCRIPTION DRUG REIMBURSEMENT

The Centers for Medicare & Medicaid Services (CMS) estimates that Medicaid expenditures for prescription drugs in calendar year (CY) 2004 totaled more than $30 billion, a substantial increase over the $9 billion spent in CY 1994. Both the States and the Federal Government share in these expenditures. Under Federal law, States have substantial discretion in setting reimbursement rates for drugs covered under Medicaid. In general, Federal regulations require that each State's reimbursement for a drug not exceed the lower of the estimated acquisition cost plus a reasonable dispensing fee or the provider's usual and customary charge for the drug. In addition, CMS sets Federal upper limits and many States implement maximum allowable costs for certain multiple source (generic) drugs that meet specific criteria.

While States must reasonably reimburse pharmacies for prescription drugs provided to Medicaid beneficiaries, they often lack access to pharmacies' actual market prices. Due to this lack of data, they rely on estimates to determine Medicaid reimbursement. Most States base their calculation of estimated acquisition costs on published average wholesale prices (AWPs). AWPs (which are not defined by law or regulation) are compiled in drug compendia such as Medical Economics' *Red Book* and First Databank's *Blue Book*. As the findings of our reports have consistently demonstrated, the published AWPs that States use to determine their Medicaid drug reimbursement amounts generally bear little resemblance to the prices incurred by retail pharmacies.

Until the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Medicare Part B also used AWP as the basis for most drug reimbursements. Based upon provisions in the MMA, Medicare Part B now generally uses Average Sales Price (ASP), a statutorily defined price based on actual sales transactions. While Congress's recent action helped lower excessive payment levels in Part B, Medicaid's reimbursement methodology continues to be based largely on the same inflated AWPs that once plagued Medicare.

Medicaid Pays Too Much for Prescription Drugs

Previous OIG work has revealed that Medicaid reimbursement for prescription drugs often exceeds pharmacies' actual acquisition costs. Our analysis comparing actual pharmacy acquisition costs to AWP for calendar year 1999 revealed that pharmacy acquisition costs for brand name and generic drugs were 21.8 percent and 65.9 percent below AWP, respectively. At that time, States, on average, reimbursed for drugs at AWP minus 10.3 percent. The 1999 estimates were higher than our previous studies of 1994 data, which showed that acquisition costs were 18.3 percent below AWP for brands and 42.5 percent below AWP for generics.[2] We estimated that the difference between actual acquisition costs

[2] Medicaid Pharmacy – Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products (A-06-02-00041).

and the amount the Medicaid program would have paid using the States' average estimated acquisition cost formulas was $1.5 billion in 1999.[3]

Today, we are releasing two reports that further indicate that the published prices that Medicaid uses to calculate reimbursement amounts for prescription drugs do not approximate pharmacy acquisition costs. The first report, *Medicaid Drug Price Comparisons: Average Manufacturer Price to Medicaid List Prices*, compares Average Manufacturer Price (AMP), a statutorily defined sales-based price used in determining Medicaid drug rebates, to published prices such as AWP and Wholesale Acquisition Cost (WAC). The second report, *Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price*, compares ASP, a statutorily defined price based on actual sales transactions used to determine reimbursement for Medicare Part B covered prescription drugs, to AWP. Both reports are available on our Web site, http://oig.hhs.gov.

Overall, these inspections found that statutorily defined prices based on actual sales (i.e., AMP and ASP) are substantially lower than published prices (i.e., AWP and WAC). Statutorily defined prices are also lower than States' estimated acquisition cost formulas, which are based on AWP and WAC. These differences are particularly large for generic drugs.

For Medicaid-reimbursed drugs overall, AMP is 59 percent lower than AWP at the median. In contrast, the median State estimated acquisition cost formula is AWP minus 12 percent. We also found that AMP is 25 percent lower than WAC at the median. Among the States that use WAC to estimate pharmacy acquisition cost, the median State formula is WAC plus 8.5 percent.

While AMP is 59 percent lower than AWP overall, the disparity between AMP and AWP is substantially larger for generic drugs than for brand name drugs. We found that for generic drugs, AMP is 70 percent lower than AWP at the median. In comparison, AMP is 23 percent lower than AWP for single source brands, and 28 percent lower than AWP for multisource brands at the median.

This pattern also held true when we compared ASP to AWP for drugs covered by Medicare Part B. For generic drugs, ASP is 68 percent lower than AWP at the median. In comparison, ASP is 26 percent lower than AWP for single-source brands and 30 percent lower than AWP for multisource brands at the median.

