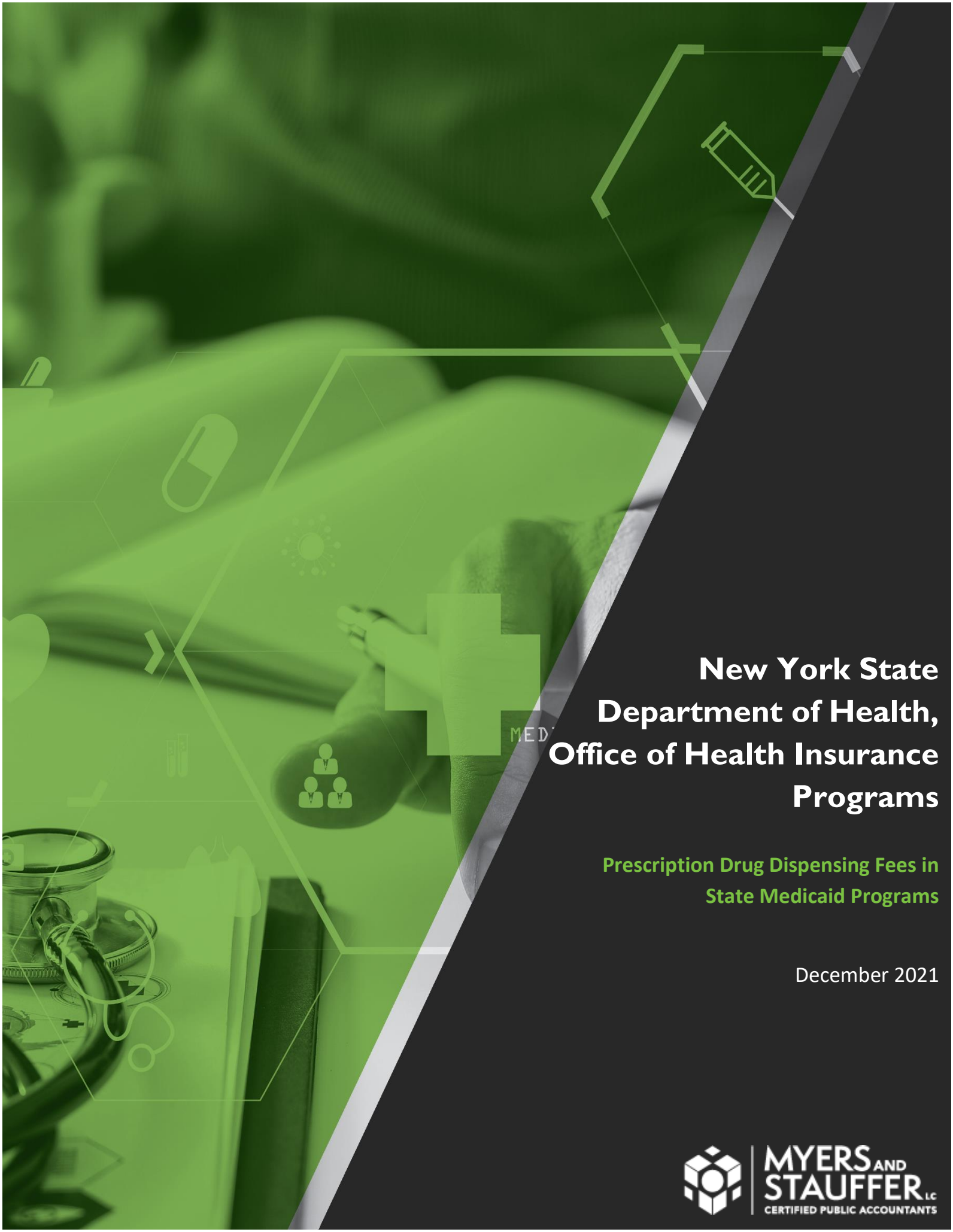

New York State Department of Health, Office of Health Insurance Programs

Prescription Drug Dispensing Fees in State Medicaid Programs

December 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Executive Summary

The New York State Enacted Budget (Part QQ of Chapter 57 of the Laws of 2021) directs the Commissioner of the New York State Department of Health (DOH) to provide a report to the Legislature by December 31, 2021, "detailing the statutes, rules, and regulations, as well as other limitations or processes, that apply to and govern the calculation and payment of prescription drug dispensing fees to retail pharmacies by the state's medical assistance program, both within the Medicaid managed care and fee-for-service programs for the legislature to review, study, and better understand the information provided in such report." In support of this effort, DOH contracted with Myers and Stauffer, LC, a national health care compliance and consulting firm with over 40 years serving as a consultant and rate-setting contractor to numerous states and the Centers for Medicare and Medicaid Services (CMS) on Medicaid pharmacy reimbursement issues, to review statutory, regulatory, and other government guidance that apply to the calculation and payment of prescription drug dispensing fees to retail pharmacies within the managed care and fee-for-service (FFS) program in New York and in the United States generally.

Generally speaking, states have the option of providing Medicaid benefits through either a managed care or FFS delivery system, or a combination of both. This state-specific decision is often dependent on a number of factors including, but not limited to, the population(s) being served, the need to reduce program costs/maintain budget predictability, the need to better manage utilization of health services, and/or the need to improve beneficiary health care quality and outcomes. Under a managed care model, managed care organizations (MCOs) accept per member, per month (PMPM) payment through a calculated capitation rate, which is required to be approved by CMS. MCOs are expected to manage cost, utilization, and quality of services. Within the managed care paradigm, states may further elect to include pharmacy as a covered benefit and place the MCO at risk for those costs (i.e., "carve-in") or retain the benefit within the FFS delivery system (i.e., "carve-out").

Under a FFS model, state Medicaid agencies make payments directly to providers for services rendered to a Medicaid member. The State typically hires vendors and/or performs some roles internally for various functions such as member enrollment, claims processing, auditing, actuarial services, rate setting, and drug rebate administration. Pursuant to Section 1902(a)(30)(A) of the Social Security Act, payments under a FFS model are required to be "consistent with the efficiency, economy, and quality of care," and be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." High-cost populations, such as people with disabilities, and coverage of certain high-cost services (e.g., nursing home and other long-term services and supports), are typically included in FFS, although many states have adopted managed care models in recent years.

New York's Medicaid program provides services to its members through a combination of managed care and FFS delivery models, with assignment of members based on various eligibility criteria. As of August 31, 2021, there were approximately 5.1 million members receiving services through 16 MCOs. There are approximately 1.3 million members enrolled in the Medicaid FFS pharmacy program.

Approaches to pharmacy reimbursement specifically, vary based on whether benefits are delivered through managed care or FFS. Although the specific focus of this report is professional dispensing fees in state Medicaid programs, it is important to consider dispensing fees in conjunction with ingredient reimbursement, given each component of pharmacy reimbursement contributes to the total payment a pharmacy receives for dispensing prescriptions. Focusing only on a comparison of approaches to establishing dispensing fees ignores the fact that there are also differing state approaches to determining ingredient reimbursement. While not universal, it is often the case that states with lower dispensing fees adopt ingredient reimbursement methodologies that result in higher ingredient reimbursement.

