# DEPARTMENT OF HEALTH AND SOCIAL SERVICES

## DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

## FINAL

### ORDER

### Reimbursement Methodology for Medicaid Services

### NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA). The Department's proceedings to amend the Title XIX Medicaid State Plan to revise the reimbursement methodology for pharmaceutical services and renal dialysis facility services were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the September 2009 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by September 30, 2009 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

### SUMMARY OF PROPOSED AMENDMENT

The purpose and effect of this proposal is to amend the Title XIX Medicaid State Plan to revise the reimbursement methodology for certain provider services.

**Statutory Authority**

- 42 CFR §440, Subpart A, *Definitions*;
- 42 CFR §447.205, *Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates*; and,
- 42 CFR §447, *Payments for Services*.

**Background**

In accordance with 42 CFR §447.205 and Section 1902(a)(13)(A) of the Social Security Act, Delaware Health and Social Services (DHSS), Division of Medicaid and Medicaid Assistance (DMMA) is required to give public notice of any significant proposed change in its methods and standards for setting payment rates for services.

**Summary of Proposed Amendments**

Effective July 1, 2009, DHSS/DMMA amends the applicable provisions of the Title XIX Medicaid State Plan governing the reimbursement methodology for certain services. In accordance with 42 CFR §440.205, public notice was published before the proposed effective date of the change on June 29, 2009 and June 30, 2009 in the two newspapers of widest circulation in the State, the *News Journal* (New Castle County, Kent County, Sussex County) and, the *Delaware State News* (Kent County).

The following significant changes are proposed:

**1) Reimbursement Methodology for Pharmaceutical Services**

Effective for dates of service on and after July 1, 2009 and subject to payment at fee for service rates, DHSS, DMMA will implement a new reimbursement methodology for pharmaceutical services.

**Community Pharmacies:**

Effective for dates of service July 1, 2009 and after, claims for drug ingredient costs reimbursed based on a percentage of the Average Wholesale Price (AWP) shall be reimbursed at AWP minus 15%. DMMA adjusted

reimbursement to AWP minus 16% effective April 1, 2009. This change was one component of a comprehensive package of provider rate adjustments. DMMA asserts that the April 1, 2009 rate is sufficient and supported by available data. However, DMMA is proposing to increase the rate to AWP minus 15% in response to comments received. Medicaid State Plan Attachment 4.19-b, Page 14 has been amended to reflect this change.

**[**Due to a negotiated settlement, effective for dates of service October 14, 2009 and after, claims for drug ingredient costs reimbursed based on a percentage of the Average Wholesale Price (AWP) shall be reimbursed at AWP minus 14.5%. Attachment 4.19-B, Page 14 has been amended to reflect this change at DMMA Final Order Regulation #09-41b.**]**

**2) Reimbursement Methodology for Renal Dialysis Facility Services**

Effective for dates of service on and after July 1, 2009 for "fee for service" claims, DHSS, DMMA will apply the payment methodology for renal dialysis facility services as follows:

**Renal Dialysis Facility Services:**

Effective for dates of service on and after July 1, 2009, renal dialysis facilities shall be paid using the lesser of the facility's usual and customary (U & C) charges or 100% of the Medicare rate. Currently, DMMA pays providers based on their U & C charges for each procedure and different providers can charge different rates for the same service. The purpose of this methodology is to promote predictability of payments, equity and consistency of those payments among providers while maintaining access to quality care. The Centers for Medicare and Medicaid Services (CMS) may issue and require a Medicaid state plan preprint page to capture and implement the reimbursement methodology for Renal Dialysis Facility Services.

The provisions of this amendment are contingent upon approval of CMS.

**Fiscal Impact Statement**

1) Community Pharmacies:

The change will result in an increase in annual aggregate expenditures (state and federal funds) of approximately $980,000 for Medicaid and $39,000 for the non-Medicaid programs for the 12 month period after implementation over what the projected expenditures would have been based on the reimbursement methodology that was in effect immediately prior to July 1, 2009. The reimbursement methodology that was in place for the period April 1, 2009 - June 30, 2009 was expected to generate savings of $2.3 million which will now be reduced as specified above.

2) Renal Dialysis Facility Services:

The change will result in a decrease in annual aggregate expenditures (state and federal funds) of approximately $460,000 for the 12 month period after implementation.

**SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE**

The State Council for Persons with Disabilities (SCPD) offered the following observations summarized below. DMMA has considered each comment and responds as follows.