OIG has recommended that Medicaid should base reimbursement on pricing data that more accurately reflect actual acquisition costs. These inspections provide additional evidence that published prices are higher than prices based on actual sales transactions. The substantial disparities between prices based on actual sales (AMP and ASP) and the published prices currently being used indicate that changing the basis of Medicaid reimbursement could have a significant impact on Medicaid expenditures.

[3] Estimate from analyses of data contained in the following reports: Medicaid Pharmacy - Actual Acquisition Cost of Brand Name Prescription Drug Products (A-06-00-00023); and Medicaid Pharmacy - Actual Acquisition Cost of Generic Prescription Drug Products (A-06-01-00053).

Missed Savings Opportunities for the Federal Upper Limit Program

The Federal upper limit program was created to help ensure that Medicaid acts as a prudent payer by taking advantage of current market prices for lower-cost generic drugs. For multiple source (generic) drugs, Medicaid generally limits reimbursement to Federal upper limit amounts if certain criteria are met (42 CFR § 447.332).

For the Federal upper limit program to truly take advantage of market prices for generic drugs, two conditions must be met: (1) qualified drugs must be added to the Federal upper limit list in a timely manner, and (2) the prices used to determine Federal upper limits must accurately reflect pharmacy acquisition costs. Previous OIG work has identified problems with regard to timely placement of qualified generic drugs onto the Federal upper limit list. Our current work, which we are releasing today, focuses on the basis for setting Federal upper limit amounts.

Medicaid misses savings opportunities when qualified drugs are not placed on the Federal upper limit list in a timely manner. Previous OIG work has quantified the missed savings opportunities when qualified drugs are not included when they first become eligible. In a report issued in February 2004, we reported that 90 drugs were not included on the list despite meeting the criteria established by Federal law and regulation. We estimated that Medicaid could have saved $123 million in 2001 if CMS had added just 55 of these 90 products to the Federal upper limit list. Four products alone accounted for 71 percent of the $123 million in potential savings. By the end of 2003, CMS had added 9 of the 90 products to the Federal upper limit list. Seven of the nine products accounted for $94 million of the $123 million in savings calculated for 2001.

In follow-up work requested by the House Committee on Energy and Commerce and released in December 2004, we again found that CMS did not consistently add qualified drugs to the Federal upper limit list in a timely manner. Of the 252 first-time generic drugs approved between 2001 and 2003, 109 products met the statutory and regulatory criteria for inclusion on the list. CMS had added only 25 of the 109 drugs to the list as of July 15, 2004, and very few of these were included in a timely manner. It took CMS an average of 36 weeks to place these products on the list once they became eligible for inclusion. Delays in adding the reviewed drugs cost the Medicaid program an estimated $167 million between 2001 and 2003. The Federal share of the $167 million was approximately $95.5 million.

One of the reports we are releasing today, *Comparison of Medicaid Federal Upper Limit Amounts to Average Manufacturer Prices*, we compare the Federal upper limit price of more than 400 generic drugs to the AMP amount. We found that current Federal upper limit amounts substantially exceed AMPs.

Federal regulation sets the Federal upper limit amount for a qualified drug at 150 percent of the lowest price published in the compendia (i.e., 150 percent of the lowest AWP or WAC) plus a dispensing fee. However, as we have repeatedly found, these published prices do not approximate actual pharmacy acquisition costs.

Each Federal upper limit amount applies to a group of at least three drugs (i.e., therapeutically equivalent drugs that meet specified criteria). Overall, we found that Federal upper limit amounts were five times greater than the average AMP for these groups of equivalent generic drug products. Among individual generic drug products, Federal upper limits exceeded average AMPs by as much as 19 times. We also compared Federal upper limit amounts to the minimum AMPs reported by drug manufacturers. Compared to the minimum AMPs among generic products, Federal upper limit amounts were 22 times higher. For 29 drug products, Federal upper limit amounts were at least 40 times the minimum reported AMPs.

Based on these pricing differences, we estimate that the Medicaid program could have saved $161 million in the third quarter of 2004 by setting reimbursement at 150 percent of the average AMP, rather than 150 percent of the lowest published price. If the Federal upper limit were based on 150 percent of the minimum reported AMP, the program could have saved up to $300 million during that same period. These findings reinforce previous recommendations that reimbursement formulas based on prices that more closely approximate acquisition costs could save substantial amounts in the Medicaid program.

