Health Care Reform in Indian Country
Self-Governance Communication & Education
Self-Governance Tribes Striving Towards Excellence in Health Care

Medicaid Pharmacy Reimbursement for Tribal Programs: Potential for Using the Encounter Rate[1]

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This Tribal Self-Governance Advisory Committee (TSGAC) brief seeks to provide guidance to Tribal health programs on Medicaid reimbursement for covered outpatient drugs (CODs). Specifically, this brief discusses the potential for reimbursing Indian Health Service (IHS), Tribal, and urban Indian organization (I/T/U) pharmacies at the encounter rate (aka the "OMB Rate" or "IHS All-Inclusive Rate").

Background

State Medicaid programs generally reimburse pharmacies for CODs based on a two-part formula consisting of the ingredient cost of a drug and a professional dispensing fee. States have the flexibility to determine reimbursement rates, consistent with applicable statutory and regulatory requirements. These reimbursement rates require approval by the federal Centers for Medicare and Medicaid Services (CMS) through the State Plan Amendment (SPA) process.

State Medicaid programs reimburse pharmacies using a variety of methods. Some states reimburse I/T/U pharmacies as they would any other pharmacy. In other cases, states have obtained federal approval through SPAs to reimburse I/T pharmacies for prescriptions dispensed using the encounter rate. **Reimbursing at the encounter rate has the potential to raise substantially more revenues for these I/T/U facilities, which typically lack adequate funding**. States have set different policies on the total number of encounter rate payments that can be made on a single day for a single Medicaid beneficiary. (See ***Attachment 1*** *for a summary of Medicaid payment methodologies for reimbursing I/T or I/T/U pharmacies in states with federally recognized Tribes*.)

Impact of New Federal Rule

On February 1, 2016, CMS issued a final rule[2] that implemented provisions of the Affordable Care Act (ACA) pertaining to Medicaid reimbursement for CODs and revised other related requirements. In response to the proposed version of the rule, Tribal organizations raised concerns about losing the encounter rate at which some states reimburse I/T pharmacies. In both the final version of the rule and a subsequent State Health Official (SHO) Letter,[3] CMS clarified that paying I/T pharmacies at the encounter rate satisfies the requirements of the rule. CMS also noted that any SPAs associated with the

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] *See* CMS-2345-FC, "Medicaid Program; Covered Outpatient Drugs" (81 FR 5170), at https://www.gpo.gov/fdsys/pkg/FR-2016-02-01/pdf/2016-01274.pdf.

[3] *See* CMS, "SHO #16-001: Implementation of the Covered Outpatient Drug Final Regulation Provisions Regarding Reimbursement for Covered Outpatient Drugs in the Medicaid Program," at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16001.pdf.

rule must comprehensively describe the payment methodology for reimbursing I/T/U pharmacies, including an indication of whether the state will use the encounter rate for I/T pharmacies.[4]

Relevance of Acquisition Costs to Use of OMB Encounter Rate

CODs Purchased Through Federal Supply Schedule (FSS)

As discussed above, the new federal rule requires that states (1) comprehensively describe their Medicaid payment methodology for reimbursing I/T pharmacies for CODs and (2) reimburse I/T pharmacies at a rate in accordance with the actual acquisition cost (AAC) of the medications. The rule and the SHO letter explicitly permit the use of the encounter rate for CODs dispensed by I/T pharmacies. The SHO letter also indicates that states can reimburse I/T pharmacies at the encounter rate for CODs purchased through the Federal Supply Schedule (FSS), whose prices are available to the IHS, Department of Defense, Department of Veterans Affairs, and other federal agencies. According to the SHO letter:

> "For drugs purchased through the Federal Supply Schedule (FSS), reimbursement should not exceed the FSS price. States that pay IHS and Tribal providers through encounter rates can continue to pay at that rate since this will satisfy the requirements in §447.518(a)(2), which specify that the state's payment methodology for these entities must be in accordance with the definition of AAC in §447.502 of the final regulation."[5]

Some states, such as Indiana and North Dakota, have State Plans that explicitly specify they will pay I/T pharmacies at the encounter rate, regardless of their method of purchasing CODs. Another state (Utah) has a State Plan that specifies (1) the state will pay I/T pharmacies at the encounter rate and (2) providers that "purchase covered outpatient drugs through the Federal Supply Schedule (FSS) and use the covered outpatient drugs to bill Utah Medicaid are required to submit the FSS acquisition cost on the claim, ***unless the reimbursement is made through a*** bundled charge or ***all-inclusive encounter rate*** [emphasis added]."[6] In other cases, states have State Plans that specify they will pay I/T pharmacies at the encounter rate but do not make reference to the use of the FSS.

CODs Purchased Through 340B Program

As with I/T pharmacies, the new federal rule requires that states comprehensively describe their Medicaid payment methodology for reimbursing 340B program "covered entities" (or pharmacies contracting with covered entities) for CODs and reimburse these entities at a rate in accordance with the

[4] Page 3 of the SHO letter reads, in part: "States that pay IHS and Tribal providers through encounter rates can continue to pay at that rate since this will satisfy the requirements in §447.518(a)(2) ... In addition, in accordance with the requirements in §447.518(a)(1) of the final regulation, SPAs must comprehensively describe the payment methodology for reimbursement of drugs dispensed by 340B entities, 340B contract pharmacies, and I/T/U pharmacies, in accordance with the definition of AAC, as well as the payment methodology for how such entities are reimbursed, including stating if encounter rates will be used for IHS and Tribal providers."

[5] *See* CMS, SHO #16-001, page 3.

[6] *See* the Utah State Plan, Attachment 4.19-B, section S, page 19a(2) at https://medicaid.utah.gov/stateplan/spa/A_4-19-B.pdf.

AAC of the medications.[7,8] In the SHO letter, CMS clarified that:

- For CODs purchased through the 340B program, reimbursement should not exceed the 340B ceiling price; and
- For CODs purchased outside the 340B program, reimbursement should not exceed AAC.[9]

Although CMS has specified that states can pay I/T pharmacies at the encounter rate and satisfy the requirements of the rule, it is not clear whether purchasing CODs through the 340B program impacts the use of the encounter rate. However, it is worth noting that, as mentioned above, at least two states (Indiana and North Dakota) have State Plans that explicitly specify they will pay I/T pharmacies at the encounter rate, regardless of their method of purchasing CODs.

Opportunity for I/Ts

As mentioned above, the new rule does not limit—and affirms—the ability of state Medicaid programs to reimburse I/T pharmacies at the encounter rate. Examples of several current Medicaid reimbursement policies under which the state pays I/T pharmacies at the encounter rate for CODs appear below. These policies vary widely in their approach, ranging from (a) allowing only one encounter rate payment per Medicaid beneficiary per day for all CODs, to (b) allowing one encounter payment per beneficiary per day for most CODs but applying a different payment methodology for high-cost/specialty medications, to (c) allowing one encounter rate payment per prescription filled, with no limit on the number of prescriptions filled per day.[10]

a. One encounter rate payment per Medicaid beneficiary per day for all CODs:
    - **Nebraska**: "Tribal pharmacies will be paid the federal encounter rate."[11] [Nebraska pays one encounter rate per beneficiary per day for pharmacy services.[12]]
    - **North Dakota**: "All Indian Health Service, tribal and urban Indian pharmacies are paid the encounter rate by ND Medicaid regardless of their method of purchasing."[13] [North Dakota

[7] The definition of 340B program "covered entities" does not explicitly include I/T facilities (but does include urban Indian health programs receiving funds under title V of the Indian Health Care Improvement Act and federally-qualified health centers (FQHCs), among other entities). For a complete definition of "covered entities" under the 340B program, *see* section 340B(a)(4) of the Public Health Service Act at https://www.hrsa.gov/sites/default/files/hrsa/rural-health/phs-act-section-340b.pdf.

[8] *See* CMS-2345-FC.

[9] *See* CMS, SHO #16-001.

[10] In addition, three states (Wyoming, Oklahoma, and North Dakota) authorize using the encounter rate to reimburse urban Indian health programs for CODs.

[11] *See* the Nebraska State Plan, Attachment 4.19-B, section 12a, page 2 at https://dhhs.ne.gov/Medicaid%20State%20Plan/Attachment%204.19b%20Item%2012a%20-%20Prescribed%20drugs.pdf.

[12] For other services provided by I/T facilities, Nebraska pays additional encounter rates when the beneficiary 1) has to return for a distinctly different diagnosis, 2) has to return for emergency or urgent care, 3) requires pharmacy services in addition to medical or mental health services, or 4) receives both medical and mental health services.

