



Center for Medicaid and State Operations

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FROM: Gale P. Arden, Director *Dale P Arden*
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SUBJECT: Third Party Liability (TPL) – Reimbursing Medicaid Beneficiaries for Out-of-Pocket-Costs for Mail Order Drugs— ACTION

TO: All Associate Regional Administrators
Division of Medicaid and State Operations

This letter provides options for States to use in reimbursing Medicaid beneficiaries for co-payments that are required in order to receive prescription drugs through a pharmacy mail order benefit. Please share this information with your State agencies.

Some Medicaid beneficiaries have private health plans that require those insured to acquire their maintenance drugs through a mail order benefit. In order to get this benefit, the insured generally has to pay a co-payment when placing the mail order. We understand that pharmacy benefit managers (PBM) have not been willing to bill Medicaid for the co-payment. Since Medicaid beneficiaries are not required to utilize a third party resource if it means they would have to pay out-of-pocket costs, with the exception of nominal cost-sharing amounts that States may impose in accordance with § 1916 of the Social Security Act (the Act), they generally choose to get their maintenance drugs at a retail pharmacy, often leaving Medicaid to cover the full costs.

While §§ 1905(a) and 1902(a) (32) of the Act (commonly referred to as the “vendor payment rules”) generally prohibit reimbursement to the beneficiary, we have identified some circumstances under which Medicaid could directly reimburse the beneficiary for mail order co-payments. Specifically, the Medicaid statute would permit direct payment to beneficiaries of co-payment amounts under the following circumstances, which are discussed in more detail below:

- in the context of cost effective group health plans under § 1906;
- if the co-payments are treated as an administrative cost under § 1903(a)(7), rather than as “medical assistance;” or
- if the State makes available to the beneficiary a voucher made out to the PBM to be used for the co-payment amounts. (Under this mechanism, no direct payment to the beneficiary would be involved.)

plans and is a State option. Thus, its authority would only permit direct payment if the State has exercised this option and has determined that enrollment of a beneficiary in the plan would be cost effective.

Administrative Expense

States may consider payments to beneficiaries for cost sharing associated with a mail order pharmacy benefit to be an administrative expense. They can be viewed as expenditures necessary for the proper and efficient administration of the State plan and would be matchable at the 50 percent rate based on the underlying premise that it would save money for the Medicaid program. Since expenditures under § 1903(a) (7) are not “medical assistance,” they need not meet the vendor payment rule. Accordingly, States could directly reimburse individuals for these co-payments and claim these expenditures as administrative expenses.

PBM Voucher

Another solution would be for the State to make available to the beneficiary a voucher, made out to the PBM, which could be used for the co-payment amounts. Under this mechanism, no direct payment to the beneficiary would be involved. Therefore, it would not violate the vendor payment rule. While we recognize this approach would be administratively cumbersome, it would not conflict with the statute ~~Medical beneficiaries to pay cost sharing on the front end, given that beneficiaries cannot be required to pay out-of-pocket costs other than nominal Medicaid cost sharing established under § 1916 of the Act.~~ As an incentive to beneficiaries, States may amend their State plans to impose nominal cost sharing for drugs purchased from a retail pharmacy and not impose nominal cost sharing for drugs purchased through mail order.

This guidance would also be applicable in other situations where Medicaid beneficiaries would be expected to pay costs related to third party coverage in order to avail themselves of medical services. For example, this can occur in situations where a third party requires the insured to pay the provider out of pocket and then submit a claim to the third party for payment.