Methods and Standards for Establishing Payment Rates — Other Types of Care

I. Drugs

A. Reimbursement

1. Participating pharmacies are reimbursed for the cost of the drug plus a dispensing fee. Payments shall not exceed the federal upper limits specified in 42 CFR 447.331 through 447.334.

2. Participating dispensing physicians are reimbursed for the cost of the drug only.

3. Providers will be reimbursed only for drugs supplied from pharmaceutical manufacturers who have signed a rebate agreement with CMS.

B. Payment Limits — Payment for the cost of drugs shall be the lesser of:

1. The Federal Upper Limit (FUL) means the maximum federal financial participation available toward reimbursement for a given drug dispensed to a Medicaid recipient.

2. The State Maximum Allowable Cost (SMAC). A SMAC may be established for any drug for which two or more A-rated therapeutically equivalent, multi- source, non-innovator drugs with a significant cost difference exist. The SMAC will be determined taking into account drug price status (non-rebatable, rebatable), marketplace status (obsolete, regional availability), equivalency rating (A-rated), and relative comparable pricing. Other factors considered are clinical indications of generic substitution, utilization and availability in the marketplace. The source of comparable drug prices will be nationally recognized comprehensive data files maintained by a vendor under contract with the Department for Medicaid Services. Resources accessed to determine SMAC include Wholesale Acquisition Cost (WAC), and Direct Price (to retail pharmacies) with weights applied based on the distribution of the volume purchased.

a. Multiple drug pricing resources are utilized to determine the estimated acquisition cost for the generic drugs. These resources include pharmacy providers, wholesalers, drug file vendors, and pharmaceutical manufacturers;

Methods and Standards for Establishing Payment Rates - Other Types of Care

I. Prescribed Drugs (continued)

4. Institutional Pharmacy. Drugs dispensed by an institutional or long-term care facility pharmacy provider (non-community or non-retail) will be reimbursed by the lowest of logic in Section A. I., plus the professional dispensing fee in Section C.
5. Hemophilia. Clotting factors acquired outside of the 340B Program will be reimbursed by the lowest of logic in Section A. I., which shall include rates as noted on the Medicare fee schedule, plus the professional dispensing fee in Section C.
6. 340B Program.
   a. 340B covered entities as described in Section 1927(a)(5)(8) of the Social Security Act, including Federally Qualified Health Centers and hemophilia treatment centers, that utilize 340B purchased drugs for Medicaid members will be reimbursed no more than their actual acquisition cost or the amount determined by the lowest of logic in Section A. I., which shall include the 340B Ceiling Price, plus the professional dispensing fee in Section C. Covered entities using drugs purchased under the 340B Program for Medicaid members must bill no more than their actual acquisition cost, plus the professional dispensing fee in Section C.
   b. 340B covered entities that do not utilize drugs purchased under 340B for Medicaid members will be reimbursed by the lowest of logic in Section A. I., plus the professional dispensing fee in Section C.
   c. Drugs acquired through the 340B Program and dispensed by 340B contract pharmacies are not covered.
7. Physician Administered Drugs. Drugs administered by a physician or in a hemophilia treatment center submitted under the medical benefit will include rates as noted on the Medicare fee schedule or the amount determined by the lowest of logic in Section A. I., and no professional dispensing fee shall be paid. Covered entities using drugs purchased under the 340B Program for Medicaid members must bill no more than their actual acquisition cost.
8. Federal Supply Schedule. Facilities purchasing drugs through the Federal Supply Schedule (FSS) will be reimbursed no more than their actual acquisition cost, plus the professional dispensing fee in Section C.
9. Nominal Price. Facilities purchasing drugs at a Nominal Price (outside of 340B or FSS) will be reimbursed no more than their actual acquisition cost, plus the professional dispensing fee in Section C.
10. lnvestigational Drugs or Investigational Uses of Drugs. investigational drugs or drugs utilized for non-FDA indications or other investigational treatments are not covered.

5. The department shall reimburse for drugs at the lesser of:

- Branded Drugs: WAC + 2% (plus dispensing fee) OR
- Generic Drugs: WAC + 3.2 % (plus dispensing fee) OR
- FUL + dispense fee OR
- MAC + dispense fee OR
- Usual & Customary (U & C)

6. For nursing facility residents meeting Medicaid patient status, an incentive of two (2) cents per unit dose shall be paid to long term care, personal care, and supports for community living pharmacists for repackaging a non-unit dose drug in unit dose form.

7. Medication Assisted Therapy (MAT)

a. Non-bundled prescribed drugs (at the pharmacy) will be reimbursed at the lowest of logic outlined in Attachment 4.19-B Page 20.1.

b. Methadone Medication Assisted Treatment will be paid as outlined in Attachment 4.19-B. Page 20.15(1)(d)(i)

9l 1905(a)(29) Medication-Assisted Treatment (MAT)

The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for prescribed drugs located in in Attachment 4.19-B, pages 20.1-20.1(a), for drugs that are dispensed or administered.

Methods and Standards for Establishing Payment Rates - Other Types of Care

C. Dispensing Fee

1. Effective February 23, 2005, the dispensing fee for a generic drug prescription is $5.00 and for a brand name drug prescription is $4.50. The dispensing fee is applied to any drug reimbursed through the pharmacy benefit program at the point of sale.