
RIDER 24 REPORT

Annual Performance Report for the Prescription Drug Rebate Program

**As Required By
Rider 24, H.B. 1,
82nd Legislature, Regular Session, 2011**

**Health and Human Services Commission
February 2013**

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Executive Summary

The *Annual Performance Report for the Prescription Drug Rebate Program*, submitted by the Health and Human Services Commission (HHSC) details the outstanding prescription drug rebate balances for the Texas Medicaid program, Children's Health Insurance Program (CHIP), Department of State Health Services' (DSHS) Kidney Health Care (KHC) Program, and DSHS' Children with Special Health Care Needs (CSHCN) Services Program. This report is required by the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 24). This report must include rebate principal and interest outstanding, age of receivables, and annual collection rates and specifies amounts billed the dollar value of pricing and utilization adjustments, and dollars collected. The required information is provided in this report for each rebate program from the last five years (calendar year 2007 through August 23, 2012). HHSC's Vendor Drug Program (VDP) operates the formularies and oversees the contractor responsible for administration of the rebate programs for Medicaid, CHIP, KHC, and CSHCN.

The federal Medicaid drug rebate program, which was initiated in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), requires drug manufacturers to enter into a national rebate agreement with the Centers for Medicare & Medicaid Services (CMS) for a drug to be included on a state's Medicaid formulary. The contracted manufacturers must report their current product and pricing information to CMS and pay the agreed-upon rebate amount for each outpatient drug dispensed to a Medicaid client. The rebate amount is based on the manufacturers' reported product and pricing information. States also may collect Medicaid rebates for drugs dispensed through CMS-approved Medicaid waivers and drugs administered by physicians in their offices. States share the rebates with CMS at the same rate as the Federal Medical Assistance Percentage (FMAP).

Since January 2004, Texas has operated a supplemental rebate program for Medicaid. Drug manufacturers who enter into supplemental rebate contracts with the Texas Medicaid program have their products considered for preferred status on the Preferred Drug List (PDL). The HHSC Pharmaceutical and Therapeutics (P&T) Committee determines which products are assigned a "preferred" or "non-preferred" PDL status based on a products' safety, clinical effectiveness, and cost (including rebates). Non-preferred drugs require prior authorization before they can be dispensed; while preferred products do not require prior authorization. This provides an incentive for manufacturers to participate in the Medicaid supplemental rebate program. The rebate dollars collected from the supplemental rebate program are also shared with CMS at the FMAP rate. All rebates received are returned to their respective state program to be used as the first source of funding for the corresponding pharmacy program.

Rebate collections are reported on an accrual basis and are based on the calendar quarter in which the claims were originally paid and are subject to change because rebate programs allow retroactive adjustments to pricing and utilization data. For the last five calendar years for all programs, HHSC invoiced \$5,354,653,733 and collected \$5,332,253,281 in principal and \$338,045 in interest – a collection rate of 99.58 percent.

The Affordable Care Act (ACA) initiated the Quarterly Rebate Offset Amount (QROA), which increased the minimum federal Medicaid OBRA '90 rebate amount paid by drug manufacturers. All of the increased revenues collected due to these changes will be remitted to the CMS through a quarterly rebate offset process. For this period, the QROA amount was \$192,226,485. The increase in Medicaid OBRA '90 rebates results in a decrease in the Medicaid supplemental rebates. The ACA requires drug manufacturers to pay rebates for drugs dispensed to Medicaid clients who receive care from a Medicaid managed care organization (MCO) and allows Medicaid to collect supplemental rebates on these encounters.

S.B. 7, 82nd Legislature, First Called Session, 2011, directed HHSC to include pharmacy benefits in the array of services provided by MCOs, and required MCOs to comply with HHSC's Medicaid and CHIP formularies and Medicaid PDL. The provisions allowing HHSC to define the formularies and PDL will expire on August 31, 2013, unless the legislature modifies the statute. If MCOs develop their own formularies and PDLs, HHSC will experience a significant decrease in Medicaid OBRA '90 and Medicaid supplemental rebates. HHSC is still assessing the potential overall fiscal impact of this provision and the impact to Medicaid providers and clients.

Introduction

The *Annual Performance Report for the Prescription Drug Rebate Program* is required pursuant to the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 24). Rider 24 requires HHSC to report annually the outstanding prescription drug rebate balances for Medicaid, CHIP, KHC, and CSHCN. This report must include rebate principal and interest outstanding, age of receivables, and annual collection rates. This report must also specify amounts billed the dollar value of pricing and utilization adjustments, and dollars collected. HHSC's Vendor Drug Program (VDP) operates the formularies and oversees the contractor responsible for administration of the rebate programs for Medicaid, CHIP, KHC, and CSHCN.

