



## Medicaid Prescription Drug Rebate Equalization (DRE) Implementation States with Prescription Drug Carve Outs

### 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.<sup>1</sup> 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 Carve Outs

Before passage of ACA, because of higher rebates offered in FFS, some states excluded or “carved-out” the prescription drug benefit from Medicaid MCO contracts. In these states, beneficiaries enrolled in Medicaid MCOs receive drug coverage through the state's FFS program. Now that DRE has been approved in the ACA, some states are re-considering whether to continue a carve-out and may move in the direction of having Medicaid MCOs coordinate both medical and pharmaceutical benefits. Such decisions will vary from state-to-state, taking into consideration various factors between the MCOs' and the state's fee-

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).

for-service programs, e.g., differences in pharmacy reimbursement rates; efficiency of utilization controls; percentage of rebate revenue collected; provider tax implications with a carve-in; and the total “per member per month” pharmacy cost (offset by rebate returns).

Illinois and Texas, who previously always carved-out the pharmacy benefit, have already taken steps to carve-in pharmacy for their managed care programs under DRE. Other carve-out changes may be considered once states have had an opportunity to review several quarters of MCO drug data and manufacturer rebate revenue.

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

## Challenges

*Some States May Mandate Drugs To Be Covered On MCO Formularies or Require a Single Formulary For All Plans To Utilize.* As carve-in concepts are being considered by states, there have been occasional discussions raised in a few states indicating that single, statewide formularies with uniform utilization management requirements may be needed. At the inception of the DRE provisions, there had been confusion amongst states as to whether or not they would be required to mandate that type of change on the Medicaid MCOs.

*States moving from a pharmacy carve-out to carve-in must become aware of lost MCO rebate revenue.* States which have recently moved to, or plan to move to, a carve-in system must recognize, MCOs now have reduced power to negotiate rebates with manufacturers. As a result, Medicaid MCOs now pay more for the prescription drugs, but state costs are reduced by federal drug rebates not shared with MCOs.

## Recommendations

1. *First and foremost, all states should include management of pharmaceutical benefits in their contracts with Medicaid MCOs.* This allows MCOs to coordinate care with complete knowledge of patients’ history of care and prescription drug usage, thereby improving a MCO’s ability to provide higher quality of care at lower costs. These savings will, in turn, reduce the total medical cost of the Medicaid program to the federal and state governments.
2. *States should allow MCOs the flexibility to continue managing their own formularies and utilization review programs.* This stance was affirmed by CMS in its September 2010 DRE guidance to state Medicaid directors. States should neither implement a single, statewide formulary nor mandate particular drugs from which MCO providers must prescribe. MCOs also should be given the flexibility to customize utilization management programs to ensure the cost-effective and safe use of drugs.

There is recognition on the federal government’s part that formulary management is one of the key tools that MCOs have used successfully to hold down pharmacy costs and ensure appropriate utilization of pharmaceuticals. By managing their own formularies and utilization management programs, Medicaid MCOs provide drug coverage in a more cost-effective manner via formulary management, high generic fill rates, comprehensive drug utilization, and coordination of care. Without such management, a formulary mandated by the state may not actually serve the state’s best long-term pharmacy cost management interests and will increase the cost of prescription drugs.

3. *States must adequately compensate MCOs in their capitation rates for managing pharmaceutical benefits based on actuarial soundness requirements.* Increases to MCO capitation rates must recognize that Medicaid MCOs are no longer able to negotiate large scale manufacturer drug rebates. Any assumptions surrounding rebate yields for MCOs should be conservative in nature and states should project rebate yields to approach zero in future rate periods. States should consider sharing rebates received from the federal drug rebate program with Medicaid MCOs as an inducement to submitting accurate prescription drug data.

## 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.