Indiana Family & Social Services Administration

Indiana Medicaid
Pharmacy Benefit Consolidation
Overview Document

Version 7.0
Updated August 31, 2009

What is a Pharmacy Benefit Consolidation?

The Office of Medicaid Policy and Planning (Office) will assume responsibility for processing all outpatient pharmacy claims and managing pharmaceutical services for drugs and drug-related supplies dispensed by enrolled pharmacy providers. Capitation payments to managed care plans and the Healthy Indiana Plans (HIP) will be reduced accordingly to reflect the change in policy.

- Currently, three managed care organizations (MCOs-Anthem, Managed Health Services (MHS) and MDwise) and two Healthy Indiana Plans (HIP plans-Anthem, MDwise) are responsible for pharmacy claims processing and prior authorization activities related to pharmaceuticals dispensed by enrolled pharmacy providers.
- Under the Pharmacy Benefit Consolidation, managed care and HIP members will receive their pharmaceutical services through the existing Indiana Fee-for-Service (FFS) delivery system. The FFS pharmaceutical benefit is comprehensive and is defined by the state plan approved by the Centers for Medicare and Medicaid Services (CMS). Members will utilize the Indiana Medicaid Preferred Drug List (PDL) which represents a subset of overall FFS pharmaceutical benefit.
- As of July, there are 627,000 members enrolled in the MCOs and 46,000 members enrolled in HIP. Less than 30% of MCO and approximately 75% of HIP enrolled members currently utilize pharmaceutical benefits.
- All other capitated services, including physician administered drugs, most medical supplies, DME and nutritional supplements will remain the responsibility of the MCOs and HIP plans.

When will the Pharmacy Benefit Consolidation be implemented?

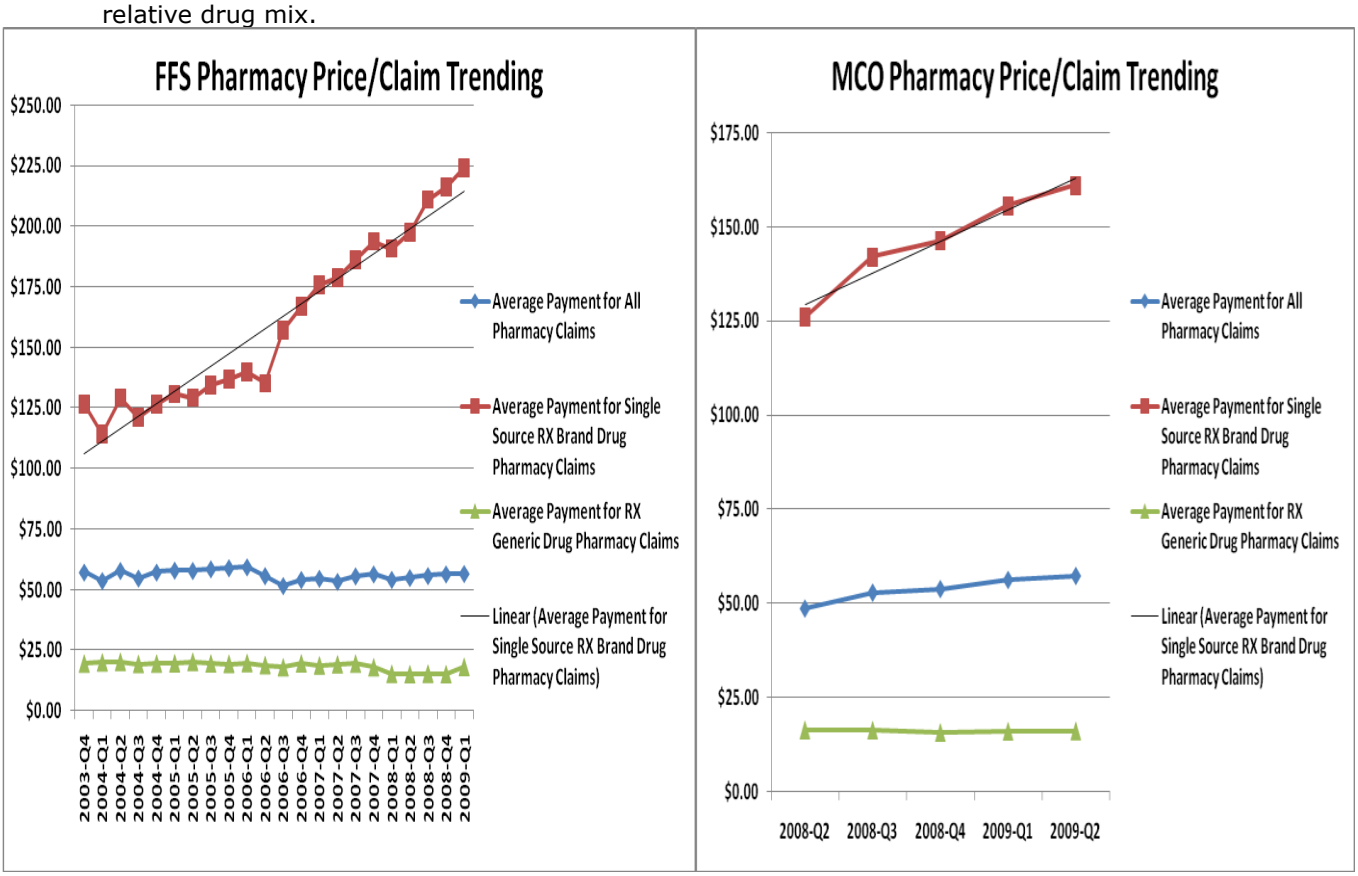
January 1, 2010

Why implement a Pharmacy Benefit Consolidation?

