Overview of Coverage of Drugs Under the Medicaid Medical Benefit

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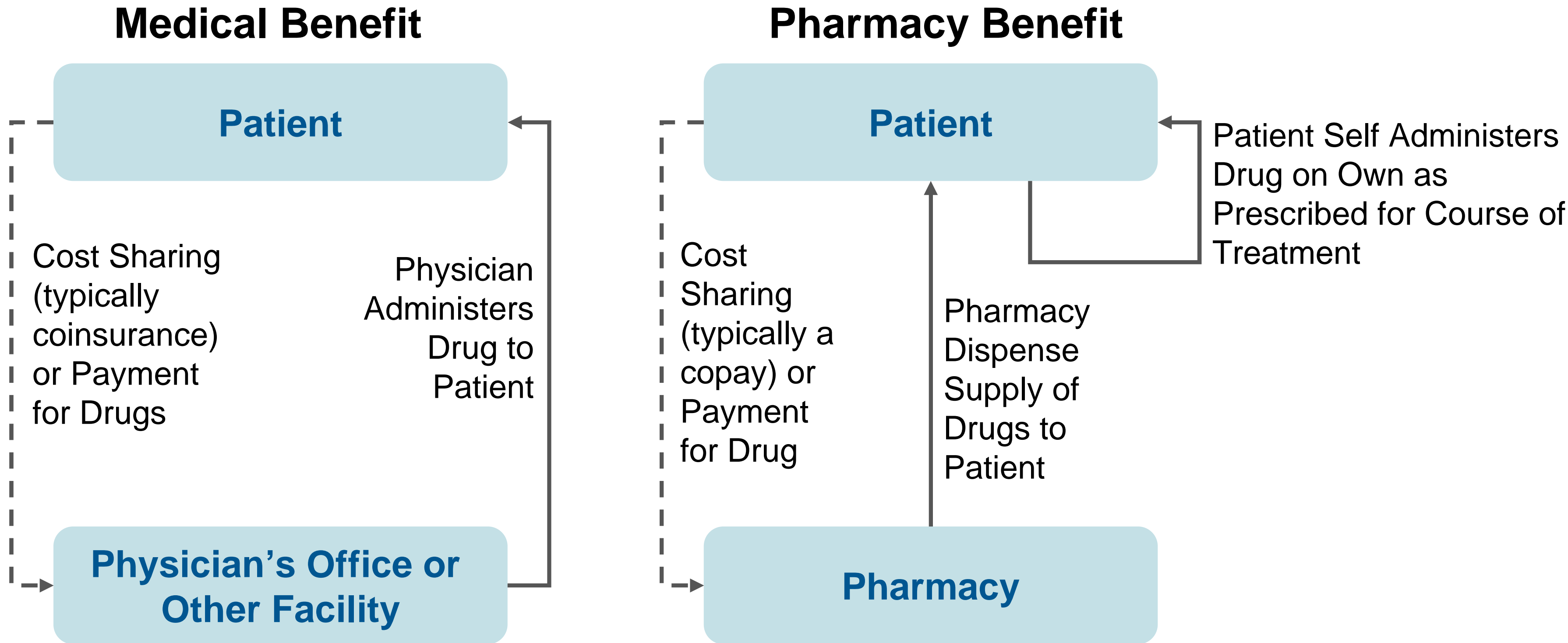
Medical vs. Pharmacy Benefit