Dispensing Fees within Medicaid Fee-for-Service

FFS pharmacy programs must follow federal regulations outlined in the Final Rule for Covered Outpatient Drugs (CMS-2345-FC). Finalized in 2016, this rule introduced a new paradigm for the reimbursement of covered outpatient drugs to beneficiaries of state Medicaid FFS pharmacy programs. The new approach required state Medicaid programs to change the basis for ingredient reimbursement from the previously defined "estimated acquisition cost" (EAC) to the concept of "actual acquisition cost (AAC).[1] Within a FFS program, the AAC standard for ingredient reimbursement was considered to be applicable to all drugs dispensed by a retail community pharmacy The Final Rule also reiterated the importance of the pharmacy dispensing fee by requiring that state Medicaid programs switching to an AAC methodology also implement a professional dispensing fee that reflects the pharmacist's services and costs associated with the dispensing of drugs to beneficiaries. Further, the Rule required that any changes in pharmacy reimbursement consider both ingredient reimbursement and the professional dispensing fee, and must be supported by adequate data, which can include a State or national survey of retail community pharmacies or other reliable data that supports any changes.

Given CMS requirements that a professional dispensing fee within a Medicaid FFS program must be based on adequate data which considered pharmacies' actual costs of dispensing prescriptions, the process of developing a dispensing fee methodology typically begins with the performance of a cost of dispensing survey, or in some cases, the review of other data, such as cost of dispensing surveys from other states.

[1] See "Medicaid Program; Covered Outpatient Drugs." (CMS-2345-FC) Federal Register, 81: 20 (1 February 2016) p 5170.

Several states have statutes and/or regulations that outline the frequency and scope for performing cost of dispensing surveys. However, many states do not have specific regulations or other policies relating to the frequency at which professional dispensing fees in the FFS pharmacy program are evaluated. Participation rates in pharmacy cost of dispensing surveys can vary significantly, primarily based on the state regulatory environment and whether the submission of a survey is considered mandatory. In some states there are requirements relating to a Medicaid enrolled provider's participation in a cost of dispensing survey, and in some instances, states which perform a cost of dispensing survey leverage language within Medicaid provider agreements to encourage participation.

The majority of Medicaid programs are in compliance with the Final Rule for Covered Outpatient Drugs (CMS-2345-FC) and have implemented reimbursement utilizing AAC and a professional dispensing fee (or fees) for their FFS pharmacy programs that have been approved by CMS. States have some flexibility in the manner in which they can structure their dispensing fees and there is some variability across FFS programs in the amounts and methodologies associated with dispensing fee assignment. There are 32 states that have adopted a single state-wide dispensing fee. These single state-wide dispensing fees range from $8.96 (Rhode Island) to $12.46 (North Dakota). There are eight states which have adopted a tiered professional dispensing fee based on providers' annual total prescription volume. In states with volume-based tiers for professional dispensing fees, there are between two and four dispensing fee tiers. Seven states have adopted differential professional dispensing fees that are based on other criteria. For example, in Alaska professional dispensing fees vary based on whether a pharmacy is located on or off of the state's road system. Professional dispensing fees in some states have been linked to the preferred or non-preferred status of a drug or to the generic dispensing rate of a pharmacy, such as in North Carolina. Some states have developed professional dispensing fees specific to specialty pharmacies or specialty drug products.

In response to CMS-2345-FC, the New York Medicaid program submitted a state plan amendment (SPA) for FFS pharmacy reimbursement that was approved by CMS on December 7, 2017. The SPA went into effect on April 1, 2017. Under this SPA, New York adopted an AAC benchmark made available by CMS, the National Average Drug Acquisition Cost (NADAC), as its primary basis for ingredient reimbursement[2]. The SPA also adopted a professional dispensing fee of $10.00. A subsequent SPA was approved by CMS on September 5, 2018 with an effective date of April 1, 2018, and increased the professional dispensing fee to $10.08.

Dispensing Fees within Medicaid Managed Care

Within a Medicaid managed care model, MCOs typically contract with a pharmacy benefit manager (PBM) to administer pharmacy benefits. PBMs manage the prescription drug benefits provided to each of their Medicaid members through the provision of several services including claims adjudication, customer service, prior authorization, and preferred drug list management. PBMs contract with

[2] New York uses a "lesser of" methodology for ingredient reimbursement in the FFS pharmacy program. The ingredient cost reimbursement for brand drugs is the lesser of NADAC, Wholesale Acquisition Cost (WAC), or the pharmacies usual and customary charge. Generic drugs are reimbursed at the lesser of NADAC, WAC, Federal Upper Limit (FUL), State Maximum Allowable Cost (SMAC), or the pharmacies' usual and customary charge.

pharmacies to provide a network to deliver required pharmacy services. MCOs and their contracted PBMs typically reimburse pharmacies using reimbursement methodologies similar to those used in commercial health plans and Medicare Part D plans. Notably, prescription drug dispensing fees within these plans tend to be on the order of $0.50 to $1.50 per prescription claim and ingredient reimbursement is based on discounted Average Wholesale Price (AWP) and proprietary maximum allowable cost (MAC) lists.

Despite the lack of specific reimbursement policies at the federal level, such as the specific rules and definitions included in CMS-2345-FC for FFS pharmacy programs, MCOs and their contracted PBMs must typically adhere to various requirements relating to adequacy of their provider network and quality of services.

One concern that has surfaced in recent years relates to the model under which PBMs have received remuneration for their services from MCOs and the frequent use of so-called “spread pricing” models. Under this model, contract pricing guarantees between MCOs and their PBMs are higher than corresponding contracts between PBMs and their member pharmacies, both in terms of ingredient reimbursement and professional dispensing fees. This margin between the amount charged to a plan sponsor and the amount paid by a PBM to pharmacies for a prescription is typically referred to as “spread pricing.” Perhaps the most significant drawback of this model is its lack of transparency, as it tends to obscure the amount of remuneration retained by PBMs and makes it difficult for state Medicaid agencies to determine whether the amount of PBM remuneration is a reasonable expense to be borne by the Medicaid program. Many states, (including New York since 2019), have implemented changes within their Medicaid managed care program to prohibit spread pricing and to require “pass-through” pricing. Under a “pass through” model, the PBM is reimbursed by the MCO exactly the amount the PBM pays a network pharmacy for each claim and a separate mechanism is established for the PBM to receive payment for their administrative services. While a prohibition on spread pricing practices may change the remuneration method between MCOs and PBMs, these changes do not directly impact the reimbursement methodology that PBMs apply within their contracted network of pharmacies.

As New York continues to evaluate and make adjustments to the provision of the pharmacy benefit to Medicaid members, the manner in which prescription drug dispensing fees are paid to pharmacies for Medicaid claims will be significantly impacted by the service delivery models adopted. To the extent that the state transitions the delivery of additional pharmacy benefits to the FFS delivery system such as through a carve-out model, the Medicaid program will be required to pay claims in accordance with CMS-2345-FC using the paradigm of AAC-based ingredient reimbursement and professional dispensing fees based on the cost pharmacies incur to provide services. To the extent that the state maintains its Medicaid pharmacy benefits within the managed care model, there will be fewer federal requirements impacting prescription drug dispensing fees and more flexibility for MCOs and their PBMs to determine prescription drug dispensing fees.

