Texas Vendor Drug Program
Pharmacy Provider Procedure Manual

Drug Rebates

May 2018

The Pharmacy Provider Procedure Manual (PPPM) is available online at txvendordrug.com/about/policy/manual.

TEXAS Health and Human Services | Medical and Social Services

Table of Contents

1 Texas Rebate Administration

The Medicaid Drug Rebate Program began in 1991 as a result of the Omnibus Budget Reconciliation Act (OBRA) of 1990 and is a partnership between the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and participating drug manufacturers ("manufacturer") that help to offset the federal and state costs of outpatient prescription drugs dispensed to Medicaid patients. Approximately 600 manufacturers currently participate in this program. The Medicaid Drug Rebate Program is authorized by Section 1927 of the Social Security Act.

In order for VDP to receive federal funds for prescription claims, the drug must be made by a manufacturer that participates in the CMS Drug Rebate program. In return for having their drugs covered by state Medicaid programs, the manufacturer agrees to pay rebates according to their state and federal contracts.

Funds received from manufacturers through the rebate programs listed below are used to supplement Medicaid funds received from both the federal and state governments and offset the costs of the Medicaid Program in Texas.

2 Rebate Programs

2.1 Medicaid

Created by OBRA 1990 and amended by OBRA 1993, the Veterans Health Care Act of 1992, the Deficit Reduction Act of 2005, and the Affordable Care Act of 2010, the Medicaid drug rebate program requires manufacturers to sign a rebate contract with the CMS. Manufacturers must pay rebates to the states based on the number of units of their product that were paid for by the state, and the states in turn, must cover the manufacturers' products.

Rebates apply to drugs supplied to program-eligible people who are enrolled as either fee-for-service or managed care participants. Prescribed drugs are obtained from a contracted pharmacy or are administered by a contracted physician/clinician. All rebates received are shared with CMS at the same level of federal financial participation as was claimed to pay the original claim.

2.1.1 Supplemental Medicaid

H.B. 2292, 78th Legislature, Regular Session, 2003, directed HHSC to create the Supplemental Drug Rebate Program in conjunction with the Medicaid Preferred Drug List (PDL).

In order for a manufacturer's product to be included on the PDL, a manufacturer must agree to pay an additional supplemental rebate amount on their products or the state has determined that there is no negative cost impact to the state. Physicians who prescribe a manufacturer's product that is in a reviewed class, but was not selected as the preferred drug, are required to get a prior authorization for the non-preferred product.

2.1.2 Children's Health Insurance Program

The 76th Texas Legislature directed HHSC to develop a rebate program under the federally authorized State Children's Health Insurance Program (CHIP). Manufacturers that want to participate in the CHIP Drug Rebate Program must complete and sign the CHIP Drug Rebate Agreement and return two originals to the CHIP rebate administrator.

2.1.3 Physician/Clinician Administered Drugs

The Deficit Reduction Act of 2005 required that all claims for drugs administered by physicians/clinicians include a National Drug Code (NDC) on the claim in order to be eligible for payment. Including the NDC allows Texas to bill manufacturers for rebates. In order to assist medical professionals with billing, each month the Texas NDC-to-HCPCS Crosswalk is published. In addition, each quarter the CMS-approved Drug Labeler Directory is published to assist with purchasing decisions. Refer to the **Texas NDC-to-HCPCS Crosswalk** and **Drug Labeler Directory** at txvendordrug.com/formulary/formulary/clinician-administered-drugs.

2.2 CSHCN and KHC State Rebate Programs

Texas Health and Safety Code Sub-section 12.025 required HHSC to establish a voluntary drug rebate program for all manufacturers whose products are covered by the Kidney Health Care (KHC) program and Children with Special Health Care Needs (CSHCN) Services Program. The 77th Texas Legislature General Appropriations Act (TDH Rider 38) authorized the KHC and CSHCN programs to receive and use all rebate monies for client services, and to establish a preference

for products from manufacturers who have signed rebate agreements with the program. KHC and CSHCN are committed to ensuring a 100 percent participation rate because of increased drug costs that have significantly impacted program budgets.

