



# ForwardHealth

# Pharmacy Reimbursement

Rachel Currans-Henry

Director, Bureau of Benefits Management

&

Mercer Government Human Services Consulting

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# Agenda

- Introductions
- Wisconsin Background
- Overview of Covered Outpatient Drugs Final Rule
- Wisconsin Implementation Plan and Timeline
- Professional Dispensing Fee Survey Discussion
- Overall Stakeholder Perspective
- Next Steps



# Introductions





# Department of Health Services

## Team Members

- Kevin Moore, Wisconsin Medicaid Director
  - [Kevin.Moore@dhs.wisconsin.gov](mailto:Kevin.Moore@dhs.wisconsin.gov)
- Rachel Currans-Henry, Director of Bureau of Benefits Management
  - [Rachel.CurransHenry@dhs.wisconsin.gov](mailto:Rachel.CurransHenry@dhs.wisconsin.gov)
- Kimberly Smithers, Pharmacy Section Chief
  - [Kimberly.Smithers@dhs.wisconsin.gov](mailto:Kimberly.Smithers@dhs.wisconsin.gov)
- Kelsey Gmeinder, Pharmacy Policy Analyst
  - [Kelsey.Gmeinder@dhs.wisconsin.gov](mailto:Kelsey.Gmeinder@dhs.wisconsin.gov)



