Pharmacy Reimbursement Methodology

Brand Name~~/ Single Source Generic Drugs~~

Reimbursement methodology for brand name drugs ~~and single source generic drugs~~ is:
The lesser of:

- The provider's usual and customary charge; or
- ~~The Federal Upper Limit (FUL), if applicable, and a dispensing fee of $3.91; or~~
- Average Wholesale Price (AWP) less 12% and a dispensing fee of $3.91; or
- Wholesale Net Unit Price/ Wholesale Acquisition Cost (WAC) plus 9% and a dispensing fee of $3.91.

Less the applicable co-payment of $3.00.

Brand name drugs are defined as single source or innovator multiple source drugs. ~~Single source generic drugs are defined as those drugs going off patent and a single source generic house has exclusivity for a period of time.~~

Multiple Source Generic Drugs

Reimbursement methodology for ~~multiple source~~ generic drugs is:
The lesser of :

- The provider's usual and customary charge; or
- The Federal Upper Limit (FUL), if applicable, and a dispensing fee of ~~$4.91*;~~ $5.50*; or
- Mississippi estimated acquisition cost (MEAC) defined as the Average Wholesale Price (AWP) less 25 % and a dispensing fee of $5.50*; or
- State Maximum Allowable Cost (SMAC) reimbursement and a dispensing fee of $5.50*.
- ~~Average Wholesale Price (AWP) less 25% and a dispensing fee of $4.91*.~~

Less the applicable co-payment of $3.00.

*The dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to $3.91.

State Maximum Allowable Cost (SMAC) reimbursement will apply to certain multi-source drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Division of Medicaid. Actual acquisition cost will be determined through the collection and review of pharmacy invoices and other information determined necessary by the Division and in accordance with applicable State and Federal law. SMAC rates are based on the average actual acquisition cost per drug of pharmacy providers enrolled in the Medicaid program, adjusted by a multiplier that is no less than 1.0, which ensures that each rate is sufficient to allow reasonable access by providers to the drug at or below the established SMAC rate. The Division will review the rates on an ongoing basis and adjust them as necessary to reflect prevailing market conditions and to ensure reasonable access by providers at or below the applicable SMAC rate.

* ~~The dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to $3.91.~~

Over the Counter (OTC) Drugs

Reimbursement for covered over-the-counter (OTC) drugs is:

- The lesser of
  - The usual and customary charge; or
  - The estimated shelf price and a dispensing fee of $3.91.

- Less the applicable co-payment of $3.00

DOM defines estimated shelf price as the lowest of the following:

- Mississippi Estimated Acquisition Cost (MEAC) – The MEAC for OTC drugs is defined as the Average Wholesale Price (AWP) less 25%. AWP is based on surveys of drug wholesalers and manufacturer-supplied information for a drug product. The AWP price is provided by First DataBank.

- Federal Upper Limit – This is the unit price as published by the Centers for Medicare and Medicaid Services (CMS) in the State Medicaid Manual, revised August 1987, Section 6305, Upper Limits for Multiple Source and Other Drugs and revisions.

- State Maximum Allowable Cost (SMAC) – The SMAC for OTC drugs are based on the average actual acquisition cost per drug of the pharmacy providers enrolled in the Medicaid program, adjusted by a multiplier that is no less than 1.0.

- ~~BaseLine Price – The BaseLine Price is developed by First DataBank as a statistical model that involves the Blue Book Unit Price, Direct Unit Price, and Net Wholesale Unit Price. This price shows the current market price and reflects changes in the market.~~

- Wholesale Net Unit Price – This is the published unit price that a manufacturer charges a wholesaler (commonly referred to as the wholesale acquisition cost, or WAC) and is provided by First DataBank.

Claims must be billed at the usual and customary charge. DOM does not reimburse claims at more than the usual and customary charge.

Usual and customary charge for prescription drugs is the price charged to the general public. DOM defines the general public as the patient group accounting for the largest number of non-Medicaid prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through a third party payer (ex: Blue Cross and Blue Shield, Aetna, etc.).

Medicaid does not cover delivery charges.

Participating Federally Qualified Health Center Providers

In reference to billing of Discounted Drugs, the Veterans Health Care Act of 1992 Title VI-Drug Pricing Agreements changed the way that drugs are billed to Medicaid by Federally Qualified Health Center (FQHC) in-house pharmacies. The Act requires that State Medicaid Agencies not request rebates on drugs that have already been discounted in price by the manufacturer at the time of purchase. The effective date of the applicable Section of the Act is December 1, 1992.

All drugs, as defined by the Act, purchased by an in-house pharmacy of an FQHC at a discounted price are to be reported on the cost report and be reimbursed through the core services encounter rate and not billed through the Pharmacy Program.