

# Effectively Managing a Medicaid Pharmacy Benefit Program

## Background

The National Community Pharmacists Association (NCPA) has developed this document to provide guidance to association executives, staff, and state policymakers in their efforts to establish effective Medicaid pharmacy programs that maximize the state's resources while improving overall beneficiary health. A well-managed pharmacy program can be an asset to a state Medicaid program—saving precious state dollars while facilitating a coordinated care approach for Medicaid patients. As part of a comprehensive solution, pharmacy can be used as a vehicle to promote best practices, care coordination, and positive patient health outcomes. Through every step of this process, NCPA is available to lend advice and consultation.

NCPA was founded in 1898 to promote pharmacy as a profession and the role of the independent community pharmacist as a health care provider. In 2011, NCPA represents the owners of more than 23,000 community pharmacies, pharmacy franchises, and chains. Our members employ over 300,000 full-time employees and dispense nearly half of our nation's retail prescription medicines. NCPA is not only a resource to our pharmacist members. We work hand-in-hand with government agencies, related interest groups, and elected officials to protect the interests of community pharmacy and the health and wellbeing of our nation's citizens. Also, we strive to contribute to a greater understanding by policymakers, both state and federal, of the many important issues facing independent community pharmacies as well as their patient customers with regard to health care and government programs.

Expansion of Medicaid rolls under the Affordable Care Act (ACA) and budget crunches have placed many states in an untenable position. In many cases, states are "testing the waters" to see if they can find savings and financial stability by overhauling their Medicaid programs or by contracting with managed care organizations (MCOs) to provide Medicaid pharmacy services for the current and soon to be increasing indigent population. NCPA offers this document as a tool to guide decision makers through this

process in regards to a pharmacy benefit structure.

NCPA welcomes the opportunity to work with state legislatures and agencies to find cost saving measures incorporating community pharmacy involvement. We hope this document provides a framework for future conversations involving such options.

## Section Overview

### Section 1: The Role of Pharmacy in State Medicaid Programs

Section one provides a number of basic best management safeguards that should be implemented in any Medicaid pharmacy benefit program. If implemented properly these standards will assist in preventing the state from paying a premium for the service and not see the savings. They also will result in an improvement to beneficiaries overall health and therefore result in cost savings to the healthcare system.

### Section 2: Contracting for Pharmacy Services with MCOs

Section two provides best management standards that should be implemented by a state that decides to contract its pharmacy benefit to an outside organization, specifically a managed care entity. It is essential that in such instances the state maintains program oversight and pharmacy program integration with other health care services. There are best practices that should be



followed to protect the state and also the health care provider—the most valuable are set out in this section.

### Section 3: Pharmacy Reimbursement

Section three explains the current and future trends regarding pharmacy reimbursement. This multi-faceted and at times complicated system is seeing many changes occur to its structure. The crux of a benefit program for the provider is how the provider is ultimately reimbursed for the services rendered. Policymakers must understand that decreasing pharmacy reimbursement can have negative impacts on patient health and the ability of a pharmacy to stay in business therefore causing access to care concerns and the potential for increased costs throughout the health care system. This section will provide a basic understanding of current and future trends within pharmacy reimbursement.



# An Effectively Managed Pharmacy Benefit Can Improve a State Medicaid Program

Prescription medications are an active and essential benefit in virtually all medical interventions. Within Medicaid programs, it is imperative that the pharmacy benefit is viewed both for its value to beneficiary health and its overall impact to the state in terms of preventing more costly downstream medical interventions. NCPA urges government officials and policymakers to approach the implementation of any pharmacy benefit program cautiously by keeping best management practices in mind. If implemented correctly, a Medicaid pharmacy program can be a valuable and cost effective program to the state and also the beneficiaries that utilize its services.

## Design and Implementation of Medicaid Pharmacy Benefit Is Critical

- While prescription drugs are considered an “optional” benefit in Medicaid by the federal government, all states provide some level of coverage for beneficiaries.
- Medicaid Pharmacy accounted for \$25 billion in spending across all states in 2009.<sup>1</sup>
- When a beneficiary’s medication adherence drops below 80%, states will see a 2.5x greater rate of hospitalization.

## Pharmacist Involvement Improves Patient Care and a State Government’s Bottom Line

- Formalized pharmacist counseling can result in dramatic improvements to patient care and cost savings for the state. Pharmacist/physician teams have shown 2:1 returns on investment from active medication therapy management (MTM) programs over one year.<sup>2</sup> These programs should be encouraged by a state’s Medicaid plan.
- Pharmacists are experts when dealing with the effects of medication on patients.

- Pharmacists have the ability to recommend cost-saving alternatives for patients’ medication regimens and community pharmacies dispense generic medications 72% of the time. A recent study reported that with each 1% increase in generic drug dispensing, the overall health care system would see a savings of approximately \$4 billion. In 2006 a report concluded that Medicare Part D showed \$12 billion lower than estimated operating costs due to higher than expected dispensing of generic medications.<sup>3</sup>

## Setting the Record Straight on Past Cost-Containment Strategies for Medicaid Pharmacy

- **Slashing pharmacy reimbursement does not result in cost savings.** As with any profession, pharmacists should be reasonably reimbursed for the services they provide. Currently, it costs a pharmacy approximately \$11 to dispense a medication<sup>4</sup> (not including the cost of the medication), yet states set reimbursement rates as low as \$1.60 per prescription. This can cause pharmacists to not participate in the

Medicaid program, or go out of business. When this happens, beneficiaries lose access to health-sustaining medicines, which may result in increased emergency room visits and hospitalizations, costing significantly more to the health care system.