State Variations in Reimbursements for the Same Drugs

As previously mentioned, States have wide latitude in setting their reimbursement amounts for prescription drugs. In September 2004, we issued a report of a study in which we assessed the extent to which States vary in their Medicaid reimbursement for the same drugs.

Based on State data, we estimated that, overall, Medicaid could have saved as much as $86.7 million in fiscal year 2001 if the 42 States in our analysis had reimbursed at the same price as the lowest paying State for each of the drugs reviewed. In fact, for nine drugs Medicaid could have cut its spending by more than half if all States had paid the same price as the lowest paying State. The total savings estimate is derived from only 28 national drug codes that were randomly selected from 600 national drug codes for which there were substantial Medicaid outlays.

We believe savings could be achieved if CMS would: (1) share with the States the various types of price data it collects, including AMP, to help States develop better estimates of pharmacy acquisition costs, (2) conduct further research on the factors that affect States' drug prices to be able to advise States more effectively on ways to set their reimbursement levels, and (3) annually review the States' drug prices in order to share AMPs and methods to reduce costs.

MEDICAID DRUG REBATE PROGRAM

State Accounting for Rebate Billings and Collections

In addition to paying too much up front for Medicaid prescription drugs, States exacerbate their overspending of State and Federal funds by poor management of their rebate billings and collections. Pursuant to the Medicaid drug rebate statute and the rebate agreements

entered by manufacturers, States collect rebates from drug manufacturers for drug reimbursements made under the Medicaid program. The drug rebate program allows Medicaid to receive pricing benefits commensurate with its position as a high-volume payor of prescription drugs.

Shortly after the statutory drug rebate program became effective in January 1991, we audited the effectiveness of the new program in eight States. We found that CMS had not ensured that States had established proper accountability and controls over the billing and collection of drug rebates. In addition, CMS could not develop a nationwide total of the uncollected portion of Medicaid drug rebates because States were only required to report the rebates that were collected. We replicated our review recently on a national scale, using 2002 data, and found that while accountability had improved since our 1993 report, improvements are needed in most States. Weaknesses included the following:

- Rebate accounting systems were inadequate.
- Information submitted to CMS was unreliable, undermining CMS's ability to oversee the program.
- Accounting for interest on late rebate payments was improper.
- Dispute resolution and collection processes were inadequate.

We are in the process of developing a national roll-up report. The individual final reports for each State and the District of Columbia are currently available on our Web site.

Drug Rebate Calculations

Additional Medicaid overspending occurs because of an inconsistency between the key values used for calculating rebates and reimbursements. Currently, Medicaid requires that rebates be based on specifically designated values, one of which is AMP. At the same time, most States do not have access to AMP data and instead use AWP for reimbursement. This creates a situation whereby fluctuations in reimbursements do not result in corresponding adjustments in the associated rebates. When a State increases its reimbursement amount for a drug, it does not receive a correspondingly higher rebate on that drug purchase because there is currently no connection between the reimbursement and rebate calculations.

In a 1998 report, we recommended that CMS seek legislation requiring drug manufacturers to pay Medicaid drug rebates on the same basis that States determine reimbursements. If rebates had been calculated based on AWP, rather than on the statutorily required AMP, Medicaid would have achieved over $1 billion in added rebates for calendar years 1994 through 1996. We used AWP to calculate the rebates for the period because most States were basing drug reimbursements on AWP minus a percentage discount. According to information States have reported to CMS, most States continue to use AWP in their reimbursement methodologies. If Congress established a specific basis for calculating Medicaid prescription drug acquisition costs, the same basis should be used for calculating rebates.

Manufacturers' Calculation of AMP

The AMP is statutorily defined and represents the price at which manufacturers sell their drugs to wholesalers for use in the retail class of trade. CMS has not issued final regulations to further define AMP. Our audit work at selected manufacturers has shown that they are making inconsistent interpretations as to what components are included in AMP. The inconsistencies have included how to treat Medicaid sales and accounting for sales and price concessions that flow through organizations representing both retail and nonretail customers. It is important that all manufacturers report consistent and accurate information for the rebate process to work as intended. We therefore continue to suggest that CMS provide additional instruction about the definition of AMP. This would both improve the rebate process and assist States in using AMP data to estimate pharmacy acquisition costs for reimbursement purposes if States gain access to AMP data.