Reimbursement Methodologies for Prescription Drugs in Medicaid Programs

Background

The New York State Enacted Budget (Part QQ of Chapter 57 of the Laws of 2021) directs the Commissioner of the New York State Department of Health (DOH) to provide a report to the Legislature by December 31, 2021 "detailing the statutes, rules, and regulations, as well as other limitations or processes, that apply to and govern the calculation and payment of prescription drug dispensing fees to retail pharmacies by the state's medical assistance program, both within the Medicaid managed care and fee-for-service programs for the legislature to review, study, and better understand the information provided in such report."

Myers and Stauffer was retained by the New York State Department of Health to review statutory, regulatory, and other government guidance relating to the managed care and FFS program in New York and in the United States generally. Myers and Stauffer has also drawn upon its own internal expertise, having served as a consultant and rate setting contractor to numerous states and CMS on Medicaid pharmacy reimbursement issues over the last 40-plus years.

States have the option of providing Medicaid benefits through either managed care plans, an FFS model, or a combination of both. This may depend on a number of factors including, but not limited to, the population being served and/or characteristics of the geographic regions in the state. Under the managed care model, MCOs accept PMPM payment for services from Medicaid agencies through a calculated capitation rate which is required to be approved by CMS. MCOs are expected to manage cost, utilization, and quality of services. Within the managed care paradigm, states may opt to include pharmacy as a covered benefit and place the MCO at risk for those costs. Under the FFS model, state Medicaid agencies make payments directly to providers for services rendered to a Medicaid member. The State typically hires vendors or performs some roles internally for various functions such as enrollment, claims processing, auditing, actuarial services, rate setting, medical policy, drug rebate administration, clinical services, and program consulting. Under the FFS model, payments are required to be efficient, economical, and consistent with quality of care. Furthermore, payments must be sufficient to provide access to the general population.

The Medicaid program in New York provides services to its members through a combination of both the FFS and managed care delivery models. As of August 31, 2021, there are approximately 5.1 million

members receiving services through 16 MCOs.[3] There are approximately 1.3 million members enrolled in the Medicaid FFS pharmacy program.

Assignment of members to either the managed care or FFS program within the New York Medicaid program is based on various eligibility criteria.

Individuals which are required to be enrolled in the managed care program include the following:

- *Parents and caretakers.*
- *Children.*
- *Blind and disabled individuals.*
- *Aged individuals.*
- *Dual-eligible; individuals requiring 120 days or more community-based long-term services and supports (LTSS).*
- *Medicaid expansion.*
- *Individuals in foster care.*

Individuals which have the option to enroll in either FFS or in managed care include the following:

- *Dual-eligible; individuals not requiring 120 days or more of community-based LTSS.*
- *Individuals participating in Office for People with Developmental Disabilities programs.*
- *Home and community-based services waiver participants.*
- *Individuals granted exemption due to special chronic care needs.*
- *Native Americans.*

Individuals which are required to be enrolled in the FFS program include the following:

- *Individuals residing in a nursing home.*
- *Individuals residing in intermediate care facilities or individuals with an intellectual or developmental disability.*
- *Individuals eligible through spend down.*
- *Residents of assisted living programs.*
- *Individuals eligible for emergency Medicaid.*
- *Residents of state psychiatric facilities.*

[3] https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2021/docs/en08_21.pdf

- *Persons with private health insurance.*
- *Infants living with incarcerated mothers.*
- *Individuals with less than six months of Medicaid eligibility.*

Prescription Drug Reimbursement within Medicaid Programs

Reimbursement for prescription drugs is generally based on two components: ingredient reimbursement and professional dispensing fee. The ingredient reimbursement is intended to cover the cost a pharmacy incurs to acquire a drug from a manufacturer or wholesaler. A dispensing fee is generally considered to be associated with covering the labor and overhead costs incurred by a pharmacy and intended to reimburse the expenses associated with the transfer of a drug from the pharmacy to a patient.

Although the specific focus of this report is prescription drug dispensing fees in state Medicaid programs, it is important to consider both dispensing fees and ingredient reimbursement since they each impact the net reimbursement which a pharmacy receives for dispensing prescriptions. To compare differing approaches to determining dispensing fees and overly focus on the amounts of those fees would ignore that there are also differing approaches to reimbursing pharmacies for prescription drug ingredients. While not universal, it is often the case that a reimbursement paradigm with lower dispensing fees similarly adopts a model for ingredient reimbursement that is higher than an alternate approach with generally higher dispensing fees. Dispensing fees and ingredient reimbursement must be considered in tandem.

Medicaid FFS

With respect to FFS Medicaid programs, CMS has promulgated regulations regarding how states must reimburse for prescription drug ingredients. Most recently, CMS issued the Final Rule for Covered Outpatient Drugs on February 1, 2016 (CMS-2345-FC). The most significant change which this rule brought about was a change to the reimbursement paradigm for the ingredient portion of reimbursement. Under this rule, Medicaid programs were required to change the basis for ingredient reimbursement for retail community pharmacies from the previously defined EAC to the concept of AAC. Whereas EAC was allowed to be based on benchmarks published by the industry (most notably the AWP) an AAC benchmark was required to be supported by data obtained through a survey.

In making the change to the AAC model of ingredient reimbursement, CMS was addressing longstanding concerns which had developed regarding the accuracy and reliability of the AWP. Utilized since the 1970s, AWP was created to help provide a pricing benchmark to third-party payers and government prescription drug programs. Because AWP is not defined in law or regulation, a manufacturer may set the AWP at any level, regardless of the actual price paid by purchasers. As a result, pharmacies may be incentivized to dispense drugs for which the greatest difference or “spread” exists between the AWP

and the actual price they pay for the drug. Studies conducted by the Office of the Inspector General (OIG) showed that these discounted AWP-based EAC formulas of state Medicaid programs were not reliable at predicting the true acquisition cost for pharmacy providers.[4]

Given the numerous flaws associated with AWP-based pricing, many state Medicaid programs began to consider the need for alternative reimbursement approaches, including reimbursement based on AAC. The AAC approach is based on the collection of pharmacy provider invoice data to establish a true average acquisition cost for drugs. In 2010, the AAC-based approach received national attention when the National Association of Medicaid Directors (NAMD) published a white paper titled, "Post AWP Pharmacy Pricing and Reimbursement."[5] Among the recommendations presented in the white paper was the establishment of a national price benchmark for pharmacy reimbursement that would be based on providers' average drug acquisition costs. NAMD, along with the OIG, issued recommendations to CMS to develop a national benchmark that would accurately estimate AAC. The OIG also recommended that CMS encourage states to consider such a benchmark when determining Medicaid reimbursement for prescription drugs.

In response, CMS developed the NADAC pricing benchmark. The purpose of this initiative is to perform a monthly nationwide survey of pharmacies and to provide state Medicaid agencies with weekly pricing file updates. The NADAC pricing files are derived by averaging survey invoice prices from retail community pharmacies across the United States. The implementation of CMS-2345-FC required that states transition from AWP-based EAC formulas and adopt an AAC model for ingredient reimbursement.