- **Establishing a monthly cap on number of prescriptions results in cost savings.** Arbitrary medication caps rarely save money. Targeted, evidence-based precertification programs utilizing the best technology and step therapy are far more financially productive and produce better patient outcomes.
- **Mail order is not the answer.** There have been no peer-reviewed studies that have proven the cost savings of utilizing mail order pharmacy services. Mail order pharmacy does not cost effectively utilize generic medications, vastly increases medication waste, dispenses expensive brand name medications at a higher rate, and prevents valuable patient/pharmacist interaction. Studies show that when given a fair choice patients rarely choose mail order and would choose to interact with their local pharmacist instead.<sup>5</sup>

<sup>1</sup> Kaiser Commission on Medicaid and the Uninsured, September 2011

<sup>2</sup> “Medication Therapy Management Digest” American Pharmacists Association, March 2011

<sup>3</sup> “Generic Drug Utilization in Medicare Part D.” Department of Health and Human Services, November 14, 2007.

<sup>4</sup> 2011 Texas Health and Human Services Commission study

<sup>5</sup> “Attitudes About Mandatory Mail Order Pharmacy.” NACDS Foundation Public Opinion Research. Wirthlin Worldwide, 2003.



# The Role of Pharmacy in State Medicaid Programs: Maximizing Value and Optimizing Quality

Prescription drugs are considered an “optional” benefit in Medicaid by the federal government. However, all states provide some level of coverage for beneficiaries. The pharmacy benefit often represents approximately one-fourth of the total Medicaid expenditures. In many cases it consumes over 5% of the state’s budget.

If the pharmacy benefit is inappropriately restrictive, it is likely that a state will be forced to increase costs in other areas of the Medicaid program (i.e., emergency room visits, hospitalizations, and extended hospital stays). There are a number of principles that policymakers and government officials should keep in mind when designing a robust and cost-effective pharmacy benefit.

## Guiding Principles:

### Structure of the Pharmacy Benefit

**Generic drug utilization leads to notable cost savings.**

Medicaid programs should support generic drug utilization whenever feasible. Generic drug utilization continues to increase as more brand name products go off patent. Medicaid programs at both the federal and state level can save billions of dollars by increasing the use of high quality, low-cost generic medications. Generally a generic prescription will cost approximately 20% of the brand name product.<sup>6</sup> However, currently brand name medications make up approximately 80% of the total spend for Medicaid prescriptions.<sup>7</sup> A Medicaid pharmacy program should be designed to measure generic utilization (how often is a generic used) as well as generic efficiency (how many times a generic was used when it could be). An evidence-based case should be made for using a brand name product over a generic medication.<sup>8</sup> In 2009, Medicaid had \$329 million in overspending as a result of underutilizing generic medications.<sup>9</sup> Face-to-face pharmacist interaction

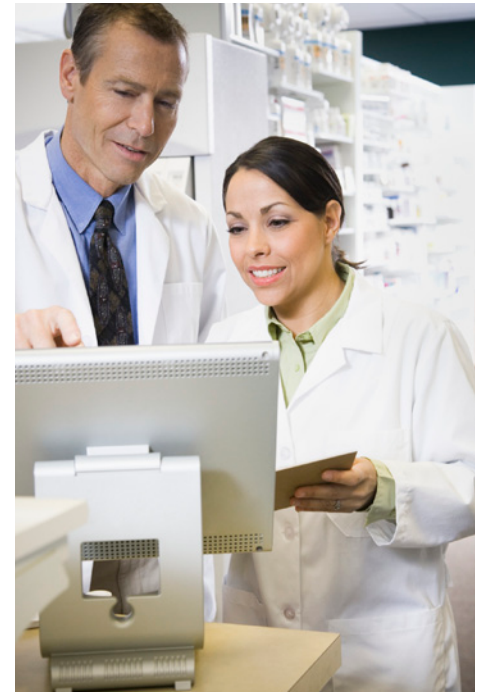
again can play an important role in assuring that patients are utilizing generic medications when possible.

**Cost control can be gained through step-therapy.**

Step-therapy is an approach to prescription drug utilization that requires a patient to first use a medication that is the most cost effective and/or the safest within a drug class and then progress to other more costly therapies in the drug class only if necessary. Step-therapy is generally applied to a select drug class with the goal of encouraging generic use and decreasing costs without compromising quality of care. For the treatment of certain medical conditions, an over-the-counter (OTC) medication could be the “first line” drug although a prescription should be required for these items as well. Step-therapy could be used to incentivize the use of an OTC (when appropriate), followed by generic drugs, preferred drugs and lastly innovator medications.