A Pharmacy Benefit Consolidation will achieve significant savings and will result in administrative simplification in the areas of prescribing, dispensing, claims submission, program analytics and prior authorization related to pharmaceutical services. A Pharmacy Benefit Consolidation will not negatively impact the quality of healthcare services provided to members or reduce the overall number of pharmaceuticals available to members.

- Under the FFS pharmacy program, in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the Office collects federal Medicaid rebates and state supplemental rebates which are not available through the MCOs or HIP plans. These rebates apply to both brand and generic pharmaceuticals. Rebates available through the FFS program are **10 times** greater than what the MCOs are able to negotiate with pharmaceutical manufacturers. The FFS program currently collects **35%** of every dollar spent on pharmaceuticals in the form of a rebate from the 550 manufacturers who participate in the program. The rebates are then shared with the federal government at the current federal medical assistance percentage (FMAP). MCOs currently collect commercial rebates amounting to 2-3% of every dollar spent.
- The *initial* annualized state only rebate-related savings for the Pharmacy Benefit Consolidation is estimated at $25-30 million. This amount will increase over time as increases in drug spend are driven primarily by brand name drug price increases. Additional savings of approximately $10 million are expected to result through the application of FFS program pharmacy benefit management tools for the expanded membership.
    - ***Note:*** *Data for HIP is not available and therefore could not be included in the estimates above.*

- Pharmaceutical rebates available through OBRA 90 insulate the pharmacy program from **continual** price increases for **brand name** drugs which on average equal **8-9%** per year. It should be noted that these price increases occur in both the FFS and MCO/HIP programs despite the population differences and the relative drug mix.



Notes:
Data according to state fiscal year and quarter. State fiscal year ends June 30th of each year. FFS pricing excludes rebates.
Data Source: OMPP Pharmacy Master Database

- A Pharmacy Benefit Consolidation eases the burden on pharmacists and prescribers of tracking multiple pharmaceutical benefits and navigating different claims processors, help desks and prior authorization requirements. Complexity is reduced, thus resulting in an overall increase in administrative efficiency.
- **All behavioral health pharmaceuticals, per state statute, are "preferred" in both the FFS and MCO pharmaceutical benefit packages. In other words, the behavioral health pharmaceutical benefits are currently identical between FFS and MCO pharmaceutical programs.**
- The MCO reported expenditures for behavioral health drugs as a percentage of total spend are: Anthem, 42.6%, MHS, 50%, and MDwise, 46.2%. The corresponding FFS percentage is 42%.
- Utilization of the FFS pharmaceutical benefit and the FFS PDL will not negatively impact the quality of care and has successfully been implemented in other states. The FFS pharmaceutical benefit is already utilized for the most chronically ill segment of the Medicaid and HIP populations (HIP Enhances Services Plan (HIP – ESP)) and for new members who eventually end up in one of the three MCO plans. On average, potential MCO members already utilize the FFS pharmaceutical benefit for two months prior to being enrolled in an MCO. The Indiana Medicaid Drug Utilization Review Board (DUR Board) is required by IC 12-15-35-28(h) to conduct regular evaluations of the FFS PDL. Specific focus areas of the evaluation include:
    - Any increase in Medicaid physician, laboratory, or hospital costs or in other funded programs as a result of the PDL.
    - The impact of the PDL on the ability of a Medicaid recipient to obtain prescription drugs.
    - The number of times prior authorization was requested and the number of times prior authorization was approved and was denied.
    - The cost of administering the PDL.

  Key Findings: **Ten consecutive** evaluations have demonstrated **no evidence** exists that suggests that the ability of Indiana Medicaid recipients to obtain prescription medications has been compromised or that quality of care for recipients has suffered as a result of the PDL program. More importantly, **adherence** by the recipient to the prescribed drug regimen was determined to be the primary issue, not whether recipients were taking a preferred or non-preferred medication. The PDL has produced a net savings of $ 61.62 million (S&F) since inception.

How many states currently utilize or are planning a Pharmacy Benefit Consolidation?

State	Full Rx Benefit Consolidation (All Pharmaceuticals Removed from Capitation Rates)	Partial Rx Benefit Consolidation (A Portion of Pharmaceuticals Removed from Capitation Rates)	General Comments/Drug Classes Excluded from Capitation Rates
Connecticut	✓		**Assumed payment responsibility Feb 1, 2008**
Delaware	✓		
District of Columbia	✓		
Illinois	✓		
Iowa	✓		
Nebraska	✓		
Nevada	✓		
New York	✓		
North Carolina	✓		
Tennessee	✓		
Texas	✓		
Utah	✓		
West Virginia	✓		
Wisconsin	✓		**Assumed payment responsibility February 1, 2008**
Arizona		✓	**HIV/AIDS Drugs, Anti-Psychotics**
California		✓	**HIV/AIDS Drugs, Mental Health Drugs, Anti-Psychotics, Alcohol & Drug Abuse Treatment**
Florida		✓	**Anti-Hemophilic drugs**
Hawaii		✓	**No examples of drug classes provided**
Kansas		✓	**Anti-Hemophilic drugs**
Kentucky		✓	**Anti-Psychotics, Other drugs dispensed by a psychiatrist**
Maryland		✓	**Selected Mental Health Drugs, Anti-Psychotics**
Michigan		✓	**HIV/AIDS Drugs, Mental Health Drugs, Anti-Psychotics**
Missouri		✓	**HIV/AIDS Drugs**
New Jersey		✓	**HIV/AIDS Drugs, Mental Health Drugs, Anti-Psychotics, Anti-Hemophilic drugs**
Oregon		✓	**Mental Health Drugs, Anti-Psychotics**
South Carolina		✓	**Family Planning Drugs for One Plan**
Washington		✓	**HIV/AIDS Drugs, Mental Health Drugs,**
West Virginia		✓	**Family Planning Drugs**
Future Plans for Full Rx Benefit Consolidation			
Indiana	✓		**Planning full benefit consolidation for January 1, 2010**
Missouri	✓		**Planning full benefit consolidation for October 1, 2009**
Ohio	✓		**Planning full benefit consolidation for February 1, 2010**
Pennsylvania	✓		**Evaluating full benefit consolidation in 2009, requires legislative approval**
Rhode Island	✓		**Evaluating full benefit consolidation in 2009**
South Carolina	✓		**Evaluating full benefit consolidation in 2009**