# Mercer Role

Policy and  
Implementation  
Consulting

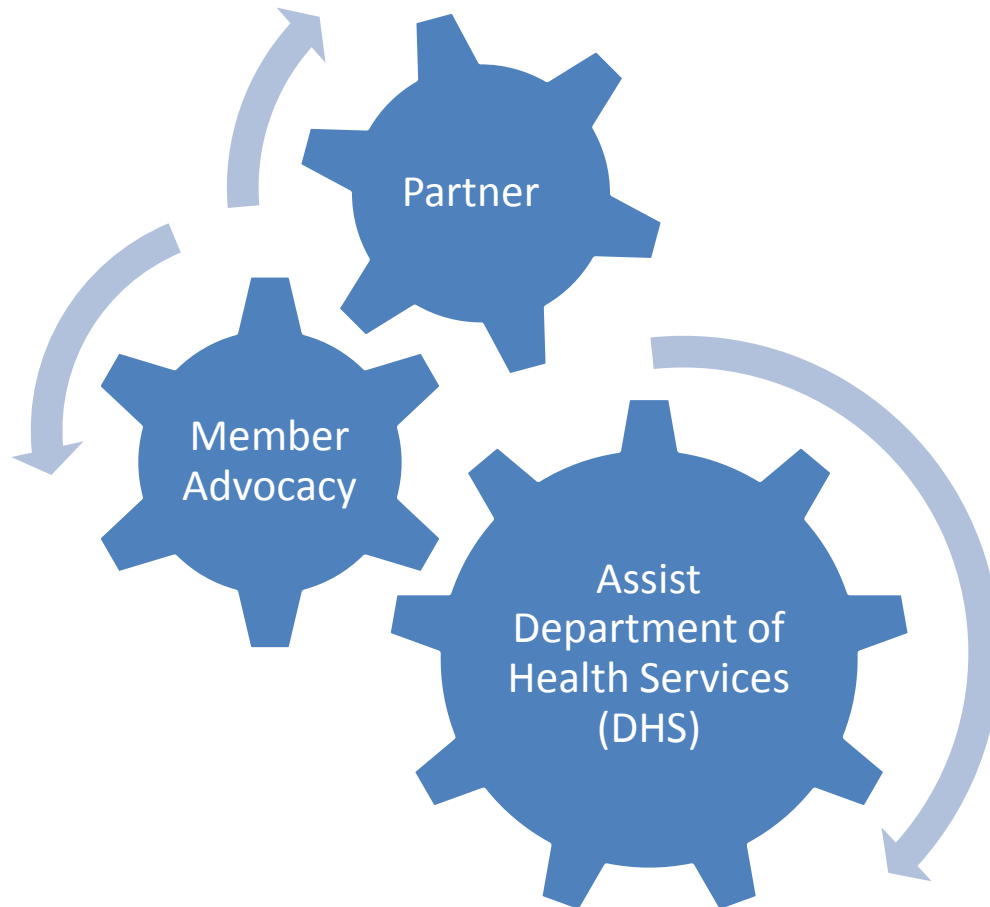
Conduct  
Dispensing Fee  
Survey

Financial  
Modeling

State Plan  
Amendment  
Preparation



# Stakeholder Role





# Wisconsin Background

- Drug and Diabetic Supply reimbursement methodology has been in place since 2011.
  - Moved from Average Wholesale Price to Wholesale Acquisition Cost (WAC) as a result of federal lawsuits.
  - Dispensing fee methodology was not updated. The last dispensing fee study was conducted in 1999.
  - Centers of Medicare and Medicaid Services (CMS) requirement to pay Estimated Acquisition Cost plus a reasonable dispensing fee.
- The same pricing methodology is used for all ForwardHealth programs: BadgerCare Plus, Medicaid, SeniorCare, Wisconsin Chronic Disease Program (WCDP), and AIDS Drug Assistance Program (ADAP).
- Approximately \$1 billion of \$8 billion Medicaid budget is spent on pharmacy expenditures.



# 2015 Reimbursement Statistics

- 16.5 percent of pharmacy claims paid in calendar year (CY) 2015 were for brand drugs.
  - These claims accounted for approximately 75 percent of total drug spend.
- 80.8 percent of pharmacy claims paid in CY 2015 were for generic drugs.
  - These claims accounted for approximately 21 percent of total drug spend.
- Less than 1 percent of paid claims in CY 2015 were for specialty drugs.
- Less than 1 percent of paid claims in CY 2015 were for compound drugs.





# Current Reimbursement

- Brand drugs WAC +2%
- Generic drugs Lesser of WAC – 3.8%,  
State Maximum Allowed  
Cost
- Specialty drugs WAC +/- %
- Dispensing Fee (Brand) \$3.44
- Dispensing Fee (Generic) \$3.94
- Unit Dose Packaging \$0.015 per unit
- Dispensing Fee (Compound) \$9.45 to \$22.16
- Medication Therapy  
Management \$10.00 or \$30.00