**Supply limits on first prescription can save program dollars.**

Selectively limiting a particular day’s supply on the first fill of a brand name prescription to treat a chronic condition can stave off potential costs and prevent medication waste. Many times medications that are new to a patient will be changed until the proper regimen is identified. This may be because the patient cannot tolerate the medication or



because the medication turns out not to be efficacious to that patient. Again, pharmacist/patient interaction is vital to determine if medication is appropriate.

**Point-of-sale edits may be necessary for cost savings.**

Point of sale pharmacy edits use predetermined thresholds to impede the dispensing of certain prescriptions. The purpose of these edits is to provide the safest and most cost-effective therapy by driving utilization away from potentially dangerous—and costly treatments.

Quantity limits, maximum dosage limits, and early refill limits are all examples of point-of-sale utilization edits. In all cases, real time point-of-sale edits should focus on ensuring safety, clinical efficacy, and cost effectiveness. Practitioner involvement is also essential so that the state Medicaid department is fully cognizant of all of

Total Rx Cost to Medicaid		
Rx Type	Brand Rx	Generic Rx
Total Rx's Dispensed	20%	80%
Total Estimated Cost	80%	20%



the potential effects on the system. If a transaction is denied, it should be apparent why and under what conditions it can be overridden and the prescription filled. (At least 85% should be totally handled with the technology and in the transmission). Any issues not handled electronically should be filtered through a call center that's appropriately staffed to adjudicate the remaining 15% of the claims.

#### **Preferred Drug List**

A preferred drug list is an established list of "first line drugs" in each therapeutic class that the agency can try to encourage. These should be consistent with best medical evidence and practice. The agency "bids" these products by therapeutic class to establish the priority of coverage. The manufacturers provide supplemental rebates on a bid basis. The lowest net cost medication, consistent with best practice, is the first priority for use.

#### **Prescription caps rarely resolve cost issues.**

Establishing arbitrary monthly prescription limits ("medication caps") is not good for the patient and does not result in cost savings to the health care system. In fact, it increases overhead for the program, confuses and frustrates providers and patients alike, plac-

es pharmacists in the position of denying vital medications, and will negatively impact a patient's health. Targeted, evidence-based precertification programs utilizing the best technology and step-therapy is far more financially productive and produces better patient outcomes.<sup>10</sup>

#### **Capitalizing on Pharmacist Expertise to Drive Patient Adherence**

##### **Maximizing access to pharmacy services is essential to patient care.**

Access to pharmacy services is a critical component for patients with chronic disease. It is even more crucial for those with mental illness. Access means both the physical presence of a pharmacy to a patient and the availability services to match the patient's needs. Face-to-face pharmacist interaction is essential. The patient should be able to freely choose the pharmacy that best meets their needs and the pharmacist with whom they have developed a patient/practitioner relationship. The provider should expect to receive a reasonable reimbursement for the product as well as the clinical services provided.

##### **Pharmacist/patient interaction is critical for cost savings.**

Adherence to a prescribed drug therapy for chronically ill patients is vital for patient health and also overall program success. Failure to

take medications and take them appropriately will result in poor patient outcomes and increased cost to the state. When adherence drops below 80% (taking a drug three times a day as opposed to four, or taking a medication for five and half days instead of seven as *prescribed*) a 2.5 times greater rate of hospitalization for seriously mentally ill patients is observed. Similar impacts occur with patients who have congestive heart failure, diabetes, asthma and other chronic diseases.

Medication adherence should be monitored within the Medicaid program and pharmacists should have direct interaction with patient's practitioners. The outcomes of these measures should be available to the practitioners. Adherence requires the patient to understand what medications they are taking, how they are to be taken, and why they are to be taken.

#### **Expanded MTM saves program dollars.**

All Medicaid pharmacy programs should support this service. Allowing a pharmacist to have face-to-face interaction with a patient and become more involved in ensuring a patient's medication adherence is one of the best ways to see cost savings. Recently, there has been an increase in the public awareness of the benefits of pharmacist services in choosing, administering, and adjusting medication therapy. Pharmacists add safety, efficacy, and cost savings to programs that use them in multidisciplinary teams. Pharmacist/physician teams have shown 2:1 returns on investment in active MTM programs over one year.<sup>11</sup>

Iowa's Pharmaceutical Case Management program is an example of a successful state MTM program. Iowa pharmacists met with 943 patients, sent recommendations to physicians for 500 of them, and ultimately found an average of 2.6 medication-related problems per patient. Pharmacists recommended new medications in 52% of these patients. Data showed that during the fiscal years 2002 through 2005, \$254,797 was paid for pharmaceutical case management, with \$241,784 paid to pharmacists.<sup>12</sup> Overall cost savings to the program is estimated to be over \$4 million.

#### **Pharmacists' involvement is vital in program development.**

An advisory board of pharmacy practitio-

ners can be helpful in fine-tuning policy, establishing cost savings, and understanding industry issues. Meetings should be no more than quarterly unless a need arises. They should be totally advisory in nature, and include practitioners from independent, chain, and specialty practices.