CMS provided some guidance regarding approaches which states could use to implement an AAC reimbursement model. This guidance includes, but is not limited to, utilizing the NADAC pricing benchmark and a state-specific survey of pharmacy ingredient costs (i.e., a state AAC). Some allowances were made for states to continue to use a published industry benchmark, such as wholesale acquisition cost (WAC), if adjustments were made to reflect discounts and other price concessions in the marketplace.

The majority of states, including New York, have adopted the NADAC as the pricing benchmark used within their FFS pharmacy program. The NADAC is designed to be a national average of the prices at which pharmacies purchase prescription drugs from manufacturers and wholesalers. The NADAC is based on a monthly voluntary survey which collects invoices from retail community pharmacies. The NADAC file is published weekly by CMS with updates reflecting new survey data, as well as other changes in the marketplace. The NADAC is not inclusive of discounts or rebates paid to PBMs or plans from manufacturers.

[4] U.S. Department of Health & Human Services, Office of Inspector General, Replacing Average Wholesale Price: Medicaid Drug Payment Policy (2011), *available at* https://tinyurl.com/y22dozaj.

[5] American Medicaid Pharmacy Administrators Association and The National Association of Medicaid Directors, Post AWP Pharmacy Pricing and Reimbursement (2009) (on file with author).

States which have not adopted the NADAC as the pricing benchmark within their FFS Medicaid program have instead adopted a state-specific AAC benchmark, similar to the NADAC, but based on survey data obtained from pharmacies participating in the state's Medicaid program. While the NADAC benchmark is limited to data obtained from retail community pharmacies, a state may leverage its State AAC program to survey specialty pharmacies and develop pricing benchmarks which cover more specialty drug products than the NADAC. A limited number of states have incorporated a state AAC benchmark which operates in tandem with the use of the NADAC benchmark. In some cases, states which rely on the NADAC may supplement those prices with additional state-specific pricing through a State Maximum Allowable Cost (SMAC) program (or similar program under a different name). SMAC pricing may have its basis in an AAC-based methodology, but other approaches to developing SMAC pricing are also in use.

Regulatory requirements for FFS Medicaid pharmacy programs also continue to incorporate the federal upper limits (FUL). The FUL is calculated as a minimum of 175 percent of the average manufacturer price (a price defined in federal statute and reported directly by manufacturers to CMS). FULs also incorporate a lower bound based on the NADAC. Although states are still required to adhere to requirements associated with FULs, the significance of this price has become less relevant since the adoption of CMS-2345-FC.

CMS-2345-FC also impacted the reimbursement methodology applied to pharmacies dispensing medications to Medicaid members using drugs acquired under the 340B program. The 340B program is a drug discount program overseen by the Health Resources and Services Administration (HRSA) that requires drug manufacturers participating in the Medicaid program to provide outpatient covered drugs to eligible covered entities at significant discounts. CMS-2345-FC essentially applied the AAC standard claims for 340B drugs and required that states not reimburse for ingredients in excess of the 340B ceiling price.

Counterbalancing the change for ingredient reimbursement within CMS-2345-FC, CMS also proposed revisions to the methodology for setting pharmacy dispensing fees within Medicaid FFS programs. While the changes in the methodology proposed for ingredient reimbursement generally reduced levels of reimbursement from the prior AWP-based EAC formulas, the revisions in the methodology required for setting dispensing fees generally led to increased dispensing fees within Medicaid FFS pharmacy programs.

CMS-2345-FC did not fundamentally change the definition of a dispensing fee for prescription medication, although it did modify the term to add the word "professional." According to the final rule (42 CFR 447.502), a professional dispensing fee means the professional fee which:

1. *Is incurred at the point of sale or service and pays for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed.*

2. *Includes only pharmacy costs associated with ensuring possession of the appropriate covered outpatient drug is transferred to a Medicaid recipient. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing drug utilization review and preferred drug list (PDL) review activities, measurement or mixing of the covered outpatient drug, filling the container, beneficiary counseling, physically providing the completed prescription to the Medicaid beneficiary, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy.*
3. *Does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including systems costs for interfacing with pharmacies.*[1]

A key aspect of the definition for the professional dispensing fee is that it is intended to reimburse the expenses associated with the transfer of the covered outpatient drug from the pharmacy to the Medicaid member. A professional dispensing fee is not intended to include ingredient cost.

The key change implemented by CMS-2345-FC with respect to the dispensing fee is the requirement at 42 CFR § 447.518(d) that when states propose changes to either the ingredient portion of pharmacy reimbursement or the professional dispensing fee for their FFS Medicaid pharmacy program, states must consider both aspects of reimbursement to ensure total payments to the pharmacy provider are in accordance with requirements of section 1902(a)(30)(A) of the Social Security Act.[6]

Additionally, states must provide adequate data, such as an in-state or other survey of retail pharmacy providers, to support any proposed changes to either the professional dispensing fee or ingredient component of the pharmacy reimbursement methodology. In practice, CMS has required states to support a SPA submission changing the professional dispensing fee with the results of an in-state COD survey (i.e., a survey which collects the labor and overhead cost incurred by pharmacies, and calculates an estimate of the average cost to dispense prescriptions) or to present an analysis based on the results of COD surveys performed in other states.

States have some flexibility in the manner in which they can structure their dispensing fees and there is some variability across FFS programs in the amounts and methodologies associated with dispensing fee assignment. The use of a single professional dispensing fee for all pharmacies represents the simplest reimbursement option and is the most widely used methodology for pharmacy dispensing fees among state Medicaid programs. There are 32 states that have adopted a single statewide dispensing fee. These single statewide dispensing fees range from $8.96 (Rhode Island) to $12.46 (North Dakota). Alternative methods used include tiered reimbursement rates, reimbursement based on specific cost factors (such as geographic location), prescription volume, or rates designed to incentivize desired

[6] "… to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area…"

behavior. There are eight states which have adopted a tiered professional dispensing fee which is based on annual pharmacy total prescription volume. In states with volume-based tiers for professional dispensing fees, there are between two and four dispensing fee tiers. Seven states have adopted differential professional dispensing fees that are based on other criteria. For example, in Alaska, professional dispensing fees vary based on whether a pharmacy is located on or off of the state's road system. Professional dispensing fees in some states have been linked to the preferred or non-preferred status of a drug or to the GDR of a pharmacy, such as in North Carolina.

In response to CMS-2345-FC, the New York Medicaid program submitted a SPA for FFS pharmacy reimbursement that was approved by CMS on December 7, 2017. The SPA went into effect on April 1, 2017, to be in compliance with the CMS-2345-FC. Under this SPA, New York adopted an AAC benchmark made available by CMS, the NADAC as its primary basis for in a lower of ingredient reimbursement. The SPA also adopted a professional dispensing fee of $10.00. An updated SPA was approved by CMS on September 5, 2018 with an effective date of April 1, 2018, which increased the professional dispensing fee to $10.08.

To supplement the overview of federal guidance with respect to professional dispensing fee within a FFS Medicaid program, Myers and Stauffer has included additional materials within the Appendix to present the discussion of professional dispensing fees included within narrative comments and responses in the Covered Outpatient Drug Final Rule.