Sources: NASMD and State Medicaid Pharmacy Directors

Will prescribing options be more limited utilizing the FFS pharmaceutical benefit and PDL?

No, the prescribing options will actually be expanded in terms of the number of pharmaceuticals available without prior authorization (PA). The overall number of pharmaceuticals requiring PA in FFS as compared to the MCOs is much lower. In addition, when a prescriber requests PA the approval frequency is much higher in the FFS program. Even though the FFS PA denial rate is low as compared to the MCOs, the FFS PDL maintains a 94% market share for preferred pharmaceuticals.

National Drug Code Payment Comparison

Fee For Service (FFS)	Managed Care Organizations (MCO)
13,744*	11,282*

*Number of unique NDCs that were reimbursed by the FFS and MCO programs. Paid claim data from Q1 2008.

Prior Authorization Comparison

Delivery System	Paid Claim Count	Prior Authorization (PA) Requests	Percentage of PA Requests Relative to Claim Count	PA Approved	Approval Rate	PA Denied	Denial Rate
Fee For Service (FFS)	**5,449,642**	**17,844**	**0.33%**	**16,473**	**92.32%**	**1,371**	**7.68%**
Managed Care Organizations (MCO)	**4,768,752**	**42,847**	**0.90%**	**19,960**	**46.58%**	**22,887**	**53.42%**
Anthem MCO	**1,042,452**	**14**	**0.00%**	**14**	**100.00%**	**0**	**0.00%**
MDwise MCO	**2,354,500**	**26,292**	**1.12%**	**11,306**	**43.00%**	**14,986**	**57.00%**
MHS MCO	**1,371,800**	**16,541**	**1.21%**	**8,640**	**52.23%**	**7,901**	**47.77%**

Notes:

- *Time Period SFY08 – July 1, 2007 through June 30, 2008*
- *MCO Paid Claim Count based on 3Q2008 data supplied by the MCOs and extrapolated for a year.*
- *Prior Authorization requests exclude behavioral health pharmaceuticals and durable medical equipment (supplies). All programs must follow the same coverage guidelines for behavioral health pharmaceuticals in accordance with IC 12-15-35.5.*
- *Anthem became a Managed Care Organization for Indiana in January 2007.*
- *Data Source: OMPP pharmacy master database; MCO 2007 Annual Report in accordance with IC 12-15-35-48*

Will existing MCO and HIP pharmacy prior authorizations be transferred?

Yes, all existing pharmacy prior authorizations will be systematically converted to the FFS claims processing system.

Does the Pharmacy Benefit Consolidation require a change to state statute?

No

How will drug co-payments be affected?

A three dollar ($3) co-payment is required for legend and non-legend covered drugs in accordance with IC 12-15-6.

However, the following services are exempt from co-payment requirement:

1) Services furnished to individuals less than eighteen years of age (represents approximately 75% of managed care enrollment).
2) Services furnished to pregnant women if such services are related to the pregnancy or any other medical condition that may complicate pregnancy.
3) Family planning services and supplies furnished to individuals of child bearing age.

See IHCP Provider Manual, Section 3: Pharmacy Coverage and Reimbursement for a complete list of exempt pharmacy services.

The HIP program does not allow cost-sharing except for the required monthly contributions and co-payments for emergency room services; therefore, HIP members will continue with no co-payment for covered drugs.

How will the implementation of the Pharmacy Benefit Consolidation be managed?

The implementation of the Pharmacy Benefit Consolidation will focus on three general tracks:

- Technical-file exchanges and access to real time pharmacy claims data
- Coordination of benefits and contract modifications
- Provider and member communication

The project plan, based on the Wisconsin Medicaid implementation which was successfully completed in February 2008, is being managed by certified project managers. MCO and HIP technical and business resources will participate in every phase of the project working directly with Office staff to ensure that the Pharmacy Benefit Consolidation is successfully implemented.

What administrative costs are associated with the Pharmacy Benefit Consolidation?

Increased administrative costs are estimated at $1.5-2 million (S&F) per year. Costs are related to the following:

- Staffing and hours of operation expansion for the Indianapolis based pharmacy help desk and prior authorization call centers. Each of the MCOs and HIP plans currently utilize out of state pharmacy call centers.
- Project management and technical development
- Increase in the number of DUR Board approved retrospective drug utilization review letters and phone calls to providers
- Addition of one clinical pharmacist to the state's pharmacy team

Who advises the Office as to the administration of the FFS pharmacy benefit?

Drug Utilization Review (DUR) Board, appointed by the Governor in accordance with IC 12-15-35-21

Members: Philip N. Eskew, Jr., MD, William J. Brown, R.Ph., Terry Lindstrom, Ph.D., Brian W. Musial, R.Ph., Patricia A. Treadwell, MD., John J. Wernert, MD.