This report details the outstanding prescription drug rebate balances as specified in Rider 24. The following rebate programs are included in this report:

- Medicaid Fee-for-Service (FFS)
 - OBRA '90 Pharmacy rebates (Appendix A-3)
 - Medicaid Buy-In for Children rebates (Appendix A-4)
 - Qualified Aliens rebates (Appendix A-5)
 - Medicaid supplemental rebates (Appendix A-6)
 - Medicaid physician-administered rebates (Appendix A-7)
- Medicaid Managed Care Organizations (MCO)
 - MCO Medicaid physician-administered rebates (Appendix A-8)
- Children's Health Insurance Program
 - Federal-State Funded (Appendix A-9)
 - State Funded (Appendix A-10)
- DSHS – Kidney Health Care (Appendix A-11)
- DSHS – Children with Special Health Care Needs (Appendix A-12)

For each of the rebate programs, appendices A-1 through A-12 include the following information from the last five years (calendar year 2007 through August 23, 2012). As of August 23, 2012, only the first calendar quarter rebates were invoiced and collected. Second quarter invoices are due by August 29, 2012 and are not included in this report.

- Amounts billed.
- Cumulative dollar value of pricing and utilization adjustments.
- Dollars collected.
- Outstanding principal and interest.
- Annual collection rates.

Background

Rebate Programs

The federal Medicaid drug rebate program, which was initiated in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), requires drug manufacturers to enter into a national rebate agreement with the Centers for Medicare & Medicaid Services (CMS). The contracted manufacturers agree to provide these federal rebates on all quantities of products dispensed to Medicaid clients in an outpatient setting. As part of this agreement, manufacturers must report their current product and pricing information to CMS within 30 days of the end of the calendar quarter. Rebates are calculated and paid to state Medicaid programs by the drug manufacturers based on the reported pricing information. Medicaid pharmacy programs are required to include all of the contracted manufacturers' drug products in their Medicaid formularies and to submit invoices to manufacturers for rebate collection. The Deficit Reduction Act of 2005 (DRA) allows states to collect rebates for outpatient drugs administered by physicians in their offices or clinics for fee-for-service clients (FFS). States are required to share all Medicaid rebates with the CMS at the same rate as the Federal Medical Assistance Percentage (FMAP).

In addition to the federally-mandated Medicaid "OBRA '90" rebates, Texas implemented a Medicaid supplemental rebate program in January 2004 in which drug manufacturers provide cash, or services in lieu of cash (i.e. Program Benefit Agreement), to the Medicaid program. Drug manufacturers who enter into supplemental rebate contracts with the Texas Medicaid program have their products considered for preferred status on the Preferred Drug List (PDL). The HHSC Pharmaceutical and Therapeutics (P&T) Committee applies clinical, safety, and cost effectiveness criteria to determine which products are assigned a "preferred" or "non-preferred" PDL status. Non-preferred drugs require prior authorization before they can be dispensed. Preferred products require no prior authorization, which provides an incentive for manufacturers to participate in the Medicaid supplemental rebate program. HHSC invoices and collects Medicaid supplemental rebates from manufacturers for their preferred products based on claims submitted for clients in FFS and managed care. These rebate dollars are also shared with the CMS at the FMAP rate. All rebates received are returned to HHSC's Vendor Drug Program (VDP) to be used as the first source of funding for the corresponding pharmacy program.

A number of manufacturers also voluntarily participate in separate CHIP, KHC, and CSHCN rebate programs. While CHIP rebates are shared with the CMS at an enhanced FMAP rate, rebate dollars collected for the KHC and CSHCN programs are returned to the respective state program budgets for use in their pharmacy programs.

Rebate collections are reported on an accrual basis and are based on the calendar quarter in which the claims were originally paid. However, rebate collections are subject to change due to manufacturers providing late or updated pricing information to the CMS or HHSC. This results in rebate rates changing retroactively. Additionally, collection rates can temporarily exceed 100 percent when manufacturers report pricing changes after rebate invoices are sent.

Recent State and Federal Legislation

The Affordable Care Act (ACA) initiated the Quarterly Rebate Offset Amount (QROA), which increased the minimum federal Medicaid OBRA '90 rebate amount and required the State to remit 100 percent of the additional rebates collected to the CMS as QROA. For this period, the QROA amount was \$192,226,485. The increase in Medicaid OBRA '90 rebates results in a decrease in the Medicaid supplemental rebates. The ACA requires drug manufacturers to pay rebates for drugs dispensed to Medicaid clients who receive care from a Medicaid MCO and allows Medicaid to collect supplemental rebates on these encounters.

QROA Payments Associated with Rebate Invoices

Year	QROA
2010	\$ 85,185,955
2011	85,185,269
2012	21,855,261
Total	\$192,226,485

Senate Bill (S.B.) 7, 82nd Legislature, First Called Session, 2011, directed HHSC to include pharmacy benefits in the array of services provided by MCOs. S.B. 7 also required MCOs to follow HHSC's Medicaid and CHIP formulary and Medicaid PDL. By March 1, 2012, MCOs were providing pharmacy benefits to their members. This resulted in an approximate 80 percent drop in FFS utilization and will be reported in a new section in future reports. HHSC is still assessing the rebate impact of this change and will need more actual data in order to produce more accurate estimates in the future. When HHSC set the MCO rates for March 1, 2012, it was assumed that there would be no decrease in rebate revenue.