[13] *See* the North Dakota State Plan, Attachment 4.19-B, section 32, page 6 at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ND/ND-16-0011.pdf.

pays one encounter rate per beneficiary per facility per day for pharmacy services.[14]]

b. One encounter rate payment per Medicaid beneficiary per day for most CODs, with a different payment methodology for high-cost/specialty medications (*i.e.*, medications whose cost exceeds the encounter rate, either generally or by a certain amount):

- **Arizona**: "The [IHS All-Inclusive Rate] may be billed for adults 19 years of age and older, when a prescription is filled at and dispensed by an IHS/638 facility pharmacy to the member."[15, 16, 17] For specialty medications, Arizona pays at a rate equal to the lesser of the FSS unit price or wholesale acquisition cost, plus a professional dispensing fee, rather than at the encounter rate.[18]]

c. One encounter rate payment per prescription filled, with no limit on the number of prescriptions filled per day:

- **Oregon**: "The I/T Pharmacy will receive one encounter [rate] per prescription filled or refilled and will not be limited to a certain number of prescriptions per day."[19]

- **Wyoming**: "Payment to all Indian Health Service, tribal, and urban Indian pharmacies shall be at the All Inclusive Rate (AIR) published annually in the Federal Register."[20] Wyoming pays one encounter rate per pharmacy claim, with no limit on the number of prescriptions per day.[21]

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[14] For most services provided by I/T facilities, North Dakota pays more than one encounter rate per day when the beneficiary 1) receives more than one diagnosis, whether the payments are for the same general service category or different general service categories (*e.g.*, inpatient hospital and pharmacy services) or 2) receives one diagnosis, if the payments are for different general service categories. *See* the North Dakota Department of Human Services guidance titled "Indian Health Services and Tribally-Operated 638 Facilities" and dated January 2024 at https://www.hhs.nd.gov/sites/www/files/documents/Medicaid%20Policies/indian-health-service-and-638-facilities.pdf. However, per the Medical Services Division of the North Dakota Department of Human Services, even in the above circumstances, the state pays only one encounter rate per beneficiary per facility per day for pharmacy services.

[15] *See* the Arizona IHS/Tribal Provider Billing Manual, Chapter 10, page 16 at https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap10Pharmacy.pdf.

[16] For children enrolled in KidsCare, Arizona reimburses I/T facilities for CODs based on the formulary set by the pharmacy benefit manager (PBM) OptumRx, not at the encounter rate. *See* the Arizona IHS/Tribal Provider Billing Manual, Chapter 10.

[17] Arizona pays as many as five encounter rates per beneficiary per facility per day but does not pay more than one encounter rate per beneficiary per facility per day for pharmacy services.

[18] I/T facilities in Arizona can bill Medicaid at the specialty medication rate when the cost of a COD exceeds the encounter rate. To receive the specialty medication rate, I/T facilities must include a clarification code of "09" in their pharmacy claim. *See* the Arizona IHS/Tribal Provider Billing Manual, Chapter 10, page 9.

[19] *See* the Oregon State Plan, Attachment 4.19-B, section 12, page 3-b at https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf.

[20] *See* the Wyoming State Plan, Attachment 4.19-B, section 12a, page 3 at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WY/WY-17-0002.pdf.

[21] *See* the Wyoming Tribal Provider Manual, page 159 at https://health.wyo.gov/wp-content/uploads/2018/04/Tribal-Manual0418-1.pdf. According to page 160 of the manual, Wyoming does not allow I/T facilities to submit claims separately for drugs dispensed as part of a clinic visit (*i.e.*, physician-administered drugs).

Attachments 2, 3, 4, 5, 6, and 7 include snapshots of the I/T pharmacies approved SPAs.

Diagnosis-Based Limitations on Encounter Rate Payments

In addition to the above approaches on Medicaid reimbursement for CODs dispensed by I/T pharmacies, a state could generally allow only one encounter rate payment per beneficiary per day for a single diagnosis but also allow multiple encounter rate payments for multiple (distinctly different) diagnoses. A number of states have implemented this type of Medicaid reimbursement policy for other (non-COD) services provided by I/T facilities. Some examples of these policies appear below (emphasis added).

- **Nebraska**: "Encounters: Visits with more than one health professional, and multiple visits with the same health professional, that take place during the same day within the IHS or Tribal (638) facility constitute a single visit. **Exceptions: a. When the patient is seen in the clinic, or by a health professional, more than once in a day for distinctly different diagnosis. ...**"[22]
- **North Dakota**: "**Encounters with more than one health professional and/or multiple encounters with the same health professionals on the same day and at a single location constitute a single visit except when one of the following conditions exist: ... Multiple visits for the same type of service on the same day with different diagnosis**."[23]
- **South Dakota**: "Only one encounter is reimbursable per date of service, per recipient. ... **Exceptions to this limit are described below: ... The same encounter type if the primary diagnosis is distinctly different.**"[24]

These policies have the effect of constraining the total number of encounter rate payments per beneficiary per day but do so in a way that provides additional resources when I/T providers are treating a distinctly different medical condition. This is important in instances in which I/T providers are treating patients with complex medical needs. And this is particularly important to I/T providers that serve a patient base with greater-than-average medical needs. At present, no states have applied these policies to CODs, but the rationale behind these policies appears to have equal relevance to CODs.

Recent Approvals of SPAs

Since the version of this memo dated February 10, 2020, two additional states have received CMS approval for an SPA associated with the new rule. (Summaries of the impact of these SPAs appear below.)

[22] *See* Nebraska State Plan, Attachment 4.19-B, section 2d at https://dhhs.ne.gov/Medicaid%20State%20Plan/Attachment%204.19b%20Item%202d%20-%20Indian%20Health%20Service%20and%20Tribal%20health%20facilities;%20telehealth.pdf.

[23] *See* the North Dakota Department of Human Services guidance titled "Indian Health Services and Tribally-Operated 638 Facilities" and dated January 2024.

[24] *See* South Dakota Medicaid Billing and Policy Manual: IHS and Tribal 638 Providers, page 4 at https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/IHS_and_Tribal_638_Facilities.pdf.

- **Minnesota**: The SPA did not indicate a separate Medicaid payment methodology for I/T pharmacies.[25] However, the Minnesota Health Care Programs (MHCP) Provider Manual, "Tribal and Federal Indian Health Services" section specifies that Minnesota pays IHS pharmacies at the encounter rate and pays Tribal pharmacies at the encounter rate or the applicable fee-for-service rate, at the discretion of the Tribe; the state pays one encounter rate per beneficiary per day.[26]

- **Washington**: The SPA did not indicate a separate Medicaid payment methodology for I/T pharmacies.[27]

In addition, several states have received CMS approval for an SPA that revised their Medicaid reimbursement policy specifically to pay I/T pharmacies at the encounter rate for CODs and/or apply a different payment methodology for high-cost medications.

- **Michigan**: The SPA indicates that Michigan pays Tribal pharmacies at the encounter rate, regardless of their method of purchasing drugs; the state pays one encounter rate per prescription filled or refilled, with no limit on the number of prescriptions filled per day.[28]

- **New Mexico**: The SPA indicates that New Mexico pays I/T pharmacies at the encounter rate; the state pays one encounter rate per prescription filled or refilled, with no limit on the number of prescriptions filled per day.[29]

- **North Carolina**: The SPA indicates that North Carolina pays I/T/U pharmacies at the encounter rate; the state pays one encounter rate per prescription filled or refilled, with a maximum of two encounter rate payments per beneficiary per facility per day. For CODs with an acquisition cost that exceeds $1,000, North Carolina pays at a rate equal to the lesser of the fee-for-service unit price or the AAC, plus a professional dispensing fee, rather than at the encounter rate.[30]

- **South Dakota**: The SPA indicates that, for CODs with an acquisition cost that exceeds the encounter rate, South Dakota pays I/T/U pharmacies at a rate no greater than the AAC, plus a professional dispensing fee, rather than at the encounter rate.[31]

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[25] *See* the Minnesota State Plan, Attachment 4.19-B, section 12a at https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-19-0006.pdf.

[26] *See* the MHCP Provider Manual, "Tribal and Federal Indian Health Services" section at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_009000.

[27] *See* the Washington State Plan, Attachment 4.19-B, Supplement A at https://www.medicaid.gov/sites/default/files/2023-11/WA-23-0050.pdf.

[28] *See* the Michigan State Plan, Attachment 4.19-B, section 2 at https://www.medicaid.gov/sites/default/files/2021-09/MI-21-0009.pdf.

[29] *See* the New Mexico State Plan, Attachment 4.19-B, section II at https://www.hsd.state.nm.us/wp-content/uploads/NM-21-0001-APPROVAL-PACKAGE.pdf.

[30] *See* the North Carolina State Plan, Attachment 4.19-B, section 12 at https://www.medicaid.gov/sites/default/files/2021-02/NC-20-0015.pdf.

[31] *See* the South Dakota State Plan, Attachment 4.19-B, section 12a at https://www.medicaid.gov/sites/default/files/2020-08/SD-20-0002.pdf.

