MEDICAID PHARMACY REIMBURSEMENT STAKEHOLDER MEETING

OHIO DEPARTMENT OF MEDICAID

December 6, 2016

Presenters
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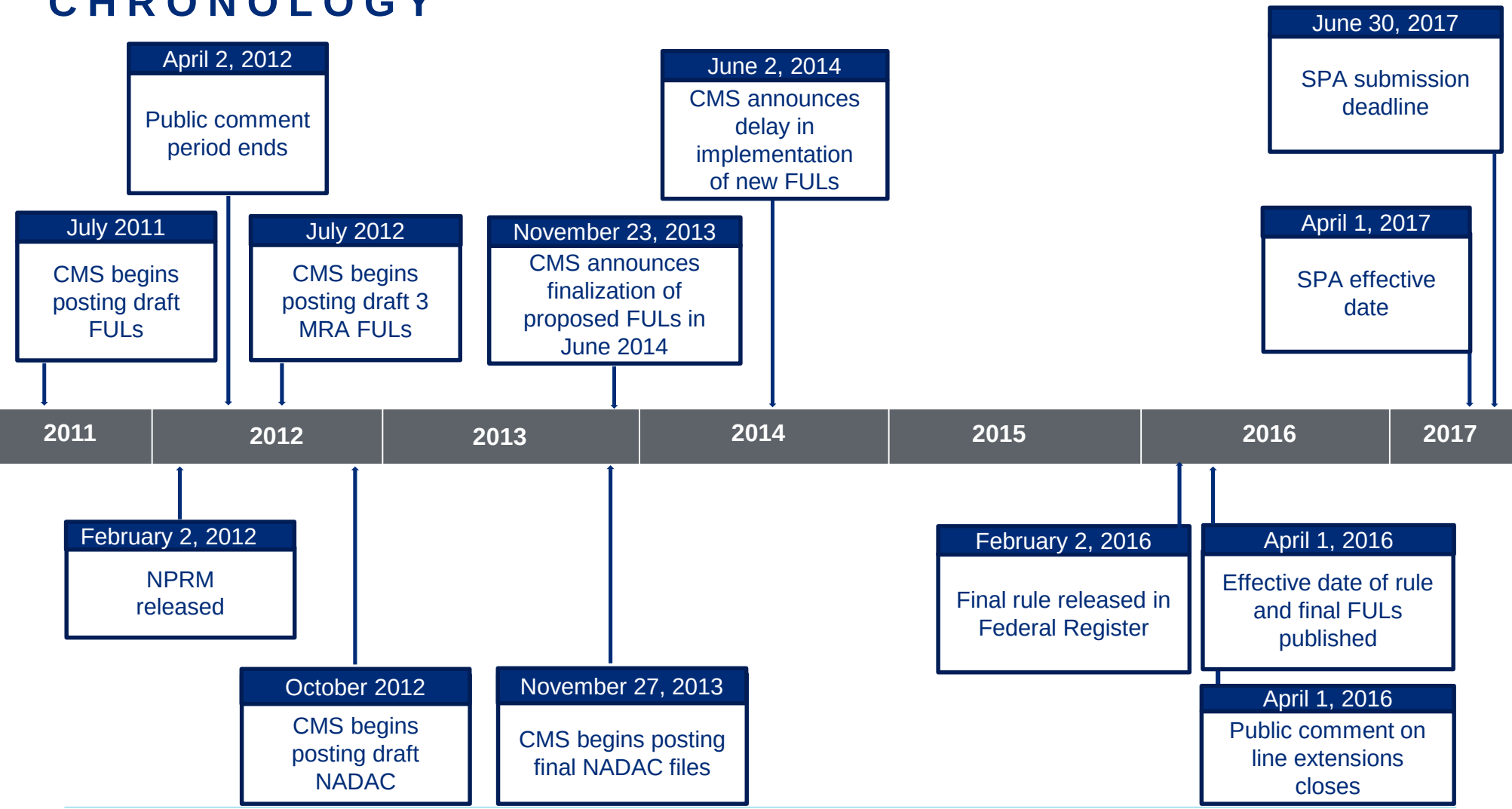
OVERVIEW OF COVERED DRUGS FINAL RULE

OVERVIEW OF COVERED OUTPATIENT DRUGS FINAL RULE CHRONOLOGY



OVERVIEW OF COVERED OUTPATIENT DRUGS FINAL RULE
FFS REIMBURSEMENT REQUIREMENTS

Federal Covered Outpatient Drugs final rule – February 1, 2016

Effective April 1, 2017, ODM will be changing its covered outpatient drug reimbursement methodology to comply with the federal rule

- Ingredient cost reimbursement will move from estimated acquisition cost (EAC) to actual acquisition cost (AAC)
- Professional dispensing fees will be implemented