### Ensuring Provider Retention and Preserving Patient Choice

#### Proper reimbursement is integral to provider retention and program success.

Currently there are vast discrepancies between pharmacy reimbursement and the true cost of the services provided. From a cost perspective, generics represent only about 20% of the cost of the program.<sup>13</sup> Therefore, savings are achieved when the generic products are used and when brand name products with no generic equivalent can be changed to a therapeutically equivalent product. The program should not disincentivize the use of generics by making reimbursements too low or by not responding to price increases in the marketplace in a timely fashion. Generic drug products are often in “spot market” prices, which can fluctuate significantly, and over short timeframes. It makes sense for the program to incentivize the utilization of generic products.

Also, it should be pointed out that some medications cost a pharmacy significantly more to purchase, compared to what they are being reimbursed. Therefore, it is essential that pharmacy dispensing fees are reasonable and accurately reflect the true costs of the product as well as the operation. A 2011 cost of dispensing study conducted by the Texas Health and Human Services Commission found that it costs a pharmacy \$11.27 to dispense a medication in Texas. This does not include the cost of the drug,

but simply incorporates administrative costs such as pharmacy overhead and packaging. In most cases, dispensing fees do not come close to reflecting the cost of pharmacy operations. States should reasonably compensate a pharmacy for the services they provide as well as monitor these reimbursements if contracting with managed care organizations if they expect to have adequate pharmacist participation and corresponding beneficiary access to services.

#### Mail order is not for everyone.

Ninety-day supplies have been touted as a cost savings approach. However, mail order has NOT proven to be a significant benefit to the Medicaid population. It also removes a patient's access to valuable patient/pharmacist counseling and increases medication waste. Also, Medicaid beneficiaries have proven to be a highly mobile population, commonly moving to different addresses, therefore making it difficult to utilize a mail order option for their maintenance medication needs. Some states have discussed using mail order pharmacy for the Medicaid population but few have attempted to use such a program. Credible evidence has not been presented that such an approach provides significant value. In fact, studies have shown because of the increased waste, mobile population, and changes in therapy, mail order is of marginal, if any benefit. When given a fair choice patients rarely choose mail order. In addition, mandating the use of mail may decrease patient medication adherence.

Providing a 90-day supply for stable chronic medications, especially those available generically, may provide some marginal savings for a public program. Allowing retail pharmacy to dispense such 90-day supplies is a procedure that should be supported.

<sup>6</sup> Health on MSNBC, June 2011 “Drug prices to plummet in wave of expiring patents”

<sup>7</sup> CMS Medicaid State Drug Utilization Data. March 2011

<sup>8</sup> Evaluation of an Automated System for Prior Authorization: A COX-2 Inhibitor Example, Norman V. Carroll, PhD; Jeff C. Smith, MA; Robert A. Berringer, PharmD; and George L. Oestreich, PharmD, Vol. 12, No. 9 *The American Journal Of Managed Care*, 501-508.

<sup>9</sup> AEI Health Policy Studies Working Paper 2011-01, March 28, 2011

<sup>10</sup> Soumerai SB, McLaughlin TJ, Ross-Degnan D, Casteris, CS, Bollini P. Effects of a limit on Medicaid drug-reimbursement benefits on the use of psychotropic agents and acute mental health services by patients with schizophrenia. *N Engl J Med* 1994;331:650-5.

<sup>11</sup> (American Pharmacists Association. *Medication Therapy Management Digest: Tracking the Expansion of MTM in 2010*. Washington, DC: American Pharmacists Association; March 2011.

<sup>12</sup> *Drug Topics*, May 2009

<sup>13</sup> CMS Medicaid State Drug Utilization Data. March 2011

# Best Management Practices for MCO/PBM/Pharmacy Contracting

Since the early 1980s, a growing national trend has been for states to use managed care organizations (MCOs) to deliver and finance care for Medicaid beneficiaries. With the implementation of health care reform this trend is expected to substantially increase. The stated goal of this approach is to increase access to care, improve quality, and reduce overall cost. However, as some Medicaid directors agree, this result is not easily achieved. If not implemented cautiously with the appropriate level of oversight, an MCO program can actually result in higher overall costs. However, if a state chooses to take this approach, there are certain guidelines and principles that should be implemented to protect valuable pharmacy services.

## What Does an MCO Do?

States contract with MCOs to provide a comprehensive package of benefits to Medicaid beneficiaries primarily on a capitation basis (the state pays a per-member-per-month premium). MCOs may be commercial HMOs that also serve persons with employer-sponsored insurance, or they may be Medicaid-only. Each state develops its own MCO standards. Usually these standards include: adherence to specified protocols, member support, requirements to ensure adequate access to care, benchmarks for quality, data collection, and submission requirements. Medicaid MCOs may be licensed by the state, or operate under contract with the Medicaid agency, regardless of licensure.



## Snapshot of Medicaid MCOs

*(data from 2011 Kaiser Commissions on Medicaid and Uninsured)*

- As of June 2009 71.9% of Medicaid beneficiaries were enrolled in some level of managed care.
- Only three states have no form of managed care operating in their state.
- Over two-thirds of states utilizing MCOs in Medicaid report beneficiary access problems
- Sixteen states carve out prescription drug services from their MCO program.
- The Accountable Care Act is causing many states to implement, or consider implementing, “carve ins” of pharmacy benefits to their MCO programs due to perceived cost savings and the new ability to collect Medicaid pharmacy rebates on purchased drugs.

