Pharmacy reimbursement changes

Effective date: April 1, 2017
Implementation date: Sept. 1, 2017
Reprocessing date: Oct. 1, 2017 (weekly schedule)

A new pharmacy reimbursement methodology for the Mississippi Division of Medicaid (DOM) impacts both fee-for-service and MississippiCAN pharmacy claims.

On Feb. 1, 2016, the Centers for Medicare and Medicaid Services (CMS) published 42 CFR, Part 447: Medicaid Program Covered Outpatient Drugs with final comments (CMS-2345-FC). This rule addresses regulations that pertain to reimbursement for covered outpatient drugs in the Medicaid program (fee for service and MississippiCAN). The document is available online at http://federalregister.gov/a/2016-01274.

DOM hosted a series of six pharmacy stakeholder meetings throughout 2016 for the purpose of engaging providers in discussions to gather feedback on pharmacy reimbursement options. Reimbursement methodology options presented at these meetings can be found at https://medicaid.ms.gov/agency-holds-pharmacy-stakeholder-meetings-about-reimbursement-options-2/.

In compliance with the Final Rule issued by CMS, DOM submitted State Plan Amendment (SPA) 17-0002 Pharmacy Reimbursement to CMS on March 15, 2017. On June 1, 2017, DOM received a formal Request Additional Information (RAI) letter from CMS. DOM submitted an RAI response letter with revised SPA changes to CMS on June 27, 2017.

On July 21, 2017, CMS approved the DOM SPA 17-0002 Pharmacy Reimbursement with an effective date of April 1, 2017. The approved SPA can be found at https://medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/.

Implementation of the CMS approved point of sale pharmacy reimbursement methodology for fee for service and MississippiCAN will begin on September 1, 2017.

I. The Division of Medicaid reimburses the following drugs as described below:

   A. Brand Name drugs – Ingredient cost based on actual acquisition cost (AAC) which is defined as the lesser of:
      1. National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee of $11.29, or
      2. Wholesale Acquisition Cost (WAC) plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
      3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
      4. The provider's usual and customary charge.

B. Generic drugs – Ingredient cost based on AAC which is defined as the lesser of:
   1. NADAC plus a professional dispensing fee of $11.29, or
   2. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
   3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
   4. The provider's usual and customary charge.

C. Reimbursement for 340B covered entities as described in section 1927(a)(5)(B) of the Act, including an Indian Health Service, tribal and urban Indian pharmacy as follows:
   1. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the covered outpatient drug plus a professional dispensing fee of $11.29.
   2. Drugs purchased outside of the 340B program by covered entities – Ingredient cost based on AAC which is defined as the lesser of:
      a. NADAC plus a professional dispensing fee of $11.29, or
      b. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
      c. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no WAC is available, or
      d. The provider's usual and customary charge.
   3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

D. Drugs acquired via the Federal Supply Schedule (FSS) – Ingredient cost based on AAC plus a professional dispensing fee of $11.29.

E. Drugs acquired at Nominal Price (outside of 340B or FSS) – Ingredient cost based on AAC plus a professional dispensing fee of $11.29.

F. Specialty drugs not dispensed by a retail community pharmacy and dispensed primarily through the mail – Ingredient cost is defined as the lesser of:
   1. WAC plus zero percent (0%) plus a professional dispensing fee of $61.14, or
   2. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $61.14 when no WAC is available, or
   3. The provider's usual and customary charge.

G. Drugs not dispensed by a retail community pharmacy (e.g., institutional or long-term care pharmacy when not included as part of an inpatient stay) – Ingredient cost based on AAC which is defined as the lesser of:
   1. NADAC plus a professional dispensing fee of $11.29, or

2. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
4. The provider's usual and customary charge.

H. Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers (HTCs), or Centers of Excellence – Ingredient cost defined as:
   1. For a 340B covered entity:
      a. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the clotting factor product plus a professional dispensing fee of $0.02 per Unit.
      b. Drugs purchased outside of the 340B program by covered entities – Ingredient cost which is defined as the lesser of:
         1) WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit, or
         2) A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02 when no WAC is available, or
         3) The provider's usual and customary charge.
   2. For a non-340B covered entity – Ingredient cost is defined as the lesser of:
      a. WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit, or
      b. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02 when no WAC is available, or
      c. The provider's usual and customary charge.

II. The Division of Medicaid does not reimburse for Investigational Drugs**.**

III. Usual and Customary Charges

The Division of Medicaid defines usual and customary charge as the lowest price the pharmacy would charge to a particular customer if such customer were paying cash for the identical prescription drug services on the date dispensed. This includes any applicable discounts including, but not limited to, senior discounts, frequent shopper discounts, and other special discounts offered to attract customers such as four dollar ($4.00) flat rate generic price lists. A pharmacy cannot have a usual and customary charge for prescription drug programs that differs from either cash customers or other third-party programs. The pharmacy must submit the accurate usual and customary charge with respect to all claims for prescription drug services.

IV. Overall, the Division of Medicaid's payment will not exceed the federal upper limit (FUL) based on the NADAC for ingredient reimbursement in the aggregate for multiple source drugs.

Reprocessing of point-of –sale, fee-for-service, and MississippiCAN pharmacy claims for dates of service April 1, 2017, through Aug. 31, 2017, will begin in weekly increments on Oct. 1, 2017. The reprocessing will follow the schedule below.

Reprocessing Adjustment Schedule

Adjust claims using new reimbursement methodology for Dates of Service =		**Adjustment amount reflected on Remittance Advice dated:**
April 1-8	(Saturday – Saturday)	October 2, 2017
April 9-15	(Sunday – Saturday)	October 9, 2017
April 16-22	(Sunday – Saturday)	October 16, 2017
April 23-29	(Sunday – Saturday)	October 23, 2017
April 30- May 6	(Sunday – Saturday)	October 30, 2017
May 7-13	(Sunday – Saturday)	November 6, 2017
May 14-20	(Sunday – Saturday)	November 13, 2017
May 21-27	(Sunday – Saturday)	November 20, 2017
May 28-June 3	(Sunday – Saturday)	November 27, 2017
June 4-10	(Sunday – Saturday)	December 4, 2017
June 11-17	(Sunday – Saturday)	December 11, 2017
June 18-24	(Sunday – Saturday)	December 18, 2017
June 25-July 1	(Sunday – Saturday)	December 25, 2017
July 2-8	(Sunday – Saturday)	January 1, 2018
July 9-15	(Sunday – Saturday)	January 8, 2018
July 16-22	(Sunday – Saturday)	January 15, 2018
July 23-29	(Sunday – Saturday)	January 22, 2018
July 30-August 5	(Sunday – Saturday)	January 29. 2018
August 6-12	(Sunday – Saturday)	February 5, 2018
August 13-19	(Sunday – Saturday)	February 12, 2018
August 20-26	(Sunday – Saturday)	February 19, 2018
August 27-31	(Sunday-Thursday)	February 26, 2018

In an effort to support providers during this adjustment period, DOM has made an estimated financial impact available to pharmacy providers. The estimated impact is based upon reprocessing fee-for-service and MississippiCAN pharmacy point of sale claims filed in the month of April 2017.

Providers can contact the Mercer Call Center to obtain their estimated financial impact total for the month of April 2017, by phone at 855-612-6863. To receive this information via secure email or when inquiring for more than 10 pharmacies, email your request to MSMedicaidRx@mercer.com and include your pharmacy name, address, Medicaid ID number and phone number.

For other questions, contact DOM's Office of Pharmacy by phone at 601-359-5253 (select option #4), or refer to the Frequently Asked Questions document on the Pharmacy page of the DOM website at https://medicaid.ms.gov/providers/pharmacy/.