Therapeutics Committee, appointed by the DUR Board in accordance with IC 12-15-35-20.5

Members: C. Andrew Class, MD., Psychiatrist, Harry Clifton Knight, Jr., MD., Family Practice, James T. Poulos, MD., Internal Medicine/Diabetes, Michael C. Sha, MD., Geriatrics, Anne J. Stump, MD., FAAP, Pediatrics, Bruce G. Hancock, M.S., R.Ph., Bill Malloy, M.S., Pharm D., BCPS

Mental Health Quality Advisory Committee (MHQAC), appointed by the Governor in accordance with IC 12-15-35-51

Members: Michael Sharp, R.Ph. Director of Pharmacy, George M. Parker, MD., Medical Director of the Division of Mental Health and Addiction, Stephen M. McCaffrey, JD., James A. Koontz, MD., Katherine Wentworth, Carol A. Ott, Pharm D., BCPP, Jeremy Thain, R.Ph.

Who oversees the administration of the FFS pharmacy benefit?

The Office directly employs 4 licensed Indiana pharmacists who are accountable for the administration of the FFS pharmacy benefit:

Michael Sharp, R.Ph., Director of Pharmacy
Marc Shirley, R.Ph., Operations Manager
Medina Lee, R.Ph., Clinical Analytics Manager
Emily Hancock, Pharm D., MPA, Intervention and Outcomes Manager

Collectively, these individuals possess 97 years of pharmacy practice experience in the areas of retail pharmacy, hospital pharmacy, long term care pharmacy, specialty pharmacy, mail order pharmacy, regulatory affairs (pharmaceutical industry), drug file compendia and pharmacy benefit management.

What type of PBM tools does the FFS Pharmacy Program have available to effectively manage pharmaceutical services?

The program utilizes a broad array of tools to assure appropriate use of pharmaceuticals while continually evaluating opportunities that benefit both taxpayers and Medicaid members. Below is a partial lists of tools utilized in the FFS program:

- Preferred Drug List (step therapy, quantity limits, prior authorization criteria, supplemental rebates)
- Rebate Collections (federal and supplemental)
- "Best in Class" State Maximum Allowable Cost Program for generic drug reimbursement, including rates for hemophilia drugs
- Commercial level AWP discount (AWP-16%) for brand drug reimbursement
- Mandatory Generic Substitution
- MHQAC Polypharmacy Editing and Dose Optimization
- Comprehensive prospective drug utilization review claim editing
- Prior Authorization criteria for contraindicated drug interactions
- SmartPA prior authorization tool (scheduled for implementation in the fall of 2009)

SmartPA

In the fall of 2009, the FFS pharmacy program will be implementing the automated prior authorization solution SmartPA. SmartPA is a real-time solution comprised of highly sophisticated clinical prior authorization rules designed to exceed the competitive demands of today's Medicaid PBM cost-containment strategies. SmartPA utilizes integrated Indiana-specific evidence-based criteria and claims data during the Point-of-Sale (POS) transaction to ensure that the prescribed therapy meets criteria for appropriate use. SmartPA uses member medical and pharmacy claims history to determine the appropriateness of the medication in less than a second. This innovative tool is able to automate up to 60 to 90 percent of the prior authorization requests, thereby lessening the burden on Medicaid recipients and providers that adhere to Indiana preferred prescribing patterns.

SmartPA

- Intelligent prior authorization and prospective Drug Utilization Review tool
- Integrated into pharmacy claims systems
- Driven by a flexible, table-driven clinical rules engine that utilizes pharmacy and medical claim information
- Fully implemented in 12 Medicaid states
- 712 different SmartPA clinical rules
- Meets all applicable Federal and HIPAA requirements
- Automates 60-90% of PA requests
- Streamlined PA process results in savings of administrative and benefit dollars
- Capability to allow specialized prescribers to bypass prior authorization editing

SmartPA Clients	Number of SmartPA Rules
Missouri Medicaid	129
Texas Medicaid	43
Arkansas Medicaid	73
Maryland Medicaid	16
Hawaii Medicaid	4
Ohio Bureau of Worker's Comp	10
Ohio Medicaid	120
Massachusetts Medicaid	160
Idaho Medicaid	96
Rhode Island Medicaid	23
Montana Medicaid	23
North Carolina Medicaid	16
Alaska Medicaid (In-Development)	

Documented SmartPA Savings (annualized):

- Texas Medicaid - $56M
- Missouri Medicaid - $42M

How will the MCOs and HIP stay involved with pharmacy benefit administration?

The MCOs and HIP plans will receive pharmacy claim files from the state's fiscal agent on a weekly or daily basis. The MCOs and HIP plans will also have real-time access to pharmacy claims through a web portal. Timely access to this information will allow the MCOs and HIP plans to perform care management activities. The MCOs and HIP plans will work closely with Office pharmacy staff in the evaluation and presentation of recommendations to the DUR Board, the Therapeutics Committee and the Mental Health Quality Advisory Committee. The Office is also developing MCO and HIP performance incentives that are tied directly to targeted pharmacy quality metrics.

Will MCO and HIP members still be able to utilize their existing pharmacy providers?

Yes, MCO and HIP members will still be able to utilize their current pharmacy providers.