ODM must demonstrate a process that meets compliance with final rule

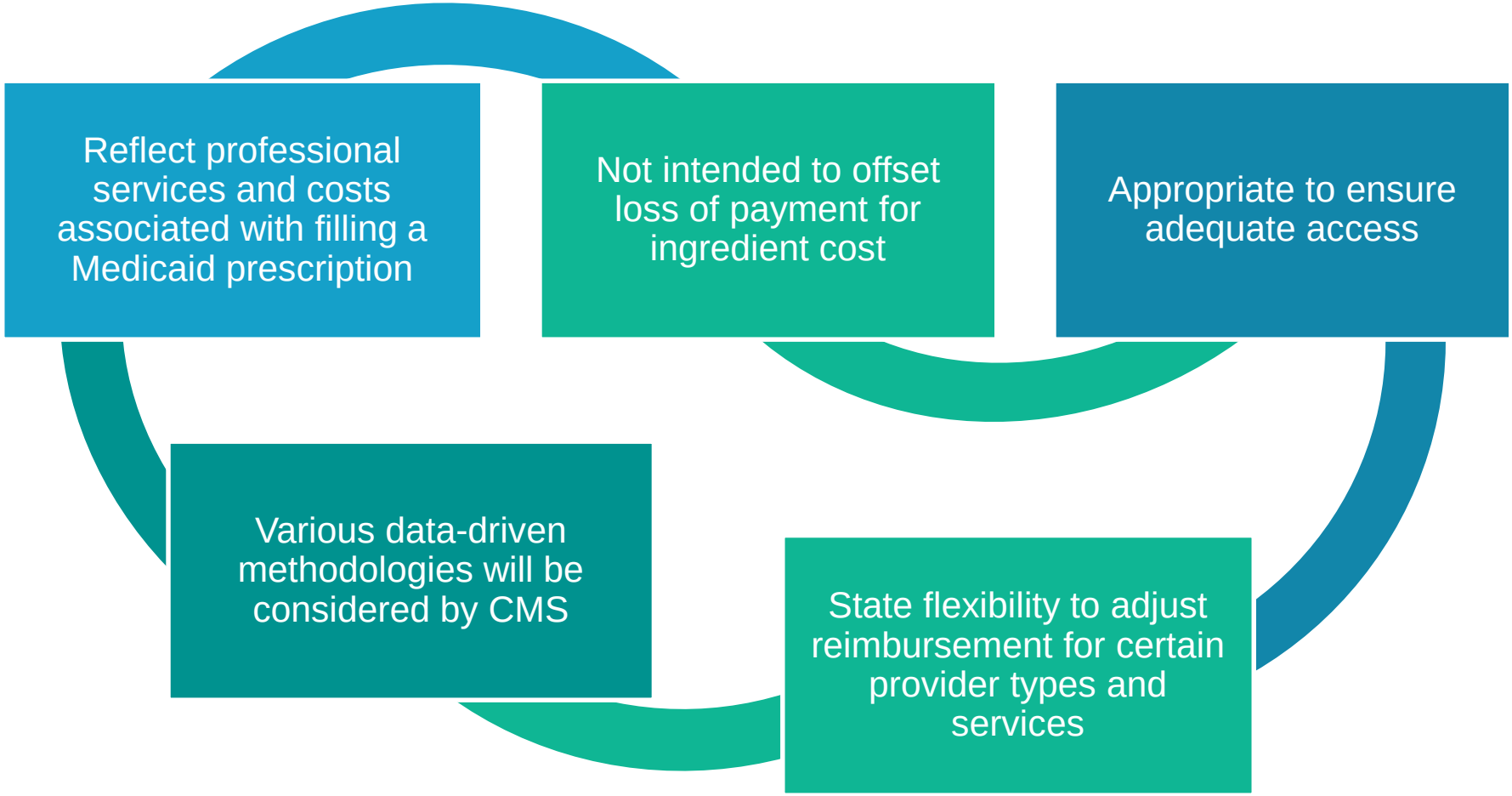
- Requires Medicaid programs review and potentially reform pharmacy reimbursement methodologies
- Each state is responsible for establishing payment methodology
  - Based on AAC + professional dispensing fee
- Effective date April 1, 2016
  - States have until June 2017 to submit State Plan Amendment (SPA)

OVERVIEW OF COVERED OUTPATIENT DRUGS FINAL RULE

FFS REIMBURSEMENT REQUIREMENTS

PROFESSIONAL DISPENSING FEE ANALYSIS

PROFESSIONAL DISPENSING FEE ANALYSIS
FINAL RULE REQUIREMENTS



PROFESSIONAL DISPENSING FEE ANALYSIS
CMS DEFINITION

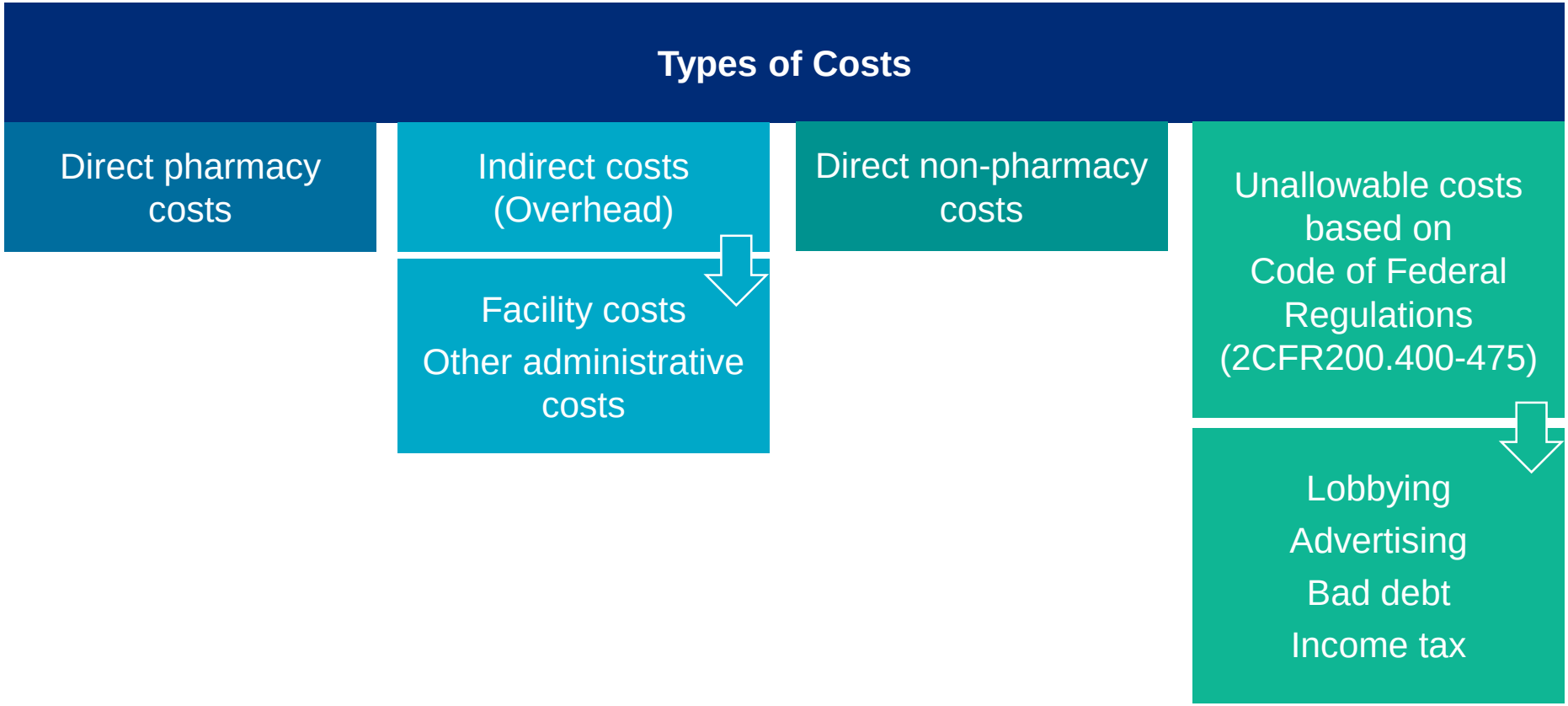
Professional dispensing fee does not include:

