

II. Payment for Prescribed Drugs.

For the Medicaid Fee-For-Service Program, the Medical Assistance Program reimburses the lesser of the final allowed amount and the amount billed by the provider, which is the usual and customary charge.

a. Computed Allowed Amount

The Computed Allowed Amount is the maximum amount that is allowed for a dispensed drug item prior to applying any final payment adjustments, such as deducting an amount paid by other insurance, recipient cost sharing amounts, considering deductibles, coinsurance, and copayments, or limiting payment to the amount billed by the pharmacy.

The Computed Allowed Amount includes the allowed professional dispensing fee plus the Allowed Ingredient Cost and any allowed fees for compounding, kit assembly, or vaccine injections.

b. Allowed Ingredient Cost

The allowed ingredient cost is the lowest of the following:

1. The National Average Drug Acquisition Cost (NADAC)

The NADAC price will be considered the actual acquisition cost (AAC) of a drug item. If there is not a NADAC amount, in its place the Wholesale Acquisition Cost (WAC) + 0%, as reported by national drug pricing services will be used.

2. The Affordable Care Act Federal Upper Limit (ACA-FUL)

An amount calculated by CMS.

For both the NADAC and the ACA-FUL, when the drug item is for a brand name drug that is also a multi-source drug, the ingredient cost will be calculated at not more than the cost of generic equivalent drug items generally available to providers in New Mexico, not to exceed the ingredient cost reported by the provider on the claim.

For brand name drugs for which a physician writes in his or her own handwriting "brand medically necessary" on the prescription, the ingredient cost will not be limited to generic drug costs when the pharmacy dispenses the brand name drug. The ingredient cost will be calculated for the brand name drug dispensed, not to exceed the ingredient cost reported by the provider on the claim.

3. The Ingredient Cost Reported by the Provider

i. A provider is required to report the 340-B acquisition ingredient cost for any drug item purchased at 340-B prices.

ii. A provider who dispenses any drug item purchased 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 the 340-B drug pricing program, must also bill the actual acquisition cost as the ingredient cost of the drug item.

iii. A provider purchasing drugs at a nominal price (outside of 340-B or FSS) will be reimbursed no more than the actual acquisition cost for the drug

c. Allowed Professional Dispensing Fee (PDF)

The allowed professional dispensing fee used in calculating the final payment to a pharmacy is set at \$10.30 effective for dates of service beginning April 1, 2017.

The PDF is considered to include all the professional services provided by the pharmacist and pharmacy including selecting, labeling, and dispensing the drug item; instructing and counseling with recipients; contacting prescribers as necessary; and medication management including managing under-utilization, over-utilization, and polypharmacy issues. It also is considered to include operational costs, overhead costs, and profit as applicable.

d. Allowed Fees in Addition to the Professional Dispensing Fee (PDF)

Compounding fees, fees for assembling kits for recipient home use, for injecting vaccines and other items allowed under state law are payable in addition to the ingredient cost and PDF as they are separately performed physical services.

1. Allowed compounding fees are limited to not more than \$12.00.
2. Allowed fees for assembling kits that include both medical supply items and drug items are calculated by the Medical Assistance Division specifically for each kit covered by the Medical Assistance Program after considering the cost of the medical supply item and time involved in preparing the kit for dispensing.
3. Allowed fees for administering an injection are based at an amount comparable to the amount that would be paid for administering a similar item in a practitioner's office.

e. Final Payment Amount

The final amount to the pharmacy is calculated as follows:

1. The Computed Allowed Amount is calculated by adding the Allowed Ingredient Cost as determined under number b., above; the Allowed Professional Dispensing Fee under number c., above; and the additional fees allowed under number d., above.
2. The Computed Allowed Amount is reduced by an amount that other insurance paid, applicable recipient cost sharing amounts, and after considering deductibles, coinsurance, and copayments calculated by prior payers. This amount is the Calculated Allowed Amount.
3. The Calculated Allowed Amount is compared to the provider's billed amount, and the lower amount becomes the Final Payment Amount. Payments made do not exceed the usual and customary amount billed by the provider, or patient responsibility amounts such as coinsurance, deductibles, and copayments calculated by a prior payer.

- f. Separate Payment Provisions for Blood Clotting Factors
Payment for clotting factors from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence are based on the drug ingredient cost plus a \$10.30 professional dispensing fee. The drug ingredient cost shall be the lowest of:
1. The Actual Acquisition cost (AAC) + 8%. AAC is defined as the providers' invoices as sent to the State that reflect the price that the covered entity paid the wholesaler or manufacturer for the drug.
 2. The National Average Drug Acquisition Cost (NADAC) of the drug. If no NADAC is available, then the drug ingredient cost reimbursement shall be the lowest of WAC (Wholesale Acquisition Cost) + 0%; the ACA-FUL; or the Actual Acquisition cost (AAC) + 8%
 3. The ACA Federal Upper Limit (ACA-FUL)
- g. Usual and Customary Charge
The usual and customary charge is defined as the charge made to a non-Medicaid patient for the same drug item. Usual and customary charges specifically must consider the following:
1. Discounts given to non-Medicaid patients for criteria such as age or being in a nursing home when the Medicaid patient meets the criteria for the discount.
 2. Discounts for paying cash. If any patient group gets discounts for paying cash, those discounts must be reflected in the usual and customary charge.
 3. Medicaid is to be given the advantage of discounts that the general public receives.
- h. Prescription Refills
There are limitations on the frequency for which the Medical Assistance Program will reimburse the same pharmacy for dispensing the same drug to the same recipient. The limitation is established individually for each drug. Most drugs are subject to a maximum of three (3) times in ninety (90) days, with grace days as needed to account for necessary early refills, lost medications, dosage changes, etc. Controlled drugs and certain other drugs may require special consideration, as necessary, due to their specific indication, dosage form, or packaging, and are subject to limitations as may be appropriate. Refills must be consistent with the dosage schedule prescribed and all existing federal and state laws.
- i. Maximum Quantities
The maximum quantity that may be dispensed at one time is a thirty-four (34) day supply, except for oral contraceptives that may be dispensed with a maximum 12-month supply when the proper agent for the patient is established, and for maintenance medications, which may be dispensed up to a ninety (90) day supply. Exceptions are made for recipients living significant distances from the nearest pharmacy, such as may be necessary for Indian Health Service and tribal health pharmacies.

- j. Coverage Limitations – The following drug items are not covered:
1. Drug items that have not been assigned a National Drug Code (NDC) or compounded drug items for which the primary ingredient has not been assigned an NDC are not covered by the Medical Assistance Program.
 2. Drug items that fall within the scope of Medicare Part D coverage. No copayments or other cost sharing is covered regardless of whether a drug item is paid or denied by Medicare Part D.
 3. Payment will not be made to physicians for oral medications that can be appropriately self-administered by the recipient unless justified by distance from the nearest pharmacy. Otherwise, payment to physicians for drugs will be limited to injectable and other medications administered by the physician or under his or her direction.
 4. Drug items that are for investigational use only are not covered under the New Mexico Medical Assistance program.
 5. Prior to dispensing controlled substances prescribed at amounts that exceed high codes limits, the pharmacy must verify the prescription with the prescriber. Otherwise, the payment for the prescription may be subject to recoupment.
 6. Drugs items that are primarily used for cosmetic purposes or for hair growth unless specifically approved as medically necessary.
 7. Dispensing of controlled substances that have not been reported as required to the New Mexico Board of Pharmacy Prescription Monitoring Program are subject to recoupment. This provision does not apply to Indian Health Service and Tribal 638 Healthcare providers as they are allowed to implement their own measures to detect over utilization or false claims.