Number of Pharmacy Providers Utilized during 1Q08

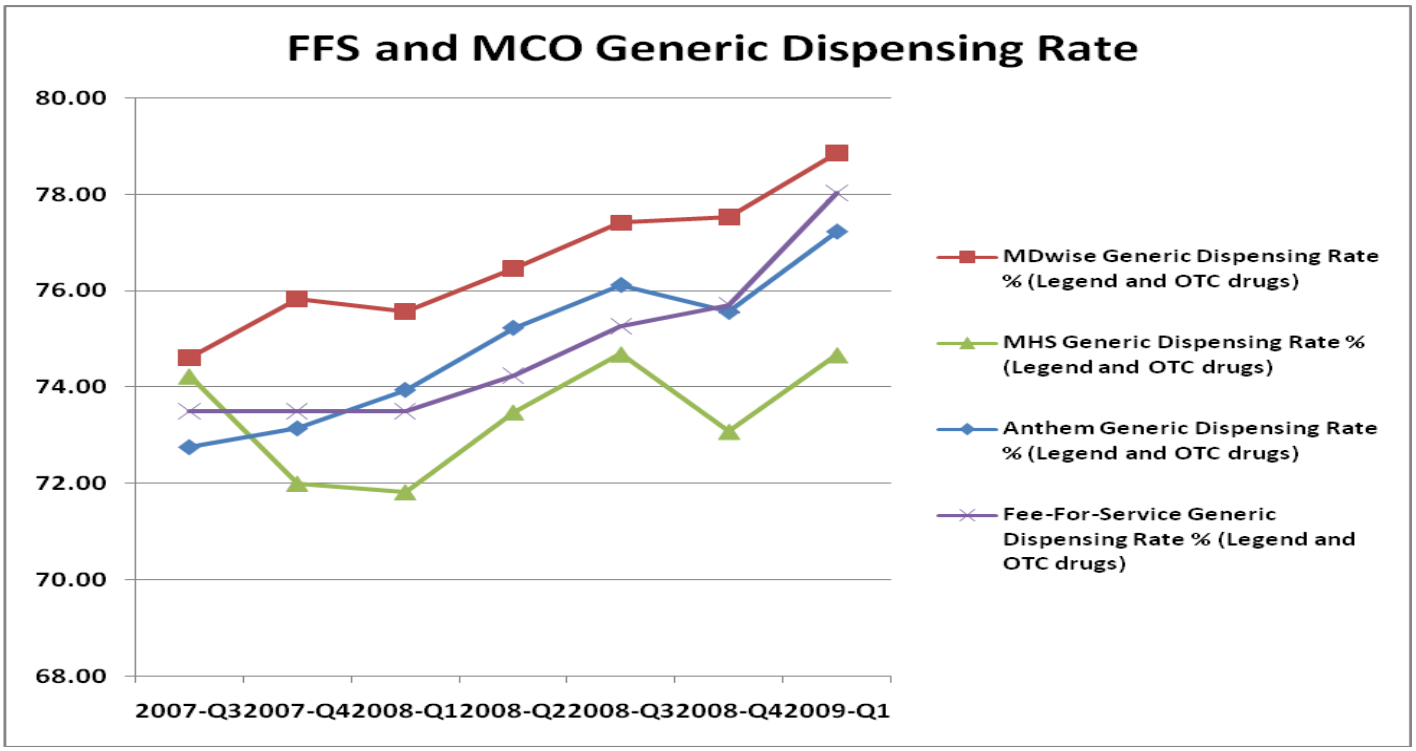
Delivery System	Pharmacy Providers
FFS	1261
MCO	1079

Notes:
A total of 1,079 providers in common out of a total of 1,288 providers

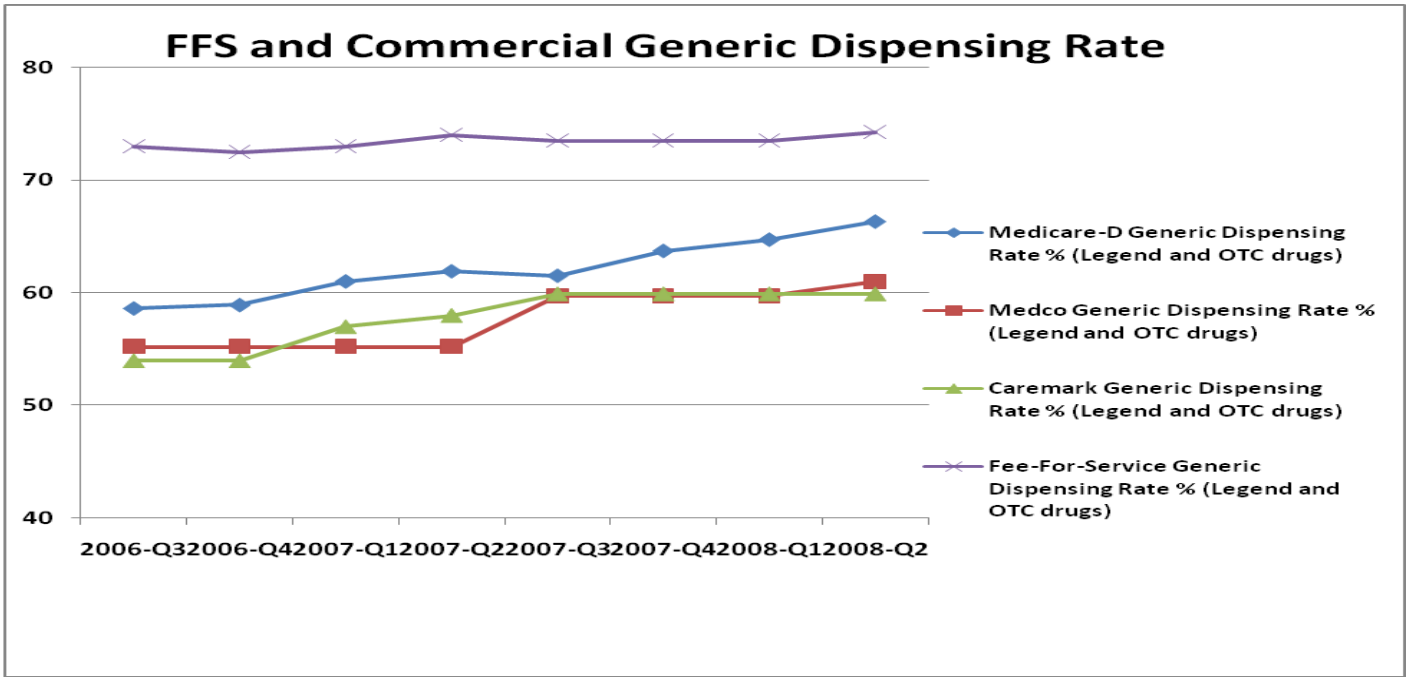
Who is the FSSA legislative contact for questions related to the Pharmacy Benefit Consolidation?