## Key Guidelines If Managed Care Is Utilized for Medicaid Pharmacy Services

- Pharmacy providers must be reasonably reimbursed for the services they provide. Reasonable reimbursement must include both drug cost and a dispensing fee. Reimbursement must represent the true cost of the medication and the true cost of dispensing that medication to a beneficiary.

- Medicaid beneficiaries are **not** required to pay a co-pay if they are truly unable to do so. Reasonable protections must be implemented regarding recoupment of such lost co-pays to protect pharmacies from being forced to absorb this cost.
- All providers must be treated fairly and on an equal basis. If a contract contains “any willing provider” language, then it must treat all providers equally and not base participation criteria on business size or number of patients served.
- Proper transparency must be incorporated into contracts between the MCO and the pharmacy benefit manager (PBM) retained to administer the pharmacy benefit AND contracts between the PBM and participating pharmacies. Properly implemented transparency measures will result in PBMs passing the proper cost savings through to the state.

# Contracting for Pharmacy Services With MCOs

**States may choose to contract the management of their pharmacy benefit services to a managed care organization (MCO) that in turn may contract with a pharmacy benefit manager (PBM). There are many factors that government officials and policymakers must take into consideration to ensure a fair and transparent marketplace that will benefit the state system, the pharmacist as a health care provider, and the patient.**

According to a study conducted by the Kaiser Commission on Medicaid and the Uninsured, across all 50 states, only three (Alaska, New Hampshire, and Wyoming) have no form of managed care operating within their Medicaid system. In addition, as of June 2009, 71.7% of Medicaid beneficiaries were to some degree involved in managed care. However, this statistic is somewhat misleading when one looks at the individual state coverage because many of these are not full-risk managed care programs. Many states claim to provide an MCO when in fact they are offering a primary care case management (PCCM) program, administrative service organization (ASO) or similar partial risk option programs. In spite of the growth in the use of managed care and its promotion as a cost containment strategy, health care costs continue to rise and Medicaid budgets continue to skyrocket. If managed care is utilized, then policy and decision makers must find more effective ways to monitor and administer these services.

If the state decides to contract the management of the pharmacy program to a private sector entity or entities, there are best practices that should be followed—the most valuable are set out in this document. It is essential that the state maintain program oversight and pharmacy program integration with other health care services. The state must also ensure that protections are set in place to provide for fair treatment of pharmacy. Failure to do so will jeopardize pharmacy provider retention, overall health outcomes, cost, and safety.

The following states found that the use of managed care in their Medicaid pharmacy

program did *NOT* result in discernable cost savings or improved coordination of care.

## Florida 2011

Insufficient evidence to verify claims of potential cost savings and also very serious concerns with regard to patient access to care, particularly with turnover among private plans that disrupt sustainable patient-provider relationships.

*(Georgetown University Health Policy Institute study, [hpi.georgetown.edu/floridamedicaid](http://hpi.georgetown.edu/floridamedicaid))*

## Missouri 2009

- No significant difference in access to, or quality of, care between fee-for-service and managed care.
- Pharmacy is frequently, if not always, best delivered through a consolidated, *state controlled* program.
- Regardless of the degree of risk a state decides to offset to a vendor, and regardless of the method of delivering services, it is clear that careful consideration should be given to pharmacy services. Pharmacy is frequently, if not always, best delivered through a consolidated, *state controlled program*. This provides the state with the most control, the most integrated benefit and the most cost-effective benefit.

*(Alicia Smith and Associates, Missouri Oversight Committee Presentation, October 27, 2009)*

## Oklahoma 2009

- States with *in-house* managed care programs could produce results equal to the MCOs **if** Medicaid agencies have

the necessary resources and a commitment to truly manage care.

*([www.mathematica-mpr.com/publications/pdfs/soonerchartbook.pdf](http://www.mathematica-mpr.com/publications/pdfs/soonerchartbook.pdf))*

## Arkansas 2001-2009

- Even with successful implementation of new programs and notable decreases in emergency room visits, the state observed increased costs per participant and increased overall caseloads.

## Contracting Principles for Medicaid MCOs and PBMs

When a state chooses to outsource its pharmacy benefit programs to MCOs the following are best practices that should be in place in contracts between the PBM/pharmacy to provide a fair and reasonable marketplace for pharmacy.





### **Proper provider reimbursement**

As was stated in previous sections of this document, proper reimbursement is vital to ensuring provider retention and fair and reasonable provider compensation. Currently there are vast discrepancies between pharmacy reimbursement and the true cost of the services provided. Therefore, it is essential that both reimbursement and pharmacy dispensing fees are reasonable and accurately reflect the true costs of the product as well as the operation. A 2011 cost of dispensing study conducted by the Texas Health and Human Services Commission found that it costs a pharmacy \$11.27 to dispense a medication in Texas. This does not include the cost of the drug but simply incorporates administrative costs such as company overhead and packaging. Currently in most cases, dispensing fees do not come close to reflecting the cost of pharmacy operations. States must reasonably compensate a pharmacy for the services they provide as well as monitor these reimbursements if contracting with managed care organizations if they expect to have adequate pharmacist participation

and corresponding beneficiary access to services.

