



Medicaid Prescription Drug Rebate Equalization (DRE) Implementation States with Prescription Drug Benefit Carve-Ins

Background

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act and a reconciliation act enacting national health reform. These laws, collectively known as the Affordable Care Act (ACA), also stipulate changes to the federal Medicaid drug rebate program. Specifically, the ACA allows states for the first time to collect federal drug rebates on prescriptions reimbursed under capitation arrangements with Medicaid managed care organizations (MCOs). This change was described as drug rebate equalization (DRE) in several stand-alone bills introduced in Congress, since it adds rebate parity between the Medicaid fee-for-service and capitated MCO sectors. Previously, federal drug rebates had been available only on Medicaid fee-for-service (FFS) prescriptions.

Implementation of the DRE

States are challenged to implement the DRE at the same time they are carrying out other ACA mandates and addressing budget deficits. Because the law was not signed until the end of March 2010, the state's January through March 2010 quarterly rebate billing could not include MCO pharmacy utilization. After operational issues are worked out between the states, MCOs, and CMS, states will make retroactive adjustments to previously billed 2010 quarters reflecting MCO claims.¹ However, the savings the states stand to gain from this program mean that timely implementation is critical in a time of budget crisis.

Key ACA Changes to the Medicaid Drug Rebate Program

Changes to the Federal Medicaid Rebate Formula	Amended Section in the Social Security Act
1. Increases the base unit rebate from 15.1% to 23.1% of AMP on most brand drugs – except limits (a) clotting factors and (b) drugs used exclusively for pediatric indications to 17.1% of AMP instead of 23.1%	Sec. 1927(c)(3)(B)
2. Applies an additional rebate to new formulations (line extensions) of existing oral solid brand drugs	Sec. 1927 (c)(2)
3. Increases the base unit rebate from 11 to 13 percent of AMP on generic drugs	Sec. 1927(c)(3)(B)
4. Authorizes a “Federal Rebate Recapture” of manufacturer rebate revenue collected by states from #1 – 3 above	Sec 1927(b)(1)

States with Prescription Drug Benefit Carve-Ins

Several states have recognized the value of allowing Medicaid MCOs to coordinate both the medical and pharmaceutical benefits for Medicaid enrollees and have, as a result, included the management of prescription drug benefit in MCO contracts. In fact, studies have shown that managed care provides drug coverage in a more cost-effective manner than fee-for-service

1. Section 1927 of the Social Security Act requires states to send invoices no later than 60 days after the end of a quarter and manufacturers are to pay the invoice within 30 days after receipt (8 days allowed for postal delays, allowing 38 total days).

programs, via formulary management, high generic fill rates, comprehensive drug utilization, and coordination of care.^{2,3,4,5} The MCO formularies are created specifically to better manage the patient population and are sensitive to their unique needs enhancing their effectiveness in providing quality care at a lower cost.

The federal drug rebate provisions in the ACA present unique challenges to carve-in states. These challenges, as well as recommendations, are identified and discussed below.

Challenges

MCO-Negotiated Rebates With Manufacturers Have Dropped Significantly. In states where MCO contracts include prescription drugs, MCOs manage their unique drug formularies and work with pharmaceutical manufacturers either directly or indirectly through their pharmacy benefit manager (PBM). As a result of this approach, MCO prescription drug costs (and in turn state costs) have been reduced by negotiated rebates received from manufacturers. Under the 2010 ACA provisions, the MCOs under contract with carve-in states must now submit prescription drug encounter information to the states. The states then collect federal rebates from manufacturers, which lowers state prescription drug costs. Now that states are receiving federal rebates for prescriptions paid by Medicaid MCOs, manufacturers have become less willing to enter into new or maintain the current rebate contracts with Medicaid MCOs and their PBMs. In cases where MCOs have existing contracts, the manufacturers have responded to the DRE by re-negotiating and lowering rebate offerings.

Because of this change, MCOs Are Paying More for Prescription Drugs. Rebate yields for Medicaid MCOs have been substantially reduced, beginning in most cases for claims filed in the second quarter of 2010, when the DRE provisions were implemented. This has occurred even for the largest of MCOs and their PBMs, and the trend toward fewer and lower rebate contracts between MCOs and manufacturers is expected to continue. As this revenue source dwindles, MCOs pay more for the prescription drugs provided to their enrollees resulting in additional costs to their programs.

Recommendations

1. *Because of the actuarial soundness requirements in Medicaid law, states must be prepared to adjust MCO capitation rates for cost increases resulting from lower rebate revenue. The new MCO rebate money the states receive from the DRE will much more than offset the increase in capitation rates.*
2. *States should share federal rebate money with the MCOs as an incentive to provide accurate data to submit for rebates, as the rebates can be more than 15% of the total cost of the states prescription drug program.*

The April 2010 CMS State Medicaid Director letter indicates, “MCO capitation rates must be based on actual cost experience related to rebates” and subject to actuarial soundness. Rates, therefore, must be increased by states in Medicaid MCO contracts to reflect increased MCO pharmacy costs. MCOs are able to share their rebate experience with state Medicaid programs and state-contracted actuaries to help facilitate *actuarially sound* adjustments, but to date, many states have been slow to engage in these discussions.

Conclusion

While DRE implementation remains a challenge, effective and timely implementation is vital. By combining the prescription drug rebate revenue with existing MCO drug utilization management capabilities, Medicaid MCOs will achieve improved quality of care for Medicaid beneficiaries as well as important savings. These savings will, in turn, reduce the cost of the Medicaid program to the federal and state governments which is critical during this time of budget pressure in the states.

2. The Lewin Group. Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs. October 2007.
3. The Lewin Group. Financial Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs. October 2007.
4. The Lewin Group. Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System. November 2003.
5. The Lewin Group. Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting. January 2003.