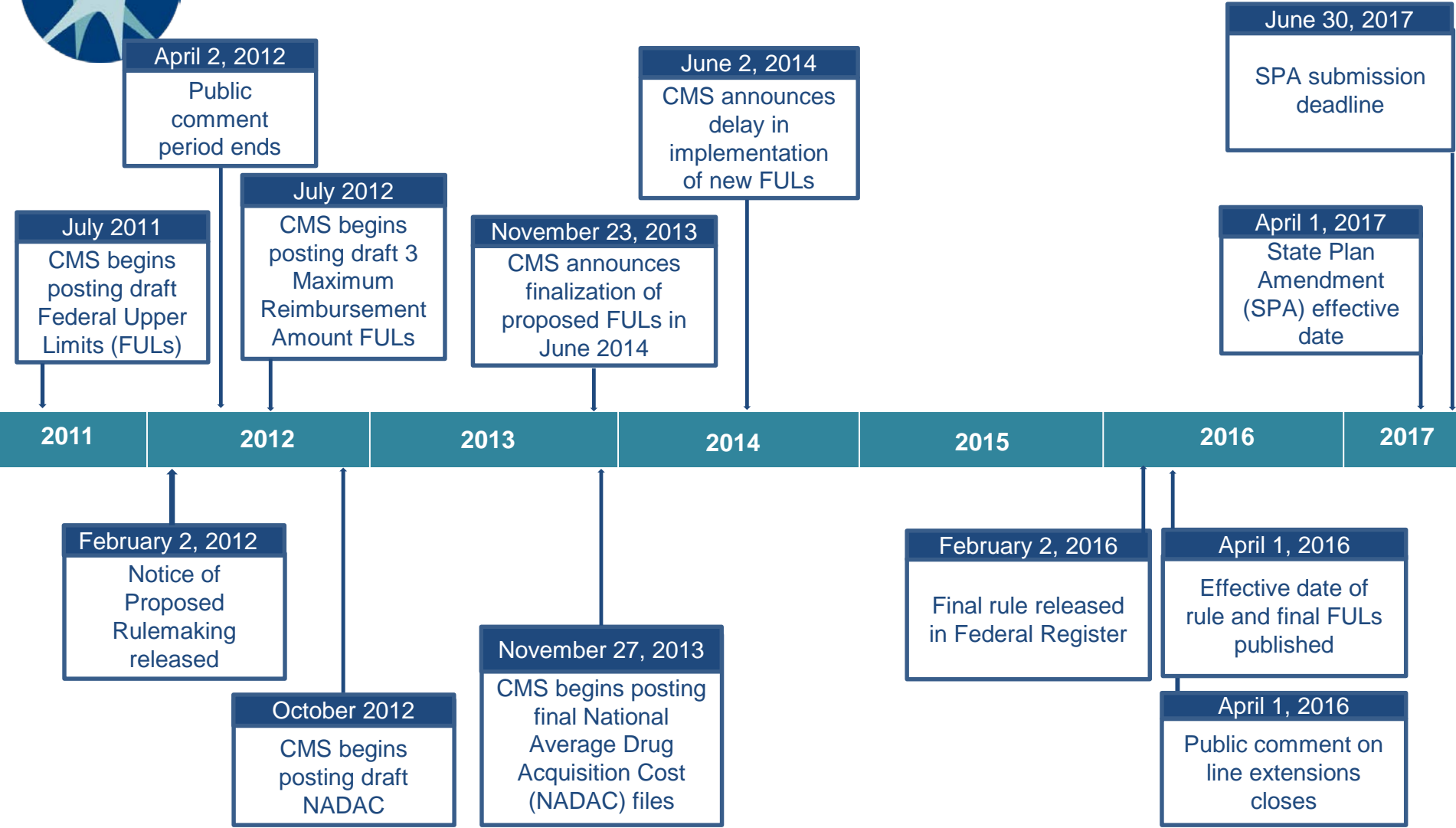


# Overview of Covered Outpatient Drugs Final Rule





# CHRONOLOGY COVERED OUTPATIENT DRUGS RULE





# FINAL RULE AREAS OF IMPACT

REIMBURSEMENT

FINAL  
RULE

FEDERAL REBATES

DRUG COVERAGE &  
PRICE CALCULATIONS



# REIMBURSEMENT CHANGES FEE-FOR-SERVICE REQUIREMENTS

Ingredient Cost



Move to Actual  
Acquisition Cost (AAC)