Medicaid Managed Care

Within a Medicaid managed care model, MCOs generally contract with a PBM to administer pharmacy benefits. MCOs and their contracted PBMs typically reimburse pharmacies using reimbursement methods similar to those used in commercial health plans and Medicare Part D plans. These reimbursement methodologies rely heavily on the following elements:

- *Ingredient reimbursement tied to published benchmarks such as the AWP. Typically, percentage adjustments are applied to these benchmarks.*
- *Proprietary MAC lists for pricing of generic products. These MAC lists are specific to each PBM, and each PBM may maintain multiple MAC lists based on their contracts with pharmacies in their respective networks.*
- *Minimal dispensing fees on the order of $0.50 to $1.50 per prescription claim.*
- *Notably, reimbursement for drugs dispensed to 340B entities is not strictly limited, as in a Medicaid FFS programs. Approaches to reimbursement for drugs dispensed by 340B entities within managed care can vary significantly.*
- *The potential for retrospective adjustments to reimbursements made through the point-of-sale system as DIR fees.*

Unlike the FFS Medicaid program in which CMS has set the paradigm for AAC-based reimbursement, along with a professional dispensing fee based on surveys of pharmacy COD, there is no such requirement at the federal level for Medicaid managed care programs. PBMs are neither required to base ingredient reimbursement rates on AAC, nor do their dispensing fees need to be tied to pharmacy COD surveys. Despite the lack of specific reimbursement policies at the federal level, MCOs and their contracted PBMs typically must adhere to various requirements relating to adequacy of their provider network and quality of services. These requirements effectively set some boundaries on the overall level of reimbursement rates.

One concern which has surfaced in recent years in several states relates to the model under which PBMs have received remuneration for their services from MCOs and the frequent use of so-called "spread pricing" models. Under this model of contracting between MCOs and PBMs, the pricing guarantees in MCO and PBM contracts are at higher levels than corresponding terms in the contracts between PBMs and their member pharmacies, both in terms of ingredient reimbursement and dispensing fees. The margin between the amount charged to a plan sponsor and the amount paid by a PBM to pharmacies for a prescription is typically referred to as "spread pricing."

Perhaps the most significant drawback of the spread pricing model is its lack of transparency. The spread pricing model tends to obscure the amount of remuneration retained by PBMs and makes it difficult for state agencies administering the Medicaid benefit to determine if the amount of PBM remuneration is a reasonable expense to be borne by a Medicaid program. Many states, including New York since 2019, have implemented changes within their managed care program to prohibit spread pricing practices and to require pass-through pricing. While a prohibition on spread pricing practices may change the remuneration method between MCOs and PBMs, such as requiring per-claim administrative fees in lieu of spread pricing, these changes do not directly impact the reimbursement methodology that PBMs apply within their contracted network of pharmacies.

State Approaches to COD Surveys and Medicaid FFS Professional Dispensing Fees

As previously described, CMS-2345-FC gives states significant flexibility to determine professional dispensing fee(s) within an FFS Medicaid program. CMS requires that states utilize adequate data, such as a survey of retail pharmacy providers, either in-state or in neighboring states, to support any proposed changes to the professional dispensing fee.

Within this portion of the report, additional information is presented regarding the various approaches which states have used to develop professional dispensing fees within their FFS Medicaid program. Drawing on Myers and Stauffer's experience of performing COD surveys and advising states on professional dispensing fees over the last 40-plus years, various issues relating to performing COD surveys and trends observed are presented. Additional information is provided regarding state-specific requirements that impact the performance of COD surveys. Finally, information relating to the structure of the dispensing fee methodologies used within various FFS Medicaid programs is presented.

COD Surveys

Given CMS requirements that a professional dispensing fee within a Medicaid FFS program must be based on survey data reflecting pharmacies' actual costs of dispensing prescriptions, the process of developing a dispensing fee methodology typically begins with the performance of a COD survey, or in some cases, the review of COD surveys from other states. If a Medicaid agency chooses to perform a COD survey, they often contract with a vendor to perform the survey.

In addition to any stakeholder outreach at the beginning of a COD survey process, an initial step is to define objectives, design a COD survey tool, and develop a survey approach to achieve those objectives. After the survey tool is developed and approved, it is sent to either all pharmacies enrolled in the Medicaid program, or a subset of pharmacies, typically based on a statistically-valid sampling approach. Pharmacies are requested to provide detailed information relating to the labor and overhead costs they incur. Pharmacies are provided with instruction and other education at the onset of the survey process, as well as assistance with questions, as needed, during the survey process. Submitted surveys are reviewed for reasonableness and accuracy, with the potential for inquiries to the pharmacy to collect missing data or to correct anomalous data. In some cases, a state Medicaid agency may require a verification or validation process, either performed in person or remotely, by which supporting documentation is requested from the pharmacy in order to validate their survey response.

Typically, cost allocation methods are applied to develop an estimate of the portion of pharmacy labor and overhead costs that were incurred for the purpose of dispensing prescriptions. That estimate of

cost, when divided by the total number of prescriptions dispensed by the pharmacy during the reporting period, yields an estimate of the average COD per prescription. Typically, survey data is aggregated to yield various measures of the average COD for all pharmacies in the state or for various subsets of pharmacies based on characteristics such as chain versus independent affiliation, location, prescription volume, provision of specialty services, etc. Depending on the specific information collected from pharmacies, and the effectiveness of efforts to validate the submitted data, a COD survey can provide a state Medicaid agency with a robust data set for various types of analyses of pharmacy cost and operational data.

Several states, including Alaska, Iowa, Louisiana, and Ohio have state statutes or regulations that mandate the frequency and scope of the COD process. The bills passed in these states also require participation of Medicaid-enrolled providers in those survey processes. Regulatory requirements in Alaska and Ohio stipulate that pharmacies that do not participate in COD surveys will be assigned the lowest possible professional dispensing fee within a tiered system. Regulatory requirements in Iowa and Louisiana give their respective state agencies the authority to remove pharmacies from the Medicaid program if they do not participate in the survey process.

Thirteen states have statutory or regulatory language addressing COD survey scope or frequency but do not mandate provider participation. Details of a statutory and regulatory review of state requirements from 21 states is included in *Appendix B: State COD Survey Policies*.

Participation rates in pharmacy COD surveys can vary significantly, primarily based on the state regulatory environment and whether the submission of a survey is considered mandatory. In Myers and Stauffer's experience over the last 10 years, states that require survey participation may see response rates of 80 percent or more. States that do not mandate participation typically see lower response rates ranging between 30 percent and 60 percent. Based on experience, many large chain pharmacies will not participate in a COD survey unless there is a requirement to do so.

While voluntary surveys yield lower response rates, they generally provide states with sufficient data to develop professional dispensing fees that are defensible and will be supported when SPAs are submitted to CMS for approval.

COD Trends

Since 2010, Myers and Stauffer has performed dozens of pharmacy COD surveys. Based on the results of these surveys, it has been observed that increases in the COD over the past decade, as measured on a per prescription basis, have been minimal. While recognizing that most input costs for pharmacies, including pharmacist and other staff labor costs, are subject to inflationary factors, the overall average COD does not appear to be following the same inflationary trajectory. Increases in pharmacy efficiency

associated with increased prescription volume and more efficient business practices appear to have had a tempering impact on inflationary factors.

