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State/Territory:

Citation	
42 CFR 447.201 **42 CFR 447.302** **52 FR 28648** **1902(a)(15), 1902(bb),** **1903(a)(1) and** **(n), and 1920** **of the Act**	**4.19(b)In addition to the services specified in paragraphs 4.19(a),(d),(k),(1), and (m),the Medicaid agency meets the following requirements:** **Sections 1902(a)(15) and 1902(bb) of the Act regarding payment for services furnished by Federally Qualified Health Centers (FQHCS) under section 1905(a)(2)(C) of the Act. <u>ATTACHMENT 4.19-B</u> describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).** **<u>ATTACHMENT 4.19-B</u> describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for individuals with intellectual disabilities that are described in other attachments.**
42 CFR 447.205 **42 CFR 447.518(a)** **1902(a)(54), 1905(a)(12),** **and 1927 of the Act**	**<u>ATTACHMENT 4.19-B</u>** describes the methods and standards for establishing payment rates for prescribed drugs. Public notice is required for any significant changes in methods and standards for setting payment rates, except for price changes that occur as a result of a change in the underlying reference price on which the reimbursement methodology is based. For instance, if the State bases its reimbursement formula on average manufacturer price (AMP), and the AMP changes for a particular drug, this would not be a significant change. However, if the State changes the way it uses AMP in its reimbursement formula, this would be a significant change. Whenever a public notice is required, States must submit a copy of the public notice for CMS review. The payment rate for

prescribed drugs will have two components, the ingredient cost of the prescribed drug, which is the estimated acquisition cost (EAC), and the dispensing fee. The EAC is the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers. States should provide a detailed explanation of how EAC is calculated. For example, States can calculate EAC by applying an algorithm where they reimburse the lesser of the billed amount, the pharmacy's usual and customary charge to the public, the applicable Federal Upper Limit (FUL) or State Maximum Allowable Cost (MAC), or a specified formula based on reliable pricing information. States should also specify how they reimburse for drugs purchased through the 340B Drug Pricing Program and drugs purchased through other Federal programs. For covered entities participating in the 340B Drug Pricing Program, States should pay no more than the pharmacy's actual acquisition cost for 340B drugs or the 340B ceiling price. States may also include a statement regarding the requirements of the FULs program and a description of the State's MAC program, if the State has a MAC program.

The dispensing fee pays for the costs of dispensing a covered outpatient drug. States should provide the actual dispensing fee or fees in the State plan.

States should carefully evaluate their payment rates for the ingredient cost and the dispensing fee for Medicaid prescription drugs to ensure they are providing appropriate reimbursement for drugs and for costs associated with dispensing drugs. Accordingly, we expect that States provide us with their rationale, data, and analyses when submitting State plan amendments to substantiate any change in these payments. Payment rates that are established pursuant to State legislation should be supported by further documentation. States should evaluate their payment methodologies for both ingredient cost and dispensing fee when making any changes to ensure that they do not inappropriately duplicate payments for the same services.

1902(a)(10) and 1902(a)(30) of the Act

<u>SUPPLEMENT 1 to ATTACHMENT 4.19-B</u> describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

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