Dispensing Fee



Move to "Professional" Dispensing  
Fee



# REIMBURSEMENT CHANGES ACTUAL ACQUISITION COST METHODOLOGY CONSIDERATIONS

Source Data for Methodology

Regulation  
effective date  
April 1, 2016

State Discretion

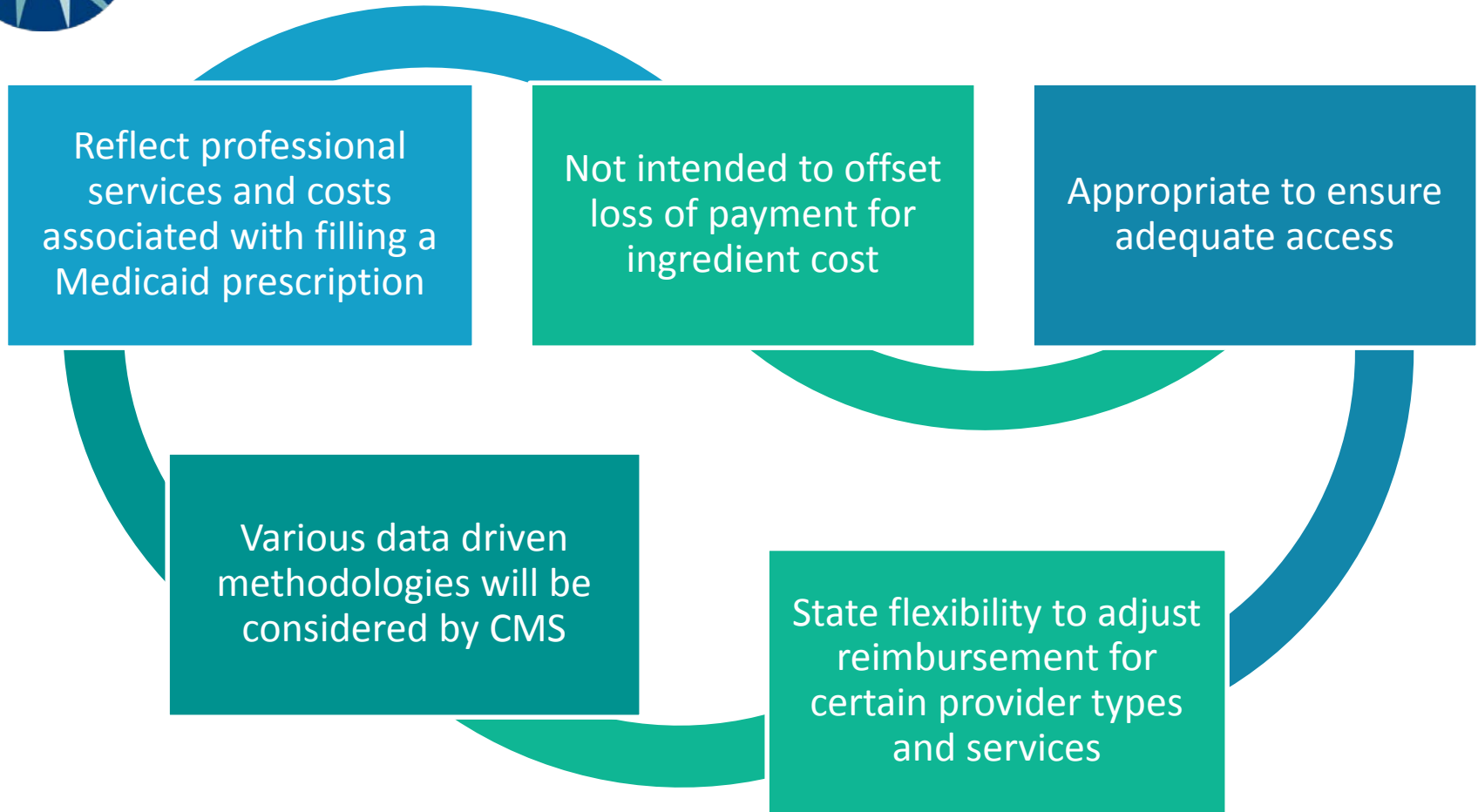
Data Driven Analysis

Latest SPA  
effective date  
April 1, 2017

Managed Care Organization  
(MCO) Implications



# REIMBURSEMENT CHANGES PROFESSIONAL DISPENSING FEES





# REIMBURSEMENT CHANGES 340B DRUG PRICING PROGRAM REIMBURSEMENT

## STATE PLAN



No duplicate discounts may be claimed

Must address total reimbursement

## AAC



State-specific 340B Drug Pricing Program AAC methodology

Encounter rates for Indian Health Service (IHS), Tribal and Urban Indian pharmacies

## PROFESSIONAL DISPENSING FEES



Evaluation of dispensing fee differential for unique circumstances





# REIMBURSEMENT CHANGES STATE PLAN AMENDMENT REQUIREMENTS

## PAYMENT METHODOLOGIES



Comprehensive description

Retail and 340B consistent with overall AAC requirements

## PAYMENT LIMITS



Multi-source drugs

Other drugs (e.g., brand medically necessary drugs and drugs other than multi-source)