Attachment 1

Table 1. Medicaid Payment Methodologies for Reimbursing I/T or I/T/U Pharmacies in States with Federally Recognized Tribes (as of 5/15/2024)

State	Has Specific Payment Methodology for I/T or I/T/U Pharmacies		Has Received Approval for SPA to Address CMS-2345-FC[1a, 1b]		Pays at the Encounter Rate[2]		Notes on Specific Payment Methodologies for I/T or I/T/U Pharmacies
	Yes	No	Yes	No	Yes	No	
Alabama		X	X			X	--
Alaska	X		X			X	For drugs purchased through the Federal Supply Schedule (FSS), Alaska makes payments to I/T/U pharmacies not exceeding the acquisition cost, plus pays a professional dispensing fee.
Arizona	X		X		X		For drugs dispensed to adults ages 18 and older and for vaccine administration, Arizona pays I/T pharmacies at the encounter rate; the state pays as many as five encounter rates per beneficiary per facility per day but does not pay more than one encounter rate per beneficiary per facility per day for pharmacy services.[3]
California	X		X			X	California makes payments to I/T/U pharmacies equal to the ingredient cost of drugs, plus pays a professional dispensing fee.
Colorado	X		X		X		Colorado pays I/T pharmacies at the encounter rate; the state does not pay more than one encounter rate per beneficiary per day for pharmacy services.[4]
Connecticut[5]		X	X			X	--
Florida		X	X			X	--
Idaho	X		X			X	Idaho makes payments to I/T/U pharmacies equal to the acquisition cost of drugs, plus pays a professional dispensing fee.
Indiana	X		X		X		Indiana pays I/T/U pharmacies at the encounter rate, regardless of their method of purchasing drugs.[6]
Iowa	X		X		X		Iowa pays I/T pharmacies at the encounter rate; the state pays one encounter rate per beneficiary per day.
Kansas	X		X			X	Kansas makes payments to I/T/U pharmacies not exceeding the acquisition cost of drugs, plus pays a professional dispensing fee.
Louisiana	X		X		X		Louisiana pays I/T pharmacies at the encounter rate; the state pays one encounter rate per beneficiary per day.[7]
Maine	X		X			X	Maine allows I/T facilities to obtain a separate National Provider Identification (NPI) number for the purpose of receiving fee-for-service payments for pharmacy and certain other services.
Massachusetts[8]		X	X			X	--
Michigan	X		X		X		Michigan pays Tribal pharmacies at the encounter rate, regardless of their method of purchasing drugs; the state pays one encounter rate per prescription filled or refilled, with no limit on the number of prescriptions filled per day.
Minnesota	X		X		X		Minnesota pays IHS pharmacies at the encounter rate and pays Tribal pharmacies at the encounter rate or the applicable fee-for-service rate, at the discretion of the Tribe; the state pays one encounter rate per beneficiary per day.[9]
Mississippi		X	X			X	--
Montana		X		X		X	--
Nebraska	X		X		X		Nebraska pays I/T pharmacies at the encounter rate; the state does not pay more than one encounter rate per beneficiary per day for pharmacy services.[10]
Nevada	X		X		X		Nevada pays I/T pharmacies at the encounter rate; the state pays as many as five encounter rates per beneficiary per day.[11]
New Mexico	X		X		X		New Mexico pays I/T pharmacies at the encounter rate; the state pays one encounter rate per prescription filled or refilled, with no limit on the number of prescriptions filled per day.
New York	X			X		X	For drugs purchased through the FSS, New York makes payments to I/T pharmacies equal to the net acquisition cost; for all other purchased drugs, the state pays the standard rate.
North Carolina	X			X	X		North Carolina pays I/T/U pharmacies at the encounter rate; the state pays one encounter rate per prescription filled or refilled, with a maximum of two encounter rate payments per beneficiary per facility per day[12]
North Dakota	X		X		X		North Dakota pays I/T/U pharmacies at the encounter rate, regardless of their method of purchasing drugs; the state pays one encounter rate per beneficiary per facility per day.[13]
Oklahoma	X		X		X		Oklahoma pays I/T/U pharmacies at the encounter rate; the state pays one encounter rate per beneficiary per facility per day.
Oregon	X		X		X		Oregon pays I/T pharmacies at the encounter rate; the state pays one encounter rate per prescription filled or refilled, with no limit on the number of prescriptions filled per day.[14]
Rhode Island	X		X		X		Rhode Island pays I/T/U pharmacies at the encounter rate.
South Carolina		X		X		X	--
South Dakota	X		X		X		South Dakota pays I/T pharmacies at the encounter rate, regardless of their method of purchasing drugs; the state pays one encounter rate per beneficiary per day.[15]
Texas	X		X			X	Texas makes payments to I/T/U pharmacies equal to the actual acquisition cost of drugs, plus pays a professional dispensing fee.
Utah	X		X		X		Utah pays I/T pharmacies at the encounter rate; the state pays one encounter rate per prescriber per day, regardless of the number of prescriptions issued by the prescriber.
Virginia[16]		X	X			X	--
Washington		X	X			X	--
Wisconsin	X			X		X	For drugs dispensed by Tribal Federally Qualified Health Centers (FQHCs), Wisconsin makes payments equal to the acquisition cost, plus pays a professional dispensing fee; the state also pays Tribal FQHCs the difference between these payments and their reasonable costs (or requires recoupment if these payments exceed their reasonable costs).[17]
Wyoming	X		X		X		For covered outpatient drugs, Wyoming pays I/T/U pharmacies at the encounter rate; the state pays one encounter rate per pharmacy claim, with no limit on the number of prescriptions filled per day.[18]
TOTAL	26	9	30	5	18	17	

Notes

[1a] This final rule, issued by CMS on February 1, 2016, implemented provisions of the Affordable Care Act (ACA) pertaining to Medicaid reimbursement for covered outpatient drugs (CODs) and revised other related requirements. In response to the proposed rule, Tribal organizations raised concerns about losing the encounter rate at which some states reimburse I/T/U pharmacies. In both the final version of the rule and a subsequent State Health Official (SHO) Letter, CMS clarified that paying I/T pharmacies at the encounter rate satisfies the requirements of the rule. CMS also noted that any SPAs associated with the rule must comprehensively describe the payment methodology for reimbursing I/T/U pharmacies, including an indication of whether the state will use the encounter rate for I/T pharmacies. In CMS-2345-FC, CMS indicated that, for states that did not already meet the new requirements, state Medicaid agencies needed to submit an SPA to come into compliance by June 30, 2017, with an effective date no later than April 1, 2017.

[1b] For this category, "Yes" indicates that CMS has approved an SPA submitted by the state Medicaid agency to meet the new requirements under CMS-2345-FC, based on a review of the list of approved SPAs at Medicaid.gov; "No" indicates that CMS has not approved such an SPA but does not necessarily mean that the state is not in compliance with the new requirements.

[2] The encounter rate is also known as the "OMB Rate" or "IHS All-Inclusive Rate."

[3] For children enrolled in KidsCare (CHIP), Arizona pays I/T pharmacies based on the formulary set by the pharmacy benefit manager OptumRx, not at the encounter rate. With the exception of vaccine administration, the Arizona State Plan does not specify a payment methodology for I/T pharmacies; the above policies appear only in the state IHS/Tribal Provider Billing Manual. For specialty medications, Arizona pays at a rate equal to the lesser of the federal supply schedule (FSS) unit price or wholesale acquisition cost, plus a professional dispensing fee, rather than at the encounter rate.

[4] For other services provided by I/Ts, Colorado pays additional encounter rates when the beneficiary 1) receives more than one diagnosis or 2) receives one diagnosis, if the payments are for different general service categories (e.g. general practitioner and dental services).

[5] The Connecticut State Plan, Attachment 4.19-B, section 12, indicates that the I/T facility in the state does not dispense CODs.

[6] The Indiana State Plan, Attachment 4.19-B, section 1, indicates that the state has no I/T/U pharmacies currently enrolled in Medicaid.

[7] In the Louisiana State Plan, Attachment 4.19-B, section 12a, reads, "Pharmacy services provided by the Indian Health Service (IHS) or tribal facilities shall be included in the encounter rate." However, Attachment 4.19-B, section 2d reads, "Reimbursement for filling or refilling of prescriptions is not part of the encounter rate and shall be limited to the existing fee for service rate for the facility."

[8] The Massachusetts State Plan, Attachment 4.19-B, section 1, indicates that the state has no I/T/U pharmacies currently enrolled in Medicaid and would establish a specific methodology for paying these pharmacies if any enrolled in the program.

[9] For other services provided by I/Ts, Minnesota pays additional encounter rates when the beneficiary 1) has to return for a different diagnosis or treatment; or 2) receives services in multiple categories (e.g. inpatient hospital and outpatient services).