THIRD-PARTY LIABILITY

Another area of concern regarding Medicaid payments for prescription drugs involves issues with recouping money owed by liable third parties. Millions of Medicaid beneficiaries have additional health insurance through third-party sources such as Medicare or private health plans. Because Medicaid is required by law to be the payer of last resort, these third parties are often liable for many prescription drug claims submitted to Medicaid. When State Medicaid agencies receive claims that have a liable third-party payer, they can (1) cost avoid, i.e., return the claim to the provider so that the provider can bill the liable third party, or (2) pay and chase, i.e., pay the provider's claim and then seek recovery from the liable third party. States are required to use cost avoidance for most services unless the State obtains a waiver from CMS allowing it to pay and chase. States report cost-avoidance and pay-and-chase collections data to CMS. States are not required to report the amount they attempted to recover from liable third parties.

Federal regulations require that for a waiver to be approved, States must demonstrate that the pay-and-chase approach is as cost effective as the cost-avoidance approach. Our previous work has found that CMS regional offices often approve waivers without considering cost effectiveness. In an OIG report released in August 2001, we found that 32 States were at risk of losing over 80 percent ($367 million) of Medicaid pharmacy payments they tried to recover from third parties through the pay-and-chase approach. Almost three-quarters of States we contacted reported facing difficulties recovering payments from liable third parties.

In addition to procedural recommendations, we suggested that CMS determine whether legislation is needed to (1) explicitly include pharmacy benefit management companies in the Medicaid program's definition of a third party, (2) require third parties to match their eligibility files with Medicaid's eligibility files, and (3) allow Medicaid up to 3 years to recover payments from liable third parties. CMS generally concurred with our recommendations and reports that it has taken steps to limit the use of the pay-and-chase approach.

CONCLUSION

Based on years of work by OIG, the U.S. Government Accountability Office, and others revealing that AWP exceeds actual acquisition costs, the Medicare program eliminated the use of AWP in its pricing methodology for Part B covered drugs. However, in the Medicaid program, most States still use AWP when setting drug reimbursement amounts. In addition, the Medicaid Federal upper limit program, which was intended to take advantage of lower prices for generic products, also bases reimbursement on inflated published prices such as AWP and WAC. The Medicaid program could achieve substantial savings if Medicaid based drug reimbursement on accurate pricing information. We believe that Medicaid drug reimbursement should be fair and accurate. Drug reimbursement should reliably reflect the actual costs of drugs to pharmacies and be based on pricing data that can be validated. Neither of these criteria applies to AWP or WAC. There is an urgent need for the Medicaid policymaking community to assist States in strengthening their ability to make reasonable payments for Medicaid-covered drugs. For our part, OIG is committed to continue working with its many partners to help prevent fraud and abuse in the Medicaid program.

This concludes my testimony, and I welcome your questions.

Appendix A

Medicaid-Related Prescription Drug Settlements
Settlements with Pharmaceutical Manufacturers

Recent Federal investigations of pharmaceutical manufacturers that led to settlements involving Medicaid prescription drug cases serve to illustrate weaknesses and vulnerabilities in the Medicaid drug reimbursement arena. Following are descriptions of some, but not all, relevant cases. Both the United States and individual States have negotiated other settlements that are not mentioned here.

The OIG's "Compliance Program Guidance for Pharmaceutical Manufacturers" is available on the OIG Web site at http://www.oig.hhs.gov/fraud/complianceguidance.html.

Schering-Plough Corporation. In 2004, Schering-Plough Corporation agreed to pay almost $345.5 million as part of a global settlement with the Government and entered a 5-year corporate integrity agreement (CIA) with the OIG. As part of the settlement, Schering-Plough agreed to pay almost $293 million to resolve its civil and administrative liabilities in connection with illegal and fraudulent pricing of its allergy drug Claritin under the Medicaid drug rebate program. The civil portion of the case focused on Schering-Plough's alleged failure to include the value of certain incentives offered to two managed care organizations in Schering-Plough's determination of the best price reported for purposes of the Medicaid drug rebate program. By failing to include the value of the incentives in its determination of best price, Schering-Plough allegedly underpaid rebates due to the States and overcharged entities (such as community health centers) that purchased drugs at ceiling prices that are based on Medicaid drug rebate prices. With regard to the criminal portion of the case, a subsidiary of Schering-Plough, the Schering Sales Corporation, pled guilty to a kickback charge and was sentenced to pay a $52.5 million criminal fine. Schering Sales Corporation was charged with paying a kickback of almost $2 million in order to keep Claritin on the formulary of a managed care organization.