Administrative costs incurred by the state in the operation of the covered outpatient drug benefit, including systems costs for interfacing with pharmacies	The Preamble of the final rule clarifies that CMS does not identify profit in the definition of professional dispensing fee

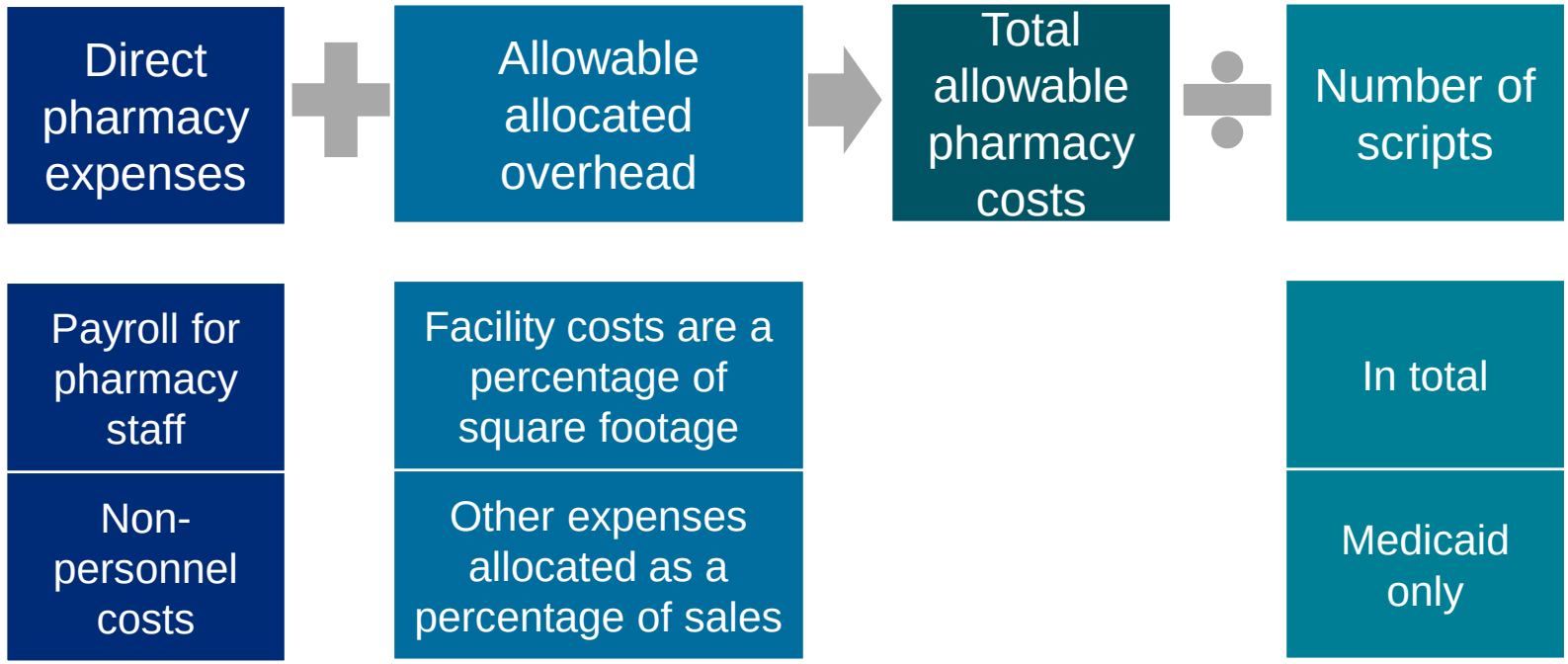
States retain the flexibility to create a differential professional dispensing fee reimbursement per provider delivery type