Jessaca Turner Stults, *General Counsel and Legislative Director*, Family and Social Services Administration, *Jessaca.TurnerStults@fssa.in.gov, 317-234-3884*

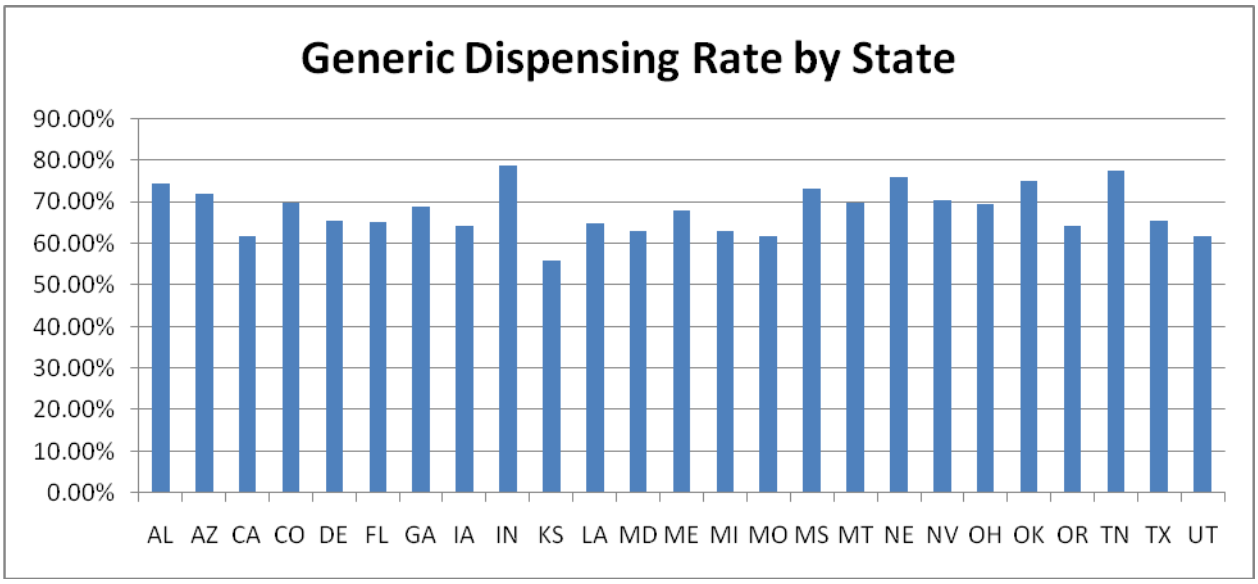
Appendix



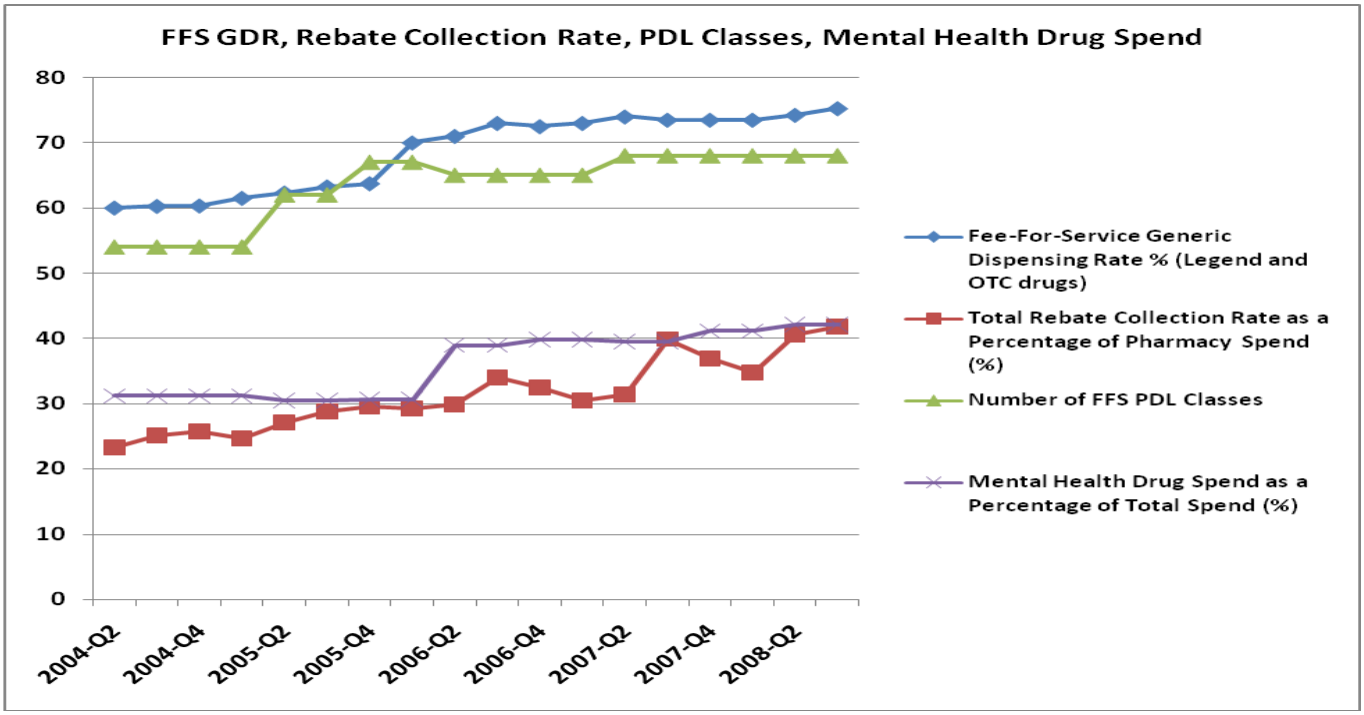
Notes:
Generic Dispensing Rate (GDR) includes all drugs (OTC and Rx). The GDR is calculated as percentage of total claims paid where the drug product was a generic drug.
Based on current IN FFS spend, each 1% increase in GDR results in $650,000 savings (S&F).
Data according to state fiscal year and quarter. State fiscal year ends June 30th of each year.
Data Source: OMPP Pharmacy Master Database