Rebate Process

CMS uses the pricing data submitted by manufacturers to calculate the rebate rate and QROA and sends this data to the states quarterly. In compliance with federal law, HHSC matches the rate from CMS and the utilization based on claims paid during the quarter. HHSC sends invoices to the manufacturers within 60 days after the end of the calendar quarter.

Manufacturers have 38 days to pay the balance before interest accrues. The following chart illustrates the rebate process timeline:

Claims Paid	Invoices Sent	Payment Due
January – March	May 30	July 7
April – June	August 28	October 6
July – September	November 30	January 7
October – December	February 28	April 5

Manufacturers are required to calculate and pay rebates based on their most current pricing and sales information. The rebate rate can change between the time HHSC submits the invoices and the time the manufacturer makes payment. In those cases, the payments will include price adjustments and will differ from the invoiced amounts, which will appear as an under or overpayment in the rebate reporting system. For Medicaid rebates, the difference will remain in the system until CMS receives the pricing changes from the manufacturer and transmits the changes to the state with their next quarterly update.

Manufacturers can make retroactive price adjustments for up to 12 calendar quarters after their original submission to CMS. For CHIP and CSHCN, HHSC relies on manufacturers to provide rebate pricing information. If the data submitted by a manufacturer contains errors, the rebate amount per unit can be overstated or understated, and may result in large rebate adjustments when corrected. Retroactive changes can be made to utilization data as well. If a claim is reversed, or research shows that a pharmacy made an error in a claim affecting an earlier invoice, the invoice is changed retroactively.

Since manufacturers have the right to dispute the number of units that a state invoices, they may withhold payment pending resolution of the dispute. The most common reasons manufacturers cite for disputes are: (1) the state did not reimburse pharmacies at a rate that should cover the pharmacies' cost for their product, and (2) the manufacturer's sales records do not substantiate the number of units invoiced.

In appendices A-1 through A-12, the principal outstanding (column K) represents the total receivables, which is the difference between the adjusted billed amount (column F) and cumulative rebates collected (column H), and is aged based on the calendar year.

In March 2012, pharmacy services were added to the array of services provided by Texas Medicaid and CHIP MCOs. This resulted in an approximate 80 percent drop in FFS utilization and will be reported in a new section in future reports.

HHSC Medicaid Programs – Drug Rebate Collections

The following rebate collection amounts are from the last five years, beginning calendar year 2007 through August 23, 2012. This timeframe is also reflected in the appendices.

Medicaid – OBRA '90 Rebate Program

The rebates reported under the Medicaid OBRA '90 heading are based on FFS pharmacy claims and are subject to the CMS' federal Medicaid drug rebate program. As shown in Appendix A-3, totaled \$4,445,308,488 for the OBRA '90 Medicaid rebate program, which is a 99.5 percent collection rate.

Medicaid – MBIC Rebate Program

CMS approved the Medicaid Buy-In for Children (MBIC) Medicaid waiver effective January 1, 2011. Since these consumers were newly eligible, the American Recovery and Reinvestment Act of 2009 (ARRA) enhanced funding was not available, therefore they are run as a separate rebate program. The Federal match rate for both MBIC and regular Medicaid reverted to the same Federal Medicaid Assistance (FMAP) percentage on July 1, 2011 when ARRA funding expired. The MBIC rebate program will only show rebate activity for the original two quarters that were billed in 2011, and any subsequent CMS allowed rate changes for the next 12 quarters.

As shown in Appendix A-4, the collections totaled \$120,517 for the Medicaid MBIC rebate program, which is an 88.83 percent collection rate.

Medicaid – QA Rebate Program

The Medicaid waiver Qualified Aliens (QA) drug rebate program also began in 2011, and is covered under the existing CMS national rebate agreements. While it is a Medicaid waiver program, it does qualify for the CMS enhanced match rate and covers many of the consumers previously covered under CHIP.

As shown in Appendix A-5, collections totaled \$3,189,192 for the Medicaid QA rebate program, which is a 93.84 percent collection rate.

Medicaid – Supplemental Rebate Program

Manufacturers who offer a supplemental rebate to the Texas Medicaid program have their products considered for preferred status on the PDL. A supplemental rebate is cash or a Program Benefit Agreement (PBA), which is services provided in lieu of cash.

The Medicaid supplemental rebate rate is particularly volatile, because it is dependent on the Medicaid OBRA '90 rebate rate. The Medicaid OBRA '90 rebate rate is affected by manufacturer price updates that may retroactively change the rate. This causes a change in the amount owed in the Medicaid supplemental rebate program. Retroactive pricing adjustments will cause manufacturers to reallocate their payments between the Medicaid OBRA '90 rebates and Medicaid supplemental rebates. The debits and credits will balance.

HHSC has collected \$582,858,979 in Medicaid supplemental rebates (see Appendix A6). Several manufacturers had not adjusted their payments (due to rate changes) between Medicaid OBRA '90 rebates and their Medicaid supplemental rebates, resulting in a portion of the outstanding balances. Additionally, some manufacturers have chosen to provide PBAs that run for a full year. Rebate balances are settled with the PBA benefits at the end of the agreement period. Until that time, the rebate system shows the balances as unpaid. Collection rates for Medicaid supplemental rebates are expected to run at the same rate as the federal Medicaid OBRA '90 rebates. The current collection rate is 100.21 percent.