PROFESSIONAL DISPENSING FEE ANALYSIS
SURVEY METHODOLOGY

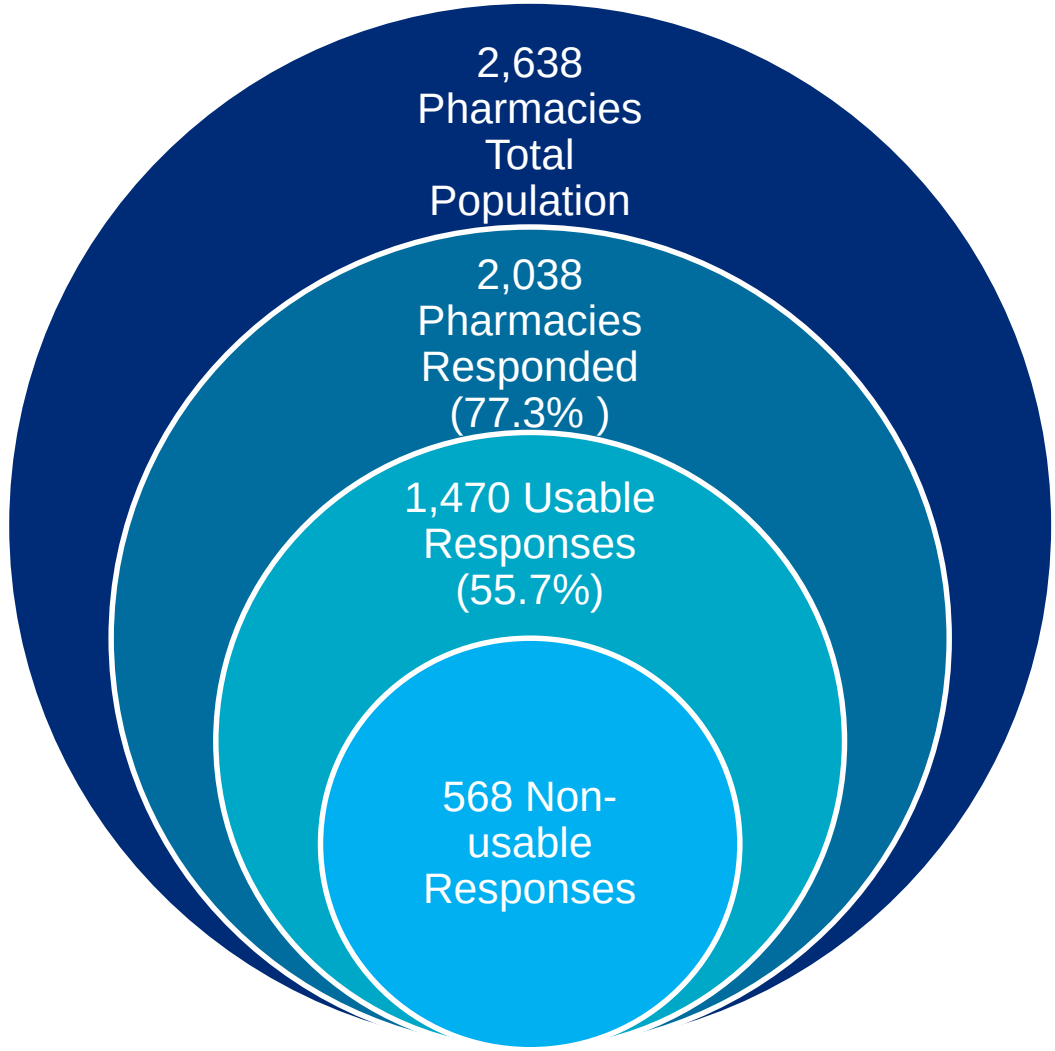
PROFESSIONAL DISPENSING FEE ANALYSIS
SURVEY METHODOLOGY



PROFESSIONAL DISPENSING FEE ANALYSIS
TOTAL CALCULATION



PROFESSIONAL DISPENSING FEE ANALYSIS
PDF SURVEY RESPONSE



PROFESSIONAL DISPENSING FEE ANALYSIS
SURVEY RESULTS

Pharmacy Type	*Annual Prescription Volume*	*Winsorized Mean Weighted by Response Probability*
Retail Community	0–49,999	$13.64
	50,000–74,999	$10.80
	75,000–99,999	$9.51
	100,000+	$8.30
	All Volumes	$10.49
Long Term Care		$15.58
Clinic/Outpatient		$12.18
FQHC/RHC		$8.86
Compounding		$113.06
Home Infusion		$122.80
Specialty		$175.31

PROFESSIONAL DISPENSING FEE ANALYSIS
REGRESSION ANALYSIS

Regression analysis simultaneously performed to identify attributes with statistical significance

Pharmacy attributes included:

- Type of pharmacy*
- Years open*
- Whether the business owns the building
- Pharmacist(s) also an owner*
- Total prescription volume*
- Percentage of prescriptions accounted for by Medicaid
- Percentage prescriptions compounded
- Whether delivery of Medicaid prescriptions are offered*

**Indicates statistical significance in the regression*

PROFESSIONAL DISPENSING FEE ANALYSIS
FISCAL IMPACT-COMMUNITY RETAIL PHARMACIES INCLUDING 340B

Method	Overall average dispensing fee	Estimated Annual Fiscal Impact
Current dispensing fee	$1.80	$10,090,000
Proposed single professional dispensing fee	$10.49	$58,804,000
Proposed tiered professional dispensing fee		
0-49,999	$13.64	$11,329,000
50,000-74,999	$10.80	$11,299,000
75,000-99,999	$9.51	$10,423,000
100,000 or more	$8.30	$21,852,000
Combined	$9.79	$54,903,000

PROFESSIONAL DISPENSING FEE ANALYSIS

DISPENSING FEE OPTION COMPARISON

Reimbursement Method	Pros	Cons
Single professional dispensing fee	• Minimal administrative burden • No need for additional verification or annual claim volume validation procedures • Rewards efficiency	• 53.6% of independent retail pharmacies reimbursed less than reported cost • Creates potential access concerns • Reimburses high volume pharmacies above reported cost to dispense
Tiered professional dispensing fee	• Distributes Medicaid funds at reimbursement levels closely reflecting costs • Increases the likelihood of Medicaid member access in underserved or rural areas	• Need for annual claims volume review and claim system update • Does not reward efficiency achieved through growth or volume • For all tiers, efficiency is rewarded by managing costs below the mean for each tier

ACTUAL ACQUISITION COST REIMBURSEMENT ANALYSIS

AAC REIMBURSEMENT ANALYSIS
FINAL RULE REQUIREMENTS

Effective April 1, 2017, ODM will be changing the covered outpatient drug reimbursement methodology to comply with the federal rule

- ✓ Ingredient cost reimbursement will move from EAC to AAC
- ✓ Applies to drugs dispensed by a retail community pharmacy and 340B Covered Entities

Payment for the following drugs do not need to meet the AAC reimbursement definition:

- ✓ Specialty drugs not typically dispensed by a retail community pharmacy
- ✓ Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers and Centers of Excellence

ODM must demonstrate a process that meets compliance with federal upper limits

AAC REIMBURSEMENT ANALYSIS
ANALYSIS METHODOLOGY

FFS pharmacy claims utilization data from CY 2015 was repriced for comparison

Current ingredient cost reimbursement

- Lower of:
  - FUL, if available
  - SMAC, if available
  - WAC + 7% or AWP - 14.4% if WAC is not available
- 340B claims were not re-priced, CY 2015 reported ingredient cost was used

AAC-based ingredient cost reimbursement

- States acquire AAC data through one, or combination of, the following:
  - National survey of retail pharmacy providers (e.g. CMS' NADAC rate process)
  - State survey of retail pharmacy providers
  - Published compendia prices (e.g., WAC)
  - AMP

AAC REIMBURSEMENT ANALYSIS
METHODOLOGY

CY 2015 FFS Pharmacy Claims Data

Compound claims excluded

Dual eligible claims flagged in data and included in analysis

All pricing files used (e.g., FUL, SMAC, WAC, AWP, NADAC and state AAC rate) have rates effective August 1, 2016

- If WAC was missing in any scenario, AWP equivalents were used

Drug type (Brand, Generic) determined using ODM's claim adjudication logic

Assumed SMAC and FUL pricing only applied to Generic or blank drug types as Brand necessary override data were not available