[10] For other services provided by I/Ts, Nebraska pays additional encounter rates when the beneficiary 1) has to return for a distinctly different diagnosis, 2) has to return for emergency or urgent care, 3) requires pharmacy services in addition to medical or mental health services, or 4) receives both medical and mental health services.

[11] The Nevada State Plan does not specify a payment methodology for I/T pharmacies; the state Medicaid Billing Guidelines for IHS/Tribal providers include pharmacies among the list of providers paid at the encounter rate. The document does not indicate whether the state pays more than one encounter rate per beneficiary per day for pharmacy services.

[12] For CODs with an acquisition cost that exceeds $1,000, North Carolina pays I/T/U at a rate equal to the lesser of the fee-for-service unit price or the AAC, plus a professional dispensing fee, rather than at the encounter rate.

[13] For most services provided by I/Ts, North Dakota pays more than one encounter rate per day when the beneficiary 1) receives more than one diagnosis, whether the payments are for the same general service category or different general service categories (e.g. inpatient hospital and pharmacy services) or 2) receives one diagnosis, if the payments are for different general service categories.

[14] Oregon received approval for its SPA on September 20, 2017, with an effective date of April 22, 2017. In Oregon, I/T pharmacies also have the option of receiving payment as a 340B entity or operating as a non-Tribal retail pharmacy and receiving the standard payment rate.

[15] For other services provided by I/Ts, South Dakota pays more than one encounter rate per day when the beneficiary 1) receives more than one diagnosis, whether the payments are for the same general service category or different general service categories (e.g. inpatient hospital and pharmacy services) or 2) receives one diagnosis, if the payments are for different general service categories.

[16] The Virginia State Plan, Attachment 4.19-B, section 7, indicates that the state has no I/T/U pharmacies currently enrolled in Medicaid and would establish a specific methodology for paying these pharmacies if any enrolled in the program.

[17] Tribal FQHCs typically receive Medicaid payments based on a rate determined by the state using the Prospective Payment System (PPS) methodology. However, states and FQHCs have the ability to agree to use an Alternative Payment Methodology (APM) in determining Medicaid payment rates, as long as the APM rate is higher than the PPS rate. Wisconsin has adopted an APM under which the state Medicaid program reimburses Tribal FQHCs at 100% of reasonable costs. The state determines reasonable costs on a per encounter basis by ascertaining the average cost per day, per provider, per recipient at a Tribal FQHC and then makes an assessment of whether the Tribal FQHC was underpaid or overpaid based on the number of encounters multiplied by the PPS (or APM) rate less revenues. If the Tribal FQHC was underpaid, the state will issue an additional payment in the amount needed to reconcile to 100% of reasonable costs; if the Tribal FQHC was overpaid, the state will issue a recoupment in the amount needed to reconcile to 100% of reasonable costs.

[18] Per the Wyoming State Plan, the state pays one encounter rate "for each pharmacy claim paid by the Department," with the applicable encounter rate "determined by the date of service submitted on the pharmacy claim." Wyoming does not allow I/Ts to submit claims separately for drugs dispensed as part of a clinic visit (i.e., physician-administered drugs). The Wyoming Tribal Provider Manual, page 160 reads: "Prescriptions written after September 5, 2017, must be processed through the Pharmacy Point of Sale system. Any physician administered drug cannot be billed separately through the point of sale system but must go on the encounter for an office visit using the revenue code 0250."

Table 2. Medicaid Reimbursement for I/T/U Pharmacies in States with Tribes: Source List		
State	**Source(s)**	**Link(s)**
Alabama	Alabama State Plan, Attachment 4.19-B, section 4	https://medicaid.alabama.gov/documents/9.0_Resources/9.8_State_Plan/9.8_A4.19-B_Payment_Medical_Care_Services_Excluding_Inpatient_Hospital_LTC_Services_4-10-24.pdf
Alaska	Alaska State Plan, Attachment 4.19-B, "Prescribed Drugs" section	https://health.alaska.gov/Commissioner/Documents/medicaidstateplan/SMP-Section-4.19-Attachment-B.pdf
Arizona	Arizona State Plan, Attachment 4.19-B, "Specialty Rates" section; AHCCCS IHS/Tribal Provider Billing Manual, chapter 10	https://www.azahcccs.gov/Resources/Downloads/StatePlans/EntireStatePlan.pdf https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap10Pharmacy.pdf
California	California State Plan, Attachment 4.19-B, Supplement 2	http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement_2_to_Attachment_4.19-B.pdf
Colorado	Colorado State Plan, Attachment 4.19-B, "Indian Health Services" section; section 12a (per SPA approved on 11/13/2017)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-17-0004.pdf
Connecticut	Connecticut State Plan, Attachment 4.19-B, section 12 (per SPA approved on 5/12/2018)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CT/CT-17-0015.pdf
Florida	Florida State Plan, Attachment 4.19-B, section 4	https://ahca.myflorida.com/content/download/5974/file/2021wu_Section_4-General_Program_Administration.pdf
Idaho	Idaho State Plan, Attachment 4.19-B, section 12a (per SPA approved on 6/21/2017)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ID/ID-17-0003.pdf
Indiana	Indiana State Plan, Attachment 4.19-B, "Pharmacy Services" section (per SPA approved on 7/21/2017)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-17-002.pdf
Iowa	Iowa State Plan, Attachment 4.19-B, section 9 (per SPA approved on 8/10/2017)	https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IA/IA-17-017.pdf
Kansas	Kansas State Plan, Attachment 4.19-B, section 12a (per SPA approved on 7/21/2017)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/KS/KS-17-004.pdf
Louisiana	Louisiana State Plan, Attachment 4.19-B, sections 2d and 12a	http://dhh.louisiana.gov/assets/medicaid/StatePlan/Sec4/Attachment4.19BItem2d.pdf http://dhh.louisiana.gov/assets/medicaid/StatePlan/Sec4/Attachment_4.19-B-Item_12a-Prescribed_Drugs.pdf
Maine	MaineCare Benefits Manual, Chapter II, Sections 9 and 80; Maine State Plan, Attachment 4.19-B, section 12 (per SPA approved on 9/13/2018)	https://www1.maine.gov/sos/cec/rules/10/ch101.htm https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ME/ME-17-0012.pdf
Massachusetts	Massachusetts State Plan, Attachment 4.19-B, section 1 (per SPA approved on 2/20/2018)	https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MA/MA-17-006.pdf
Michigan	Michigan State Plan, Attachment 4.19-B, section 2 (per SPA approved on 9/13/2021)	https://www.medicaid.gov/sites/default/files/2021-09/MI-21-0009.pdf
Minnesota	Minnesota Health Care Programs (MHCP) Provider Manual, "Tribal and Federal Indian Health Services" section	http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_009000#
Mississippi	Mississippi State Plan, Attachment 4.19-B, section 12a	https://medicaid.ms.gov/wp-content/uploads/2024/03/Attachment-4.19-B-Searchable-eff.-11.1.23-Updated-3.1.24-1.pdf

Table 2. Medicaid Reimbursement for I/T/U Pharmacies in States with Tribes: Source List (continued)		
State	**Source(s)**	**Link(s)**
Montana	Montana State Plan, Attachment 4.19-B, section 12a (per SPA approved on 11/8/2018)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MT/MT-18-0048.pdf
Nebraska	Nebraska State Plan, Attachment 4.19-B, sections 2d and 12a	https://dhhs.ne.gov/Medicaid%20State%20Plan/Attachment%204.19b%20Item%202d%20-%20Indian%20Health%20Service%20and%20Tribal%20health%20facilities;%20telehealth.pdf
		https://dhhs.ne.gov/Medicaid%20State%20Plan/Attachment%204.19b%20Item%2012a%20-%20Prescribed%20drugs.pdf
Nevada	Nevada State Plan, Attachment 4.19-B, section 12a; Nevada Medicaid Billing Guidelines, provider types 51, 52, 78, and 79	http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSP/Sec4/5%20-%204.19%20Attach%20B%20Pay%20for%20Med%20Care.pdf
		https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT51-52-78-79.pdf
New Mexico	New Mexico State Plan, Attachment 4.19-B, section II (per SPA approved on 5/10/2021)	https://www.hsd.state.nm.us/wp-content/uploads/NM-21-0001-APPROVAL-PACKAGE.pdf
New York	New York State Plan, Attachment 4.19-B, section 4d	https://www.hcrapools.org/medicaid_state_plan/Attachment_PDF_PROD/attach_4-19b.pdf
North Carolina	North Carolina State Plan, Attachment 4.19-B, section 12 (per SPA approved on 12/17/2020)	https://www.medicaid.gov/sites/default/files/2021-02/NC-20-0015.pdf
North Dakota	North Dakota State Plan, Attachment 4.19-B, sections 29 and 32 (per SPA approved on 2/14/2017)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ND/ND-16-0011.pdf
		https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/ND/ND-16-0011.pdf
Oklahoma	Oklahoma State Plan, Attachment 4.19-B, "Payment for Prescribed Drugs" section	https://oklahoma.gov/content/dam/ok/en/okhca/docs/research/title-xix-state-plans/2024/State%20Plan%2005.07.2024.pdf
Oregon	Oregon State Plan, Attachment 4.19-B, section 12 (per SPA approved on 9/20/2017)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OR/OR-17-0007.pdf
Rhode Island	Rhode Island State Plan, Attachment 4.19-B (per SPA approved on 9/20/2017)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/RI/RI-17-004.pdf
South Carolina	South Carolina State Plan, Attachment 4.19-B, section 12a	https://www.scdhhs.gov/sites/default/files/ATTACHMENT%204.19-B_7.pdf
South Dakota	South Dakota State Plan, Attachment 4.19-B, section 12a (per SPA approved on 8/11/2020); South Dakota Medicaid Billing and Policy Manual: IHS and Tribal 638 Providers	https://www.medicaid.gov/sites/default/files/2020-08/SD-20-0002.pdf
		https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/IHS_and_Tribal_638_Facilities.pdf
Texas	Texas State Plan, Attachment 4.19-B, "Pharmacy Reimbursement Methodology" section (per SPA approved on 9/22/2017)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/TX/TX-17-0011.pdf
Utah	Utah State Plan, Attachment 4.19-B, section S; Utah Medicaid Provider Manual, Section 2: Indian Health	https://medicaid.utah.gov/stateplan/spa/A_4-19-B.pdf
		https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Indian%20Health%20Services/IndianHealthServices.pdf