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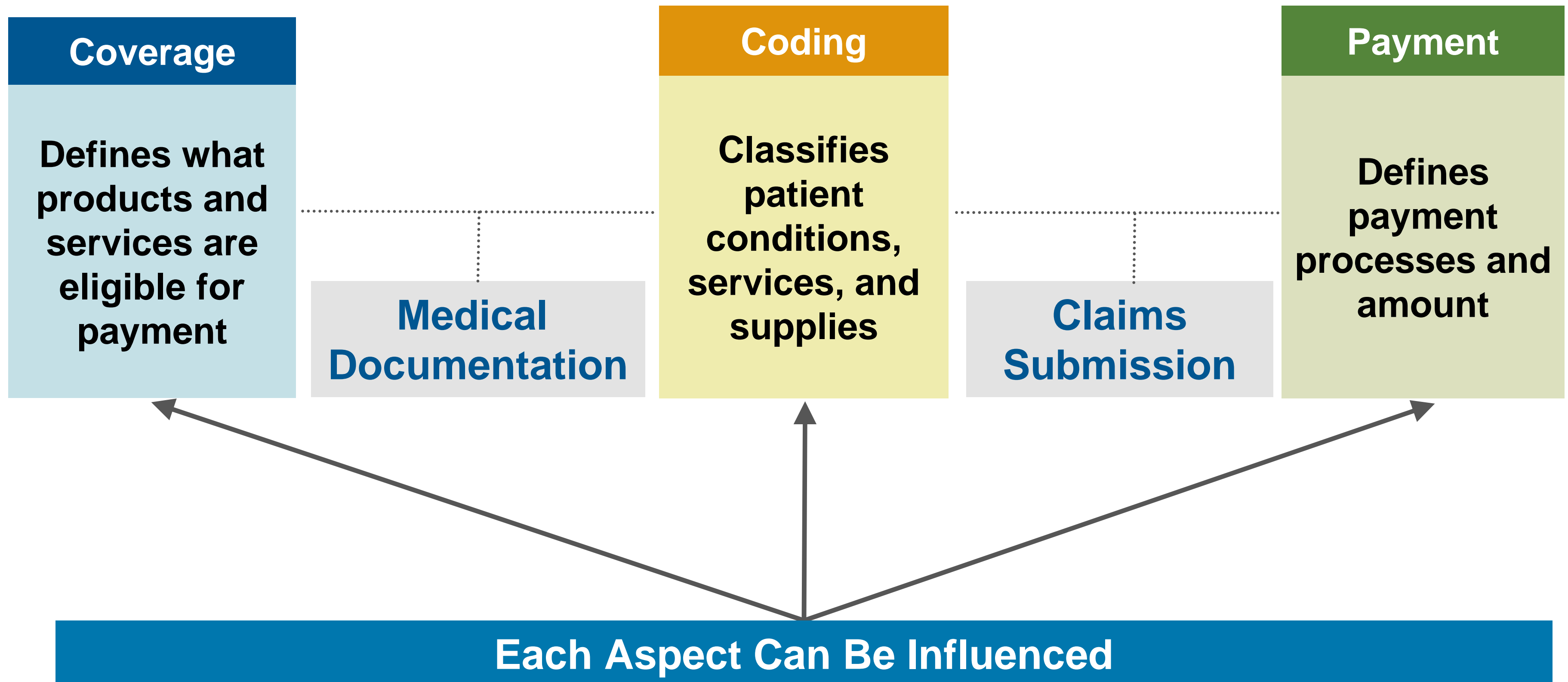
Basic Reimbursement Concepts

Coverage, Coding, and Payment Are Key to Reimbursement



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Coverage Describes which Products and Services Are Eligible for Payment

- Insurance contracts specify coverage policies for services that are:
  - »Safe and effective
  - »Not experimental or investigational (few exceptions)
  - »Medically necessary
- Insurers (including Medicare) use coverage policies to control utilization of medical devices, procedures, and pharmaceuticals
  - »Increasingly important given the rapid increase in healthcare costs and utilization, and the introduction of high-cost therapeutics into the market
- Only when a product or service is covered can it be reimbursed
- FDA approval is necessary, but not sufficient, for insurer coverage
  - »If a technology receives FDA approval, insurer coverage and payment are not guaranteed

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Codes Facilitate Payment for Health Care Services and Supplies

What are codes?

Standard systems to convey information between providers and payers

What do codes describe?

Medical services, procedures, drugs, supplies, devices, and patient conditions

Where are codes used?

On insurance claim forms

What do codes do?

Enable payers to process and pay claims

What codes are necessary for drugs?