Medicaid – Physician-Administered Drug Rebate Program

HHSC has been invoicing and collecting federal Medicaid rebates for outpatient drugs provided in a physician's office, clinic, or hospital outpatient setting since 2003. The VDP pays for pharmacy-dispensed drugs, identified by their National Drug Code (NDC). However, Texas' acute care claims administrator vendor pays for drugs administered in an outpatient medical setting. Physician-administered drugs are identified by Healthcare Common Procedure Coding System (HCPCS) codes that generally start with the letter “J” and are commonly referred to as “J-codes”.

Beginning January 1, 2008, as part of the DRA, physicians’ offices, hospitals, and clinics were required to submit the NDC of the specific drug administered, in addition to the HCPCS code. Medicaid rebate billing is based on NDCs, not on HCPCS codes. A drug product identified by a single HCPCS code may refer to one or many NDCs. HCPCS codes for single-source drugs (e.g. brand) may refer to one NDC from one manufacturer, while multi-source drugs (e.g. generic) may refer to multiple NDCs from several manufacturers.

Rebate invoices on drugs provided in physicians' offices have been subject to numerous disputes, resulting in a lower average collections rate (95.70 percent) than other programs. The following issues continue to cause disputes:

- The quantities of billable units of physician-administered drugs must be converted from the dosage-based unit of measure used to pay the claims (HCPCS units) to the rebate unit of measure, based on NDC. For example, a claim for a single 5 ml dose of penicillin should be billed by the physician as a HCPCS quantity of “1” dose, but converted and billed to the manufacturer as an NDC quantity of “5” ml. Manufacturers often dispute the conversion process because they understand that the conversion process can inflate physician’s occasional billing mistakes (e.g. submitting 5 instead of 1, in this example).
- Physicians do not consistently submit claims using the correct HCPCS unit of measure. This results in the incorrect conversion to rebate units and can cause tens of millions of dollars in disputes.

HHSC has collected \$165,210,118 in rebates for physician-administered drugs (see Appendix A-5).

HHSC MCO Programs – Drug Rebate Collections

The ACA, which allowed states to collect drug rebates for claims paid by Medicaid MCOs, and S.B. 7 (82nd Legislature, First Called Session, 2011) that carved pharmacy services into Medicaid managed care, resulted in the creation of three new drug rebate programs – MCO Pharmacy, MCO Physician-Administered and MCO Supplemental. As S.B. 7 required MCOs to follow the FFS formulary and PDL, MCO pharmacy claims are eligible for Medicaid supplemental rebates.

On March 1, 2012, pharmacy services were carved into the array of services provided by Medicaid MCOs. The rebate system will be able to invoice for rebates for encounters paid by

MCOs through the MCO Pharmacy and MCO Supplemental rebate programs at the end of August 2012 and will be included in future reports.

Medicaid – MCO Physician-Administered Drug Rebate Program

The ACA requires drug manufacturers to pay rebates for drugs dispensed to Medicaid beneficiaries who receive care from a Medicaid MCO. Therefore, HHSC sent rebate invoices to manufacturers for MCO-related physician-administered claim encounters dating back to the start of the quarter after the March 23, 2010, effective date of the ACA. The 2010 claim encounters were billed in May 2012 and the 2011 claim encounters will be billed in late August 2012. As of the November 2012 invoices, HHSC will have invoiced all previous MCO-related physician-administered claim encounters.

The MCO physician-administered drug rebates face the same challenges as the FFS rebates due to the differences between NDCs and HCPCS.

The invoices for the 2010 MCO physician-administered drug rebates resulted in collections of \$71,366 (see Appendix A-8).

HHSC CHIP Programs – Drug Rebate Collections

The CHIP rebate program is a voluntary state rebate program that began in March 2002. Because of the Medicaid ‘best price’ requirements included in Section 1927 of the Social Security Act, the CHIP rebate rates are below the Medicaid rates to protect manufacturer’s Medicaid ‘best price’ and entice participation.

For the CHIP rebate program, manufacturers are required to report rebate pricing to HHSC on a quarterly basis. If a manufacturer fails to comply with price reporting requirements, HHSC mails an invoice that reports the utilization of each NDC, but does not calculate an amount due because the current rate in the system is zero. Pursuant to the terms of the contract, the manufacturer is responsible for calculating the rebate amount and paying. As a result, it appears in the rebate system as though HHSC has been overpaid (greater than 100 percent collections) until the manufacturer corrects and provides the pricing data from the previous quarter. If a manufacturer’s pricing file contains errors, it can result in large price adjustments when corrected.

CHIP is divided into two subprograms, depending on the funding source: the federally-matched federal-state funded (FSF) program and the state-funded-only (SF) program for Qualified Aliens – most of whom moved into the Medicaid Qualified Aliens (QA) Waiver in 2011.