Pfizer Inc. As part of a fiscal year 2004 global settlement of $430 million plus interest, Pfizer Inc. (Pfizer), Warner-Lambert Company LLC (Warner-Lambert), and the Parke-Davis Division agreed to pay $190 million in a civil False Claims Act settlement relating to Warner-Lambert's promotion of the drug Neurontin. Pfizer acquired Warner-Lambert and its Parke-Davis Division in June 2000. Between July 1995 and June 2001, Neurontin was approved by FDA only for use in treating epilepsy, but Warner-Lambert allegedly engaged in a wide-ranging program to promote Neurontin for other uses. The Government alleges that these activities caused the submission of false and/or fraudulent claims to Medicaid. To resolve its criminal liability, Warner-Lambert pled guilty to violating the Federal Food, Drug and Cosmetic Act and agreed to pay a $240 million criminal fine. Pfizer entered a comprehensive 5-year corporate integrity agreement with OIG.

AstraZeneca Pharmaceuticals, LP and Zeneca Inc. In June 2003, the United States announced a global settlement with AstraZeneca. The company agreed to pay a total of almost $355 million and enter a 5-year CIA with OIG to resolve its criminal and civil liabilities relating to the marketing and pricing of its prostate cancer drug, Zoladex. AstraZeneca pled guilty to conspiracy to violate the Prescription Drug Marketing Act by causing the submission of reimbursement claims for Zoladex that had been provided free of charge as samples. The Government also alleged that AstraZeneca paid illegal remuneration (in various forms including grants, travel, and entertainment) to induce the

purchase of Zoladex; that AstraZeneca created and marketed an average wholesale price (AWP) spread between the Medicare reimbursement for Zoladex and its cost; and that AstraZeneca misreported and underpaid Medicaid rebates for Zoladex. AstraZeneca also agreed to enter separate settlements with the States.

Bayer Corporation. In April 2003, Bayer Corporation agreed to pay $257.2 million in criminal fines and civil assessments to settle a False Claims Act case relating to the Medicaid drug rebate program. Bayer agreed to plead guilty to charges that it violated Federal law by failing to report certain information to FDA. The case focused on Bayer's failure to include certain sales to Kaiser Permanente Medical Care (an HMO) in its calculation of Best Price reported for purposes of the Medicaid drug rebate program. The Medicaid drug rebate program requires drug manufacturers to report their Best Prices to CMS and to pay rebates to the State Medicaid programs based on those reported prices.

GlaxoSmithKline. Also in April 2003, GlaxoSmithKline settled a Medicaid drug rebate case for almost $88 million, based on facts similar to the Bayer matter discussed above. In connection with the settlement, GlaxoSmithKline entered a 5-year CIA with OIG. GlaxoSmithKline also agreed to enter into separate settlement agreements with the States.

Pfizer, Inc. In October 2002, the United States settled a Medicaid drug rebate case with Pfizer, Inc., Warner-Lambert Company and the Parke-Davis Division. The Government alleged that Warner-Lambert failed to include the value of certain unrestricted educational grants in the Best Price reported for purposes of the Medicaid drug rebate program and, as a result, underpaid rebates due. The government alleged that Warner-Lambert paid the grants to a managed care organization in order to obtain unrestricted formulary status for the cholesterol-lowering drug, Lipitor. As part of the settlement, Pfizer paid $49 million and entered a five-year CIA with OIG.

TAP Pharmaceutical Products, Inc. In October 2001, the United States announced a major global health care fraud settlement with TAP Pharmaceutical Products Inc. TAP agreed to pay a total of $875 million to resolve its liabilities. TAP agreed to plead guilty to violating Federal law governing the use of drug samples. In addition, TAP allegedly set and reported AWPs for its prostate cancer drug, Lupron, at levels far higher than the actual acquisition cost of the majority of its customers (such as physicians) and caused those customers to receive excess reimbursement from Medicare and Medicaid. TAP also allegedly paid kickbacks to induce the purchase of Lupron and underpaid rebate amounts due to the States under the Medicaid drug rebate statute. TAP entered a seven-year CIA with OIG.