Depends on type of medical service, setting of care, and existing codes

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Payment for Health Care Services Varies by Setting and by Payer

- Medicare has standardized systems to pay for care
- Private insurer payment is highly variable depending on the health plan
- Medicaid payments vary by state, but are often based on Medicare systems
- In general, insurers make one payment to the hospital and one to the physician
- Drugs and devices may be paid separately, or bundled with a larger group of services
  - » In the hospital, drugs and devices are more likely to be bundled in with payment for other services
  - » In the physician office, drugs and devices are often paid separately

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Medicaid Medical Benefit Drug Reimbursement

Medicaid Reimbursement for Medical Benefit Drugs

2005

Beneficiary

Copay not enforceable

Physician Office/ Hospital Outpatient

Wholesaler/ Distributor

Manufacturer

CMS

Federal Matching Rate

AWP/WAC-based Reimbursement

State Medicaid

Federally mandated rebate (some states collected)

2006 - present

Premium (if applicable) may be enforceable

Beneficiary

Copay may be enforceable

AWP/WAC/ASP-based Reimbursement

Physician Office/ Hospital Outpatient

Wholesaler/ Distributor

Federally mandated rebate (required for certain drugs)

Manufacturer

- Product Flow
- Reimbursement Flow
- Rebate Flow
- Beneficiary Cost sharing

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Dual Eligibles' Access to Medical Benefit Drugs Did Not Change With Part D

- Medicare is the primary payer for dual eligibles, Medicaid provides wraparound coverage for Medicaid-only services and most Medicare cost sharing
- Most state Medicaid programs cover the 20 percent coinsurance for Part B drugs
  - » States that have Medicaid-only reimbursement rates that are lower than the Medicare rate (80 percent) are not required to cover duals' coinsurance
  - » Coverage of medical benefit drugs, or those in Part B, did not change with introduction of Part D

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Medicaid Rebates Must Now Be Collected for Physician Administered Drugs

- Medicaid rebates have been collected for drugs covered in the pharmacy benefit
  - » 15.1% AMP or best price for brand name drugs
  - » Additional CPI penalty for drugs where prices increased faster than CPI
  - » Incremental supplemental rebates, where they apply
- Most states have been unable to collect rebates for drugs used in the office
- A significant revenue opportunity exists for states if they collect rebates in the office
- Therefore, Congress mandated that all states must collect these rebates:
  - » Beginning in January of 2006 for single source drugs
  - » Beginning in January of 2008 for certain multi-source drugs (still to be specified)
- In addition, states may collect the rebates retrospectively
  - » A “statute of limitations” does not exist

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DRA Increases Manufacturers' Rebate Liability for Medical Benefit Drugs

- The DRA requires states to crosswalk HCPCS codes with NDCs to collect Medicaid rebates on certain medical benefit drugs*
- Historically, states have been challenged operationally and financially in making such costly adjustments to their systems
- Claim forms used by Medicaid programs typically do not accommodate NDC codes
- Once states use NDC codes, states will be able to identify when specific drugs are used; use of HCPCS codes does not provide product-specific information

Example of a HCPCS-NDC Code Crosswalk: Drugs From Several Manufacturers May Be Mapped to the Same J-Code

J-code	Drug	Dosage	Manufacturer	NDC Code
J1234	Drug X	25 mg	Company A	00015-0503-02
	Drug X	50 mg	Company A	00015-0503-01
	Drug Y	25 mg	Company B	00015-0504-01
	Drug Y	50 mg	Company B	00054-4130-25
	Drug Z	25 mg	Company C	00054-8130-25
	Drug Z	50 mg	Company C	00054-4129-25

Medicaid rebate liability will increase for physician administered drugs.

* States must collect rebates on single source and the top 20 multiple source product administered in the physician office or in hospital outpatient settings

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Reimbursement Rate for Medicaid Medical Benefit Drugs

- Avalere recently conducted a survey of state Medicaid programs
  - » Finding: reimbursement rates vary widely
- Many states reimburse at the lower of multiple methodologies
  - » For example, Georgia uses lower of acquisition cost, submitted charges, or AWP-11 percent
- Eight of eighteen states surveyed use a percentage of AWP*
- Six states use a percentage addition to ASP**
- Missouri uses a percentage addition to WAC
- California uses invoices and bases reimbursement on the price of the drug minus five percent, plus the administration fee
- Maine uses a variable fee schedule
- New York uses invoices and bases reimbursement on NDC and acquisition cost