Children’s Health Insurance Program (CHIP) – Federal-State Funded (FSF)

On March 1, 2012 the pharmacy services were added to the array of services provided by CHIP MCOs. The rebate system will be able to invoice for CHIP rebates for encounters paid by MCOs at the end of August 2012 and will be included in future reports

For the CHIP-FSF program, HHSC has collected \$95,778,806 in rebates (see Appendix A-9). Because of the fact that some manufacturers are delinquent in providing the contracted unit rebate information, the collection rate is 106.50 percent.

Children's Health Insurance Program (CHIP) – State Funded (SF)

The CHIP-SF rebate program covers prescriptions for legal immigrants, most of who were moved into the Medicaid QA waiver in 2011, so this rebate program is ending. This program is funded entirely from general revenue. Total collections for this rebate program are \$1,660,805 (see Appendix A-10). Like CHIP-FSF, CHIP-SF faces challenges related to manufacturer data.

DSHS Programs – Drug Rebate Collections

Kidney Health Care (KHC) Program

The KHC rebate program is a voluntary DSHS program that is administered by HHSC's VDP. Because KHC qualifies as a State Pharmaceutical Assistance Program (SPAP) under Section 1927 of the Social Security Act, it is able to use the same rebate rates as Medicaid for participating manufacturers, without jeopardizing the manufacturers' Medicaid rate. The increase in the Medicaid rate as a result of changes from the ACA has increased the KHC rebates. However, the KHC client base is declining.

HHSC has collected \$34,863,576 in KHC drug rebates (see Appendix A-11). Collections have averaged 101.57 percent of the amount invoiced.

Children with Special Health Care Needs (CSHCN) Services Program

Like KHC, CSHCN began collecting voluntary rebates in 1997 and HHSC's VDP administers this program for DSHS. However, the CSHCN program does not qualify as a SPAP, therefore its rates are limited as is the case with CHIP. HHSC continues to send zero-rate utilization invoices for which the manufacturers are responsible for calculation and payment. If a manufacturer fails to submit rates, but pays the invoice, the outstanding balance in the system appears to be a credit to the manufacturer (a greater than 100 percent collections rate) until the manufacturer submits the required rates.

Total collections (principal and interest) for the CSHCN rebate program were \$3,191,433 (see Appendix A-12).

Conclusion

Summary of Rebate Collections

From 2007 through August 23, 2012, HHSC collected a total of \$5,332,253,281 in rebates and \$338,045 in interest. Appendix A-1 contains the summary breakdown by year. Appendix A-2

contains the summary breakdown by program. The average collection rate calculated for all programs is 99.58 percent for the last five years.

It is important to note that collection rates are subject to change because rebate programs allow retroactive adjustments to pricing and utilization data. Manufacturers regularly provide late and/or updated pricing information to CMS or HHSC. These updates to pricing information may retroactively change the rebate rates. Additionally, collection rates can exceed 100 percent when manufacturers report pricing changes after rebate invoices are sent.

The provisions in S.B. 7 that allow HHSC to define a single state-wide formulary for Medicaid and CHIP and a Medicaid PDL will expire on August 31, 2013 unless the legislature modifies the statute. If MCOs develop their own formularies and PDLs, HHSC will experience a significant decrease in Medicaid OBRA '90 and Medicaid supplemental rebates. HHSC is still assessing the potential overall fiscal impact of this provision and the impact to Medicaid providers and clients.

The table below provides the total rebates billed and collected for each calendar year for all programs combined. Rebates are tracked on an accrual basis and are tied to the calendar year.

Table 1
Rebate Collections by Calendar Year for All Programs (All Funds)
As of August 23, 2012

Year	Current Value of Invoices	Total Collections	Outstanding Principal	Outstanding Interest	Collection Rate
2007	\$ 687,809,968	\$ 682,396,800	\$ 5,413,168	\$ 114,040	99.21%
2008	820,889,038	807,798,688	13,090,350	51,508	98.41%
2009	953,613,945	953,072,096	541,849	19,182	99.94%
2010	1,198,653,750	1,183,327,986	15,325,764	144,596	98.72%
2011	1,355,088,962	1,364,820,585	(9,731,623)	35,080	100.72%
2012	338,598,070	340,837,126	(2,239,056)	-	100.66%
TOTAL	\$5,354,653,733	\$5,332,253,281	\$ 22,400,452	\$ 364,405	99.58%

Table 2
Total Rebate Collections by Program (All Funds)
As of August 23, 2012

Program	Current Value of Invoices	Total Collections	Outstanding Principal	Outstanding Interest	Collection Rate
Medicaid - OBRA 90	\$4,467,562,246	\$4,445,308,488	\$22,253,759	\$87,821	99.50%
Medicaid - Buy In for Children	135,676	120,517	15,158	4	88.83%
Medicaid - Qualified Alien	3,398,534	3,189,192	209,341	225	93.84%
Medicaid - Supplemental	581,642,467	582,858,979	(1,216,512)	162	100.21%
Medicaid - Physician Administered	172,630,158	165,210,118	7,420,040	165,581	95.70%
MCO - Physician Administered	485,612	71,366	414,246	232	14.70%
CHIP - Federal State Funded	89,934,933	95,778,806	(5,843,874)	82,559	106.50%
CHIP - State Funded	1,369,405	1,660,805	(291,400)	767	121.28%
DSHS - Kidney Health Care Program	34,323,939	34,863,576	(539,638)	10,813	101.57%
DSHS - Children w/ Special Health Care Needs	3,170,764	3,191,433	(20,669)	16,241	100.65%
TOTAL	\$5,354,653,733	\$5,332,253,281	\$22,400,452	\$364,405	99.58%

