DEPARTMENT OF HEALTH
AND HOSPITALS

MODERNIZING LOUISIANA'S MEDICAID PHARMACY PROGRAM

Prescription for Reform

FINAL REFORM CONCEPT

AUGUST 24, 2012

Our Vision: Principles for Integrated Care and Better Health

Introduction

In June 2012, the Louisiana Department of Health and Hospitals published a concept paper on its plans to reform and strengthen the Medicaid pharmacy program. That concept paper outlined the department's intention to add pharmacy as a covered benefit in the three prepaid Health Plans serving Medicaid enrollees in the Bayou Health program. Those plans were underscored with six key principles:

1. Access to in-person pharmacy services is essential to patient care management.
2. For prepaid Health Plans, network formation should only begin with their existing pharmacy networks, with additional requirements for network adequacy and consideration of significant legacy Medicaid providers.
3. Prepaid health plans should have the flexibility to effectively manage the pharmacy benefit, including appropriate care, network and formulary management.
4. Enrollees should have access to the robust Bayou Health appeals and grievances process.
5. For those outside prepaid Bayou Health plans, the existing state-run pharmacy program management should be strengthened.
6. Pharmacists' and stakeholders' involvement is important to program development and ongoing operation.

From there, department officials conducted more than 14 hours of public forums in seven cities across the state to gather feedback from stakeholders about the plans. Based on that feedback, DHH has made important changes to its plans. These changes are significant, strengthen the reforms and are summarized below.

Preserving Today's Pharmacy Network

DHH will adopt "any willing provider" language in its rule, meaning that Health Plans may not deny contracts to any pharmacy currently participating in the Medicaid program. Any pharmacy or pharmacist participating in the Medicaid program may participate as a network provider if they are licensed and in good standing with the Louisiana State Board of Pharmacy and accept the terms and conditions of the contract offered to them by the Health Plan.

Further, DHH will prohibit Health Plans from mandating the use of mail service pharmacy or exceeding a set volume limit based on historic utilization (one percent of all claims). Health Plans will still be required to make good-faith efforts to contract with significant traditional providers, and must meet DHH network adequacy requirements.

Minimum Dispensing Fee

DHH received tremendous feedback surrounding pharmacy reimbursement. In the Medicaid managed care marketplace, the average generic dispensing fee ranges from $1.75 - $2.00, and the average brand dispensing fee ranges from $1.50 - $1.75. According to DHH's actuaries, no state with managed Medicaid

pharmacy has established a rate floor for pharmacy services. However, based on concern and feedback shared by pharmacists across the state, DHH will require the Health Plans to pay a per-prescription dispensing fee no less than $2.50.

Prohibition of Co-Branding

DHH will adopt and enforce guidelines consistent with Medicare Part-D regarding co-branded PBMs. Health Plans will be prohibited from displaying the names or logos of co-branded PBMs on the Health Plan's member identification cards. For any other marketing materials, the Health Plans will be required to include the following language: "Other Pharmacies are Available in Our Network."

Additional Transparency Requirements

In addition to the robust reporting and transparency requirements of Bayou Health, DHH will require, specific to pharmacy, that the Health Plans:

- Disclose to DHH all financial terms and arrangements that apply between the Health Plan and any prescription drug manufacturer or labeler,
- Keep all Pharmaceutical and Therapy (P & T) committee meetings open to the public,
- Report claims-level encounter data to DHH,
- Report prior authorization performance specific to pharmacy, and
- Keep an up-to-date formulary and preferred drug list prominently posted on their websites.

Limits on Repackaging

DHH will require that the Health Plans follow rules consistent with repackaging requirements in Medicaid pharmacy today. The Health Plan will be required to ensure that the manufacturer number, product number and package number for the drug dispensed shall be listed on all claims. Repackaged drug products supplied through co-ops, franchises or other sources not readily available to other providers will not be allowed to be used. In such instances, the manufacturer number, product number, and package number for the largest package size, as reported in one or more national compendia for the drug, shall be listed.

Medication Therapy Management

DHH will require the Health Plans to develop Medication Therapy Management (MTM) programs that include participation from community pharmacists and include both in-person and telephonic interventions with trained clinical pharmacists. DHH will require that any reimbursement for MTM services with participating pharmacists be separate and above dispensing and ingredient cost reimbursement.