In general, pharmacy total prescription volume has been on an upward trend over the past several decades. Furthermore, in recent years, many pharmacies have implemented changes to business operations that have increased efficiency. For example, more pharmacies are participating in e-prescribing, central fill dispensing, and the increased use of automated dispensing methods. These changes have made pharmacists and other pharmacy staff more efficient at dispensing medications and appears to have curtailed the rate of increase in the average COD on a per prescription basis. Although the COVID-19 pandemic has undoubtedly had an impact on pharmacy operations, there is insufficient data at this point to assess the long-term impacts that the pandemic will have on pharmacy COD.

Professional Dispensing Fee Methodologies

The majority of states choose to adopt a single statewide dispensing fee within its Medicaid FFS program (based on an average COD, representing all pharmacies surveys). However, several options other than a single statewide professional dispensing fee are available to state Medicaid programs. Other than the requirement that professional dispensing fees have a basis in a survey of pharmacy dispensing cost, CMS allows states significant flexibility to design its professional dispensing fees. Some states have used this flexibility to develop tiered dispensing fees based on pharmacy prescription volume, pharmacy location, or to create incentives for the dispensing of certain preferred products. Many state Medicaid programs are also looking closely at the dispensing cost observed for specialty pharmacies with the understanding that changes to the ingredient reimbursement for specialty pharmacies will also require an evaluation of the professional dispensing fees paid to those pharmacies.

Tiered Professional Dispensing Fees

A number of states have adopted professional dispensing fees within their Medicaid FFS program that are based on tiers. California, Colorado, Idaho, Montana, Ohio, Oregon, Tennessee, and Wisconsin use between two and four tiers associated with the total prescription volume for pharmacies. Since many of the expense components related to the professional dispensing fee are fixed, a greater volume of prescriptions dispensed is associated with a lower average COD per prescription. One advantage seen with tiered systems is that they can allow for higher professional dispensing fees for pharmacies in rural areas since those pharmacies typically have lower overall prescription volume. However, tiered systems associated with prescription volume may give the perception of incentivizing inefficient operations, since low-volume, inefficient pharmacies will receive a higher reimbursement than more efficient operations. Tiered dispensing fees may also be perceived to incentive market saturation since numerous pharmacies in the same market area could potentially receive higher Medicaid professional dispensing fees than would occur if there were fewer pharmacies in the same market area dispensing the same number of prescriptions.

North Carolina utilizes a unique approach within its tiered professional dispensing fee. The tiers used in North Carolina are based on the GDR which is a calculation of the generic or preferred drug dispensing percentage each quarter. North Carolina performs GDR calculations each quarter to determine the percentage of generic or preferred drugs dispensed by each pharmacy for Medicaid members. If the pharmacy's GDR is 85 percent or more, the pharmacy receives a professional dispensing fee of $13.00; if the GDR is less than 85 percent, the pharmacy receives a professional dispensing fee of $7.88. Pharmacies receive a professional dispensing fee of $3.98 for non-preferred brand drugs. Although this methodology was created with the intention to incentive providers to dispensing generic and preferred drugs, the approach does create significant administrative overhead to recalculate the GDR each quarter and also requires the claims processor to make frequent changes within the claims payment system.

Arkansas and Michigan also base their tiered professional dispensing fees on the preferred or non-preferred status of a brand drug. Pharmacies receive: a professional dispensing fee of $9.00 for claims for non-preferred brand products; a professional dispensing fee of $10.50 for claims for preferred brand products; and a professional dispensing fee of $10.50 for claims for generic products. Under Michigan's methodology, pharmacies receive: a professional dispensing fee of $10.80 for claims for drug products indicated as preferred on the state's PDL; a professional dispensing fee of $9.00 for claims for drug products indicated as not preferred on the state's PDL; and a professional dispensing fee of $10.64 for claims for drug products not referenced on the PDL.

Alaska and Utah use pharmacy location for tier assignment of professional dispensing fees. Alaska professional dispensing fees are tiered based on whether a pharmacy is located on the state's road system as opposed to being located in a community not accessible by road (i.e., access by only plane and/or boat). Utah utilizes three tiers: in-state rural, in-state urban, and out-of-state.

Professional Dispensing Fees Associated with Specialty Pharmacies or Specialty Drugs

Recently, more states have developed professional dispensing fees that are targeted specifically for either specialty pharmacies or specialty drug products. Prior to the implementation of CMS-2345-FC, the prior reimbursement mechanism for specialty pharmacies was discounted AWP. Since the ingredient reimbursement associated with specialty drugs was relatively high, the spread between reimbursement and acquisition cost was significant. Consequently, there was little adverse impact to specialty pharmacies if they were reimbursed with a dispensing fee that was significantly less than their actual cost to dispense products. Although CMS-2345-FC only applies the AAC requirement to retail community pharmacies, a term which typically does not encompass specialty pharmacies, some states have opted to apply the principles of AAC-based reimbursement to at least a portion of specialty dispensing. Concerns have been expressed that as margins on ingredient reimbursement become smaller or disappear for specialty products, a dispensing fee that is more closely matched to the COD of specialty pharmacies becomes more important. However, specialty pharmacy reimbursement has been a challenge for many state Medicaid programs since there are fewer precedents from other states to use

as models. Although COD survey data provides valuable information on the COD specialty products, there is often significant variability in the cost observations among pharmacies making it more difficult to reach a consensus regarding ideal professional dispensing fees for specialty products.

There have also been challenges associated with addressing the scope of applying specialty professional dispensing fees. Some states have approached this at the pharmacy level; others at the product level. Since state Medicaid agencies do not generally have a uniform definition of a specialty drug or of specialty pharmacies, there are challenges with either approach.

A number of states have established differential dispensing fees for specialty drugs. North Carolina, Tennessee, and Utah have established a professional dispensing fee for clotting factor products. North Carolina pays a professional dispensing fee for clotting factor that is calculated as $0.04 per unit of clotting factor for prescriptions dispensed from a hemophilia and thrombosis centers. A professional dispensing fee of $0.025 per unit is calculated for other providers dispensing clotting factor. Tennessee currently pays of professional dispensing fee of $153.54 per clotting factor dispensation. Utah pays a professional dispensing fee of $716.54 per dispensation of clotting factor to contracted pharmacies in accordance with their hemophilia disease management program. Payment of an enhanced professional dispensing fee specific to clotting factor drugs commonly incorporates costs for pharmacy accreditation, specialized clinical training, and provision of additional supportive services. It should be noted that a key component for states that pay enhanced professional dispensing fees for clotting factor is the establishment of AAC rates for reimbursement clotting factor products. These products are not generally included on the NADAC file; published pricing such as AWP or WAC is significantly higher than AAC-based rates. States which have established in-state invoice surveys of clotting factors providers to establish state-specific AAC rates for clotting factor products, generally have achieved overall savings despite the payment of enhanced professional dispensing fees.