Table 2. Medicaid Reimbursement for I/T/U Pharmacies in States with Tribes: Source List (continued)		
State	**Source(s)**	**Link(s)**
Virginia	Virginia State Plan, Attachment 4.19-B, section 7 (per SPA approved on 10/19/2016)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VA/VA-16-002.pdf
Washington	Washington State Plan, Attachment 4.19-B, section IV (per SPA approved on 11/13/2023)	https://www.medicaid.gov/sites/default/files/2023-11/WA-23-0050.pdf
Wisconsin	Wisconsin State Plan, Attachment 4.19-B, section 3	https://www.dhs.wisconsin.gov/mandatoryreports/mastateplan/4-19b-noninstitutional.pdf
Wyoming	Wyoming State Plan, Attachment 4.19-B, section 12a (per SPA approved on 10/6/2017)	https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/WY/WY-17-0002.pdf

Attachment 2: Nebraska State Plan—Medicaid Payment Policy for CODs

ATTACHMENT 4.19-B
Item 12a, Page 1 of 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Professional Dispensing Fees

Professional Dispensing Fee: A professional dispensing fee of $10.02 shall be assigned to each claim payment based on the lesser of methodology described below.

PRESCRIBED DRUGS (Continued)

Cost Limitations: The Nebraska Medicaid Drug Program is required to reimburse ingredient cost for covered outpatient legend and non-legend drugs at the lowest of:

Brand Drugs

a. The usual and customary charge to the public, or;
b. The National Average Drug Acquisition cost (NADAC), plus the established professional dispensing fee, or;
c. The ACA Federal Upper Limit (FUL) plus the established professional dispensing fee, or;
d. The calculated State Maximum Allowable Cost (SMAC) plus the established professional dispensing fee.

The FUL or SMAC limitations will not apply in any case where the prescribing physician certifies that a specific brand is medically necessary. In these cases, the usual and customary charge or NADAC will be the maximum allowable cost.

Generic Drugs

a. The usual and customary charge to the public, or;
b. The National Average Drug Acquisition cost (NADAC), plus the established professional dispensing fee, or;
c. The ACA Federal Upper Limit (FUL) plus the established professional dispensing fee, or;
d. The calculated State Maximum Allowable Cost (SMAC) plus the established professional dispensing fee.

Backup Ingredient Cost Benchmark
If NADAC is not available, the allowed ingredient cost shall be the lesser of Wholesale Acquisition Cost (WAC) + 0%, State Maximum Allowable Cost (SMAC) or ACA Federal Upper Limit plus the established professional dispensing fee.

Specialty Drugs
Specialty drugs shall be reimbursed at NADAC plus the established professional dispensing fee. If NADAC is not available, then the Backup Ingredient Cost Benchmark will apply.

340B Drug Pricing Program
Covered legend and non-legend drugs, including specialty drugs, purchased through the Federal

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ATTACHMENT 4.19-B
Item 12a, Page 2 of 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Nebraska
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Public Health Service's 340B Drug Pricing Program (340B) by covered entities that carve Medicaid into the 340B Drug Pricing Program, shall be reimbursed at the 340B actual acquisition cost, but no more than the 340B ceiling price, plus the established professional dispensing fee. A 340B contract pharmacy under contract with a 340B covered entity described in section 1927 (a)(5)(B) of the Act is not covered.

Federal Supply Schedule (FSS)
Facilities purchasing drugs through the Federal Supply Schedule (FSS) shall be reimbursed at no more than their actual acquisition cost, plus the established professional dispensing fee.

Clotting Factor

a. Pharmacies dispensing Antihemophilic Factor products will be reimbursed at the lesser of methodology plus the established professional dispensing fee. If NADAC is not available, the lesser of methodology for the allowed ingredient cost shall be the Wholesale Acquisition Cost (WAC) + 0%, ASP + 6% or ACA Federal Upper Limit.
b. Pharmacies dispensing Antihemophilic Factor products purchased through the Federal Public Health Service's 340B Drug Pricing Program (340B) by pharmacies that carve Medicaid into the 340B Drug Pricing Program shall be reimbursed at the 340B actual acquisition cost, but no more than the 340B ceiling price, plus the established professional dispensing fee.

Drugs Purchased at Nominal Price
Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) shall be reimbursed by their actual acquisition cost plus the established professional dispensing fee.

Investigational Drugs
Excluded from coverage.

Tribal Rates
Tribal pharmacies will be paid the federal encounter rate.

Certified Long-Term Care
Pharmacies providing covered outpatient prescription services for Certified Long-Term Care beneficiaries will be reimbursed for ingredient cost using the lesser of methodology plus the established professional dispensing fee.

Physician Administered Drugs

a. Practitioner administered injectable medications will be reimbursed at ASP + 6% (Medicare Drug Fee Schedule); injectable medications not available on the Medicare Drug Fee Schedule will be reimbursed at WAC + 6.8%, or manual pricing based on the provider's actual acquisition cost.
b. Practitioner administered injectable medications, including specialty drugs, purchased through the 340B Program will be reimbursed at the 340B actual acquisition cost and no more than the 340B ceiling price.

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Attachment 3: North Dakota State Plan—Medicaid Payment Policy for CODs

STATE: North Dakota

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32. For prescribed drugs, including specific North Dakota Medicaid covered non-legend drugs that are prescribed by an authorized prescriber and legend drugs prescribed by an authorized prescriber, North Dakota Medicaid will reimburse at the following lesser of methodology (in all instances, the professional dispensing fee will be $12.46):

    1. The usual and customary charge to the public, or
    2. North Dakota Medicaid's established Maximum Allowable Cost (MAC) for that drug plus the professional dispensing fee (ND Medicaid's MAC is acquisition cost based and includes all types of medications, including specialty and hemophilia products), or
    3. The current National Average Drug Acquisition Cost (NADAC) for that drug plus the professional dispensing fee, or if there is no NADAC for a drug, the current wholesale acquisition cost (WAC) of that drug plus the professional dispensing fee; In compliance with 42 Code of Federal Regulations (C.F.R.) 447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.
    4. For 340B purchased drugs, the lesser of logic will include the 340B MAC pricing (ceiling price) plus the professional dispensing fee.
        a. Covered entities as described in section 1927 (a)(5)(B) of the Social Security Act are required to bill no more than their actual acquisition cost plus the professional dispensing fee.
        b. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.
    5. All Indian Health Service, tribal and urban Indian pharmacies are paid the encounter rate by ND Medicaid regardless of their method of purchasing.
    6. For Federal Supply Schedule purchased drugs, their provider agreements will require them to bill at no more than their actual acquisition cost plus the professional dispensing fee.
    7. Drugs not distributed by a retail community pharmacy (such as a long-term care facility) will be reimbursed as outlined in items 1-6 above and 8-13 below in this section.
    8. Drugs not distributed by a retail community pharmacy and distributed primarily through the mail (such as specialty drugs) will be reimbursed as outlined in items 1-7 above and 9-13 below in this section since ND Medicaid's MAC is acquisition cost based and includes all types of drugs.
    9. Clotting factors from Specialty Pharmacy, Hemophilia Treatment Centers (HTC), Center of Excellence will be reimbursed as outlined in items 1-8 above and 10-13 below in this section since ND Medicaid's MAC is acquisition cost based and includes all types of drugs.

