MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Medical Services Administration
Pharmacy Management Division

Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR
NICK LYON, DIRECTOR

Pharmacy Provider Liaison
Minutes from Meeting on December 8, 2016

Attendees

Ray Casambre, Joe Leonard and Chad Downing, Walgreens; Stephanie Raymond and Chelsea Seal, Cascade Hemophilia; Karen Jonas, Michigan Association of Health Plans; Jim Mathews, Dave Lieber, Amanda Lick, Eric Liu, Sarah Barden and Eric Roath, Michigan Pharmacists Association; Jennifer Porras, Great Lakes Bay Health Centers; Ed Saleh, MedCart; Brett Gingrich, Cherry Health; Quinn Kline and Dale Masten, Genoa Healthcare; Ron Melaragni, Sparrow Health Services; Kevin Roeder, MI IV Rx; Sara Hernly, Clark Hill representing Rite Aid; Jim Horton, Clinical Hospital Pharmacy Management, P.C.; Autumn Gillard, Acuitas, LLC; Warren Deppong, University of Michigan HomeMed; Amy Drumm, Michigan Retailers Association; Halee Michel, MGS Consultants; Ghada Abdallah, Park Pharmacy; Sabato Caputo, Helen Walley, Tina Villarreal, Trish O'Keefe, Vicki Goethals, Linda VanCamp and Rita Subhedar, Michigan Department of Health and Human Services (MDHHS). A web conference line was made available for remote participants to listen to and view the PowerPoint presentation shared at the meeting.

Updates on Proposed Policies Scheduled to be Implemented in 2017

Rita Subhedar provided an update on a number of proposed policies scheduled for implementation in early 2017 that will have an impact on pharmacy claims:

Family Planning Services for Maternity Outpatient Medical Services (MOMS) Program Enrollees

During their 60-day postpartum period of eligibility, MOMS benefit plan beneficiaries will be eligible to receive family planning services, including oral contraceptives and treatment for sexually transmitted infections, with no cost-sharing liability. This policy will be effective February 1, 2017.

Healthy Michigan Plan Co-Pay Increases

Healthy Michigan Plan beneficiaries with incomes greater than 100% of the Federal Poverty Level will have increased co-pays of $4 for preferred drugs and $8 for non-preferred drugs. This policy will be effective April 1, 2017.

Early Refills for Prescription Drugs

Early refill overrides will be granted once per drug per 12 months for any of the following circumstances:

- To replace medication that has been lost, stolen or destroyed
- For the purposes of vacation or travel

The early refill will not exceed a 34-day supply. This policy will be effective April 1, 2017.

Coverage of Physician-Administered Injectable Drugs as Pharmacy Claims for Administration in Residential Treatment Centers

Coverage of Physician-Administered Injectable Drugs as Pharmacy Claims for Administration in Residential Treatment Centers

This policy expands upon bulletin MSA 15-19 to allow residential treatment centers to obtain injectable drugs from a pharmacy for inpatient administration. This policy will be effective April 1, 2017.

Enhanced 340B Claim Reporting Requirements

Section 340B of the Public Health Service Act requires participating drug manufacturers to provide outpatient drugs to eligible health care organizations at reduced prices. This program, known as the 340B program, also protects manufacturers from paying both a Medicaid rebate and a 340B discount on the same drug.

Section 438.3(s)(3) of the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) requires states and Managed Care Organizations to develop a process to identify claims subject to discounts under the 340B drug pricing program so that states can exclude them from the Federal Medicaid Drug Rebate process.

A June 2016 report from the US Department of Health and Human Services Office of Inspector General titled "State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates" recommended that states use claim-level methods to identify 340B claims for the purposes of excluding the claims from the Medicaid drug rebate process.

MDHHS currently uses a manual process for identifying 340B claims that must be excluded from the Medicaid drug rebate process. In order for MDHHS to further automate this process, providers will be responsible for accurate reporting of drugs purchased through the 340B program as outlined below:

Pharmacy Claims

Pharmacy providers must identify claims for drugs purchased through the 340B program by entering a value of 20 in the Submission Clarification Code field 420-DK.

Institutional/Professional Claims

Providers must identify professional claims for physician-administered drugs that are purchased through the 340B program by adding the modifier U6 to these claims. The National Drug Code (NDC) and its supplemental information must also be included on the claim.

