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Pharmacy reimbursement

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Many states are looking at steps needed to implement the new outpatient pharmacy rule. These include changes to outpatient pharmacy reimbursement, the drug rebate program, price calculations and drug coverage. States have come to Mercer Government with questions and challenges, such as:

"What data do we need to present to the CMS to support our reimbursement methodologies?"

"How do we design a COD survey that meets the professional dispensing fee requirements?"

"What options exist for developing AAC pricing?"

"Do we have to use the NADAC, or may we develop our own AAC rates? How do we set specialty reimbursement?"

"We have not included FULs in our reimbursement methodology for years. What do we need to do to effectively ensure that we meet the new FUL requirements?"

"What options exist for a compliant 340B specific reimbursement model?"

"What MMIS changes will be needed for compliance? Do any of those changes need an APD or qualify for enhanced funding?"

Moving to new reimbursement methodologies

The new rule requires state Medicaid FFS programs to adopt AAC pricing and professional dispensing fees that provide total reimbursement to pharmacies sufficient to ensure adequate access for beneficiaries. States will need to evaluate current FFS pharmacy reimbursement methodologies for outpatient drugs and implement changes based on an AAC-based reimbursement model, which includes the following:

- **States need to determine** whether ingredient cost reimbursement will be based on a state-specific AAC, NADAC, AMP, or other published compendia. States that implement NADAC will need to develop an AAC-based reimbursement methodology for any product without a published NADAC
- **States must determine** the basis of their FFS professional dispensing fee. States may consider options including a flat rate, tiered rates by provider or claims volume, and the potential accommodation for payment of specialized services
- **States must include** 340B reimbursement policies in their SPAs

Change to drug rebate requirements

The rule finalizes several changes to the drug rebate program that were implemented in 2010, such as increased rebate percentages and related savings offsets, along with collection of rebates from Medicaid managed care organizations (MCOs).

Changes made in the final rule will most likely have significant impacts to Medicaid Management Information Systems (MMIS) and drug rebate processing systems. These include:

- A separate calculation for unit rebate amounts for drugs that are line extensions; however, Centers for Medicare & Medicaid Services (CMS) did not finalize the regulatory definition of a line extension drug
- Inclusion of territories into the definition of states to allow participation in the CMS rebate program a year after implementation
- Final calculation requirements for alternative rebates for line extension drugs

States must ensure that:

- Drug claims requiring coverage by Medicare Part D plans are excluded from the drug rebate invoicing process
- Drug claims (for example, epoetin) that are part of bundled end-stage renal disease payments are excluded from invoicing
- Processes are in place to separately identify MCO and fee-for-service (FFS) claims in the drug rebate invoicing process
- MMIS claims processing systems have the ability to invoice MCO utilization based on date of service rather than the MCO date of payment. Mercer recommends that states make this evaluation as soon as possible to allow time to make the necessary system changes to accommodate the date of service requirement

Coverage and program requirements

Finally, the rule further clarified the following aspects of coverage of outpatient drugs and requirements for both FFS and MCO programs in addition to the statutory language:

- Modifies requirements for retail community pharmacy
- Outlines reporting requirements for states and manufacturers
- Allows states to have optional coverage of investigational drugs and other drugs not subject to rebates
- Includes a definition of over-the-counter drugs to clarify existing pharmacy benefit exclusions and early and periodic screening, diagnosis, and treatment (EPSDT) benefit inclusions

Price calculation, reimbursement, and drug coverage impacts

The final Medicaid Covered Outpatient rule made changes to certain price calculations and drug coverage rules, including:

- If the federal upper limit (FUL) is in the state's current payment logic, states must ensure that their pharmacy claims processing systems are capable of receiving the new monthly FUL pricing updates beginning May 1, 2016, in accordance with their current State Plan Amendment (SPA). This includes the capability to update the FULs on a monthly basis
- States must ensure that their pharmacy programs meet the FUL aggregate requirements established by CMS for drugs with and without an FUL
- States should evaluate coverage policies for investigational drugs and update their state plans with coverage determinations
- States should be aware of several key definition changes — including retail community pharmacy, covered outpatient drugs, and over-the-counter drugs — which affect rebates, reimbursement, and coverage
- A CMS process to create an exception to raise FULs in situations where they fall below the National Average Drug Acquisition Cost (NADAC)

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Whether you need help with a single issue, such as technical assistance in developing a cost of dispensing (COD) survey, writing the compliance SPA, or developing your ingredient cost reimbursement strategy, Mercer is your best choice for help with:

- Evaluation of the new rule impact, including creating strategies, timelines, and work plans for implementation of the rule
- Development of progressive policies addressing both cost containment and access
- Engagement of stakeholders
- Development of and conducting provider training/ orientation to new surveys or reimbursement methodologies
- Reimbursement methodology revisions
- Evaluation, modeling, and implementation of COD surveys and average acquisition cost (AAC) reimbursement methodologies
- Evaluation and implementation of 340B reimbursement alternatives
- Assistance with the development and submittal of required SPAs
- Assessment and management of the MCO impact, including developing actuarially sound rates and MCO contract oversight
- Evaluation of MMIS impact analysis and system enhancement needs
- Evaluation and ongoing program monitoring, including conducting FUL aggregate testing, quarterly monitoring, and managing continuous improvement; provider accountability; and program performance, such as audits and vendor oversight

Since 1985, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

We deliver an individualized focus, powered by industry-leading experience, integrated capabilities, and passionate people. We help clients achieve better outcomes, develop and deploy defensible strategies, and reshape the delivery of health care.

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