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STATE: North Dakota

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10. Drugs acquired at Nominal Price (outside of 340B or FSS) will be reimbursed at no more than the actual acquisition plus the professional dispensing fee while also using the logic as outlined in items 1-9 above and 11-13 below in this section.
11. All of the logic as outlined in items 1-10 above in this section (with the exception of the professional dispensing fee being included in the calculations) will apply to Physician Administered Drugs (no professional dispensing fee will be paid for Physician Administered Drugs).
12. Investigational drugs are paid at invoice pricing which includes the cost of the drug, the international regulatory, shipping and handling fee, and next day delivery service.
13. A fee of fifteen cents per pill will be added to the dispensing fee for the service of pill splitting. Pill splitting is entirely voluntary for the patient and the pharmacist. Pill splitting will only be permitted under the following circumstances: when Medical Services determines it is cost effective, the pill is scored for ease of splitting, and the pharmacy staff splits the pill. This fee will only be allowed for medications that have been evaluated by the state for cost-effectiveness and entered into the Point-of-Sale system.

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Attachment 4a: Arizona State Plan—Medicaid Payment Policy for I/Ts (General, Including Specialty Drugs)

State Plan for Title XIX — Attachment 4.19 B

State _ARIZONA_ — Page 7

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

AHCCCS will reimburse the Indian Health Service (IHS) and tribal facilities based on the following reimbursement methodologies reflected in Tables 1 and 2. The AHCCCS capped fee schedule can be found at the following link: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/. The Effective date for the AHCCCS fee schedule can be found on 4.19B page 1.

As the Tables 1 and 2 reflect, the methodologies may differ depending on a specific situation. The various situations are whether:

- the services include or exclude professional services.
- the service is provided by the IHS or a tribal facility
- the tribal facility is set up to bill outpatient services with specific coding and requests this format
- based on specific CMS guidance (transportation).

TABLE 1 - IHS OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital	1500 / 00099	Outpatient All-inclusive Rate
	Clinic	1500 / 00099	Outpatient All-inclusive Rate AHCCCS Capped Fee Schedule
	Ambulatory Surgery Center	1500 / 00090-00098	AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	

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State Plan for Title XIX — Attachment 4.19 B

State _ARIZONA_ — Page 7(a)

REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES

Title XIX (Long Term Care)	Outpatient Hospital Clinic Ambulatory Surgery Center Professional Services Specialty Drugs	1500 / 00099 1500 / 00099 1500 / 00090-00098 1500 / HCPCS/CPT codes National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Outpatient All-inclusive Rate Outpatient All-inclusive Rate AHCCCS Capped Fee Schedule AHCCCS Capped Fee Schedule Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
Title XIX (Behavioral Health)	Outpatient Hospital Clinic Professional Services Specialty Drugs	1500 / 00099 1500 / 00099 1500 / HCPCS/CPT codes National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Outpatient All-inclusive Rate Outpatient All-inclusive Rate AHCCCS Capped Fee Schedule Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost

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State Plan for Title XIX Attachment 4.19 B

State _ARIZONA_ Page 8

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

TABLE 2 - '638 TRIBAL FACILITY OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital (including professional services) (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 – Specific revenue codes	Outpatient All-inclusive Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	Outpatient All-inclusive Rate (or) AHCCCS Capped Fee Schedule
	Ambulatory Surgery Center (including professional services) (or) Ambulatory Surgery Center (excluding professional services)	1500 / 00090-00098 (or) 1500 / CPT codes	AHCCCS Capped Fee Schedule)
	Professional Services (services included in procedure bill)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
Title XIX (Long Term Care)	Outpatient Hospital (including professional services (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	Outpatient All-inclusive Rate (or) Statewide Cost to Charge Rate

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State Plan for Title XIX — Attachment 4.19 B

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REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

	Clinic(including professional services (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	Outpatient All-inclusive Rate (or) AHCCCS Capped Fee Schedule
	Professional Services (services included in procedure billed)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	HCBS Services	1500 / HCPCS or AHCCCS specific codes	AHCCCS Capped Fee Schedule
	Transportation (Air & Ground)	1500 / HCPCS codes	AHCCCS Capped Fee Schedule
	Transportation (Non-Ambulance)	1500 / HCPCS/AHCCCS specific codes	AHCCCS Capped Fee Schedule
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
Title XIX (Behavioral Health)	Outpatient Hospital (including professional services) (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	Outpatient All-inclusive Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	Outpatient All-inclusive Rate (or) AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	Transportation (Air & Ground)	1500 / HCPCS codes	AHCCCS Capped Fee Schedule
	Transportation (Non-Ambulance)	1500 / HCPCS/AHCCCS codes	AHCCCS Capped Fee Schedule
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost

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Attachment 4b: Arizona IHS/Tribal Provider Billing Manual—Medicaid Payment Policy for I/Ts (non-specialty drugs)

> The AIR may be billed for adults 19 years of age and older, when a prescription is filled at and dispensed by an IHS/638 facility pharmacy to the member. The AIR for prescription services may be billed once daily, per member, per facility pharmacy. The maximum number of AIRs that may be billed daily is 5 per facility per member and they must be for non-duplicative visits.

Attachment 4c: OptumRx Provider Manual: 2019 1st Edition—Definition of Specialty Drugs

> **Specialty Drugs:**
> Includes biotechnology products, orphan Drug Products used to treat rare diseases, typically high-cost Drug Products, including infusions in any outpatient setting, Drug Products requiring ongoing frequent management/monitoring of the patient by Pharmacist or Drug Products used to treat chronic and potentially life-threatening diseases.

Attachment 5: Oregon State Plan—Medicaid Payment Policy for CODs

Transmittal # 17-0007
Attachment 4.19-B
Page 3

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs

A. General

(1) The Oregon Health Authority, Medical Assistance Program will pay the lesser of the provider's usual charge to the general public for a drug or the actual acquisition cost (AAC) plus a dispensing fee. The AAC is defined by the Authority as :

a. The Oregon-specific Average Acquisition Cost (OR-AAC) of the drug. The OR-AAC will be established by the Authority or its contractor by rolling surveys of enrolled pharmacies to verify the actual invoice amount paid by the pharmacy for the product and as such will serve as the basis for reimbursement;
b. In cases where no OR-AAC is available, reimbursement will be at the National Average Drug Acquisition Cost (NADAC) developed by CMS;
c. In cases where no OR-AAC and no NADAC is available, reimbursement will be Wholesale Acquisition Cost (WAC) ;

B. Payment Limits for Single and Multiple Source Drugs

(1) Reimbursement for single source and multiple source drugs in the Medicaid Program shall follow the methodology outlined in section A.(1) of this state plan attachment. a.
(2) The maximum allowable cost set by the Authority for multiple source drugs will not exceed, in aggregate, the upper limits established under 42 CFR 447.512.

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Attachment 4.19-B
Page 3-a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs (continued)

C. Payment Limits for 340B entity:

(1) 340B covered entity pharmacies who carve in for Medicaid, shall not exceed the entity's actual acquisition cost, plus the assigned professional dispensing fee.
(2) 340B covered entities that purchase drugs outside of the 340B program are reimbursed at the AAC rate defined in section A. (1) of this state plan attachment, plus the usual professional dispensing fee.
(3) Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.
(4) The professional dispensing fee allowed for a 340B covered entity is the same as for any enrolled pharmacy, according to claims volume as outlined in section J of this state plan.

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Attachment 4.19-B
Page 3-b

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs (continued)

D. Indian Health Service/Tribal (I/T) Pharmacy:
An eligible I/T pharmacy may choose to participate in the Medicaid Program and receive reimbursement for Medicaid covered services under any of following options:

(1) I/T Pharmacy will receive reimbursement as a 340B entity outlined in this State Plan attachment section C (1) through (4);

(2) I/T pharmacy will receive the Indian Health Service (IHS) per visit outpatient encounter rate, called the All-Inclusive Rate (AIR). Under an encounter rate methodology, a single rate is be applied to "A face-to-face contact between a health care professional and an IHS beneficiary eligible for the Medical Assistance Program for services through an IHS, AI/AN Tribal Clinic or Health Center, or a Federally Qualified Health Clinic with a 638 designation within a 24-hour period ending at midnight, as documented in the client's medical record. The I/T Pharmacy will receive one encounter per prescription filled or refilled and will not be limited to a certain number of prescriptions per day.

(3) I/T Pharmacy operating as a non tribal retail pharmacy will receive reimbursement as outlined in Attachment 4.19-B of this state plan, section 12.A.

E. Pharmacies who purchase drugs at Nominal Price (outside of 340B or FSS) will be reimbursed their actual acquisition cost plus the usual professional dispensing fee.