## ADEQUATE DATA



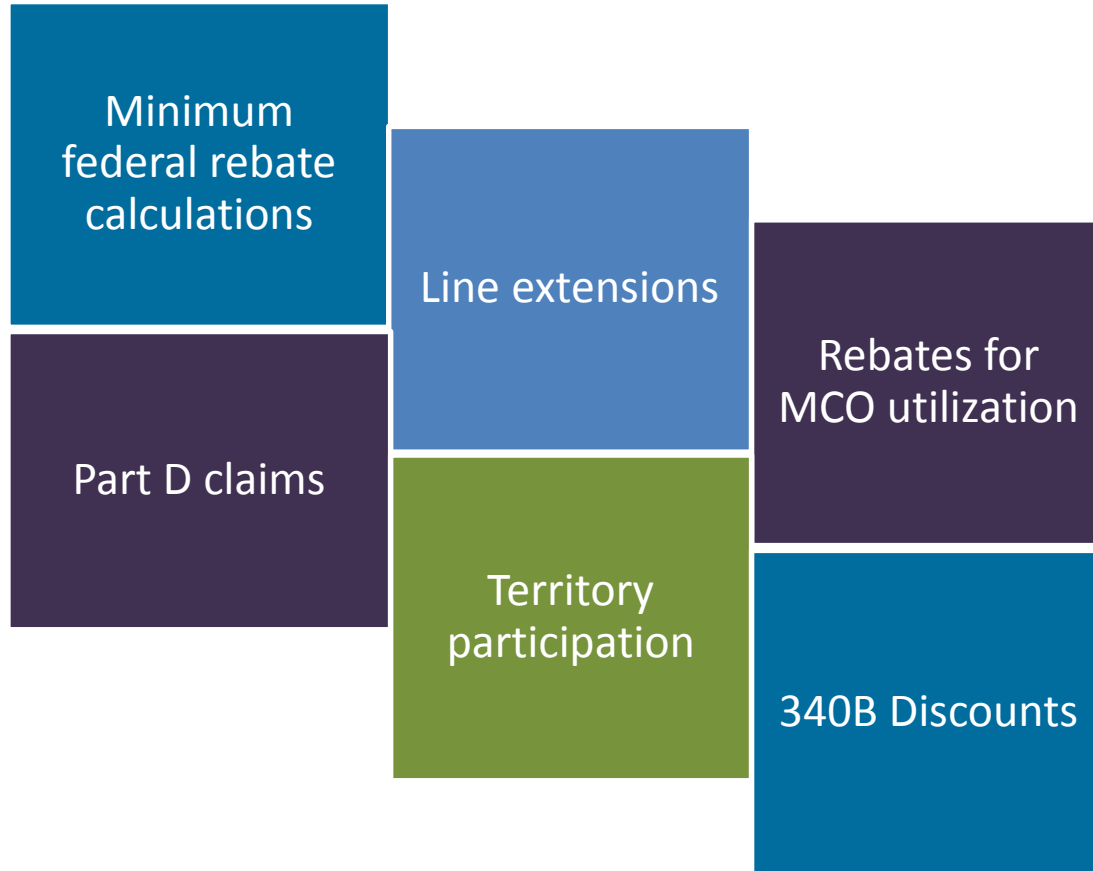
Survey or other reliable data

Data evaluation of compliance with federal requirements



# Drug Rebate Program Changes

## Overview





# Coverage and Price Calculations

## Federal Upper Limit

### Multi-Source Drugs

Published by CMS for a multiple source drug group

175 percent of the weighted AMP

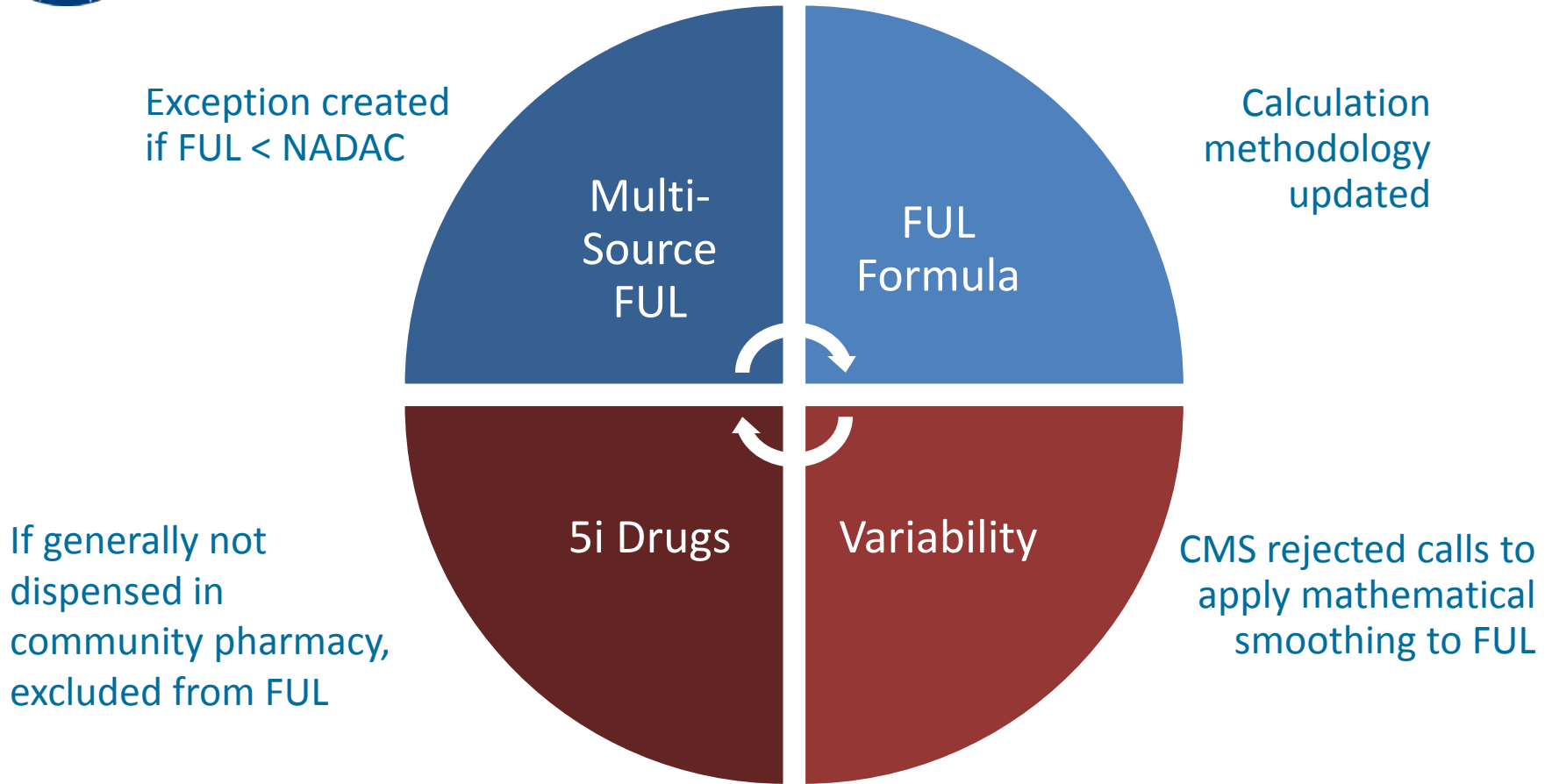
### Other Drugs

AAC plus dispensing fee or providers' usual and customary charge to the public



# Coverage and Price Calculations

## Federal Upper Limit Clarifications





# Coverage and Price Calculations

## Federal Upper Limit Implementation

**February 2016**  
Draft FULs  