These changes, and more, are outlined below. This document reflects a comprehensive and detailed summary of the rule and contracts that will guide the Bayou Health pharmacy program. Additionally, this summary includes plans to reform and strengthen the existing state-run pharmacy program, which will continue to provide pharmacy benefit services to 62 percent of Medicaid enrollees.

Covered services

The Health Plan must provide coverage for all classes of drugs covered by the Medicaid fee-for-service pharmacy benefit. The Health Plan may manage coverage and utilization of drugs through the formation of a Formulary or Preferred Drug List. Procedures used to manage utilization may include, but are not limited to, prior authorization, utilization and clinical edits.

The Health Plan is not required to enforce the DHH monthly prescription drug quantity limits (currently four). However, the Health Plan may not enact quantity limits more stringent than the Medicaid State Plan.

Copays/Cost Share

The Health Plan is not required to impose any copay or cost sharing requirements on their members. The Health Plan, however, is not permitted to charge any copay or cost-sharing amount above what exists in the Medicaid State Plan.

A Health Plan or its subcontractors may not:

- Deny services to an individual who is eligible for services because of the individual's inability to pay the cost sharing;
- Restrict its members' access to needed drugs and related pharmaceutical products by requiring that members use mail-order pharmacy providers; or
- Impose copayments for the following:
  - Family planning services and supplies
  - Emergency services
  - Services provided to:
    - ◊ Individuals younger than 21 years old
    - ◊ Pregnant women
    - ◊ Individuals who are inpatients in long-term care facilities or other institutions
    - ◊ Native Americans, and
    - ◊ Alaskan Eskimos

P&T Committee

The Health Plans is required to establish a Pharmaceutical and Therapeutics (P&T) Committee, or similar entity, for the development of the Formulary and Preferred Drug List (PDL). The Health Plan must ensure that Louisiana network physicians, pharmacists, dentists and specialists have the opportunity to participate in the development of the Formulary, PDL and clinical drug policies and, prior to any changes to the Formulary or PDL, to review, consider and comment on proposed changes.

The P&T committee must meet at least biannually to consider products in categories recommended for consideration for inclusion/exclusion on the Health Plan's Formulary or PDL. In developing its recommendations for a Formulary and PDL, the P&T committee must consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product.

The Health Plan must develop policies governing the conduct of P&T committee meetings, including procedures by which it makes its Formulary and PDL recommendations. P&T Committee meetings must be open to the public.

Formulary

The Health Plan is required to have a Formulary that meets the following minimum requirements:

1. The Formulary must be kept up-to-date and available to all providers and members via Health Plan website and electronic prescribing tools.
2. The Formulary only excludes coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act. In addition, the Health Plan must include in its formulary any FDA-approved drugs that may allow for clinical improvement or are clinically advantageous for the management of a disease or condition.
3. The Formulary must be reviewed in its entirety and updated at least annually.
4. The Health Plan must expand its Formulary, as needed, to include drugs that are equivalent to new drugs approved by the FDA, and which are deemed to be appropriate, safe and efficacious in the medical management of members.
5. The Formulary and any revision must be reviewed and approved by DHH prior to implementation. Any changes to the Formulary must be submitted to DHH at least 30 days prior to implementation.
6. The Formulary must include only FDA-approved drug products. For each Therapeutic Class of drugs, the selection of drugs included for each drug class must be sufficient to ensure enough provider choice and include FDA-approved drugs to best serve the medical needs of members with special needs.
7. The Health Plan must authorize the provision of a drug not on the Formulary requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the Health Plan to support the medical necessity of the drug. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.

8. The Health Plan must have in place a DHH-approved prior approval process for authorizing the dispensing of non-Formulary drugs.
9. Except for the use of approved generic drug substitution of brand drugs, under no circumstances shall the Health Plan permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.
10. The Health Plan will not be allowed to make negative changes to the formulary (e.g., remove a drug, impose step therapy, etc.) more than four times annually, unless urgent circumstances require more timely action, such as drug manufacturer's removal of a drug from the market due to patient safety concerns.