ASP is becoming a more common Medicaid reimbursement rate under the medical benefit

Note: Based on 18 respondents.
* CO, FL, GA, IN, NJ, OK, PA, SC
** LA, MN, MT, NC, TX, WA

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Changes in the Medicaid Program May Increase Scrutiny of Drugs Under the Medical Benefit

	Current Environment	Future Environment
Coverage of Benefits	▪ States do not aggressively manage medical benefit drugs ▪ Limited use of medical benefit drug policies that restrict use by diagnosis ▪ States are facing rapid increases in healthcare costs, utilization, and increasing high-cost medical benefit products	▪ States may increase restrictions, such as limitations on diagnosis and/or clinical guidelines for high-cost products, similar to Medicare Local Coverage Determinations ▪ NDC data may increase states' abilities to implement product-specific restrictions ▪ Specialty pharmacy arrangements may become more common to manage medical benefit drugs

Source: Recent Avalere survey of 20 state Medicaid programs.

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Medicaid Drug Coding Is Becoming More Specific

Drug Coding	Current Environment	Future Environment
	▪ Medicaid historically utilizes the same codes as Medicare Part B » HCPCS codes for products under the medical benefit (e.g., physician office) » Miscellaneous codes at launch until unique code available ▪ HCPCS codes do not allow for precision as to exact product used; difficult for states to implement drug-specific policies	▪ DRA requires collection of rebates for certain physician-administered drugs ▪ This requires NDC code submission by providers ▪ Current claim forms do not support electronic NDC submission, but they will in the future ▪ This will increases states' ability to implement drug-specific tracking and policies

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Changes in the Medicaid Program May Increase Scrutiny of Drugs Under the Medical Benefit

	Current Environment	Future Environment
Payment	▪ States use several reimbursement metrics, such as AWP-%, WAC+%, and/or ASP+% ▪ Office copayments typically include payment for drug	▪ More states may adopt ASP as a reimbursement metric, which will decrease provider payments if states do not include appropriate multipliers and/or drug administration payment increases

Source: Recent Avalere survey of 20 state Medicaid programs.

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States May Increase Drug Utilization Controls Under the Medical Benefit

- States currently require few prior authorization requirements on medical benefit drugs
  - » However, once states collect the full rebate information on medical benefit drugs, they may be better able and thus more inclined to manage utilization more closely
  - » Also, physician-pharmaceutical industry interactions have become a focus of intense regulatory oversight by federal and state agencies
- States may be more apt to require prior authorization procedures for:
  - » Specific drugs classes;
  - » Very expensive individual drug treatments; and/or
  - » Physician-administered drug regimens that exceed a state's definition of a "standard" or evidence-based treatment for a certain condition
- However, even those states that place restrictions on medical benefit drugs, they are generally less stringent than pharmacy benefit restrictions
  - » States generally do not carve-out medical benefit drugs if they carve-out the pharmacy benefit from Medicaid managed care organizations
- Trend is unlikely accelerate quickly given complexities of medical benefit management

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Medicaid Coverage, Coding and Payment Principles

Coverage

- States cover products either through the medical or pharmacy benefit
  - Medical benefit used for injectable products requiring provider administration
- In certain cases, pharmacy benefit used for infusable products
  - Patient accessing infusable product in a home setting
- Formularies are not used under Medicaid's medical benefit, but medical review policies are
  - Preferred drug lists (PDLs) do not apply either for medical benefit drugs in most states

Coding

- Medicaid utilizes the same codes as Medicare
  - HCPCS codes for products under the medical benefit (e.g., physician office)
  - NDC codes for products under pharmacy benefit (e.g., home health)

Payment

- States determine payment and administration/dispensing fees for drugs
  - AWP or WAC based reimbursement typically used for medical and pharmacy benefit drugs (e.g., AWP minus 15%)
  - ASP used by limited number of states for payment under medical benefit
  - Average Manufacturer Price (AMP) under consideration by some states for pharmacy benefit
  - Copayments may apply, depending on setting