Bayer Corporation. In February 2001, the United States entered a $14 million settlement with Bayer Corporation in connection with Bayer's AWP pricing and Medicaid drug rebate practices relating to six drugs. The Government alleged that Bayer set and reported AWPs for the drugs at levels far higher than the actual acquisition costs of the products; that Bayer made misrepresentations to the Medicaid programs of certain States; and knowingly misreported and underpaid Medicaid rebates for the drugs. As part of the settlement, Bayer entered a five-year CIA with OIG.

Appendix B

Selected Medicaid Drug Reports Available on the OIG Web Site
(http://www.oig.hhs.gov)

A-06-91-00092 May 1992	HCFA Needs to Provide Additional Guidance to Drug Manufacturers To Better Implement the Medicaid Drug Rebate Program. (Inconsistencies in manufacturers methods used to determine AMP.)
A-06-91-00102 April 1992	Improvements Needed in HCFA's Procedures To Implement the Medicaid Drug Rebate Program. (Errors in AMP and best price.)
A-06-92-00029 June 1993	Management Controls Over the Medicaid Drug Rebate Program. (Inadequate State controls and accountability over billing and collection of rebates.)
A-06-96-00030 April 1997	Medicaid Pharmacy: Actual Acquisition Cost of Prescription Drug Products for Brand Name Drugs. (Based on invoices, in 1994 pharmacy acquisition costs for brand name drugs averaged 18.3 percent below AWP.)
A-06-97-00011 August 1997	Medicaid Pharmacy - Actual Acquisition Cost of Generic Prescription Drug Products. (Based on invoices, in 1994 pharmacy acquisition costs for generic drugs averaged 42.5 percent below AWP.)
OEI-05-99-00611 July 2001	Containment of Medicaid HIV/AIDS Drug Expenditures. (Comparison of Medicaid payments to other pricing methods.)
A-06-97-00052 May 1998	Need to Establish Connection Between the Calculation of Medicaid Drug Rebates and Reimbursement for Medicaid Drugs. (Increases in reimbursement do not trigger corresponding increases in rebates.)
A-06-00-00023 August 2001	Actual Acquisition Cost of Brand Name Prescription Drug Products. (Based on invoices, in 1999 pharmacy acquisition costs for brand name drugs averaged 21.84 percent below AWP.)
OEI-03-00-00030 August 2001	Medicaid Recovery of Pharmacy Payments from Liable Third Parties. ($367 million of unrecovered Medicaid pharmacy payments at risk.)
OEI-03-01-00010 September 2001	Medicaid's Use of Revised Average Wholesale Prices. (States' use of price revisions by First Databank.)
A-06-01-00053 March 2002	Medicaid Pharmacy - Actual Acquisition Cost of Generic Prescription Drug Products. (Based on invoices, in 1999 pharmacy acquisition costs for generic drugs averaged 65.93 percent below AWP.)
A-06-02-00041 September 2002	Medicaid Pharmacy - Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products. (A 4-tier discounting methodology would bring reimbursement more in line with acquisition costs.)

OEI-05-02-00080 August 2003	Medicaid's Mental Health Drug Expenditures. (Comparison of Medicaid payments to 4 other Federal payers.)
OEI-05-02-00680 October 2003	State Strategies to Contain Medicaid Drug Costs. (Review of States' methods to control spending on drugs.)
OEI-03-02-00670 February 2004	Omission of Drugs from the Federal Upper Limit List in 2001. (CMS did not ensure timely placement of drugs on the FUL list.)
OEI-03-02-00660 April 2004	Medicaid Rebates for Physician-Administered Drugs. (Some States' systems are inadequate to ensure rebate collections.)
OEI-05-02-00681 September 2004	Variation in State Medicaid Drug Prices. (States' reimbursements vary widely for the same drugs.)
OEI-03-04-00320 December 2004	Addition of Qualified Drugs to the Medicaid Federal Upper Limit List. (CMS did not ensure timely placement of drugs on the FUL list.)
OEI-03-05-00200 June 2005	Medicaid Drug Price Comparison: Average Sales Price to Average Wholesale Price. (Medicaid reimbursement based on AWP greatly exceeds what Medicaid would otherwise pay if reimbursement were based on ASP.)
OEI-05-05-00240 June 2005	Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices. (Medicaid reimbursement based on published prices greatly exceeds what Medicaid would otherwise pay if reimbursement were based on AMP.)
OEI-03-05-00110 June 2005	Comparison of Medicaid Federal Upper Limit Amounts to Average Manufacturer Prices. (Medicaid reimbursement for prescription drugs on the FUL list greatly exceeds what Medicaid would otherwise pay if FUL were based on AMP.