**Appendix A1
Summary by Calendar Year**

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$678,178,864	\$20,145,845	(\$10,514,746)	\$5	\$687,809,968	\$682,933,771	\$682,396,800	\$203,036	\$682,599,836	\$5,413,168	\$114,040	99.21%
2008	872,764,205	(420,680,565)	367,367,390	1,438,008	820,889,038	811,434,716	807,798,688	65,144	807,863,832	13,090,350	51,508	98.41%
2009	1,064,101,286	2,653,721	(113,191,062)	50,000	953,613,945	947,905,284	953,072,096	25,668	953,097,763	541,849	19,182	99.94%
2010	647,611,317	622,667,270	(71,584,078)	(40,760)	1,198,653,750	1,182,137,485	1,183,327,986	20,627	1,183,348,613	15,325,764	144,596	98.72%
2011	1,193,914,864	4,846,705	161,374,514	(5,047,121)	1,355,088,962	1,263,699,902	1,364,820,585	19,080	1,364,839,666	(9,731,623)	35,080	100.72%
2012	341,176,572	199,579	(2,778,080)	0	338,598,070	328,411,599	340,837,126	4,490	340,841,616	(2,239,056)	0	100.66%
TOTAL	\$4,797,747,108	\$229,832,555	\$330,673,938	(\$3,599,868)	\$5,354,653,733	\$5,216,522,756	\$5,332,253,281	\$338,045	\$5,332,591,326	\$22,400,452	\$364,405	99.58%

**Appendix A2
Summary by Program**

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
Medicaid - OBRA 90	\$3,312,121,043	\$ 590,949,202	\$ 569,556,602	(\$5,064,600)	\$4,467,562,246	\$4,429,624,858	\$4,445,308,488	\$ 247,974	\$4,445,556,462	\$22,253,759	\$ 87,821	99.50%
Medicaid - Buy In for Children	112,554	(273)	23,395	0	135,676	120,517	120,517	2	120,520	15,158	4	88.83%
Medicaid - Qualified Alien	2,681,716	(126,019)	842,983	(147)	3,398,534	3,189,192	3,189,192	21	3,189,213	209,341	225	93.84%
Medicaid - Supplemental	1,001,075,311	(420,533,799)	(373,614)	1,474,569	581,642,467	483,694,859	582,858,979	23,156	582,882,136	(1,216,512)	162	100.21%
Medicaid - Physician Administered	311,868,951	28,012,474	(167,251,235)	(32)	172,630,158	164,440,663	165,210,118	39,435	165,249,554	7,420,040	165,581	95.70%
MCO - Physician Administered	867,414	0	(381,802)	0	485,612	0	71,366	3	71,370	414,246	232	14.70%
CHIP - Federal State Funded	136,094,406	24,599,310	(70,751,018)	(7,765)	89,934,933	95,741,624	95,778,806	23,315	95,802,122	(5,843,874)	82,559	106.50%
CHIP - State Funded	800,482	436,591	147,659	(15,327)	1,369,405	1,660,805	1,660,805	133	1,660,937	(291,400)	767	121.28%
Kidney Health Care Program	29,105,028	6,411,964	(1,193,050)	(4)	34,323,939	34,860,926	34,863,576	1,139	34,864,715	(539,638)	10,813	101.57%
Children w/ Special Health Care Needs	3,020,201	83,106	54,018	13,438	3,170,764	3,189,313	3,191,433	2,866	3,194,299	(20,669)	16,241	100.65%
TOTAL	\$4,797,747,108	\$ 229,832,555	\$ 330,673,938	(\$3,599,868)	\$5,354,653,733	\$5,216,522,756	\$5,332,253,281	\$ 338,045	\$5,332,591,326	\$22,400,452	\$364,405	99.58%

**Appendix A3
Medicaid OBRA 90**

A	B	C	D	E	F	G	H	I	J	K	L	M
Calendar Year	Amounts Billed					Collections				Outstanding Balances		Collection Rates
	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$542,460,661	\$20,485,209	(\$7,644,935)	\$12	\$555,300,947	\$552,354,478	\$552,772,891	\$143,201	\$552,916,092	\$2,528,056	\$32,732	99.54%
2008	645,119,177	(404,457,435)	407,906,131	0	648,567,873	646,003,935	646,182,232	46,962	646,229,194	2,385,641	24,136	99.63%
2009	772,626,335	5,102,923	(7,776,091)	0	769,953,168	765,769,498	767,262,276	19,060	767,281,336	2,690,891	3,317	99.65%
2010	0	980,354,127	11,903,239	(32,835)	992,224,531	981,952,768	983,337,298	17,140	983,354,438	8,887,233	10,137	99.10%
2011	1,027,286,314	(10,512,111)	165,849,714	(5,031,778)	1,177,592,139	1,167,340,978	1,167,936,983	17,282	1,167,954,265	9,655,155	17,500	99.18%
2012	324,628,555	(23,511)	(681,456)		323,923,589	316,203,201	327,816,806	4,330	327,821,136	(3,893,217)	0	101.20%
TOTAL	\$3,312,121,043	\$590,949,202	\$569,556,602	(\$5,064,600)	\$4,467,562,246	\$4,429,624,858	\$4,445,308,488	\$247,974	\$4,445,556,462	\$22,253,759	\$87,821	99.50%