AAC REIMBURSEMENT ANALYSIS

AAC OPTIONS MODELED

Ingredient Cost

Move to AAC

NADAC

- NADAC with WAC + 0% for all non-NADAC drugs
- NADAC with CMS reported WAC equivalents for all non-NADAC drugs (WAC - 3.4% brands, WAC - 40.9% generics)

Representative State AAC

- Lower of FUL, Representative State AAC or WAC + 0% for all non-State AAC drugs
- Lower of FUL, Representative State AAC or CMS Reported WAC equivalents for all non-State AAC drugs (WAC - 3.4% brands, WAC - 40.9% generics)

WAC-Based

- Lower of FUL and State Utilization-based WAC Rates (WAC - 3.1% brands, WAC - 44.5% generics)
- Lower of FUL and CMS reported WAC Rates (WAC - 3.4% brands, WAC - 40.9% generics)

- Hemophilia drugs repriced with ASP+6% as directed by ODM (minus the furnishing fee)
- Under AAC reimbursement, specialty drugs repriced at WAC + 0% or other WAC equivalents to NADAC

AAC REIMBURSEMENT ANALYSIS
COMPARISON OF AAC OPTIONS

	Total	No NADAC, No WAC	Percent of Total	No NADAC, No WAC, No AWP	Percentage of Total	No State AAC, No WAC	Percentage of Total	No State AAC, No WAC, No AWP	Percentage of Total
NDC Count	19,200	1,050	5.5%	380	2.0%	1,240	6.5%	300	1.6%
Claim Count	5,523,400	95,700	1.7%	12,900	0.2%	107,000	1.9%	9,800	0.2%
Estimated Ingredient Cost (Current EAC Methodology)	$467,619,000	$1,172,000	0.3%	$23,800	0.0%	$1,836,000	0.4%	$1,900	0.0%

- Observations:
  - All scenarios will require an alternative pricing benchmark for claims payment
  - Utilizing AWP rate, from Medispan, decreased the gap to 0.2% of claims without a pricing benchmark
  - Mercer observed a number of specialty drugs in ODM's CY 2015 FFS pharmacy data that do not have a NADAC price that are included in the table above

AAC REIMBURSEMENT ANALYSIS
AAC OPTIONS – ESTIMATED FISCAL IMPACT

Scenario	Estimated Annual Ingredient Cost	Estimated Annual Ingredient Cost Difference From Current EAC Methodology	Percentage Difference Compared to Current EAC Methodology
Current EAC Reimbursement Methodology	$467,619,000	N/A	N/A
NADAC Scenarios			
NADAC with WAC+0% for all non-NADAC drugs	$410,903,000	($56,716,000)	-12.1%
NADAC with WAC-3.4% for non-NADAC brand drugs and WAC-40.9% for non-NADAC generic drugs	$406,246,000	($61,373,000)	-13.1%
Representative State AAC Scenarios			
Lower of FUL and Representative State AAC or WAC + 0% if State AAC not available	$410,264,000	($57,355,000)	-12.3%
Lower of FUL and Representative State AAC or WAC - 3.4% for no State AAC brand drugs and WAC - 40.9% for no State AAC generic drugs	$401,783,000	($65,836,000)	-14.1%
WAC Scenarios			
Lower of FUL and State utilization-based NADAC WAC Equivalent Rate of WAC - 3.1% for brands and WAC - 44.5% for generics	$399,881,000	($67,738,000)	-14.5%
Lower of FUL and CMS-based NADAC WAC Equivalent Rate of WAC - 3.4% for brands and WAC - 40.9% for generics	$401,405,000	($66,214,000)	-14.2%

AAC REIMBURSEMENT ANALYSIS
340B AAC ANALYSIS

Per the final rule:

- 340B drug claims are subject to AAC reimbursement
- States must reimburse 340B drugs, but should not reimburse at an amount higher than the 340B ceiling price
- Applies to both 340B Covered Entities (CEs) and 340B contract pharmacies

340B ceiling price is calculated as the difference between Average Manufacturer Price (AMP) and Unit Rebate Amount (URA)

ODM currently specifies that 340B contract pharmacies may not use 340B drugs for Medicaid members

AAC REIMBURSEMENT ANALYSIS
340B AAC OPTIONS MODELED

340B AAC

- 340B AAC, if 340B AAC is unavailable, use WAC - 50% (or AWP - 58.33%)

340B Ceiling Price

- Ceiling Price, if 340B Ceiling Price is unavailable use WAC - 50% (or AWP - 58.33%)

Lower of 340B AAC and Celling Price

- Lower of 340B AAC and Ceiling Price, if unavailable use WAC - 50% (or AWP - 58.33%)

AAC REIMBURSEMENT ANALYSIS
340B AAC CLAIM COMPARISON

340B AAC	Total 340B	No 340B AAC	Percent of Total	No 340B AAC, No NADAC	Percent of Total	No 340B AAC, NADAC, or WAC	Percent of Total	No 340B AAC, NADAC, WAC, or AWP	Percent of Total
NDC Count	5,220	400	7.7%	290	5.6%	90	1.7%	10	0.2%
Claim Count	82,200	4,700	5.7%	3,600	4.4%	1,600	1.9%	100	0.1%
CY 2015 Ingredient Cost	$3,885,000	$300,000	7.7%	$287,300	7.4%	$15,300	0.4%	$200	0.0%