Vermont has developed a professional dispensing fee of $17.03 for specialty drugs including, but not limited to, biologics and limited distribution drugs. Pharmacies must be enrolled as a specialty pharmacy and meet certain accreditation standards in order to receive the specialty professional dispensing fee. Furthermore, in order to receive the specialty professional dispensing fee, a specialty drug must meet a minimum of two requirements related to cost, condition treated, limited distribution status, or special handling requirements. [7]

Michigan has a specialty drug professional dispensing fee of $20.02. The specialty drug professional dispensing fee is paid for drugs that are included on a list maintained by the program which includes various infusion and intravenous products, as well as compounds with a least one covered drug. [8]

[7] https://dvha.vermont.gov/sites/dvha/files/documents/Provider%20Manual.pdf
[8] https://michigan.magellanrx.com/provider/

Other Variations of Professional Dispensing Fees

Some states have developed other unique aspects within their professional dispensing fee methodologies. Generally, states can set separate professional dispensing fees for different classes of pharmacies or drugs if supported by survey data. Idaho, Tennessee, and Rhode Island have differing professional dispensing fees applied to pharmacies that serve long-term care facilities. Alaska has a separate professional dispensing fee for pharmacies that provide a certain type of unit dose packaging. Arizona, Tennessee, and Wisconsin pay a higher professional dispensing fee for compounded drugs. Illinois pays a higher professional dispensing fee to pharmacies designated as "critical access."

Texas utilizes a unique approach with its professional dispensing fee by incorporating a complex formula to calculate the professional dispensing fee for each drug dispensed. The formula is defined as:

> *(acquisition cost + fixed component) ÷ (1 – the percentage to calculate the variable component – acquisition cost) + delivery incentive + preferred generic incentive.*

Reliance on Survey Data from Other States

For its revision to the professional dispensing fee in 2017, New York Medicaid reviewed and relied on survey data from Delaware and New Jersey. Several other states, including Georgia, Kentucky, Nebraska, and Wyoming, also appear to have relied on survey data from neighboring states in order to determine its professional dispensing fees.

Appendix A: Federal Regulations

Myers and Stauffer conducted a policy review of United States Code and the Code of Federal Regulations (CFR) to look for specific language or guidance surrounding Professional Dispensing Fees (PDF). The 2016 Covered Outpatient Drug Rule[9] was reviewed in addition to the Managed Care Rule[10] for guidance on calculating PDFs. Public comments and corresponding Centers for Medicare & Medicaid Services (CMS) responses were also reviewed for both rules in an attempt to identify additional Agency guidance and/or policy rationales regarding PDF reimbursement.

- *42 CFR 438 Managed Care.*
  - *Requires managed care organization (MCO) to report drug utilization data that is necessary for states to bill manufacturers for rebates.*
  - *Requires MCO to provide a detailed description of its drug utilization review program activities to the State on an annual basis.*
  - *Requires MCO operate a drug utilization review program that complies with the requirements described in section 1927(g) of the Act.*
  - *Requires MCO conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the Act, as if such requirements applied to the MCO, prepaid inpatient health plan, or prepaid ambulatory health plan instead of the State.*
- *42 CFR 447.518(a) Covered Outpatient Drug.*
  - *Requires state plan to comprehensively describe the agency's payment methodology for prescription drugs.*
  - *The agency's payment methodology in paragraph (a)(1) of this section must be in accordance with the definition of AAC in § 447.502.*
- *Comments and Responses to Covered Outpatient Drug Rule.*
  - *Several comments requested that CMS provide more guidance to states on how to assess PDFs.*
    - *In response, CMS updated language in the rule requiring that both the PDF and actual acquisition cost (AAC) be addressed in the state plan amendment if the State was proposing changes to either portion.*

[9] 42 CFR § 447
[10] This rule amended 42 CFR § 431, 42 CFR § 433, 42 CFR § 438, 42 CFR § 440, 42 CFR § 457, and 42 CFR § 495

- *Many commenters wanted CMS to require states to consider PDFs in addition of AAC when making a change to either portion of their drug reimbursement scheme.*
    - *CMS declined to further require how states assess PDF for Medicaid reimbursement.*
- *Several commenters asked CMS to address the impact of this rule on MCOs. Many noted the proposed rules state that plans may be affected by this rule if manufacturers reduce rebate payments to the plans to any extent that these rebates are paid to the states, but these costs would likely be mitigated because it is likely that the MCO rates would be adjusted.*
    - *CMS response noted that issues regarding MCO payment rates are beyond the scope of this final rule. CMS noted that states are responsible for establishing capitation rates in accordance with 42 CFR part 438.*

Comments and Responses to Managed Care Rule.

- *One comment indicated that the overall cost to dispense an over-the-counter (OTC) drug is the same as a prescription drug, and therefore, urged CMS to require states to implement adequate and fair dispensing fees for all managed care claims, including OTC drugs.*
    - *The CMS response noted that the dispensing fees paid by managed care plans for OTC drugs is part of the contract terms negotiated between the managed care plan and the pharmacy and is, therefore, beyond the scope of this rule.*

CMS Guidance 2016.

- *Summary.*
    - *CMS defines "Professional Dispensing Fee" but does not intend to mandate a specific formula for determining an appropriate fee. However, CMS requires states to consider both the ingredient cost and dispensing fee when proposing changes to either the ingredient cost or the dispensing fee. CMS requires states provide adequate data such as state or national survey of providers or other reliable data to support proposed changes.*
- *Full Language from Guidance.*
    - *PDF in the final regulation, the revision of the term "dispensing fee" to "professional dispensing fee" at §447.502 is designed to reinforce our position that the dispensing fee should reflect the pharmacist's professional services and costs to dispense a drug to a Medicaid beneficiary. While CMS defines this term, we do not intend to mandate a specific formula or methodology that states must*

use to determine the professional dispensing fee. However, states need to ensure pharmacy providers are reimbursed adequately for their professional services consistent with the requirements of the final regulation. Pharmacy provider reimbursement rates should be consistent with efficiency, economy, and quality of care while ensuring sufficient beneficiary access, in accordance with section 1902(a)(30)(A) of the Act.

- *Therefore, in compliance with the requirements codified at §447.518(d) of the final regulation, states must consider both the ingredient cost reimbursement and the professional dispensing fee reimbursement when proposing changes to either the ingredient cost reimbursement or the professional dispensing fee reimbursement to ensure total reimbursement to the pharmacy provider is calculated in accordance with requirements of section 1902(a)(30)(A) of the Act. States must provide adequate data, such as a state or national survey of retail pharmacy providers or other reliable data other than a survey, to support any proposed changes to either or both of the components of the reimbursement methodology. CMS will review the survey/data that a State submits on a case-by-case basis to ensure the reimbursement proposed aligns with the State's cost to dispense as documented in the survey/data. States retain the option to adjust the professional dispensing fee for provider type or services rendered such as special packaging or delivery.*

Appendix B: State COD Survey Policies

Myers and Stauffer conducted a policy review of state statutory and regulatory requirements associated with the performance of COD surveys for the purpose of developing professional dispensing fees for Medicaid fee-for-service (FFS) programs.