### **Fair and timely pharmacy reimbursement standards**

PBMs and MCOs should outline the requirements for prompt pay/reimbursement to a pharmacy. Generally, pharmacies should expect to be reimbursed no less than biweekly. For example, section 162 of Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires the sponsors to pay all clean claims submitted by network retail pharmacies within 14 days for electronic claims.

An ideal program would state that this time begins to toll once a complete and correct claim is transmitted and accepted by the payer. Detail should be provided indicating how quickly claims are returned to the provider for any corrections and how quickly corrections need to be resubmitted. If this is not defined, abusive practices may occur whereby a pharmacy enters into a period of comment and correction while not being reimbursed.

If a pharmacy does not receive reimbursement within the contractually agreed upon “prompt pay” time frame, interest should immediately begin to accrue at that time and continue to do so until payment is made. The rate of interest should be established in contractual terms between the pharmacy and PBM/MCO.

### **Consistent and protected co-pays**

Generally, a federally approved State Plan Amendment (SPA) sets out the terms and conditions of implementing the Medicaid program within the given state and all co-pays should be consistent with this established framework. For the average Medicaid recipient, the co-pay must not exceed a certain amount as determined by the Centers for Medicare and Medicaid Services. Currently, \$3 is the maximum co-pay that CMS has approved and it is important that the co-pay relationship to the total reimbursement amount be clearly stipulated. If it is a true co-pay, it will be a deduction from the aggregate reimbursement submitted consisting of the aggregate of the cost of the medication and the dispensing fee.

Generally, CMS has held that the failure to pay co-pays by the recipient cannot be the sole basis for withholding services. This is a measure to protect health care accessibility for the truly needy population that cannot afford such co-pays. Legitimate reasons for being unable to pay co-pays do exist and pharmacists understand this. However, states should implement measures to protect pharmacy against fraudulent activities regarding co-pays.

### **Transparent “any willing provider” provisions**

Many states have some type of “any willing provider” statute guaranteeing a provider the opportunity to be offered a contract to participate in a third-party program. This is applicable as the provider willingly accepts all of the terms and conditions of the contract that the MCO makes available to any other like provider in the state. States should only contract with MCOs that ensure that there will be no variations in the terms and conditions applicable to providers.

In some cases, smaller pharmacy operations are at a contractual disadvantage in

comparison to larger chain operations and PBM mail order facilities. This is due to the size of the pharmacy operations in gross sales, physical facility size, and the volume (in dollars or prescription volume) that the pharmacy expects to provide for the MCO. This does not provide a level playing field, especially for independent pharmacies that compete with these corporate PBM giants or large chains. If “any willing provider” language is incorporated into a program, then it must be fair and transparent for all parties.

### **Required PBM disclosures to the state Medicaid agency**

Properly contractually implemented transparency measures will result in MCOs and PBMs passing the proper cost savings measures through to plans and the state itself. At a minimum, PBMs should be required to disclose to the MCO and to the state the same information that PBMs that will serve the State Health Insurance Exchanges must disclose to the U.S. Health and Human Services Secretary and the health plans under the Affordable Care Act (ACA). Under Title VI Section 6005 of PPACA, PBMs that serve the health plans in the exchange will be required to confidentially disclose to the Secretary and the plans information on:

- The percent of all prescriptions provided through retail pharmacies compared to mail order and the generic dispensing rate and substitution rates of each;
- The aggregate amount and types of rebates, discounts and price concessions that the PBM negotiates on behalf of the plan and the aggregate amount of these passed on to the plan sponsor;
- The average aggregate difference between the amount the plan pays the PBM and the amount that the PBM pays the retail and mail order pharmacy.

The disclosure of this data will enable the state to determine whether or not the PBM is in fact doing its job by acting in the best interests of the state and maximizing cost savings opportunities.

### **Fair and uniform pharmacy auditing standards**

Any contract offered by an MCO or PBM payer to a pharmacy should have set out

within the contract clear definition of the requirements of any auditing process that is anticipated to occur to enforce the individual contract. Also set out should be the requirements between the individual contracting third-party (MCO or PBM) and the Medicaid agency. Specifically, it should be noted in the contract if any of the terms and conditions associated with the primary contract is relevant to this secondary provider contract. In other words, it should be clearly set out who the auditing agency will be to alleviate any confusion and to assure that the pharmacy will not be audited by multiple parties under the same criteria.

### **“Fair audit” provisions should be required to be included in contracts between the MCO/PBM and the pharmacy and at a minimum should include the following provisions:**

- The entity conducting the audit shall not use extrapolation in calculating the recoupments or penalties for the audits.
- Interest may not accrue during the audit period.
- Clerical or record-keeping errors may not be the basis for the recoupment of funds by the PBM—unless the PBM can provide proof of intent to commit fraud or such error results in actual financial harm to the PBM, the state or a consumer.
- Any legal prescription that complies with the State Board of Pharmacy requirements may be used to validate claims in connection with prescriptions, refills or changes in prescriptions.