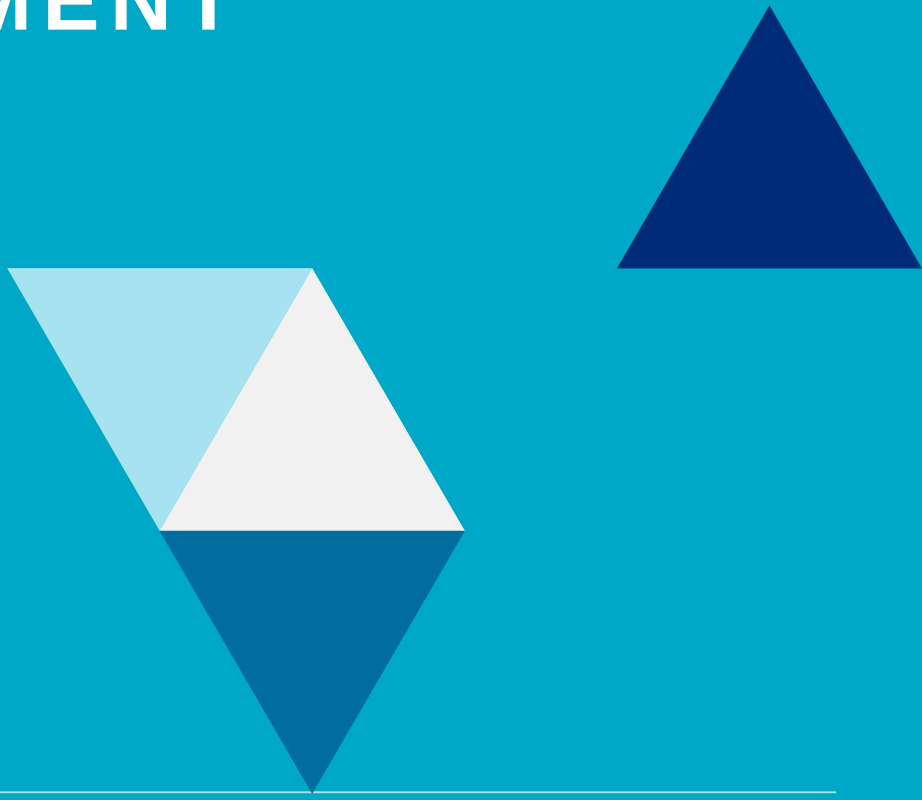
340B Ceiling Prices	Total 340B	No Ceiling Price	Percent of Total	No Ceiling Price, No 340B AAC	Percent of Total	No Ceiling Price, No 340B AAC, No WAC	Percent of Total	No Ceiling Price, No 340B AAC, No WAC, No AWP	Percent of Total
NDC Count	5,220	430	8.2%	230	4.4%	90	1.7%	10	0.2%
Claim Count	82,200	8,800	10.7%	3,400	4.1%	1,600	1.9%	100	0.1%
CY 2015 Ingredient Cost	$3,885,000	$150,000	3.9%	$84,100	2.2%	$15,100	0.4%	$100	0.0%

- Observations
  - 7.7% of NDCs and 5.7% of 340B claims did not have a 340B AAC price for this analysis
  - 8.2% of NDCs and 10.7% of 340B claims did not have a 340B Ceiling Price for this analysis
  - Approximately 4% of NDCs and claims and 2% of 340B ingredient costs did not have a 340B AAC or Ceiling price

AAC REIMBURSEMENT ANALYSIS
340B AAC – ESTIMATED FISCAL IMPACT

Scenario	CY 2015 Ingredient Cost/Estimated Annual Ingredient Cost	Estimated Difference From CY 2015 Ingredient Cost	Percentage Difference Compared to CY 2015 Ingredient Cost
CY 2015 Ingredient Cost	$3,885,000	N/A	N/A
340B AAC Scenario			
340B AAC, if unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$3,080,000	($805,000)	-20.7%
Ceiling Price Scenario			
Ceiling Price, if unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$1,998,000	($1,887,000)	-48.6%
Lower of 340B AAC and Ceiling Price Scenario			
Lower of 340B and Ceiling Price, if one of two are available use the one, if both are unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$1,962,000	($1,923,000)	-49.5%

TOTAL REIMBURSEMENT ANALYSIS



TOTAL REIMBURSEMENT ANALYSIS
ESTIMATED FISCAL IMPACT – TRADITIONAL OUTPATIENT DRUG SPEND (NON-340B, NON-COMPOUND)

	Ingredient Cost	Current Dispensing Fee	Single Dispensing Fee	Tiered Dispensing Fee
Dispensing Fee Amounts	-	$10,090,000	$57,941,000	$54,065,000
Current EAC	$467,619,000	$477,709,000		
NADAC with WAC + 0% for all non-NADAC drugs	$410,903,000	-	$468,844,000	$464,968,000
NADAC with WAC - 3.4% for non-NADAC brand drugs and WAC - 40.9% for non-NADAC generic drugs	$406,246,000	-	$464,187,000	$460,311,000
Lower of FUL and Representative State AAC or WAC + 0% if State AAC not available	$410,264,000	-	$468,205,000	$464,329,000
Lower of FUL and Representative State AAC or WAC - 3.4% for no State AAC brand drugs and WAC - 40.9% for no State AAC generic drugs	$401,783,000	-	$459,724,000	$455,848,000
Lower of FUL and State utilization-based NADAC WAC Equivalent Rate of WAC - 3.1% for brands and WAC - 44.5% for generics	$399,881,000	-	$457,822,000	$453,946,000
Lower of FUL and CMS-based NADAC WAC Equivalent Rate of WAC - 3.4% for brands and WAC - 40.9% for generics	$401,405,000	-	$459,346,000	$455,470,000

TOTAL REIMBURSEMENT ANALYSIS
ESTIMATED FISCAL IMPACT – 340B DRUG SPEND

	Ingredient Cost	Current Dispensing Fee	Single Dispensing Fee	Tiered Dispensing Fee
Dispensing Fee Amounts	-	$148,000	$863,000	$838,000
CY 2015 Ingredient Cost	$3,885,000	$4,033,000		
340B AAC, if unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$3,080,000	-	$3,943,000	$3,918,000
Ceiling Price, if unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$1,998,000	-	$2,861,000	$2,836,000
Lower of 340B and Ceiling Price, if one of two are available use the one, if both are unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$1,962,000	-	$2,825,000	$2,800,000

