

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

PROPOSED

Title XIX: Reimbursement Methodology for Medicaid Services

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**), with 42 CFR §447.205, and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is amending the Title XIX Medicaid State Plan to revise the reimbursement methodology for certain Medicaid services.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to (302) 255-4454 by September 30, 2009.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

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.

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.

DMMA PROPOSED REGULATION #09-31

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 ~~46%~~ 15% plus dispensing fee per prescription, effective for dates of service on or after April 1, 2009
 - For Non-Traditional Pharmacies: AWP minus 18% plus dispensing fee per prescription, effective for dates of service on or after ~~April~~ July 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. 375 (09/01/09) (Prop.)