ACAP
Association for Community Affiliated Plans

ACAP Fact Sheet

Implementation of Medicaid Drug Rebate Equalization

The Medicaid Drug Rebate Program, created by the Omnibus Budget Reconciliation Act of 1990, requires drug manufacturers to enter into rebate agreements with the Secretary of Health and Human Services. These agreements are required as a condition of the federal government providing funding to states for outpatient drugs dispensed to Medicaid patients as part of their fee-for-service programs.

When enacted more than twenty years ago, the requirement specifically excluded Medicaid managed care plans. But the Affordable Care Act, commonly known as the health reform law, expanded the Medicaid prescription-drug rebate program to apply to enrollees of Medicaid managed care programs.

This expansion owes itself, in part, to the significant increase of enrollees in Medicaid managed care plans: in 1990, only 2.8 million people were enrolled in Medicaid managed care plans. Since then, however, states have increasingly turned to managed care as a cost-effective way to deliver needed services. Today, more than 24 million Medicaid beneficiaries are enrolled in capitated managed care of one kind or another.

Before the Affordable Care Act, rebates were only available to traditional Medicaid fee-for-service programs. This created a financial incentive for states to remove, or "carve out," prescription drugs from health plan benefits. These carve-outs allowed states greater access to the rebates they understandably desired. But removing drugs from the health plan benefits made it far more difficult for MCOs to use prescription data to coordinate and enhance care.

The provision in the ACA providing drug rebate equality to managed care organizations (MCOs) provides a pathway for the federal government to realize significant cost savings—up to $11 billion over the next decade, according to the Congressional Budget Office. Another positive result of the extension of the rebate program was that it opened the door to better care coordination and pharmaceutical management for people served by MCOs.

Despite the strong incentive the rebate program provided to carve out prescription drug benefits, 27 states left some or all of the benefits to be managed by MCOs. They opted for managed care's better coordination and management of enrollees' care and their use of prescription drugs.

These states were able to see savings almost immediately when the expanded rebate provision went into effect in April 2010. According to a recent study by Health Management Associates, savings for the 14 states that allowed Medicaid MCOs to administer drug benefits amount to nearly $770 million a year--about six percent of their total Medicaid managed care spending[1]. Annual rebates will more than double in some states that have large managed care programs.

[1]Health Management Associates. In Focus: The Impact Of Drug Rebate Equalization On State Pharmacy Expenditures And An Update On State Plans To "Carve-In" Pharmacy Benefits. http://www.healthmanagement.com/files/Weekly_Roundup/HMA_Roundup_031611.pdf. Accessed June 23, 2011.

ACAP
Association for Community Affiliated Plans

States Move to End Carve-Outs

The most pressing issues now are to be found in the "carve-out" states. As a 2008 Lewin Group report sponsored by the Association for Community Affiliated Plans (ACAP) noted, the unequal availability of drug rebates presented states with an "unwelcome choice," forcing them to choose between "the most cost-effective management of the pharmacy benefit (achieved through managed care), and the most inexpensive price for the medications (achieved through carving out pharmacy benefits from managed care)."

But with rebates equalized between managed care and fee-for-service programs under the ACA, states no longer face this difficult choice; many are moving to put drug benefits back into their managed care programs. Among them:

- **New York:** Adopted a "carve-in" provision as part of a March 2011 budget agreement. Slated to go into effect October 1, 2011, it will save the state an estimated $100 million next year.

- **Texas:** A budget measure passed by the Texas Legislature will allow Medicaid managed care programs to administer prescription drug benefits, saving the state $51 million over two years. Governor Rick Perry signed the measure on July 18, 2011.

- **Ohio:** Reconsidered a decision to "carve out" drugs that took effect just last year. Governor John Kasich's budget for 2012-13 restored drug benefits to Medicaid managed care plans. The budget passed the Ohio Legislature and will take effect October 1, 2011. The Ohio Association of Health Plans estimates the move will save Ohio approximately $184 million over two years.