Preferred Drug List

The Health Plan may use a preferred drug list (PDL) as long as the requirements of covered services and the following minimum requirements are met:

1. The PDL is a subset of preferred drug products available on the Formulary and an up-to-date version is available to all providers and members through the Health Plan website and electronic prescribing tools.
2. The PDL must be reviewed in its entirety and updated at least annually.
3. The PDL, and any revision thereto, must be reviewed and approved by DHH prior to implementation. Any changes to the PDL must be submitted to DHH at least 30 days prior to implementation.
4. The selection of drugs included for each drug class must be sufficient to ensure enough provider choice and include FDA-approved drugs to best serve the medical needs of enrollees with special needs.
5. The Health Plan must authorize the provision of a drug not listed on the PDL requested by a prescriber on behalf of the enrollee, if the approved prescriber provides relevant clinical information to the Health Plan to support the medical necessity of the drug. Medically accepted indications shall be consistent with Section 1927(k)(6) of the Social Security Act.
6. The Health Plan must have in place a DHH-approved prior approval process for authorizing the dispensing of non-PDL drugs.
7. Except for the use of approved generic drug substitution of brand drugs, under no circumstances may the Health Plan permit the therapeutic substitution of a prescribed drug without a prescriber's authorization.
8. The Health Plan will not be allowed to make negative changes to the PDL (e.g., remove a drug, impose step therapy, etc.) more than four times annually, unless urgent circumstances require more timely action, such as drug manufacturer's removal of a drug from the market due to patient safety concerns

The Health Plan may only restrict or require a prior authorization for prescriptions or pharmacy services prescribed by Mental Health or Substance Abuse (MH/SA) providers if one of the following exceptions is demonstrated:

1. The drug prescribed is not related to the treatment of substance abuse/dependency/addiction or mental illness or to any side effects of the psychopharmacological agents. These drugs are to be prescribed by the Health Plan's Primary Care Physicians or specialists in the Health Plan's network.
2. The prescribed drug does not conform to standard rules of the Health Plan's pharmacy plan.
3. The Health Plan, at its option, may require a prior authorization (PA) process if the number of prescriptions written by MH/SA providers for MH/SA-related conditions exceeds four (4) per month per enrollee or are shown to be contraindicated based on the enrollee's medical conditions or other drugs already prescribed. For drugs that require weekly prescriptions, these prescriptions shall be counted as one (1) per month and not as four (4) separate prescriptions.

Submission and Publication of the Formulary/PDL

The Health Plan shall publish and make available to members and providers upon request a hard copy of the most current Formulary and PDL. Updates to the Formulary or the PDL shall be made available thirty (30) days before the change. The Health Plan must prominently post the most current Formulary on its website. The Health Plan must submit an electronic version of its formulary and PDL to DHH at least quarterly.

Prior Authorization Process

A. The Health Plan may utilize a prior authorization process for drug products under the following conditions:
   1. When prescribing medically necessary non-Formulary or non-preferred (non PDL) drugs.
   2. When prescribing drugs inconsistent with FDA approved labeling, including behavioral health drugs.
   3. When prescribing is inconsistent with nationally accepted guidelines.
   4. When prescribing brand name medications that have A-rated generic equivalents.
   5. To minimize potential drug over-utilization.
   6. To accommodate exceptions to Medicaid drug utilization review standards related to proper maintenance drug therapy.

B. Any prior approval issued by the Health Plan must take into consideration prescription refills related to the original pharmacy service.

C. The Health Plan must notify the requesting practitioner of the approval or disapproval of the request within 24 hours once relevant medically necessary information is obtained from the prescriber.

D. The Health Plan must provide access to a toll-free call center for prescribers to call to request prior authorization for non-preferred drugs or drugs that are subject to clinical edits. The Health Plan must allow prescribers to submit automated prior authorization requests, as well as requests by phone or fax. If the Health Plan or its PBM operates a separate call center for prior authorization requests, it will be subject to the provider call center standards and monetary penalties set forth in the Bayou Health contract.

E. The Health Plan must not penalize the prescriber or enrollee, financially or otherwise, for such requests and approvals.

F. Denials of prior authorization requests or offering of an alternative medication must be provided to the prescriber and/or enrollee in writing.

G. An enrollee receiving a prescription drug that was on the Health Plan's Formulary or PDL and subsequently removed or changed must be permitted to continue to receive that prescription drug if determined to be medically necessary. The Health Plan must make that determination in consultation with the prescriber.

H. If a prescription for a medication is not filled when the prescription is presented to the pharmacy due to a prior authorization requirement, the Health Plan must have an automated process that allows the pharmacy to dispense up to a 72-hour supply of a product without having to obtain an override. The pharmacy may fill consecutive 72-hour supplies if the prescriber remains unavailable. The Health Plan must reimburse the pharmacy for dispensing the temporary supply of medication.