Appendix A4 Medicaid Buy-In for Children

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
2008	0	0	0	0	0	0	0	0	0	0	0	
2009	0	0	0	0	0	0	0	0	0	0	0	
2010	0	0	0	0	0	0	0	0	0	0	0	
2011	\$112,554	(\$273)	\$23,395	\$0	\$135,676	\$120,517	\$120,517	\$2	\$120,520	\$15,158	\$4	88.83%
2012	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	\$112,554	(\$273)	\$23,395	\$0	\$135,676	\$120,517	\$120,517	\$2	\$120,520	\$15,158	\$4	88.83%

**Appendix A5
Medicaid Qualified Aliens**

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
2008	0	0	0	0	0	0	0	0	0	0	0	
2009	0	0	0	0	0	0	0	0	0	0	0	
2010	0	0	0	0	0	0	0	0	0	0	0	
2011	2,680,342	(126,019)	842,983	(147)	3,397,159	3,187,817	3,187,817	21	3,187,838	209,342	225	93.84%
2012	1,375	0	0	0	1,375	1,374	1,375	0	1,375	(0)	0	100.03%
TOTAL	\$2,681,716	\$(126,019)	\$842,983	(\$147)	\$3,398,534	\$3,189,192	\$3,189,192	\$21	\$3,189,213	\$209,341	\$225	93.84%

**Appendix A6
Medicaid Supplemental Rebates**

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$114,437,630	(\$7,264,775)	(\$1,187,173)	\$0	\$105,985,683	\$104,404,646	\$103,449,291	\$17,465	\$103,466,756	\$2,536,392	\$0	97.61%
2008	154,112,397	(19,276,635)	(6,558,834)	1,424,569	129,701,498	122,820,875	119,006,551	4,026	119,010,577	10,694,947	0	91.75%
2009	125,262,382	(2,318,972)	(955,990)	50,000	122,037,421	119,429,398	123,103,054	518	123,103,572	(1,065,634)	0	100.87%
2010	518,956,862	(392,767,796)	(184,111)	0	126,004,955	117,421,774	117,156,867	739	117,157,606	8,848,088	0	92.98%
2011	88,306,039	1,094,378	8,512,493	0	97,912,911	19,618,167	120,143,216	408	120,143,624	(22,230,306)	164	122.70%
2012	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	\$1,001,075,311	(\$420,533,799)	(\$373,614)	\$1,474,569	\$581,642,467	\$483,694,859	\$582,858,979	\$23,156	\$582,882,136	(\$1,216,512)	\$164	100.21%

**Appendix A7
Medicaid Physician Administered Rebates**

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$6,965,571	\$3,084,101	\$138,523	\$0	\$10,188,195	\$11,219,433	\$11,219,433	\$30,024	\$11,249,457	(\$1,031,238)	\$20,832	110.12%
2008	50,846,302	1,040,245	(31,410,306)	(0)	20,476,242	20,409,669	20,409,669	5,459	20,415,128	66,573	7,804	99.67%
2009	136,818,147	129,437	(103,777,330)	0	33,170,255	33,205,108	33,205,486	1,743	33,207,228	(35,231)	4,126	100.11%
2010	43,775,649	25,005,824	(15,677,879)	18	53,103,612	49,912,403	49,911,916	1,084	49,913,000	3,191,695	117,988	93.99%
2011	63,547,994	(1,248,293)	(14,474,710)	(49)	47,824,942	43,940,034	43,939,692	1,002	43,940,694	3,885,250	14,832	91.88%
2012	9,915,288	1,160	(2,049,534)	0	7,866,913	5,754,017	6,523,922	124	6,524,046	1,342,991	0	82.93%
TOTAL	\$311,868,951	\$28,012,474	(\$167,251,235)	(\$32)	\$172,630,158	\$164,440,663	\$165,210,118	\$39,435	\$165,249,554	\$7,420,040	\$165,581	95.70%

**Appendix A8
MCO Physician Administered Rebates**

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
2008	0	0	0	0	0	0	0	0	0	0	0	
2009	0	0	0	0	0	0	0	0	0	0	0	
2010	867,414	0	(381,802)	0	485,612	0	71,366	3	71,370	414,246	232	14.70%
2011	0	0	0	0	0	0	0	0	0	0	0	
2012	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	\$867,414	\$0	(\$381,802)	\$0	\$485,612	\$0	\$71,366	\$3	\$71,370	\$414,246	\$232	14.70%