This process applies to Fee-for-Service (FFS) and Medicaid Health Plan (MHP) claims. If providers do not follow this process for drugs purchased through the 340B program, these claims will be included in the Medicaid drug rebate process and providers may be contacted by drug manufacturers, rebate staff, the U.S. Health Resources & Services Administration (HRSA), and other entities about reversing and resubmitting the claims with the correct indicator. This policy will be effective April 1, 2017.

Federal Rule on Covered Outpatient Drugs

Rita provided an update on MDHHS' implementation of the Federal Rule on Covered Outpatient Drugs. The Rule directs states to implement certain changes to pharmacy claim reimbursement. These changes will be effective April 1, 2017.

Ingredient Cost

The Rule stipulates that ingredient cost reimbursement must be based on Actual Acquisition Cost (AAC). CMS has created the National Average Drug Acquisition Cost (NADAC) for states to use in order to meet the AAC requirement. The NADAC is available at data.medicaid.gov.

Dispensing Fee

- The Rule replaces the term "dispensing fee" with "professional dispensing fee" and requires states to provide data to support a new professional dispensing fee.
- MDHHS engaged Myers & Stauffer LC to conduct a Cost of Dispensing Study.

Presentation from Myers & Stauffer on Michigan Cost of Dispensing Study

Allan Hansen from Myers & Stauffer provided an overview of the Cost of Dispensing survey methodology.

Overview of Cost of Dispensing Survey Methodology

- Myers and Stauffer's cost of dispensing survey approach is based on actual (not estimated) historical costs incurred by pharmacies and relies upon existing records (e.g., financial statements, federal income tax returns, prescription summary reports, etc.) for support. The survey tool collects all overhead and labor expenses incurred at each pharmacy.
- Shared expenses are allocated to the prescription department using an appropriate basis (e.g., "sales ratio", "area ratio", percentage of time in prescription department, etc.). Allocation methodologies are consistent with Medicare and Medicaid cost reporting principles (i.e., similar to hospital and nursing facility cost reports).
- The average cost of dispensing is calculated at each pharmacy by summing the allowable prescription-related costs at each pharmacy and dividing this sum by the number of prescriptions dispensed.

Matt Hill from Myers & Stauffer provided an overview of the Cost of Dispensing survey process and findings.

Cost of Dispensing Survey Process for Michigan

- The survey forms were designed in collaboration with MDHHS.
- On July 29, 2016 survey forms were distributed to all 2,683 pharmacies enrolled in the Michigan Medicaid pharmacy program. On August 17, 2016 a reminder letter was sent to all providers that had yet to submit a survey. On August 31, 2016 a second reminder letter was sent to pharmacies that had yet to submit a survey extending the survey due date from August 31, 2016 to September 14, 2016.
- 1,862 of the 2,683 pharmacies surveyed submitted a useable survey (approximately 72%). All 1,862 returned surveys were subjected to desk reviews to ensure completeness and accuracy.
- Survey data was analyzed to calculate the Cost of Dispensing (COD) at each pharmacy. The COD was summarized for all pharmacies and subsets of pharmacies. Results were reviewed by statisticians. The findings were presented in a draft report to MDHHS.

Cost of Dispensing Survey Findings

- Distribution of cost of dispensing (the majority of pharmacies had a COD between $5 and $14)
- The mean cost of dispensing weighted by Medicaid volume (excluding specialty pharmacies) is $10.64.
- Some pharmacy attributes did have a significant impact on the cost of dispensing:
    - Specialty services (i.e., provision of compounded infusion, intravenous, clotting factor or other specialty products)
    - Prescription volume
- 138 pharmacies were identified as specialty pharmacies. The mean cost of dispensing weighted by Medicaid volume (for specialty pharmacies) is $20.02.

Questions and Comments

- Ghada Abdallah asked why advertising costs were not included in calculating the average cost of dispensing. Allan responded that advertising costs were not allocated as a prescription expense per CMS guidelines.

- Ron Melaragni asked whether Myers & Stauffer's findings have been consistent with findings from other states. Allan responded that cost of dispensing studies conducted in other states have produced similar results.

- Ron asked if MDHHS is planning on imposing penalties on pharmacies that did not respond to the survey. Rita responded that at this time there are no plans to penalize pharmacies that did not

respond to the survey, though the Department will have a list of pharmacies that did not respond to the survey or submitted surveys that were unusable due to being incomplete.