**Renal Dialysis Reimbursement**

Pursuant to the changes adopted in August, renal dialysis centers were to be reimbursed at 85% of charges [12 **DE Reg.** 1483 (June 1, 2009). However, in adopting its final regulation, DMMA noted that it intended to revise the rate effective July 1, 2009 to the “lesser of the facilities” usual and customary (U & C) rate charges or 100% of the Medicare rate.” See commentary at 13 **DE Reg.** 259, 262 (August 1, 2009). DMMA is now following up by formally proposing this change based on the following rationale:

Currently, DMMA pays providers based on their U&C charges for each procedure and different providers can charge different rates for the same service. The purpose of this methodology is to promote predictability of payments, equity and consistency of those payments among providers while maintaining access to quality care.

SCPD endorses this approach.

**Pharmacy Reimbursement**

In June, DMMA proposed a 2% reduction in reimbursement rates for community pharmacy and non-traditional pharmacy drug acquisition costs, i.e., from the average wholesale price (AWP) minus 14% and 16%, to AWP minus 16% and 18% respectively. The dispensing rate of $3.65 remained unchanged. See 12 **DE Reg.** 1481, 1489

(June 1, 2009). This proposal led to a proposed withdrawal of Walgreens as a Delaware Medicaid provider and litigation against DMMA. See attached articles. DMMA then reached a compromise with Walgreens. See attached August 11, 2009 News Journal article and commentary at 13 **DE Reg.** 259, 262 (August 1, 2009). The compromise is to reduce community pharmacy rates to AWP minus 15% effective July 1, 2009. This change is now reflected in the September proposed regulation. See 13 **DE Reg.** 375, 375-376 (September 1, 2009).

SCPD endorses this compromise which reduces Medicaid costs while maintaining access to Walgreens by Medicaid beneficiaries. The August 11 article recites that Walgreens has traditionally served approximately half of the State's Medicaid population.

***Agency Response:*** DMMA thanks the Council for their endorsement.

**FINDINGS OF FACT:**

The Department finds that the proposed changes as set forth in the September 2009 *Register of Regulations* should be adopted.

**THEREFORE, IT IS ORDERED**, that the proposed regulation regarding the reimbursement methodologies for pharmaceutical services at AWP Minus 15% effective July 1, 2009 and AWP minus 14.5% effective October 14, 2009 and renal dialysis facility services is adopted and shall be final effective November 10, 2009.

Rita M. Landgraf, Secretary, DHSS

**DMMA FINAL ORDER REGULATION #09-41a**
**REVISION:**

**ATTACHMENT 4.19-B**
**PAGE 14**

**State/Territory DELAWARE**

**Reimbursement for Pharmaceuticals:**

Overview

The Delaware Medical Assistance (DMAP) program will reimburse pharmaceuticals using the lower of

- The usual and customary charge to the general public for the product,
- The Estimated Acquisition Cost (EAC) which is defined for both brand name and generic drugs as follows:
  - For Traditional Pharmacies: AWP minus ~~16%~~ 15% plus dispensing fee per prescription, effective for dates of service on or after ~~April~~ July 1, 2009
  - **[For Traditional Pharmacies: AWP minus ~~15%~~ 14.5% plus dispensing fee per prescription, effective for dates of service on or after ~~July 1~~ October 14, 2009]**
  - For Non-Traditional Pharmacies: AWP minus 18% plus dispensing fee per prescription, effective for dates of service on or after April 1, 2009
- A State-specific maximum allowable cost (DMAC) and, in some cases, the Federally defined Federal Upper Limit (FUL) prices plus a dispensing fee.

Entities that qualify for special purchasing under Section 602 of the Veterans Health Care Act of 1992, Public Health Service covered entities, selected disproportionate share hospitals and entities exempt from the Robinson-Patman Price Discrimination Act of 1936 must charge the DMAP no more than an estimated acquisition cost (EAC) plus a professional dispensing fee. The EAC must be supported by invoice and payment documentation.

Dispensing Fee:

The dispensing fee rate is $3.65. There is one dispensing fee per 30-day period unless the class of drugs is routinely prescribed for a limited number of days.

Definitions:

Delaware Maximum Allowable Cost (DMAC) - a maximum price set for reimbursement:

- for generics available from three (3) or more approved sources, or
- when a single source product has Average Selling Prices provided by the manufacturer that indicates the AWP is exaggerated, or
- if a single provider agrees to a special price.

Any willing provider can dispense the product.

**13 DE Reg. 259 (8/1/09)**
**13 DE Reg. 658 (11/01/09) (Final)**