12VAC30-80-40. Fee-for-service providers: pharmacy.

Payment for pharmacy services shall be the lowest of items 1 through 5 (except that items 1 and 2 will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331 (c) if the brand cost is greater than the HCFA upper limit of VMAC cost) subject to the conditions, where applicable, set forth in subdivisions 6 and 7 of this section:

1. The upper limit established by the Health Care Financing Administration (HCFA) for multiple source drugs pursuant to 42 CFR 447.331 and 447.332, as determined by the HCFA Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

2. ~~The Virginia Maximum Allowable Cost (VMAC) established by the agency plus a dispensing fee for multiple source drugs listed on the VVF.~~
The Virginia Medicaid Maximum Allowable Cost (VMAC) established by the Virginia Department of Medical Assistance Services to be inclusive of appropriate multiple source and specific high cost drugs plus a dispensing fee. Multiple source drugs include but are not limited to Food and Drug Administration-rated products such as drugs established by

a Virginia Voluntary Formulary (VVF) drugs, Federal Upper Limit Drugs and any other state or federally approved listing. Multisource drugs means covered outpatient drugs, for which there are two or more drug products, which:

a. Are included in the Centers for Medicare and Medicaid Services'state drug rebate program;

b. Have been approved by the Federal Food and Drug Administration (FDA);

c. Are included in the Approved Products with Therapeutic Equivalence Evaluations as generically equivalent; and

c. Are sold or marketed in Virginia.

3. The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percentage discount established by the General Assembly or in the absence thereof by the methodology set out in a through c below.

a. Percentage discount shall be determined by a statewide survey of providers' acquisition cost.

b. The survey shall reflect statistical analysis of actual provider purchase invoices.

c. The agency will conduct surveys at intervals deemed necessary by DMAS.

4. (Reserved.)

5. The provider's usual and customary charge to the public, as identified by the claim charge.

6. Payment for pharmacy services will be as described above; however, payment for legend drugs will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements.

7. The Program pays additional reimbursement for the 24-hour unit dose delivery system of dispensing drugs. This service is paid only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the nit dose add-on fee and an allowance for the cost of unit dose packaging established by the state agency. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC based on the 60th percentile cost level identified by the state agency or ~~HCFA's~~ CMS’upper limits. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency.

8. ~~Determination of EAC was the result of an analysis of FY89 paid claims data of ingredient cost used to develop a matrix of cost using 0 to 10% reductions from AWP as well as discussions with pharmacy providers. As a result of this analysis, AWP minus 9.0% was determined to represent prices currently paid by providers effective October 1, 1990.~~ Determination of EAC was the result of a report by the Office of the Inspector General (OIG) which focused on appropriate Medicaid marketplace pricing of pharmaceuticals based on the documented costs to the pharmacy. An EAC of AWP minus 10.25% shall become effective July 1, 2002.

~~The same methodology used to determine AWP minus 9.0% was utilized to determine a dispensing fee of $4.40 per prescription as of October 1, 1990. A periodic review of dispensing fee using Employment Cost Index--wages and salaries, professional and technical workers will be done with changes made in dispensing fee when appropriate. As of July 1, 1995, the estimated Acquisition Cost will be AWP minus 9.0% and dispensing fee will be $4.25.~~

The dispensing fee of $4.25 (effective July 1, 1995) shall remain in effect, creating a payment methodology based on the previous algorithm (least of 1 through 5 of this subsection above) plus a dispensing fee where applicable.

9. Home infusion therapy.

a. The following therapy categories shall have a pharmacy service day rate payment allowable: hydration therapy, chemotherapy, pain management therapy, drug therapy, total parenteral nutrition (TPN). The service day rate payment for the pharmacy component shall apply to the basic components and services intrinsic to the therapy category. Submission of claims for the per diem rate shall be accomplished by use of the HCFA 1500 claim form.

b. The cost of the active ingredient or ingredients for chemotherapy, pain management and drug therapies shall be submitted as a separate claim through the pharmacy program, using standard pharmacy format. Payment for this component shall be consistent with the current reimbursement for pharmacy services. Multiple applications of the same therapy shall be reimbursed one service day rate for the pharmacy services. Multiple applications of different therapies shall be reimbursed at 100% of standard pharmacy reimbursement for each active ingredient.

CERTIFIED:

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Date

Patrick W. Finnerty, Director
Department of Medical Assistance Services