2.2.1 CSHCN

The CSHCN Services Program is the payer of last resort for approximately 2,300 eligible people. The program does not qualify as a CMS defined State Pharmaceutical Assistance Plan (SPAP).

2.2.2 KHC

The KHC program covers approximately 20,000 eligible people with end-stage renal disease. The program qualifies as a CMS-approved State Pharmaceutical Assistance Plan (SPAP). The Medicaid statute allows manufacturers participating in the Medicaid Drug Rebate Program to exclude prices to SPAPs from their Medicaid Best Price calculations. This allows the state to use the full CMS rebate rate to simplify the paperwork for both the state and the manufacturer.

2.3 Healthy Texas Women Program

The Texas Women's Health Program established a rebate program in 2014. The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015, adopted by the Legislature, merged the women's health strategies (DSHS Strategy B.1.3., and Strategy B.1.4.) into a single strategy within the HHSC Budget (HHSC Strategy D.2.3., Women's Health Services) and created the Healthy Texas Women (HTW) Program.

The HTW program is entirely state-funded, is recognized by CMS as an SPAP and serves approximately 300,000 people annually. Program-eligible people are:

- At or below 200% of the federal poverty level
- Ages 15-44
- Not pregnant

3 Desk Reviews and Disputes

Each calendar quarter, VDP summarizes all of the paid claims data by NDC number and bills the drug companies for their products. The manufacturer pays the invoice but may have questions about Texas' reported utilization. If this occurs, the rebate auditors provided by the VDP rebate administrator will review the claim level data for that specific NDC. If the claim was originally billed to a Medicaid managed care health plan then the questions will be directed to that plan for resolution.

3.1 Pharmacy

The manufacturer will dispute a claim if the decimal is omitted or the quantity is rounded up to the next whole number. If a manufacturer disputes a claim, the rebate auditors will either contact the dispensing pharmacy for clarification or refer the dispute to the health plan. If the pharmacy has made an error, and the service date of the claim is within the 90-day filing period, the pharmacy can reverse the original claim and resubmit the corrected data. If the claim is over 90 days, the rebate auditors will instruct VDP or the health plan to correct the claim.

Some of the common reasons pharmacy claims are disputed include:

- The quantity claimed does not match the package size (e.g. 14.5-grams claimed and the NDC is for a 17-gram inhaler);
- Excess quantity: this can be valid, a keying error, or the claim was billed using the wrong unit of measure (e.g. entered 300 in the quantity and the price is for 30);
- Low reimbursement: this can be because of keying errors, or billing the wrong unit of measure;
- The pharmacy is listed on the Health Resources Administration (HRSA) Medicaid Exclusion File. Refer to the link for “Medicaid Exclusion File” at 340bopais.hrsa.gov/medicaidexclusionfiles.

Please verify the units that are being submitted are accurate for the claim and product being submitted.

3.2 Physician/Clinician Administered

The manufacturer will dispute a claim if the decimal is omitted, the quantity is rounded up to the next whole number, or the physician/clinician does not enter the

number of units administered based on the Healthcare Common Procedure Coding System (HCPCS) description. If a manufacturer disputes a claim, the rebate auditors may contact the provider for clarification. The provider may be asked to appeal their claim so that they can correct the quantities on the claim.

Some of the common reasons medical claims are disputed include:

- The quantity administered was not reported correctly. This is most common if the HCPCS description is for more than "1".
  - For example, the description for HCPCS code J1885 is “Injection, ketorolac tromethamine, per 15 mg”, therefore 15 mg = 1 HCPCS unit. If 15 mg is administered, then the correct number of units to claim is 1, not 15. Likewise, if 30 mg is administered, the number of units claimed would be 2.
- Low reimbursement is received for the quantity of services provided or amount claimed. This can be a result of the “percent of billed charges,” a reimbursement methodology employed by TMHP, or as a result of the provider entering the wrong quantity;
- Missing or invalid NDC on the claim;
- The facility is listed on the Health Resources Administration Medicaid Exclusion File and should be excluded from rebate but the facility either failed
  - To include their Medicaid Number or NPI with HRSA; or
  - To include the payment modifier “U8" on the claim.