I. A member, or a provider on member's behalf, may appeal prior authorization denials in accordance with the Bayou Health Grievances and Appeals provisions, outlined in the Health Plan's contract.

Step Therapy and/or Fail First Protocols

Health Plans are allowed to implement step therapy or fail first protocols to first drive utilization toward the most cost-effective and safest drug therapy. These protocols may be applied to either individual drugs or classes of drugs. However, the Health Plan must provide a clear process for a

provider to request an override of such restrictions. At a minimum, the Health Plan should grant the override when the prescribing physician provides evidence that the preferred treatment method has been ineffective in the treatment of the patient's medical condition in the past or will cause or will likely cause an adverse reaction or other physical harm to the patient.

Medication Therapy Management

Within 90 days of implementation, the Health Plan is required to implement a Medication Therapy Management (MTM) program. The MTM program should include participation from community pharmacists and include both in-person and telephonic interventions with trained clinical pharmacists.

Reimbursement for MTM services with participating pharmacists should be separate and above dispensing and ingredient cost reimbursement.

These programs should be developed to identify and target members who would most benefit from these interactions. They should include coordination among the Health Plan, the member, the pharmacist and the prescriber using various means of communication and education.

Drug Utilization Review (DUR) Program:

The Health Plan must establish and maintain a drug utilization review (DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act. The Health Plan shall include review of MH/SA drugs in its DUR program.

1. DUR standards shall encourage proper drug utilization by ensuring maximum compliance, minimizing potential fraud and abuse, and taking into consideration both the quality and cost of the pharmacy benefit.
2. The Health Plan must implement an online claims adjudication system, which shall include a prospective review of drug utilization, and include age-specific edits where appropriate.
3. The prospective and retrospective DUR standards established by the Health Plan must be consistent with those same standards established by fee-for-service Medicaid program.
4. The Health Plan's DUR program must include the standards for each category of DUR, e.g. therapeutic duplication, drug-drug interaction, maximum daily dosage and therapy duration.
5. The Health Plan's DUR program must include a procedure/process for utilization review for each category of DUR.
6. DHH will review and approve the Health Plan's DUR policy and procedures; DUR utilization review process/procedure and the standards included therein; and any revisions. The DUR program and revisions must be submitted to DHH for prior approval in advance of the effective date.

Pharmacy Network, Access Standards and Reimbursement

The Health Plan must provide a pharmacy network that complies with DHH requirements but at a minimum includes only licensed and registered pharmacies that conform to the Louisiana Board of Pharmacy rules concerning the records to be maintained by a pharmacy.

No Health Plan may prohibit any pharmacy or pharmacist participating in the Medicaid program from contracting as a network provider provided the pharmacy or pharmacist is licensed and in good standing with the Louisiana State Board of Pharmacy and is willing to accept the terms and conditions of the contract offered to them by the Health Plan.

Access standards will also be determined by travel distance requirements:

1. Urban areas: Travel distance for members living in urban parishes shall not exceed 10 miles
2. Rural areas: Travel distance for members living in rural parishes shall not exceed 30 miles

The Health Plan must keep an up-to-date

pharmacy provider directory on its website for public access. This directory must include, but not be limited to, the following information on all contracted network pharmacies:

1. Names, locations and telephone numbers
2. Any non-English languages spoken
3. Identification of hours of operation, including identification of providers that are open 24-hours per day
4. Identification of pharmacies that provide vaccine services
5. Identification of pharmacies that provide delivery services

The Health Plan must make a hard copy of this directory available to its members upon request. The hard copy must be updated at least annually. The online version should be updated in real time, but no less than weekly.

While the Health Plan must ensure it or its PBM has a network audit program, the Health Plan shall not utilize contingency-fee based pharmacy audits. The Health Plan must submit to DHH the policies of its audit program for approval.

The Health Plan must ensure that pharmacies submit the NPI of the prescriber on claims.

The Health Plan must educate network providers about how to access their formulary and PDL on their websites. The Health Plan must also deliver provider education on claims processing and payment policies and procedures.

The Health Plan shall pay a per-prescription dispensing fee at a rate no less than $2.50.