In addition, contracts between the PBM and the pharmacy should also include the methodology and resources utilized for maximum allowable cost (MAC) pricing as well include details on how often these files will be updated and how pharmacies will be notified of such changes. The PBM should also include provisions in which they agree to pay pharmacies promptly for clean claims and not require that a pharmacy or pharmacist participate in a pharmacy network managed by such PBM as a condition for the pharmacy to participate in another network managed by such PBM.



# Best Management Practices for MCO/PBM/Pharmacy Contracting

## Snapshot of Current Pharmacy Reimbursement Landscape

- Pharmacy reimbursement models are extremely complex.
- Establishing an appropriate pharmacy reimbursement methodology is critical to maintaining adequate provider participation to ensure beneficiary access to care and containing costs of downstream medical interventions.
- In challenging economic times, provider reimbursement rates often are targeted for drastic reductions.
- Due to the expected phase-out of the widely used average wholesale price (AWP) reimbursement benchmark and the perception that greater savings are to be had—many states are now exploring the use of average acquisition cost (AAC) as a potential reimbursement benchmark.

## Current Approaches to Pharmacy Reimbursement

- Generally, states have relied on three reimbursement methods or benchmarks.
- List price such as AWP or Wholesale Acquisition Cost (WAC)
- Fixed price such as a Federal Upper Limit (FUL) or MAC
- Cost-plus, basing reimbursement on data collected from manufacturers and/or wholesalers
- Alabama and Oregon have implemented AAC for Medicaid pharmacy reimbursement

## Future Reimbursement Trends

- Growing interest in use of AAC as pharmacy reimbursement benchmark (Alabama and Oregon currently use)
- 41 of 50 states (plus Puerto Rico) wish to have a single national reimbursement pricing benchmark.
- CMS has contracted with Myers & Stauffer, LLC, to develop the National Drug Acquisition Cost (NADAC)—essentially a national AAC benchmark—through a pharmacy-administered survey process.
- State Medicaid programs could use AAC or NADAC instead of AWP or WAC to establish pharmacy reimbursement rates.

## Pharmacy Reimbursement Benchmarks Are Always Linked to a Dispensing Fee

- Benchmarks are combined with a dispensing fee to arrive at the total reimbursement to the pharmacy.
- Most Medicaid dispensing rates are inadequate and do not cover actually medication or dispensing costs.
- Pharmacy dispensing fees are typically well below the actual cost it takes to dispense medication.



# Medicaid Pharmacy Reimbursement in a Dynamic Health Care Environment

The crux of a benefit program for the provider is how they can continue to serve the Medicaid population during a time when states are increasingly relying on reimbursement cuts to solve their budget shortfalls and in an continually hostile business environment for smaller community pharmacies. As government entities face economic challenges, many times providers are the sector most often targeted for cuts—with the most visible areas being the provider fee and product reimbursement. However, policymakers must understand that decreasing pharmacy reimbursement can have negative impacts on patient health and the ability of a pharmacy to stay in business. This can result in causing access to care concerns and the potential for increased costs throughout the health care system.

## Current Pharmacy Reimbursement Trends

Overall, most states currently generally rely on three methods of pricing models, sometimes mixing more than one, which are:

- List price such as AWP or WAC
- Fixed price such as a FUL or MAC
- Growing interest in use of AAC-based on data collected from manufacturers, pharmacies and/or wholesalers (currently only used in Alabama and Oregon)

These are then combined with a dispensing fee to arrive at the total product or prescription reimbursement. Many studies have shown that pharmacies typically rely on the product price differential and a dispensing fee that many times is significantly lower than most surveys have shown the true cost of dispensing to be. A state-funded study in Texas found that it cost a pharmacy \$11.27 to dispense medication. This figure does not include cost of the medication itself but incorporates overhead costs to the pharmacy. Medicaid dispensing fees do not even begin to approach this amount—typically falling between \$1–\$4. However, the states,

