§949. Fee for Service Cost Limits

A. Brand Drugs. The department shall make payments for single source drugs (brand drugs) based on the lower of:

1. national average drug acquisition cost (NADAC) plus the professional dispensing fee:

a. if no NADAC is available, use the wholesale acquisition cost (WAC) plus the professional dispensing fee; or

2. the provider's usual and customary charges to the general public not to exceed the department's "maximum payment allowed."

a. For purposes of these provisions, the term *general public* does not include any person whose prescriptions are paid by third-party payors, including health insurers, governmental entities, and Louisiana Medicaid.

B. Generic Drugs. The department shall make payments for multiple source drugs (generic drugs), other than drugs subject to "physician certifications", based on the lower of:

1. NADAC plus the professional dispensing fee:

a. if no NADAC is available, use the WAC plus the professional dispensing fee; or

2. federal upper payment limits plus the professional dispensing fee; or

3. the provider's usual and customary charges to the general public not to exceed the department's "maximum payment allowed."

a. For purposes of these provisions, the term general public does not include any person whose prescriptions are paid by third-party payors, including health insurers, governmental entities, and Louisiana Medicaid.

C. Federal Upper Payment Limits for Multiple Source Drugs

1. Except for drugs subject to "physician certification," the Medicaid Program shall utilize listings established by the Centers for Medicare and Medicaid Services (CMS) that identify and set upper limits for multiple source drugs that meet all of the following requirements:

a. All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the most current edition of their publication, Approved Drug Products with Therapeutic Equivalence Evaluations (including supplements or in successor publications).

b. At least three suppliers list the drug, which has been classified by the FDA as category "A" in the aforementioned publication based on listings contained in current editions (or updates) of published compendia of cost information for drugs available for sale nationally.

2. Medicaid shall utilize the maximum acquisition cost established by CMS in determining multiple source drug cost.

3. The Medicaid Program shall provide pharmacists who participate in Medicaid reimbursement with updated lists reflecting:

a. the multiple source drugs subject to federal multiple source drug cost requirements;

b. the maximum reimbursement amount per unit; and

c. the date such costs shall become effective.

D. Physician Certifications

1. Limits on payments for multiple source drugs shall not be applicable when the prescriber certifies that the brand name drug is medically necessary for the care and treatment of a recipient in his own handwriting or via an electronic prescription. Such certification shall be written directly on the prescription, on a separate sheet which is dated and attached to the prescription, or submitted electronically. A standard phrase such as "brand necessary" indicating the medical necessity of the brand will be acceptable.

E. Fee for Service 340B Purchased Drugs. The department shall make payments for self-administered drugs that are purchased by a covered entity through the 340B program at the actual acquisition cost which can be no more than the 340B ceiling price plus the professional dispensing fee, unless the covered entity has implemented the Medicaid carve-out option, in which case 340B drugs should not be billed to or reimbursed by Medicaid. 340B contract pharmacies shall not bill 340B stock to Medicaid. Fee-for-service outpatient hospital claims for 340B drugs shall use a cost to charge methodology on the interim cost report and settled during final cost settlement. Federally qualified health center (FQHC) and rural health clinic (RHC) claims for physician administered drugs shall be included in the all-inclusive T1015 encounter rate.

F. Federal Supply Schedule Drugs. Drugs acquired at federal supply schedule (FSS) and at a nominal price shall be reimbursed at actual acquisition cost plus a professional dispensing fee.

G. Indian Health Service All-Inclusive Encounter Rate. Pharmacy services provided by the Indian Health Service (IHS) shall be included in the encounter rate. No individual pharmacy claims shall be reimbursed to IHS providers.

H. Mail Order, Long-Term Care and Specialty Pharmacy. Drugs dispensed by mail order, long-term care and/or specialty pharmacies (drugs not distributed by a retail community pharmacy) will be reimbursed using the brand/generic drug reimbursement methodology.

I. Physician-Administered Drugs. Medicaid-covered physician-administered drugs shall be reimbursed according to the Louisiana professional services fee schedule. Reimbursement shall be determined utilizing the following methodology, and periodic updates to the rates shall be made in accordance with the approved Louisiana Medicaid State Plan provisions governing physician-administered drugs in a physician office setting.

1. Average sales price (ASP) plus 6 percent, for drugs appearing on the Medicare file.

2. Reimbursement rates for drugs that do not appear on the Medicare file shall be determined utilizing the following alternative methods:

a. the wholesale acquisition cost (WAC) of the drug, if available;

b. if there is no WAC available, the reimbursement rate will be 100 percent of the provider's current invoice for the dosage administered.

J. Clotting Factor. Pharmacy claims for clotting factor will be reimbursed using the brand/generic drug reimbursement methodology.

K. Investigational or Experimental Drugs. Investigational or experimental drugs shall not be reimbursed by Medicaid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1065 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1185 (June 2017), LR 43:1554 (August 2017), LR 44:1020 (June 2018), LR 45:571 (April 2019), LR 45:665 (May 2019), amended LR 46:35 (January 2020).