Mail order/Mail Service Pharmacy

The Health Plan cannot require its members to use a mail service pharmacy. Mail order must not exceed more than one (1) percent of all pharmacy claims. Members cannot be charged anything above applicable copays (e.g. shipping and handling fees).

Specialty Drugs and Specialty Pharmacies

DHH recognizes the importance of providing adequate access to specialty drugs to Medicaid members while ensuring proper management of handling and utilization. For the purposes of this program, "specialty drugs" shall be determined by the definition below. The Health Plan may limit distribution of specialty drugs from a network of specialty pharmacies that meet the requirements to distribute specialty drugs and are willing to accept the terms of the Health Plan's agreement.

A specialty drug is defined as one that is:

1. The drug is not typically available at community retail pharmacies or under limited distribution per manufacturer/FDA; or
2. The drug includes at least two of the following characteristics:
   a. Requires inventory management controls including but not limited to unique storage specifications, short shelf life, and special handling; or
   b. Must be administered, infused or injected by a health care professional; or
   c. The drug is indicated primarily for the treatment or prevention of:
      i. A complex or chronic medical condition, defined as a physical, behavioral or developmental condition that may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated, such as, but not limited to, multiple sclerosis, hepatitis C, cancer and rheumatoid arthritis; or
      ii. A rare medical condition, defined as any disease or condition that typically affects fewer than 200,000 people in the United States.
   d. The total monthly cost is $3,000 or more.

Rebates

The Health Plan will be required to submit all pharmacy encounters, with the exception of inpatient hospital pharmacy encounters, to DHH. DHH or its vendor will submit these pharmacy encounters for rebate from manufacturers.

In addition to the monetary sanctions outlined in the Health Plan contract, failure of the Health Plan to submit monthly pharmacy encounter claims files and/or a response file to any disputed encounters within 60 calendar days will result in a quarterly offset to the capitation payment equal to the value of the rebate assessed on the disputed encounters being deducted from the Health Plan's capitation payment.

Claims Processing

The Health Plan will be required to maintain an automated claims and encounter processing system for pharmacy claims that meets current transactions standards and will support the requirements of their contracts and ensure the accurate and timely processing of claims and encounters.

The system shall provide for an automated update to the National Drug Code file, including all product, packaging, prescription and pricing information. The system shall provide online access to reference file information and maintain a history of the pricing schedules and other significant reference data. The Health Plans will be required to update pricing information based on the most recently available information on at least a weekly basis.

Use of a Pharmacy Benefits Manager (PBM)

While the Health Plan will use a PBM to process prescription claims, the PBM must pay claims in accordance with the applicable section of the Health Plan contract, including the Bayou Health prompt pay requirements.

The Health Plan will be required to identify the proposed PBM and its ownership. The Health Plan must submit its PBM subcontract to DHH for approval prior to launch. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store or pharmaceutical manufacturer, the Health Plan must submit a written description of the assurances and procedures that will be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of proprietary information. The Health Plan must provide a plan documenting how it will monitor such subcontractors. These assurances and procedures must be provided to DHH for review and approval prior to the date pharmacy services begin.

The Health Plan must submit to DHH for approval a plan for oversight of the PBM's performance.

Financial Disclosures for Pharmacy Services

The Health Plan must disclose to DHH all financial terms and arrangements of any kind that apply between the Health Plan and any prescription drug manufacturer or labeler, including, without limitation, formulary management, educational support, claims processing, pharmacy network fees, data sales fees and any other fees. The Health Plan's contract provides that DHH or state auditors may audit such information at any time.

Transition of Care

The Health Plan must submit for approval a transition of care program that ensures members can continue treatment of maintenance medications for at least 60 days after launch of pharmacy services or enrollment into the Health Plan. The Health Plan must continue any treatment of antidepressants and antipsychotics for at least 90 days after enrollment or launch. Additionally, an enrollee receiving a prescription drug that is not on the Health Plan's Formulary or PDL shall be permitted to continue to receive that prescription drug if it is medically necessary.

Repackaged Products

DHH will adopt in its contracts language consistent with the current Medicaid pharmacy rule. The Health Plan must ensure that the manufacturer number, product number and package number for the drug dispensed shall be listed on all claims. This information must be taken from the actual

package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia. Repackaged drug products supplied through co-ops, franchises or other sources not readily available to other providers must not be used. In such instances, the manufacturer number, product number and package number for the largest package size, as reported in one or more national compendia for the drug, shall be listed.

