Pharmacy Reimbursement Methodology

Brand Name/ ~~Single Source Generic Drugs~~ (single source, innovator multiple-source) – In reimbursing for brand name drugs Medicaid shall pay:

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

- ~~The lesser of~~
  - ~~The 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~~.

1. The lesser of:
   - The provider's usual and customary charge; or
   - The EAC for brand name drugs which is defined as the lesser of :
     - AWP minus 12% plus a dispensing fee of $3.91; or
     - WAC plus 9% plus a dispensing fee of $3.91.
2. Less the applicable co-payment.

Multiple Source Generic Drugs- In reimbursing for multi-source generic drugs Medicaid shall pay:

~~Reimbursement methodology for multiple source generic drugs is:~~

- ~~The lesser of~~
  - ~~The usual and customary charge; or~~
  - ~~The Federal Upper Limit (FUL), if applicable, and a dispensing fee of $4.91*; or~~
  - ~~Average Wholesale Price (AWP) less 25% and a dispensing fee of $4.91*.~~

- ~~Less the applicable co-payment of $3.00.~~

1. The lesser of:
   - The provider's usual and customary charge; or
   - The Federal Upper Limit (FUL), if applicable, plus a dispensing fee of $5.50*; or
   - The EAC for multiple source drugs which is defined as the lesser of :
     - AWP minus 25% plus a dispensing fee of $5.50 or
     - SMAC rate and a dispensing fee of $5.50*.

2. Less the applicable co-payment.

* 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.~~

- ~~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.~~

Reimbursement for covered non-legend products or over-the-counter products is the lesser of:

- The provider's usual and customary charge; or
- The EAC for multiple source drugs which is defined as the lesser of :
  a) AWP minus 25% plus a dispensing fee of $3.91 or
  b) SMAC rate and a dispensing fee of $3.91.
- Less the applicable co-payment

EAC (Estimated Acquisition Cost) is defined as the Division's estimate of the price generally paid by pharmacies for pharmaceutical products. EAC may be based on the Average Wholesale Price (AWP) or the Wholesale Acquisition Cost (WAC) or the State Maximum Allowable Cost (SMAC).

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 deemed 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 1.3, 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 no less than an annual basis and adjust them as necessary to reflect prevailing market conditions and to assure reasonable access by providers.

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.

Notice of Proposed Rule Adoption

State of Mississippi
Office of the Governor
Division of Medicaid

Economic Impact Statement

Implementation of the State Maximum Allowable Cost (SMAC) Program enables the Division to reimburse pharmacy ingredient costs for multi-source drugs according to the *actual* acquisition costs of Medicaid-enrolled pharmacy providers. Unlike national pricing benchmarks which produce rates that are too high for some drugs and too low for others, SMAC rates will be accurate, consistent, and predictable. In addition, rates are regularly updated to remain current and reflective of changes in pharmacy market conditions.

The Division expects to initially set SMAC rates for 838 drugs groups, which is expected to reduce annual expenditures for those drugs by $32.9 million in total program expenditures. The estimate was determined by analyzing historical utilization data; specifically, by taking the annual units dispensed for each drug group and then multiplying that amount by the estimated per unit reduction in ingredient reimbursement.

Generic Legend Drugs	
Annualized Paid Generic Claims*	2,741,648
Current Generic Dispensing Fee	$4.91
Current Generic Dispensing Fee Expenditure	$13,461,492
Proposed Generic Dispensing Fee	$5.50
Projected Generic Dispensing Fee Expenditure	$15,079,064

Decrease in expenditures due to initial SMAC rates	$32.9M
Increase in dispensing fee	$ 1.6 M
	$31.3M total funds
	$7.56M state funds

These expenditure reductions are consistent with new Federal upper limit reductions that are being imposed by the Centers for Medicare and Medicaid Services under the authority of the Deficit Reduction Act of 2005.