Notes:
Generic Dispensing Rate (GDR) includes all drugs (OTC and Rx). The GDR is calculated as percentage of total claims paid where the drug product was a generic drug.
Based on current IN FFS spend, each 1% increase in GDR results in $650,000 savings (S&F).
Data according to state fiscal year and quarter. State fiscal year ends June 30th of each year.
Data Source: OMPP Pharmacy Master Database



Notes:
Medicaid rate of prescribing generics for CY08.
Indiana is ranked number one among these states with a GDR of 79%.
Data Source: Compiled by staff in the Colorado Medicaid office



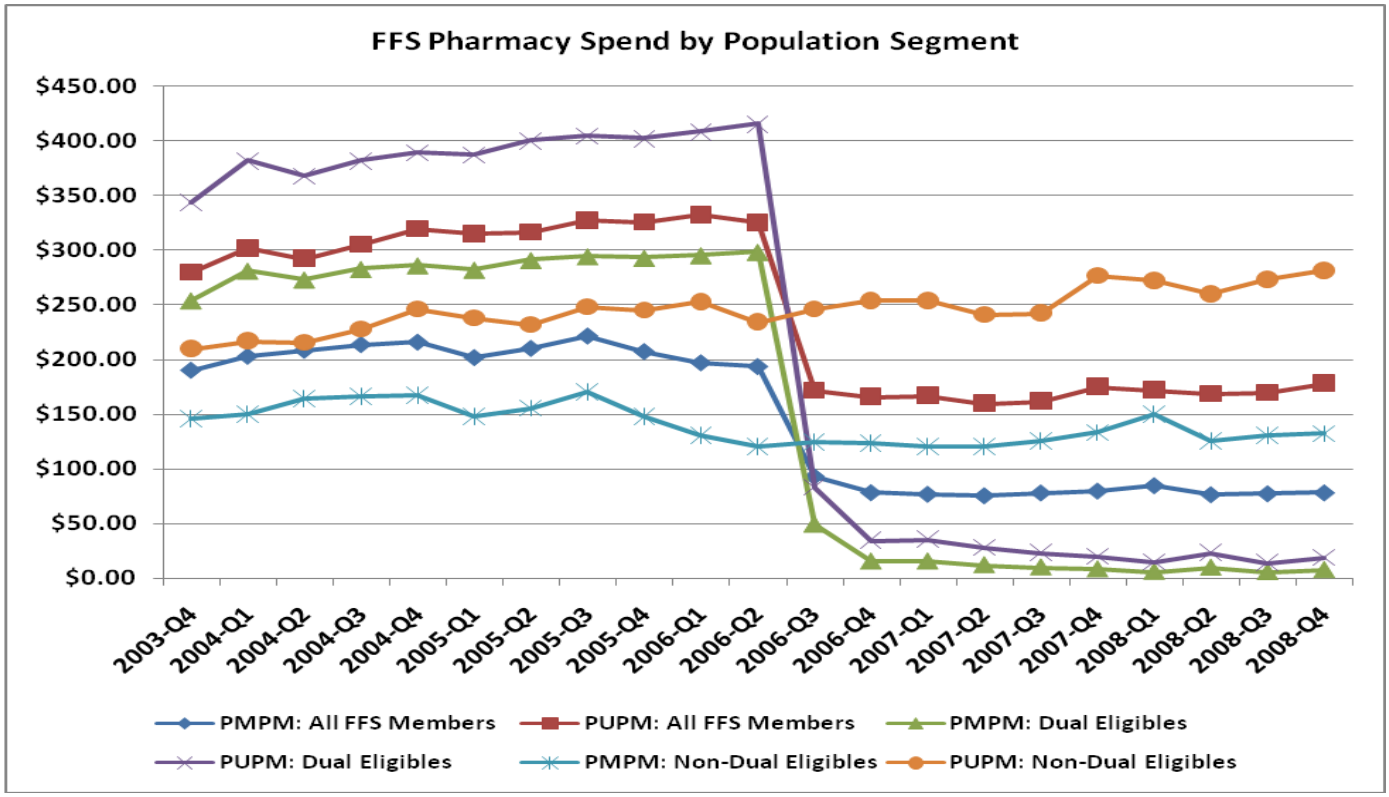
Notes:
Data Source: OMPP Pharmacy Master Database

The MCO reported expenditures for mental health drugs as a percentage of total spend are: Anthem, 42.6%, MHS, 50%, and MDwise, 46.2%. All behavioral health pharmaceuticals, per state statute, are "preferred" in both the FFS and MCO pharmaceutical benefit packages. In other words, the behavior health pharmaceutical benefits are currently identical between FFS and MCO pharmaceutical programs.