Marketing and Member Education

The Health Plan and all subcontractors, including PBMs and providers, are subject to the Marketing and Member Education requirements set forth in the Health Plan's contract. This includes the review and approval of all marketing and member education materials including, but not limited to, websites and social media, ID cards, call scripts for outbound calls or customer service centers, provider directories, advertisement and direct member mailings.

Members of a Health Plan must have free access to any pharmacy participating in the Health Plan's network (except in cases where the member is participating in the pharmacy lock-in program). Neither the Health Plan nor any subcontractor is allowed to steer members to certain network providers. DHH retains the discretion to deny the use of marketing and member education material that it deems to promote undue patient steering.

Health Plans are prohibited from displaying the names and/or logos of co-branded PBMs on the Health Plan's member identification cards. Health Plans that choose to co-brand with providers must include on marketing materials (other than ID cards) the following language: "Other Pharmacies are Available in Our Network."

Like all marketing material, co-branded materials must be submitted to DHH by the Health Plan for approval.

ID Card

The Health Plan must provide on the member's Bayou Health Plan identification card, or on a separate prescription benefit card, prescription billing information that:

(a) Complies with the standards set forth in the National Council for Prescription Drug Programs pharmacy ID card prescription benefit card implementation guide at the time of issuance of the card; and

(b) Includes, at a minimum, the following data elements:

1. The name or identifying trademark of the Health Plan and the prescription benefit manager (see co-branding restrictions);
2. The name and Louisiana Medicaid identification number of the recipient;
3. The telephone number that providers may call for:
   a. Pharmacy benefit assistance;
   b. 24-hour member services and filing grievances;
   c. Provider services and prior authorization; and
   d. Reporting Medicaid Fraud (1-800-488-2917)
4. All electronic transaction routing information and other numbers required by the Health Plan or its benefit administrator to process a prescription claim electronically.

If the Health Plan chooses to include the prescription benefit information on the Bayou Health Plan card, the Health Plan must ensure all members have a card that includes all necessary prescription benefit information, as outlined above.

If the Health Plan chooses to provide a separate prescription benefit card, the card mailer that accompanies the card must include language that explains the purpose of the card, how to use the card and how to use it in tandem with the DHH-issued Medicaid Card and the Health Plan-issued card.

Lock-In (Restriction) Program

The Health Plan may implement a restriction program including policies, procedures and criteria for establishing the need for the lock-in, which must

be prior approved by DHH. The lock-in program will be required to meet guidelines similar to the current Medicaid lock-in program.

Lock-in is a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The lock-in mechanism does not prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits.

Required Reports

DHH will add additional reporting requirements to the existing contract requirements, including, but not limited to:

- Pharmacy help desk performance
- Prior authorization performance
  - Request turnaround
  - 72-hour emergency supply
  - Denials
- Pharmacy network access
- Pharmacy grievances and appeals

Strengthening the State-Run Pharmacy Program

It is important to note than some 62 percent of Medicaid enrollees will continue to have their pharmacy benefit managed by the existing state-run program. DHH intends to conduct continued dialogue with providers and stakeholders on improvements to state-run PBM, to be phased in over course of the fiscal year. This will include:

- Enhancements to formulary/PDL
- Changes to prior authorization process
- Modernization of the point-of-sale system
- Efforts to promote lowest net cost product

Effective for claims submitted with dates of service beginning September 5, 2012, Louisiana Medicaid will implement a pharmacy reimbursement methodology change to a reimbursement up to Average Acquisition Cost (AAC) plus a $10.13 dispensing fee. This shift in reimbursement methodology is intended to establish an accurate pharmacy reimbursement system based on actual acquisition cost (invoice) data and a statistically validated cost of dispensing survey. AAC-based reimbursement reimburses at the average actual cost of obtaining the product, which necessitates a higher dispensing fee than what is paid under Average Wholesale Price, which is a higher ingredient cost reimbursement.

Reimbursement at AAC with no multiplier is consistent with federal Centers for Medicare and Medicaid Services approvals for AAC based-methodology. DHH is distributing a notice to providers with detailed information about this change in reimbursement, including answers to commonly asked questions. That information will be posted on the Louisiana Medicaid provider website, while alerts will be issued regularly through email.

Modernizing Louisiana's Medicaid Pharmacy Program

For additional information, please visit MakingMedicaidBetter.com

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