F. Pharmacies who purchase drugs at the Federal Supply Schedule will be reimbursed their actual acquisition cost plus the usual professional dispensing fee.

G. Specialty Drugs (Not distributed by a Retail Pharmacy and distributed primarily through the Mail): The Authority reimburses at the AAC rate defined in this state plan attachment, plus the usual professional dispensing fee.

H. Long-Term Care Pharmacy: The Authority reimburses at the AAC rate defined in this state plan, plus the usual professional dispensing fee.

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Page 3-c

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs (continued)

I. Physician Administered Drugs: reimbursement is based on Medicare's Average Sale Price (ASP) +6%. When no ASP rate is listed the rate shall be based upon the Wholesale Acquisition Price (WAC) plus 6.25%. If no WAC is available, then the rate shall be reimbursed at Acquisition Cost. 340B covered entities that bill for Physician Administered Drugs and carve in for Medicaid, shall not exceed the entity's actual acquisition cost.

J. Investigational Drugs – Investigational drugs are not a covered service under the Oregon Medical Assistance pharmacy program.

K. Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers:
OHA contracts with a specialty provider of hemophilia treatment products subject to 1915(b)(4) waiver terms. Clotting factor payments outside of the contract, reimbursement is in accordance with section 12(A)(1) of this state.

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Page 3-d

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OREGON

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

12. Prescribed Drugs (continued)

L. Dispensing or Professional Fees

(1) The Authority establishes pharmacy dispensing fee payments based on the results of surveys of pharmacies. The dispensing fee structure will be one of 3 rate tiers. The Authority or its designated representative will conduct an annual survey of every enrolled pharmacy to determine which tier the pharmacy will be paid.

(2) Based upon the annual volume of the enrolled pharmacy, the dispensing fee will be as follows:

- Less than 30,000 claims a year = $14.01
- Between 30,000 and 49,999 claims per year = $10.14
- 50,000 or more claims per year = $9.68

(3) Pharmacies that fail to respond to the annual survey will default to the highest volume tier dispensing fee.

(4) Pharmacies dispensing through a unit dose or 30-day card system must bill OHA only one dispensing fee per medication dispensed in a 30-day period.

(5) Dispensing fee tiers are applicable to all pharmacies: retail independent, Institutional, mail order, compounding and 340 programs. Retail chain affiliated pharmacy dispensing fee is paid at the lowest tier regardless of volume.

(6) Independently owned pharmacies in communities that are the only enrolled pharmacy within a fifteen (15) mile radius from another pharmacy shall be reimbursed at the lowest volume tier.

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Attachment 6: Wyoming State Plan—Medicaid Payment Policy for CODs

ATTACHMENT 4.19B
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

12.a. PHARMACY PROVIDERS

1. Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;
c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
d) The Federal Upper Limit (FUL);
e) The State Maximum Allowable Cost (SMAC);
f) The Ingredient Cost submitted;
g) The Gross Amount Due (GAD); or
h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional $10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

2. Payment for specialty drugs not dispensed by a retail community pharmacy but dispense primarily through the mail will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;
c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
d) The Federal Upper Limit (FUL);
e) The State Maximum Allowable Cost (SMAC);
f) The Ingredient Cost submitted;
g) The Gross Amount Due (GAD); or
h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional $10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

3. Payment for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies) will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;

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ATTACHMENT 4.19B
Page 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
d) The Federal Upper Limit (FUL);
e) The State Maximum Allowable Cost (SMAC);
f) The Ingredient Cost submitted;
g) The Gross Amount Due (GAD); or
h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional $10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

4. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;
c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
d) The Federal Upper Limit (FUL);
e) The State Maximum Allowable Cost (SMAC);
f) The Ingredient Cost submitted;
g) The Gross Amount Due (GAD); or
h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional $10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

5. Entities that purchase products under Section 340B of the Public Health Service Act must request, in writing, to use these drugs for Wyoming Medicaid clients. 340B entities that request and are granted such an arrangement shall bill Medicaid no more than their actual acquisition cost (AAC) for the drug and will be reimbursed no more than the AAC plus a $10.65 dispensing fee. 340B entities that fill Wyoming Medicaid client prescriptions with drugs not purchased under the Section 340B of the Public Health Services Act will be reimbursed in accordance with section 1 of this State Plan Amendment plus the $10.65 professional dispensing fee.

5.1. Drugs acquired through the federal 340B drug price program and dispensed by 340B contract pharmacies are not covered.

6. Facilities purchasing drugs through the Federal Supply Schedule (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than 340B drug pricing program will be

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee.

7. Facilities purchasing drugs a Nominal Price (outside of 340B or FSS) will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee. Nominal Price as defined in §447.502 of the Code of Federal Regulation, Part 42 means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

8. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 100 percent of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at an aggregate Wholesale Acquisition Cost (WAC) + 0% for the pertinent HCPCS code. PADs without and ASP or WAC will be reimbursed at an aggregate AWP for the HCPCS code. If it is clearly demonstrated by the provider that reimbursement at the ASP, WAC, or AWP rate will negatively impact a provider's ability to continue service delivery, the DHCF may reimburse for PADs up to 100% of the established Medicare rate for the same PAD. In accordance with section 5 above, covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act for Medicaid members must bill Medicaid their actual acquisition cost (AAC).

9. Payment to all Indian Health Service, tribal, and urban Indian pharmacies shall be at the All Inclusive Rate (AIR) published annually in the Federal Register. One AIR reimbursement shall be made for each pharmacy claim paid by the Department. The applicable AIR shall be determined by the date of service submitted on the pharmacy claim. Pharmacies reimbursed using the AIR will not be eligible for a dispensing fee.

10. Investigational drugs are not a covered service under the Wyoming Medicaid program.

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Attachment 7: North Carolina State Plan—Medicaid Payment Policy for CODs

Attachment 4.19-B
Section 12, Page 1

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

12. **Covered outpatient drugs (COD)**

a.

- Legend and Non-legend drugs
- Drugs not Dispensed by a Retail Community Pharmacy, Long Term Care Pharmacy
- Specialty Drugs not Dispensed by a Retail Community Pharmacy and Dispensed Primarily through the Mail
- Payment for Drug Purchased Outside of the 340B Program by Covered Entities

Reimbursement for the above drugs dispensed to covered beneficiaries shall not exceed the federal upper limit defined as the lowest of:

1. The Actual Acquisition Cost (AAC) plus a professional dispensing fee;
2. The provider's usual and customary charge (U&C) to the general public;
3 The provider's gross amount due (GAD (430-DU) = Total price claimed from all sources: sum of 'Ingredient Cost Submitted' (409-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (480-H9), or
4. The amount established by the State of North Carolina to determine the upper payment limit plus a professional dispensing fee.

In compliance with 42 Code of Federal Regulations 447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.

A professional dispensing fee will not be paid for covered outpatient drugs refilled in the same month, whether it is the same drug or generic equivalent drug, except for blood clotting factor / hemophilia drugs.

For blood clotting factor / hemophilia drugs reimbursement and professional dispensing fee see Section 12, Page 1a.1.

Multiple Source Drugs – North Carolina has implemented a State determined list of multiple source drugs. All drugs on this list are reimbursed at limits set by the State unless the provider writes in their own handwriting, brand name drug is "medically necessary".

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Attachment 4.19-B
Section 12, Page 1a

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

12. **Covered outpatient drugs (COD)**

b. **North Carolina Actual Acquisition Cost (AAC) For Covered Outpatient Drugs:**

Effective January 1, 2016, North Carolina will base brand and generic drug ingredient pricing on the actual acquisition cost (AAC). The National Average Drug Acquisition Cost (NADAC) pricing will be used for AAC when available. If NADAC is unavailable, then the AAC will be defined as Wholesale Acquisition Cost (WAC).

c. **Professional Dispensing Fee (PDF):**

The professional dispensing fee is paid to pharmacy providers for the initial dispensing and excludes refills within the same month for the same drug or generic equivalent.

The professional dispensing fee is $3.98 for non-preferred brand drugs.

For blood clotting factor / hemophilia drugs professional dispensing fees see Section 12, Page 1a.1.

The generic and preferred brand professional dispensing fee will be based on an enrolled pharmacy's preferred brand and generic drugs during the previous quarter, as documented in the Medicaid Management Information System (MMIS). Based on the previous quarterly volume of an enrolled pharmacy, as documented in MMIS, the total number of generics and preferred brands is divided by the total number of prescriptions billed.

Preferred brand drugs are brand drugs whose net cost to the State after consideration of all rebates is less than the cost of the generic equivalent.