- Under the FFS pharmacy program, in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the Office collects federal Medicaid rebates and state supplemental rebates which are not available through the MCOs or HIP plans. These rebates apply to both brand and generic pharmaceuticals. Rebates available through the FFS program are 10 times greater than what the MCOs are able to negotiate with pharmaceutical manufacturers. The FFS program currently collects approximately 35% of every dollar spent on pharmaceuticals in the form of a rebate from the 550

manufacturers who participate in the program. The rebates are then shared with the federal government at the current federal medical assistance percentage (FMAP). MCOs currently collect commercial rebates amounting to 2-3% of every dollar spent. ***Note:*** *Data for HIP is not available and therefore could not be included in the estimates above.*

Due to the federal methodology used in calculating rebates, a manufacturer can control its rebate liability by virtue of their own pricing policy. It should be noted that manufacturer rebate liability is tied directly to the **discounts they provide** in the pharmaceutical marketplace and the rate at which **their price increases** exceed the Consumer Price Index (CPI). Pharmaceutical rebates available through OBRA 90 insulate the pharmacy program from **continual** price increases for **brand name** drugs which on average equal **8-9%** per year. There are two components to Medicaid rebates on branded drugs: the basic rebate and, in some cases, an inflation adjustment. For brands the basic rebate is the lower of a) a flat rate (currently 15.1%) of the Average Manufacturer Price (AMP) or b) the difference between AMP and the best, or lowest, price offered to any private buyer. For example, if a manufacturer offers an HMO a price that is more than 15.1% below its AMP, that price would be a "best price" and drugs provided through all 49 Medicaid programs would get that same discount. Even if the manufacturer sells to only one customer at a very low price, that price triggers a large discount for drugs provided through all state Medicaid programs. The basic rebate on brand name drugs is augmented by a CPI component, which limits price increases to the rate of inflation. If the drug's price has increased more than the rate of inflation, then the incremental price increase must be included in the rebate in addition to the basic amount.



Notes:
Enrollment not complete in most recent quarter(s) due to retro-eligibility (thus overstating PMPM). Does not include rebates.
Data according to state fiscal year and quarter. State fiscal year ends June 30th of each year.
Data Source: MedInsight

The FFS pharmacy program budgetary variance. Rebates not included.

Date	Variance
SFY2006	$37,412,008
SFY2007	$51,726,356
SFY2008	$18,605,559
SFY2009 YTD (Through September)	$8,305,225

Percent of Members that switch MCOs Quarterly

By Quarter in SFY08	Q1	Q2	Q3	Q4
Members with more than one MCO	9,784	8,521	12,470	11,787
Members Enrolled	611,696	619,496	622,059	629,207
Percent of members in 1+ MCO	1.5995%	1.3755%	2.0046%	1.8733%

	SFY 2008
Members with more than one MCO	64,812
Members Enrolled	781,274
Percent of members in 1+ MCO	8.2957%

Asthma Emergency Room (AER) Rates by Delivery System

Evidence Based Measure	Delivery System	Population Count Total	Numerator Total	Rate (%)
Asthma ER Rate	MHS	42,087	7,191	17.09
Asthma ER Rate	Anthem	20,400	3,448	16.9
Asthma ER Rate	MDwise	74,585	12,895	17.29
Asthma ER Rate	FFS	62,805	9,731	15.49

Notes:

Definition of the Numerator - Patients with asthma having one or more ER visits with a diagnosis of asthma in the first or second position. Admissions occurred in the year ending on the measure month.

Definition of the Denominator - Patients aged 5 through 56

Literature Review of Selected Carve-Out Studies

Title	Source	Date	Conclusion	Comments
Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System	CHCS, Center for Health Care Strategies, Inc.	November 2003	The pharmacy carve-out option is not anticipated to create additional savings for Arizona. However, since the cost-effectiveness estimates were fairly close to neutral, and because circumstances could evolve such that sizeable supplemental rebates are achievable and sustainable, we further recommend that Arizona re-assess the carve-out option after the current flurry of state and industry activity surrounding the Medicaid pharmacy benefit has played out and clarified the landscape.	Rebates were estimated at 15% during this analysis. The FFS program currently collects 35% of every dollar spent on pharmaceuticals in the form of a rebate from the 550 manufacturers who participate in the program.
Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs	The Lewin Group an Ingenix Company	July 2007	When the state rebates average less than 30% of claims costs, the carve-in approach will yield the lowest net costs. Conversely, when the state rebates average more than 30% of initial claim costs, the carve-out model is likely to minimize net outlays.	The FFS program currently collects 35% of every dollar spent on pharmaceuticals in the form of a rebate from the 550 manufacturers who participate in the program.
Programmatic Assessment of Carve-In and Carve-Out Arrangements in Medicaid Managed Care	ACAP Association for Community Affiliated Plans	October 2007	Extending Medicaid drug rebates to managed care plans would reduce states' incentives to carve drugs out.	The Medicaid Drug Rebate Equalization Act (S. B. 1589 and H. R. 3041) extends rebates to Medicaid managed care organizations. This bill was introduced July 12, 2007 and never became law. Re-introduced on February 4, 2009, H. R. 904 is in the first step in the legislative process. It was referred to the House Committee on Energy and Commerce. Extending Medicaid drug rebates to managed care plans is included in President Obama's 2010 United States budget.