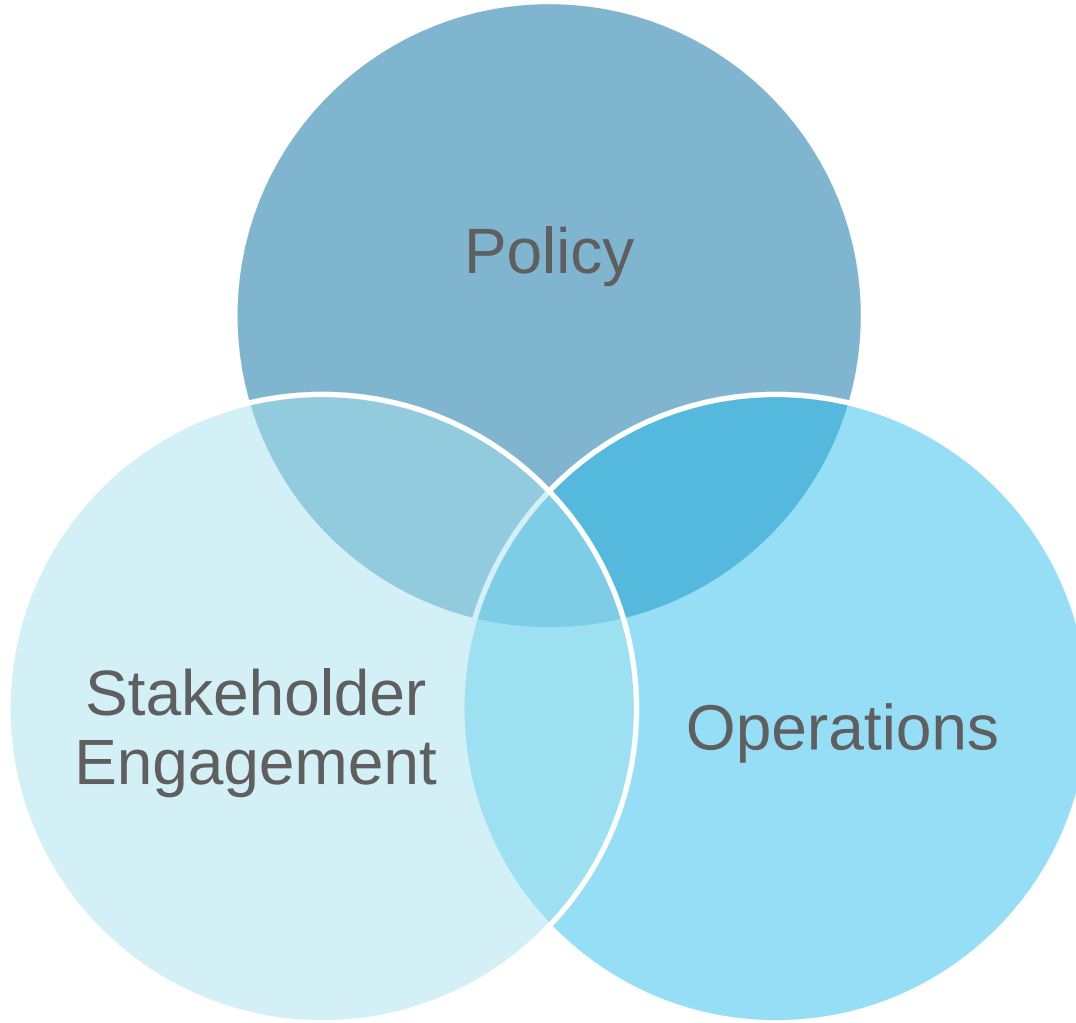
- Observations
  - The Ceiling Price scenario reflects CMS guidance that states pay no more than the Ceiling Price for 340B drugs

TOTAL REIMBURSEMENT ANALYSIS
ESTIMATED FISCAL IMPACT – TOTAL DRUG SPEND

Single Dispensing Fee			
	Estimated Annual Ingredient Cost	Dispensing Fee	Total Reimbursement
Current EAC Reimbursement Methodology	$471,504,000	$10,090,000	$481,594,000
Final Proposed Reimbursement with Single Dispensing Fee			
NADAC with WAC+0% for all non-NADAC drugs (Hemophilia ASP+6%)	$410,903,000	$57,941,000	$468,844,000
Ceiling Price, if unavailable use WAC-50%, if unavailable use AWP-58.33%	$1,998,000	$863,000	$2,861,000
Total	$412,901,000	$58,804,000	$471,705,000
Difference	-$58,603,000	$48,714,000	-$9,889,000
% Difference			-2.1%
Tiered Dispensing Fee			
	Estimated Annual Ingredient Cost	Dispensing Fee	Total Reimbursement
Current EAC Reimbursement Methodology	$471,504,000	$10,090,000	$481,594,000
Final Proposed Reimbursement with Tiered Dispensing Fee			
NADAC with WAC+0% for all non-NADAC drugs (Hemophilia ASP+6%)	$410,903,000	$54,065,000	$464,968,000
Ceiling Price, if unavailable use WAC-50%, if unavailable use AWP-58.33%	$1,998,000	$838,000	$2,836,000
Total	$412,901,000	$54,903,000	$467,804,000
Difference	-$58,603,000	$44,813,000	-$13,790,000
% Difference			-2.9%