The generic and preferred brand professional dispensing fee will be as follows:

- 85% or more claims per quarter - $13.00
- Less than 85% claims per quarter - $7.88

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Attachment 4.19-B
Section 12, Page 1a.1

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

12. **Covered outpatient drugs (COD)**

d. Payment for Clotting Factor / Hemophilia Drugs from Specialty Pharmacies, Hemophilia Treatment Centers (HTC), Centers of Excellence or any other pharmacy provider:

Reimbursement for blood clotting factor / hemophilia drugs purchased through the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:

1) The 340B state maximum allowable cost, plus a per unit professional dispensing fee;
2) The provider's usual and customary charge (U&C) to the general public or their submitted charge plus a per unit professional dispensing fee, or
3) The provider's gross amount due (GAD (430-DU) = Total price claimed from all sources: sum of 'Ingredient Cost Submitted' (409-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (480-H9).

Reimbursement for blood clotting factor / hemophilia drugs purchased outside of the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:

1) The state maximum allowable cost, plus a per unit professional dispensing fee;
2) The provider's usual and customary charge (U&C) to the general public or their submitted charge plus a per unit professional dispensing fee, or
3) The provider's gross amount due (GAD (430-DU) = Total price claimed from all sources: sum of 'Ingredient Cost Submitted' (409-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (480-H9).

The above reimbursement methodology stated in Section 12.d is only applicable to pharmacy claims.
For procedure coded professional / medical drug claims see Section 12, Page 2.

The per unit professional dispensing fee for all units dispensed will be $.04/unit for HTC pharmacies and $.025/unit for all other pharmacies.

Blood clotting factors / hemophilia drugs per unit professional dispensing fees shall be established by a blood clotting factor / hemophilia dispensing fee survey.

e. Payment for 340B Purchased Drugs Dispensed by a Covered Entity, a Contract Pharmacy Under Contract with a 340B Covered Entity, or an Indian Health Service, Tribal or Urban Indian Pharmacy:
Reimbursement for 340B purchased drugs dispensed by 340B covered entities, contract pharmacies under contract with a 340B covered entity, and Indian health service, tribal, or urban Indian pharmacies will be reimbursed at no more than their 340B acquisition cost plus the professional dispensing fee as defined on Attachment 4.19-B, Section 12, Page 1a, Section c.

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Attachment 4.19-B
Section 12, Page 1a

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

12. **Covered outpatient drugs (COD)**

b. **North Carolina Actual Acquisition Cost (AAC) For Covered Outpatient Drugs:**

Effective January 1, 2016, North Carolina will base brand and generic drug ingredient pricing on the actual acquisition cost (AAC). The National Average Drug Acquisition Cost (NADAC) pricing will be used for AAC when available. If NADAC is unavailable, then the AAC will be defined as Wholesale Acquisition Cost (WAC).

c. **Professional Dispensing Fee (PDF):**

The professional dispensing fee is paid to pharmacy providers for the initial dispensing and excludes refills within the same month for the same drug or generic equivalent.

The professional dispensing fee is $3.98 for non-preferred brand drugs.

For blood clotting factor / hemophilia drugs professional dispensing fees see Section 12, Page 1a.1.

The generic and preferred brand professional dispensing fee will be based on an enrolled pharmacy's preferred brand and generic drugs during the previous quarter, as documented in the Medicaid Management Information System (MMIS). Based on the previous quarterly volume of an enrolled pharmacy, as documented in MMIS, the total number of generics and preferred brands is divided by the total number of prescriptions billed.

Preferred brand drugs are brand drugs whose net cost to the State after consideration of all rebates is less than the cost of the generic equivalent.

The generic and preferred brand professional dispensing fee will be as follows:

- 85% or more claims per quarter - $13.00
- Less than 85% claims per quarter - $7.88

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Attachment 4.19-B
Section 12, Page 1a.1

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

12. **Covered outpatient drugs (COD)**

d. Payment for Clotting Factor / Hemophilia Drugs from Specialty Pharmacies, Hemophilia Treatment Centers (HTC), Centers of Excellence or any other pharmacy provider:

Reimbursement for blood clotting factor / hemophilia drugs purchased through the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:

1) The 340B state maximum allowable cost, plus a per unit professional dispensing fee;
2) The provider's usual and customary charge (U&C) to the general public or their submitted charge plus a per unit professional dispensing fee, or
3) The provider's gross amount due (GAD (430-DU) = Total price claimed from all sources: sum of 'Ingredient Cost Submitted' (409-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (480-H9).

Reimbursement for blood clotting factor / hemophilia drugs purchased outside of the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:

1) The state maximum allowable cost, plus a per unit professional dispensing fee;
2) The provider's usual and customary charge (U&C) to the general public or their submitted charge plus a per unit professional dispensing fee, or
3) The provider's gross amount due (GAD (430-DU) = Total price claimed from all sources: sum of 'Ingredient Cost Submitted' (409-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (480-H9).

The above reimbursement methodology stated in Section 12.d is only applicable to pharmacy claims.
For procedure coded professional / medical drug claims see Section 12, Page 2.

The per unit professional dispensing fee for all units dispensed will be $.04/unit for HTC pharmacies and $.025/unit for all other pharmacies.

Blood clotting factors / hemophilia drugs per unit professional dispensing fees shall be established by a blood clotting factor / hemophilia dispensing fee survey.

e. Payment for 340B Purchased Drugs Dispensed by a Covered Entity, a Contract Pharmacy Under Contract with a 340B Covered Entity, or an Indian Health Service, Tribal or Urban Indian Pharmacy:
Reimbursement for 340B purchased drugs dispensed by 340B covered entities, contract pharmacies under contract with a 340B covered entity, and Indian health service, tribal, or urban Indian pharmacies will be reimbursed at no more than their 340B acquisition cost plus the professional dispensing fee as defined on Attachment 4.19-B, Section 12, Page 1a, Section c.

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Attachment 4.19-B
Section 12, Page 1a.2

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

12. **Covered outpatient drugs (COD)**

f. Reimbursement for drugs purchased through the Federal Supply Schedule will be reimbursed no more than the Federal Supply Schedule acquisition cost plus a professional dispensing fee, unless the reimbursement for covered outpatient drugs is made through a bundled charge or all-inclusive encounter rate.

g. Reimbursement for drugs purchased at Nominal Price (outside of 340B or FSS) will be reimbursed no more than the Nominal Price acquisition cost plus a professional dispensing fee.

h. Covered outpatient drugs dispensed or delivered by *Indian health care provider* (means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) will be reimbursed at OMB encounter rates.

OMB encounter rates will be paid for pharmacy encounter, as follows:

1. For Medicaid covered outpatient drugs dispensed or delivered to all patients seen by the I/T/U pharmacy providers;

2. Covered outpatient drugs dispensed or delivered by I/T/U facilities as authorized by Public Law 93-638 Agreement ("I/T/U facilities") will be reimbursed at the OMB encounter rates;

   I/T/U facilities will receive one OMB encounter payment for each covered outpatient ~~prescription~~ drug filled or refilled; for a maximum of two (2) OMB encounter payments, per beneficiary, per day, per facility.

   Non-covered under the OMB encounter rates:

   I. Specialty and high cost for covered outpatient drugs with acquisition costs greater than $1,000. These covered outpatient drugs will continue to be reimbursed at the lesser of the fee for service (FFS) unit price or the actual acquisition costs (AAC), plus a professional dispensing fee (PDF);

   II. Eyeglasses, prosthetic devices, hearing aids, diabetic testing equipment and supplies;

   III. Drugs dispensed to beneficiaries assigned to the Health Choice or the Family Planning waiver benefit plans.

3. Encounter is defined as a prescription, whether the prescription is for a single drug or compound drugs. No more than one OMB encounter rate payment is made per covered outpatient drug filled whether the prescription is for a single ingredient drug or a compound drug;

4. There will be no limit on the number of prescriptions filled per patient per day by an I/T/U facility, but an I/T/U facility will receive no more than two (2) OMB encounter payments per day per patient per facility for prescriptions filled or refilled, and these payments shall constitute payment in full for all covered outpatient drugs dispensed for the patient on that day;

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Attachment 4.19-B
Section 12, Page 1a.2a

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

12. **Covered outpatient drugs (COD)**

h. (Continue)

5. The applicable encounter rate will be determined by the date of service submitted on the pharmacy claim; date of service is defined as the date the covered outpatient drug is dispensed.

6. I/T/U facilities receiving an all-inclusive OMB encounter payment for a covered outpatient drug filled or refilled shall not be eligible to receive professional dispensing fees, delivery fees, ingredient costs and any costs associated with drug counseling or medication therapy management (MTM).

i. Investigational drugs are not covered.

j. Reimbursement for drugs delivery by mail, courier or person to person delivery will be established as follows:

$1.50 for mail or courier
$3.00 for person to person

Delivery payment will be for a single claim, once per day per beneficiary per pharmacy, unless the reimbursement for covered outpatient drugs is made through a bundled charge or all-inclusive encounter rate.

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