calculated and  
published

**Late March 2016**  
Final FULs  
published

**April 1, 2016**  
Effective date  
of FULs

**May 1, 2016**  
30 days to  
implement FULs  
First update of  
FUL

**June 30, 2017**  
Last date to  
submit SPA  
complying with  
FUL

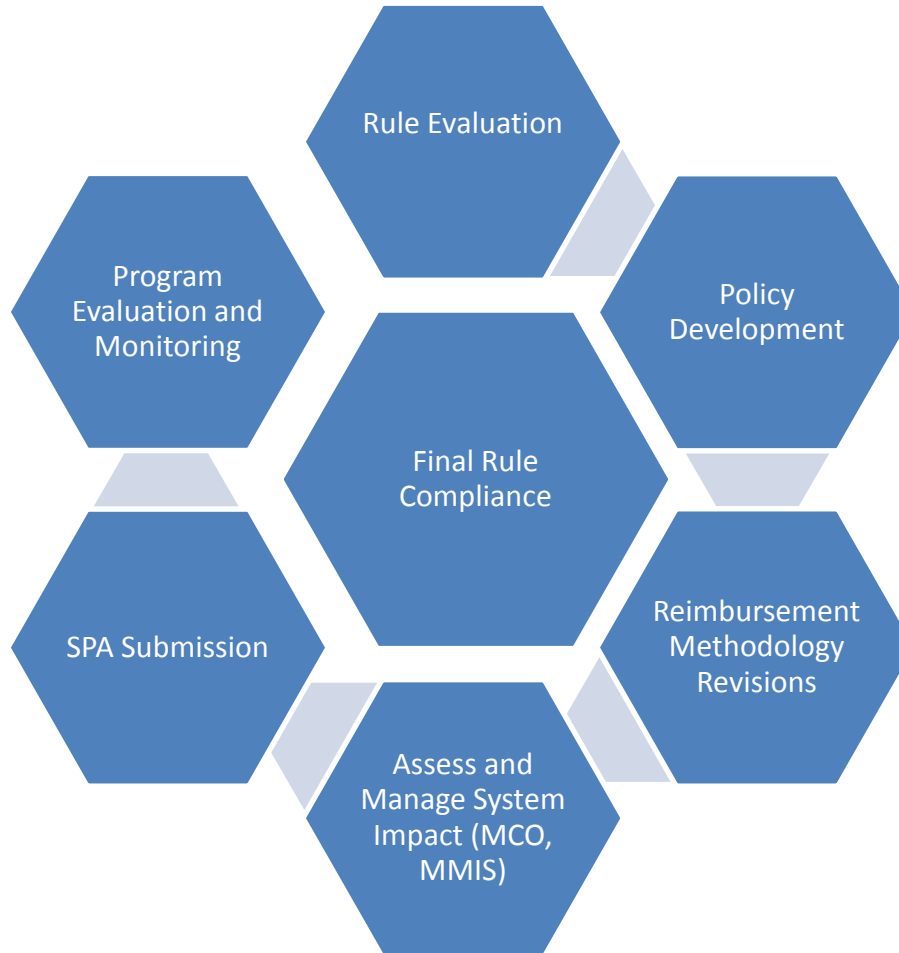
# COVERAGED AND PRICE CALCULATIONS DEFINITION CLARIFICATIONS



- Covered outpatient drug
- Retail community pharmacy
- Bona fide service fees
- Over-the-counter drugs
- State
- Professional dispensing fee
- Single source and multi-source drugs



# Rule Compliance Considerations





# Wisconsin's Implementation

- DHS will be changing the pharmacy reimbursement methodology to comply with the federal rule.
  - AAC-based ingredient cost and professional dispensing fees.
  - Methodology will impact all providers (pharmacies, 340B, etc.) and programs (WCDP, ADAP, SeniorCare) that dispense outpatient drugs.
  - DHS will work with stakeholders throughout the process.
- DHS must demonstrate a process that meets compliance with federal upper limits in its payment logic.
- DHS will be updating drug rebate to meet new reporting requirements.