Appendix A9
CHIP – National and State Funded Rebates

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$9,767,166	\$3,559,767	(\$275,649)	(\$2)	\$13,051,282	\$11,722,970	\$11,722,940	\$10,755	\$11,733,695	\$1,328,342	\$45,812	89.82%
2008	14,899,206	1,953,119	(595,923)	(0)	16,256,402	16,394,022	16,394,022	7,044	16,401,066	(137,620)	15,255	100.85%
2009	18,514,436	(294,666)	(273,760)	(0)	17,946,010	19,401,426	19,401,426	3,837	19,405,264	(1,455,416)	8,321	108.11%
2010	82,776,932	3,462,904	(67,316,506)	(0)	18,923,330	22,511,752	22,511,752	1,425	22,513,177	(3,588,422)	11,408	118.96%
2011	5,670,895	15,696,241	(2,289,180)	(7,763)	19,070,193	21,085,345	21,085,345	220	21,085,565	(2,015,152)	1,762	110.57%
2012	4,465,771	221,944	0	0	4,687,715	4,626,109	4,663,321	34	4,663,355	24,395	0	99.48%
TOTAL	\$136,094,406	\$24,599,310	(\$70,751,018)	(\$7,765)	\$89,934,933	\$95,741,624	\$95,778,806	\$23,315	\$95,802,122	(\$5,843,874)	\$82,559	106.50%

**Appendix A10
CHIP State Funded Rebates**

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$103,308	\$30,687	(\$1,073)	(\$1)	\$132,921	\$121,972	\$121,972	\$65	\$122,037	\$10,949	\$515	91.76%
2008	76,916	15,941	(504)	0	92,353	92,579	92,579	37	92,615	(226)	106	100.24%
2009	66,684	(368)	(571)	0	65,745	68,666	68,666	8	68,674	(2,921)	14	104.44%
2010	239,373	84,404	7,839	(7,943)	323,673	538,967	538,967	18	538,985	(215,294)	84	166.52%
2011	313,939	305,928	141,968	(7,384)	754,451	838,384	838,384	4	838,388	(83,933)	49	111.13%
2012	262	0	0	0	262	237	237	0	237	25	0	90.31%
TOTAL	\$800,482	\$436,591	\$147,659	(\$15,327)	\$1,369,405	\$1,660,805	\$1,660,805	\$133	\$1,660,937	(\$291,400)	\$767	121.28%

Appendix A11
DSHS – Kidney Health Care Rebates

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$4,124,463	\$115,488	(\$1,531,175)	(\$4)	\$2,708,772	\$2,663,245	\$2,663,245	\$274	\$2,663,518	\$45,527	\$4,561	98.32%
2008	7,225,406	5,657	(1,936,747)	0	5,294,316	5,204,743	5,204,743	85	5,204,828	89,574	1,804	98.31%
2009	10,259,655	(7,309)	(374,589)	0	9,877,757	9,453,553	9,453,553	481	9,454,033	424,204	1,941	95.71%
2010	0	6,711,831	30,764	0	6,742,596	8,999,427	8,999,425	175	8,999,601	(2,256,830)	2,087	133.47%
2011	5,478,992	(413,689)	2,665,733	0	7,731,036	6,901,970	6,901,940	124	6,902,064	829,097	420	89.28%
2012	2,016,511	(15)	(47,035)	0	1,969,461	1,637,988	1,640,671	0	1,640,671	328,791	0	83.31%
TOTAL	\$29,105,028	\$6,411,964	(\$1,193,050)	(\$4)	\$34,323,939	\$34,860,926	\$34,863,576	\$1,139	\$34,864,715	(\$539,638)	\$10,813	101.57%

Appendix A12
DSHS – Children with Special Health Care Needs Services Rebates

A	B	C	D	E	F	G	H	I	J	K	L	M
	Amounts Billed					Collections				Outstanding Balances		Collection Rates
Calendar Year	Original	Dollar Value of Pricing Adjustments since billing	Dollar Value of Utilization Adjustments since billing	Other Adjustments	Current Value of Invoices =B+C+D+E	Collections Prior to Current SFY	Total Principal Collected =G+CY	Total Interest Collected	Total Collections =H+I	Outstanding Principal	Outstanding Interest	Collection Rates for Principal =H/F
2007	\$320,064	\$135,368	(\$13,264)	(\$1)	\$442,168	\$447,029	\$447,028	\$1,252	\$448,280	(\$4,861)	\$9,589	101.10%
2008	484,800	38,542	(36,427)	13,439	500,354	508,893	508,892	1,531	510,423	(8,538)	2,402	101.71%
2009	553,646	42,676	(32,732)	0	563,590	577,634	577,634	21	577,655	(14,045)	1,463	102.49%
2010	995,087	(184,024)	34,378	0	845,442	800,394	800,394	41	800,436	45,047	2,660	94.67%
2011	517,794	50,544	102,119	0	670,457	666,690	666,690	19	666,709	3,766	127	99.44%
2012	148,810	0	(55)	0	148,754	188,673	190,794	2	190,796	(42,040)	0	128.26%
TOTAL	\$3,020,201	\$83,106	\$54,018	\$13,438	\$3,170,764	\$3,189,313	\$3,191,433	\$2,866	\$3,194,299	(\$20,669)	\$16,241	100.65%