- Ron asked whether MDHHS could disclose the cost that MDHHS paid to Myers & Stauffer to perform the study. Trish responded that she will confirm that this information can be made public.

- Kevin Roeder asked whether Myers & Stauffer receive a percentage from any potential budget savings realized through a change in reimbursement. Rita responded that Myers & Stauffer will be paid a flat fee based on the work performed and is not receiving a percentage of any potential savings.

- Kevin asked how often NADAC prices are updated. Allan responded that the NADAC rates are updated on a weekly and monthly schedule:

    - Weekly updates occur for help desk calls and brand drugs to reflect changes in published pricing

    - Monthly updates occur to reflect the results of the ongoing monthly acquisition cost survey for brand and generic drugs

    - In addition, prices may be adjusted when pharmacies contact the NADAC Help Desk about recent drug price changes that are not reflected in posted NADAC files. The NADAC Help Desk can be contacted through the following means:

        - Toll-Free: (855) 457-5264

        - E-Mail: info@mslcrps.com

        - Fax: (844) 860-0236

- Ghada asked how NDCs without a NADAC rate will be paid. Trish responded that NDCs that do not have a NADAC rate assigned would be paid using other pricing methodologies available, which may include Wholesale Acquisition Cost (WAC) and Maximum Allowable Cost (MAC).

- Amanda Lick asked about the methodology used to calculate the NADAC. Allan responded that the methodology for calculating the NADAC is available on CMS' website: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/ful-nadac-downloads/nadacmethodology.pdf

- Amy Drumm asked about the types of dispensing fees that the Department is considering. Allan responded that Myers & Stauffer provided the Department with several models for professional dispensing fees, including tiered professional dispensing fees based on pharmacy volume, and professional dispensing fees based on pharmacy type. Rita added that the Department is considering a separate professional dispensing fee for specialty products and a tiered professional dispensing fee based on the drug's status as preferred or non-preferred.

- Eric Roath asked about how the inflation rate was factored into the study. Allan responded that the midpoint and terminal month indices used were taken from the Employment Cost Index published by the Bureau of Labor Statistics (BLS). The majority of submitted cost surveys were based on a fiscal year which ended on or within two months of December 31, 2015.

  Although the survey methodology incorporates short term inflation adjustments to account for the varying fiscal year ends dates associated with the data submitted by pharmacies, it is not necessarily the case that long-term inflation adjustments need to be considered for purposes of setting the professional dispensing fee to be used within a Medicaid program. Inflationary pressures do impact the input costs pharmacies incur in their operations. However, these increased input costs appear to have been offset in recent years by gains in pharmacy efficiency.

  In general, pharmacy total prescription volume has been on an upward trend. In the early 2000's many pharmacy chains were frequently opening new stores. These new stores started with a relatively small customer base and with corresponding low prescription volumes. This time period coincided with a period in which there was a shortage of available pharmacists and pharmacist salaries were increasing sharply. However, over time, the growth of new pharmacies has slowed and stores which were new ten or more years ago have built their customer base and increased their overall prescription volume. The pharmacist shortage appears to have passed.

  Additionally, in recent years, many pharmacies have implemented changes to business operations that have increased efficiency. For example, more pharmacies are participating in e-prescribing, central fill dispensing and the use of automated dispensing. These changes have made pharmacists and other pharmacy staff more efficient at dispensing medications. All of these trends have resulted in gains in efficiency, and have curtailed the rate of increase in the average cost of dispensing on a per prescription basis.

- Ron requested that the Department take the top 100 utilized products and reprice those National Drug Codes and units dispensed using NADAC (or WAC + 0% or existing Michigan MAC) along with the draft $10.64 dispensing fee to demonstrate what that reimbursement would look like compared to actual reimbursement. Trish O'Keefe responded that the Department would look into this.

- Ed Saleh asked how specialty pharmacies were identified in the study. Allan responded that specialty pharmacies were identified based on whether their reported sales for intravenous, home infusion, blood factor and/or other specialty services were 10% or more of their total prescription sales. Rita added that the Department has asked Myers & Stauffer to perform an additional analysis on cost of dispensing for URAC-accredited pharmacies.

The next meeting will be on March 9th 2017 at the Capitol Commons Center in Lansing from 2:30 – 4:30 pm.