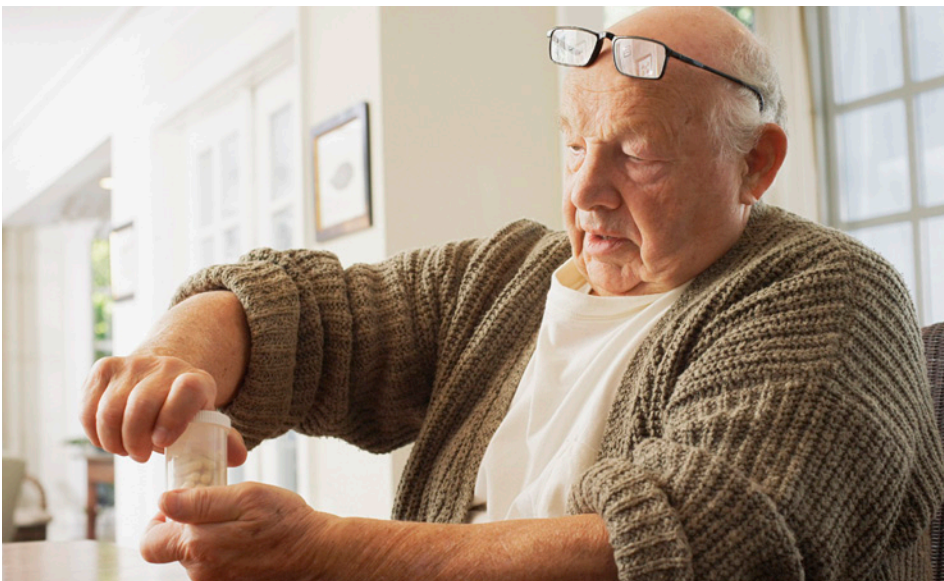
in their economically stressed positions, are reluctant to provide an increase in the fee, even when unbiased surveys clearly indicate that an increase is warranted. The states often simply reduce the reimbursement of the product. In fact, many states have sought to lower both ingredient cost and dispensing fee at the same time—irrespective of their overall impact on the pharmacy community. This approach can be catastrophic to independent pharmacists in highly-served Medicaid areas.

## Shift Away From AWP and Growing Interest in Use of AAC

First Data Bank, one of the major sources of AWP data used by many state Medicaid agencies, announced that it would cease publishing AWP's after September 26, 2011. This announcement has prompted many states that use AWP to either seek alternate data sources for AWP or other reimbursement methodologies or benchmarks. A number of states have expressed a growing interest in the use of AAC as a reimbursement benchmark, although to date, only Alabama and Oregon have actually implemented this approach. Under this model, the state through an independent contractor solicits invoices from participating pharmacies. The contractor then calculates the average cost per drug and the resulting prices are posted online. Both Alabama and Oregon conducted a cost of dispensing study—designed to reflect the true costs of dispensing a medication. In both states, this resulted in an augmented dispensing fee being used with the AAC benchmark—a critical factor if AAC is used.

## Best Practices for Implementing an Average Acquisition Cost Reimbursement Model

As with managed care implementation, an AAC model must also be approached cautiously to assure providers are protected



and are reimbursed fairly. The following principles that should be addressed during the development of an AAC model. States should take these principles into consideration if they choose to take this route of pharmacy reimbursement.

- Benchmark must be updated frequently; otherwise, AAC will become outdated and pharmacies will be underpaid. It should also be recognized that the benchmark will be outdated by several months—even when it is first published—so a percentage increase in the benchmark may be necessary to avoid underpaying pharmacies. The SPA should specify the frequency of the reimbursement updates.
- Benchmark must correspond to community retail pharmacy costs and not include purchasers such as hospitals, physicians, PBMs, and other similar entities. The benchmark for pharmacy reimbursement should only be inclusive of discounts, rebates, and other price concessions that are specifically available to retail pharmacies.
- Benchmark and dispensing fee must be considered together in order to ensure that pharmacies are properly reimbursed (need to factor in the total cost of acquiring the drug, inventory management, dispensing, and professional services) with an adequate return.
- Need to maintain incentives to dispense lower-cost generic drugs. Because generics are purchased in a commodity market, there are a wide range of manufacturer prices. Smaller pharmacies purchase at a higher price than large self-warehousing chains. For this reason, states may wish to consider using a “median” reimbursement benchmark, rather than average, for generics for independent pharmacies.
- A pharmacy cost of dispensing (COD) survey should be completed on an annual basis. The state should include with the survey instrument a clear explanation for the pharmacist as to what the data is going to be used for and the extreme importance of an accurate and timely response. The state

may also wish to stipulate that a certain response rate will be required in order for the COD survey to be deemed statistically valid.

- States may wish to provide a dispensing fee incentive for those pharmacies that serve a significant number of Medicaid beneficiaries or where Medicaid claims make up a certain percentage of their total prescription volume. These pharmacies could receive an additional amount (e.g., \$0.50) added to the base dispensing fee or to those pharmacies for whom generics make up at least a certain percentage of their total prescription volume.

### **National Average Drug Acquisition Cost**

Most recently CMS announced in August 2011 that it plans to publish a national average drug acquisition cost or NADAC pricing benchmark to be based on a national survey of pharmacies through a contracted survey.

The benchmark will be based upon pharmacies’ acquisition costs for both brand and generic drugs, which state Medicaid programs could use instead of conducting their own AAC benchmark based on a state-specific survey or using another benchmark. CMS has entered into a contract with Myers & Stauffer, LC, to develop the NADAC. Myers & Stauffer currently collects pharmacy acquisition costs for Oregon and Alabama, two states that have made such costs an element of their Medicaid pharmacy reimbursement. The Office of the Inspector General (OIG) found that 41 of 50 states (plus Puerto Rico) would prefer that CMS develop a single national pricing benchmark.

### **Additional Guidance Needed for States Needed Prior to Use of NADAC**

Although the NADAC process has not yet started, some industry experts have pointed out that this national survey data may not accurately reflect the actual conditions apparent in any given state and that additional guidance or alternatives may be necessary for those states that choose this route.

