Comparison of Acquisition-Cost Based Reimbursement Models

*In 2012—CMS issued a proposed rule that would require states to pay pharmacies based on "**actual** acquisition cost" plus a "professional dispensing fee" instead of the current requirement that references "**estimated** acquisition cost" plus a professional dispensing fee. In the proposed rule, CMS suggests that states may survey pharmacies or use AMP data that manufacturers are already required to report to determine rebates and FUL pricing. Final rule is expected very soon (October 2015). In addition, CMS has created another option-- the NADAC—a national system in which the CMS surveys the pharmacies to determine acquisition cost.*

Average Manufacturers Price (AMP)-based Federal Upper Limits (FULs)

- AMP is the average price paid to the manufacturer by wholesalers for drugs distributed to retail pharmacies and by retail pharmacies that purchase directly from the manufacturer—These figures are used as a baseline to determine ACA Medicaid rebates (owed to the government) and as the basis for calculating the federal upper limit for generic drugs (for the purposes of pharmacy reimbursement)

- The FUL (used for pharmacy reimbursement) is calculated for generic drugs only and must be "no less than 175% of AMP price"

- Continued controversy over using the AMP-based FULs for the purposes of pharmacy reimbursement—posted AMP pricing often well below pharmacy acquisition cost and subject to volatility—Final AMP rule/regulation expected to be released soon (October 2015)

- If AMP-based FULs are used by a state for pharmacy reimbursement—they would have to use a separate reimbursement metric for brand name drugs (most likely WAC or AWP based or could possibly MAC-brand name drugs)

State Average Acquisition Cost (AAC)

- Based on an individual state survey of pharmacy invoice pricing
- Some of these state AAC surveys are mandatory if the provider wishes to participate in the Medicaid program
- In all currently existing State AAC programs Individual drug values are the result of a simple average
- Drug purchase information is submitted for generic and brand drugs
- State-specific AAC programs also conduct COD study

- To date the following states have adopted a state-specific AAC process with the corresponding dispensing fee amount: Alabama (dispensing fee $10.64); Colorado (dispensing fee range $9.31-$14.14); Idaho (dispensing fee range $11.51-%15.11); Iowa (dispensing fee $10.12); Louisiana (dispensing fee $10.51); Oregon (dispensing fee range $9.68-$14.01)

- All states that have adopted an AAC model have also retained "lower of" pricing terminology

- Rebate amounts not included

National Average Drug Acquisition Cost (NADAC)

- Relatively new CMS pricing benchmark based on average invoice costs that pharmacies use to acquire Medicaid outpatient drugs

- Based on voluntary national surveys and intended to provide states with a reference price for brand and generic drugs

- States have the option to use the NADAC as a reference for setting their reimbursement methodology

- Drug acquisition cost data collected through **voluntary** monthly surveys of retail pharmacies (random sample of both independent and chain)—specialty data is excluded

- NADAC is calculated using a simple average of invoice cost data

- **NADAC Brand Reimbursement [roughly AWP minus 18.33% or WAC minus 2%]**
- **NADAC Generic Reimbursement [range between AWP minus 75% and AWP minus 85% depending on utilization mix]**

- To date, three states have adopted NADAC and an updated dispensing fee: Mississippi (dispensing fee $11.20); Delaware (dispensing fee $10.00); and Alaska (dispensing fee $10.76)

- States that have adopted NADAC have retained "lower of" pricing terminology

- Rebate amounts not included

Additional Considerations w/the use of AMP-based FULs

- FULs are only calculated for generics and if a state would still have to use another methodology for brands (either AWP/WAC based).

- It is possible that the profit margin on brands (under a WAC/AWP basis) could be sufficient to offset the potential losses pharmacies might see on the generic side)

- Utilization of this metric would also require an increase in the corresponding dispensing fee

Additional Considerations with the Use of AAC or NADAC

- Recent strategic partnerships between large pharmacy chains and wholesalers have the potential to drastically affect invoice pricing/reporting. [Walgreens-Amerisource, CVS-Cardinal; and Rite-Aid-McKesson)

- CMS could move towards using NADAC/AAC model for Part D reimbursement

- Commercial plans could start using NADAC/AAC pricing for pharmacy reimbursement

- Reimbursement for specialty drugs?

Overall Marketplace Considerations/Variables

1. Recent strategic partnerships between large pharmacy chains and wholesalers have the potential to shift the leverage each of these entities regarding purchasing from generic manufacturers as well as shifts in supply chain/distribution responsibilities.

- For example, under the Walgreens/Amerisource deal, Amerisource has the right to source generic drugs and other products through Walgreens/Boots Alliance. The CVS-Cardinal and McKesson-Rite Aid arrangements also seek to aggregate generic purchasing.

- Also, under the Walgreens-Amerisource and the McKesson-Rite Aid deals, the wholesaler will take over distribution of generics for the chain and the wholesaler will take over direct store delivery of brand and generic drugs.

2. Rise in specialty drug utilization