IMPLEMENTATION ROADMAP

IMPLEMENTATION ROADMAP
KEY AREAS OF CONSIDERATION AND DECISION MAKING



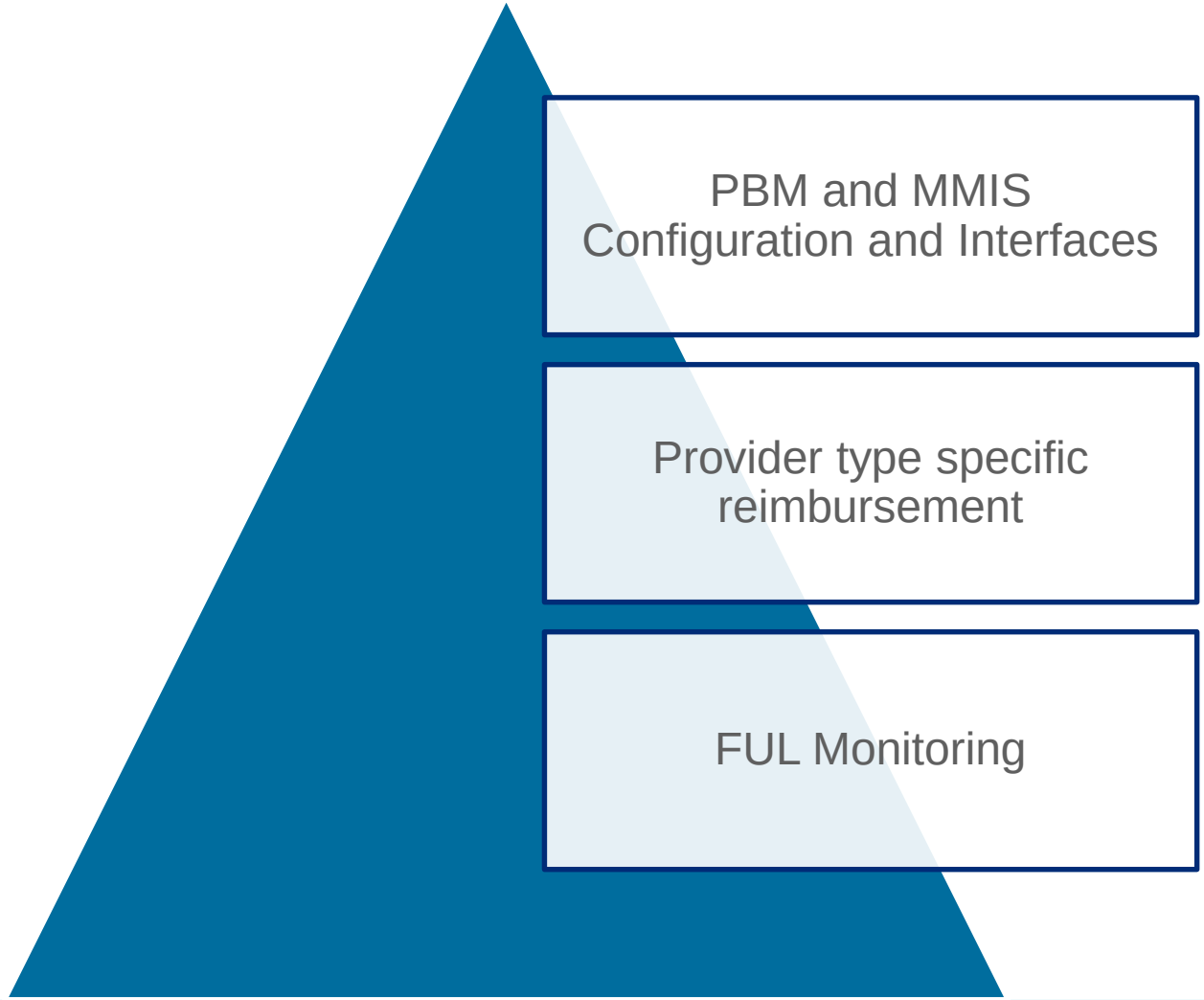
IMPLEMENTATION ROADMAP
POLICY CONSIDERATIONS

State Plan Modifications	• Evaluate all areas impacted • Determine affected provider types • Evaluate opportunity to align reimbursement among providers • Develop and submit State Plan Amendment

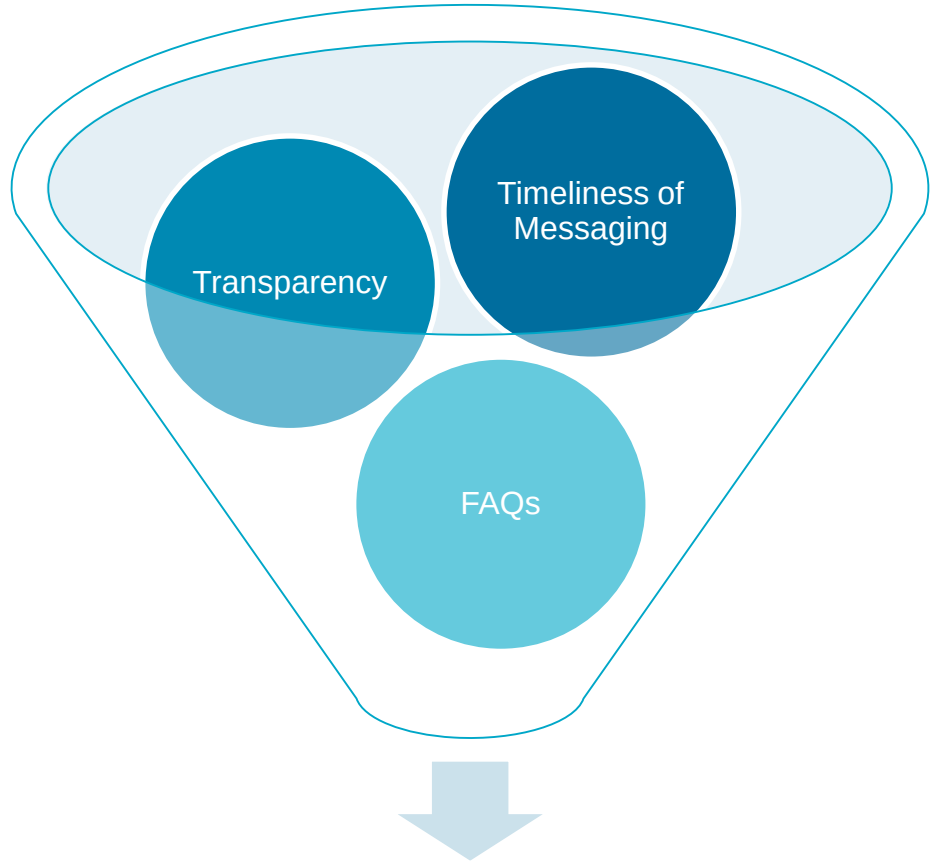
Access Monitoring Review Plan	• Develop Monitoring Review Plan
	  • Availability of Medicaid pharmacy providers
	  • Utilization of Medicaid prescription drugs
	  • Monitor extent to which Medicaid beneficiaries needs are fully met
	• Respond to CMS Standard Access Questions

Policy and Program Updates	• Review and update all program materials, rules and billing guidelines
	• Develop and implement communication plan
	  • Direct outreach to providers
	  • Transition web page and FAQ

IMPLEMENTATION ROADMAP
OPERATIONAL CONSIDERATIONS



IMPLEMENTATION ROADMAP
STAKEHOLDER ENGAGEMENT



AAC-based Reimbursement Implementation

IMPLEMENTATION ROADMAP
IMPLEMENTATION TIMELINE

Activity	Dates
Conduct stakeholder outreach and engagement	Ongoing
Develop Access Monitoring Review Plan (AMRP)	October – November 2016
Finalize overall reimbursement methodologies	November – December 2016
Develop State Plan Amendment (SPA)	November – December 2016
Solicit Public Comment on SPA and AMRP	December 2016
Submit SPA and AMRP to CMS	January 2017
Conduct Claims Volume Review (tiered approach only)	January – February 2017
Develop and configure PBM and MMIS systems	January – February 2017
Review and update all policy and program materials	January – March 2017
Provider messaging and website launch	February – March 2017
Test PBM systems and MMIS	March 2017
Go Live with AAC based reimbursement	April 2017

MAKE TOMORROW, TODAY