These three states are at the forefront of restoring drug benefits to Medicaid managed care plans; legislatures in as many as a dozen other are likely to consider similar moves. Their motive for doing so is clear: a recent Lewin Group analysis found that if the 14 carve-out states were all to restore prescription drug benefit administration to MCOs, they would produce 10-year savings of $11.7 billion, with a state share of nearly $5 billion. These savings come from the better care coordination and management of drug utilization that are a hallmark of Medicaid managed care plans.

Quality Improvement Through Coordinated Care

States are no longer faced with the "unwelcome choice" of better care coordination or rebates on prescription drugs through a carve-out of benefits. With nearly every state in the Union facing severe pressures on its budget, bringing equity to the prescription drug rebate program couldn't have come at a better time.

While the rebates themselves will provide a measure of budgetary relief, the most important benefit of the expansion of the program is its potential to improve the quality of health care for patients served by Medicaid managed care plans.

A hallmark of managed care organizations is better care coordination, ensuring that patients' treatment is managed by medical staff. As prescription drugs now play a greater role in treating illness, especially

chronic conditions, the need for proactive care management is more apparent than ever. Carving out prescription drug benefits effectively erects roadblocks to care integration, displaces financial responsibility, and creates confusion among patients who must go to a separate entity to address concerns about their prescriptions.

One of the greatest benefits of managed care is its ability to access and analyze pharmaceutical data to enhance care and control costs. One way MCO plans control costs is through curbing the inappropriate use of drugs. For example, CareSource, the leading health plan in Ohio, found that the use of Oxycontin by children and families enrolled in Medicaid increased by a staggering 325 percent after the state carved out prescription drugs from Medicaid health plans.

Beyond coordinating drug benefits with other medical services, MCOs provide more cost-effective and efficient use of pharmacy benefits. MCOs charge lower dispensing fees to pharmacies than fee-for-service programs. Numerous studies show that MCOs use more of the less-costly generic drugs than their counterparts.

Challenges Ahead

As the National Association of State Medicaid Directors wrote during the federal health reform debate, drug rebate equalization allows "states (and the federal government) to benefit from both the reduced cost of drugs and the MCOs' superior management of utilization, the best of both worlds." Passage of drug-rebate equalization—now the law of the land—is a win for both Medicaid patients and taxpayers.

Attention now turns to smooth, timely implementation of the changes. States, plans and manufacturers are seeking guidance from the Center for Medicaid, CHIP, Survey & Certification (CMCS); as of publication, such guidance has yet to be issued.

Issues to be addressed in a "carve-in" process include:

- **Actuarially sound capitation.** Under the new law, rebates from drug manufacturers are paid directly to the states rather than MCOs. Accordingly, many manufacturers have stopped paying health plans private rebates that some plans had previously negotiated on their own. This has led to a direct decrease in the amount of revenue paid to plans. Given that Medicaid rules require states to pay "actuarially sound" rates to Medicaid MCOs, the decrease in drug rebates to plans should result in a proportionate increase in the capitation rates paid from the states. A year after rebate law went into effect over a year ago, many states had not yet adjusted health plans' rates to reflect the shift in rebates.[2]

- **Clarity of documentation.** While manufacturers must pay the rebates to the states, there are several steps in between that need to be taken. For example, it is not clear who will provide the documentation to manufacturers about the number of enrollees and their prescription drug utilization – the states or the plans.

[2] Because plans often negotiate discounts in excess of what the states can get via the federal rebate, states can still realize net savings even if capitation rates are increased.

- **Dispute resolution.** In the event of a dispute over the rebates, it must be clear whether the state or the health plan will be responsible for negotiating a resolution with the pharmaceutical manufacturer.

ACAP is working closely with its member health plans, the U.S. Department of Health and Human Services, and the states to address these issues. Resolving them will ensure that states and the federal government can maximize their realized savings – and the pathway to positive change laid out in the ACA does not inadvertently harm health plans' capacity to provide high-quality service to their members.

Managed care organizations have historically focused on the patient and effectively managing their care. To fully realize their promise of providing the best system of care coordination, MCOs must be able to manage pharmacy benefits too. Restoring those benefits to MCOs will enable the remaining carve-out states to fully realize not only the cost savings inherent in better care coordination, but also better health and more fulfilling, productive lives for their citizens.