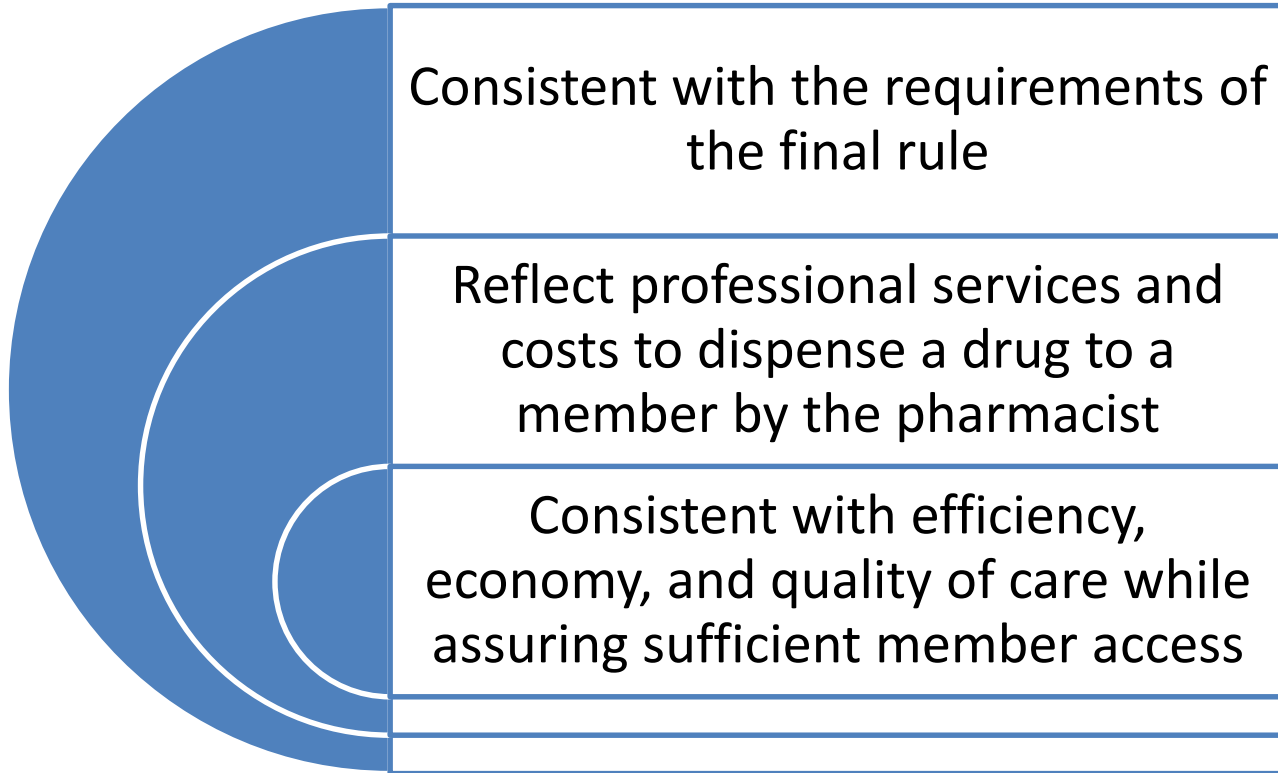


# Major Milestones and Stakeholder Involvement

- Spring and Summer 2016: Feedback on professional dispensing fee survey and completion of actual survey
- Summer 2016: Stakeholder meeting on ingredient cost analysis
- Fall 2016: Stakeholder meeting on ingredient cost and professional dispensing fee proposal
- Fall 2016: Industry review and public comment on State Plan Amendment language and *ForwardHealth Update*
- Winter 2016-17: Submit materials to CMS and negotiate agreement
- Spring 2017 (April): Implement ingredient cost and professional dispensing fee in the Medicaid Management Information System (MMIS)



# Professional Dispensing Fee





# CMS Definition of Professional Dispensing Fee

A professional dispensing fee is the professional fee that:

- Is incurred at the point of sale or service and pays for costs in excess of the ingredient of a Covered Outpatient Drug (COD) each time a COD is dispensed
- Includes only pharmacy costs associated with ensuring that possession of the appropriate COD is transferred to a Medicaid beneficiary, including:
  - The costs associated with a pharmacist's time in checking the computer for information about an individual's coverage
  - Performing drug utilization review and preferred drug list activities
  - Measurement or mixing of the covered outpatient drug
  - Filling the container
  - Beneficiary counseling
  - Providing the completed prescription to the Medicaid beneficiary
  - Delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy



# CMS Definition of Professional Dispensing Fee

- The professional dispensing fee does not include administrative costs incurred by the State in the operation of the COD benefit including systems costs for interfacing with pharmacies.
- The Preamble clarifies that CMS does not identify profit in the definition of professional dispensing fee.
- States retain the flexibility to create a differential professional dispensing fee reimbursement per provider delivery type.



# Professional Dispensing Fee Survey

## Timing

- Pre-survey: April
- PDF Survey: May–June

## Questions

- Pre-survey: Identify provider type
- PDF Survey: Identify direct and indirect dispensing costs following CMS cost principles.

## PDF Formula

- Total direct pharmacy costs + allowable indirect costs / number of scripts

## Data Needed

- Recent financial data, including revenue and expenses, and data used to allocate indirect costs, such as square footage

## Unallowed costs

- Sample of costs excluded: profit, lobbying costs, charitable contributions, bad debt, income taxes, advertising, and marketing



# Thank You and Next Steps

- Contact [CODSurvey@mercer.com](mailto:CODSurvey@mercer.com) for dispensing fee survey comments, feedback, and questions.
- Contact [DHSOutpatientDrugRule@dhs.wisconsin.gov](mailto:DHSOutpatientDrugRule@dhs.wisconsin.gov) for general project questions and comments.