State and Code Citation	Full Provision *Emphasis added	Mandatory Language (Y/N)
Alabama Ala. Admin. Code 560-X-16-.06(4)	(4) Dispensing Fees. **A professional dispensing fee is set by the Agency. This fee is reviewed periodically, and when deemed appropriate by Medicaid, may be adjusted.**	No
Alaska Alaska Admin. Code tit. 7, § 145.4109 (c)	(c) Upon request by the department**, a pharmacy shall produce business records and invoice information relevant to the cost of drugs and the cost of dispensing.** If a pharmacy does not provide cost of drugs or dispensing fee data as requested by the department, the department may assign that pharmacy the dispensing fee of $3.45 and sanction the pharmacy as provided under 7 AAC 105.400 - 7 AAC 105.490.	Yes
Arkansas Ark. Code Ann. § 20-77-403 (b) (West)	(b) However, until existing federal regulations limiting reimbursement for a drug to the lower of the pharmacist's usual and customary charge, or cost of the drug plus a reasonable dispensing fee, are modified or declared invalid by a court, the secretary and the deputy director shall pay for each prescription, the lower of: (1) The pharmacist's usual and customary charge to the general public for the drug; or (2) The pharmacist's cost of the drug plus a dispensing fee. **The fee will be adjusted annually on July 1 of each year by the percentage change in the Consumer Price Index, except that on any July 1 immediately following a subsequent cost-of-dispensing survey conducted by the appropriate division of the Department of Human Services**, the fee will be adjusted using the formula used by the secretary and the deputy director to determine the July 1, 1980, fee or other such formula as may be developed subsequently by the secretary and the deputy director with the approval of the Legislative Council.	No
California Cal. Welf. & Inst. Code § 14105.45	(F) Prior to the implementation of an AAC methodology, **the department shall collect data through a survey of pharmacy providers for purposes of establishing a professional dispensing fee** or fees in compliance with federal Medicaid requirements.	No

State and Code Citation	Full Provision *Emphasis added	Mandatory Language (Y/N)
Colorado 10 Colo. Code Regs. § 2505-10:8.800	**8.800.13.H. Dispensing Fees shall be determined based upon reported dispensing costs provided through a Cost of Dispensing (COD) survey completed every two fiscal years.** The Dispensing Fees for Retail Pharmacies, 340B Pharmacies, Institutional Pharmacies and Mail Order Pharmacies shall be tiered based upon annual Total Prescription Volume. The Dispensing Fees shall be tiered at: 1. Less than 60,000 total prescriptions filled per year = $13.40 2. Between 60,000 and 90,000 total prescriptions filled per year = $11.49 3. Between 90,000 and 110,000 total prescriptions filled per year = $10.25 4. Greater than 110,000 total prescriptions filled per year = $9.31 **8.800.13.I.** The designation of a pharmacy's Dispensing Fee shall be updated annually. Every October, the Department shall contact a pharmacy requesting the completion of an attestation letter stating the pharmacy's Total Prescription Volume for the period September 1 to August 31. A pharmacy shall have until October 31 to provide the completed attestation letter to the Department. Using the attestation letter, the Department shall update a pharmacy's Dispensing Fee effective January 1. A pharmacy failing to provide the Department an attestation letter on or before October 31, regardless of their previous Dispensing Fee, shall be reimbursed the $9.31 Dispensing Fee.	No
Idaho Idaho Admin. Code r. 16.03.09.665	j. Claims Volume Survey for Tier-Based Professional Dispensing Fees. **The Department will survey pharmacy providers to establish a professional dispensing fee for each provider. The professional dispensing fees will be paid based on the provider's total annual claims volume. The provider must return the claims volume survey to the Department no later than May 31st each year.** Pharmacy providers who do not complete the annual claims volume survey will be assigned the lowest professional dispensing fee starting on July 1st until the next annual survey is completed. Based upon the annual claims volume of the enrolled pharmacy, the professional dispensing fee is provided online at: http://healthandwelfare.idaho.gov/Portals/0/Medical/PrescriptionDrugs/PharmacyReimbChangesFAQs.pdf. (4-1-17)	Yes
Iowa Iowa Admin. Code r. 441-79.1(249A)	c. Professional dispensing fee. (1) For purposes of this subrule, **the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries.** The survey shall be conducted every two years beginning in state fiscal year 2014-2015. (2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.	No

State and Code Citation	Full Provision *Emphasis added	Mandatory Language (Y/N)
Louisiana 50 La. Admin. Code Pt XXIX, 915 (B)	(B) **Provider participation in the Louisiana cost of dispensing survey shall be mandatory.** A provider's failure to cooperate in the survey shall result in his/her removal from participation as a provider of pharmacy services in the Medicaid Program. Any provider removed from participation shall not be allowed to re-enroll until a professional dispensing fee survey document is properly completed and submitted to the department.	Yes
Maryland Md. Code Regs. 10.09.03.03	**To participate in the Program, the provider shall: . . . . (R) Participate in the cost of dispensing survey** and, on the Department's request and within the Department's timeline, provide to the Department all documentation that the Department or its designee determines is necessary	Yes
Minnesota Minn. Stat. Ann. § 256B.0625(h)	(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. **Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members *must* respond to the cost of dispensing survey.** The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.	Yes
Montana Mont. Admin. R. 37.86.1105	(3) The dispensing fee for filling prescriptions is determined for each pharmacy provider annually. (a) The dispensing fee is based on the pharmacy's average cost of filling prescriptions and prescription volume. **The average cost of filling a prescription is based on the direct and indirect costs that can be allocated to the cost of the prescription department and that of filling a prescription, as determined from the Montana Dispensing Fee Questionnaire.** The prescription volume of a provider is determined using the information provided on the annual Montana Dispensing Fee Questionnaire. **If a provider fails to submit a properly completed dispensing fee questionnaire, the provider will receive a dispensing fee in an amount equal to the lowest calculated cost to dispense assigned that year.** A copy of the Montana Dispensing Fee Questionnaire is available upon request from the department. (b) The dispensing fees assigned are as provided in ARM 37.85.105(3). (c) If the individual provider's usual and customary average dispensing fee for filling prescription is less than the foregoing method of determining the dispensing fee, then the lesser dispensing fee is applied in the computation of the payment to the pharmacy provider.	No

State and Code Citation	Full Provision *Emphasis added	Mandatory Language (Y/N)
New Jersey N.J. Admin. Code § 10:51-1.7	(a) The dispensing fee for legend drugs, dispensed by providers having retail permits to beneficiaries other than those in long-term care facilities, including State-operated Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), nursing facilities, and State- and county-operated long-term psychiatric hospitals, is $3.73. **Additional dispensing fees (add-ons) per prescription shall be given to pharmacy providers who provide the following:** . . . .(d) In order to receive any or all of the above increments, the provider shall certify annually to the Division on Form FD–70, that the service(s) as defined in (a) above, are being provided and/or that the provider is entitled to the impact increment as defined in (a) above. . . . . **(e) Failure to submit this report annually shall result in retail pharmacy provider payments based on the basic dispensing fee of $3.73.**	No
Ohio Ohio Admin. Code 5160-9-01	(B) Provider types described in paragraph (A) of this rule are ***required*** **to submit a complete response to the cost of dispensing survey** conducted according to section 5164.752 of the Revised Code. . . . . (2) Providers that do not submit a complete response to the cost of dispensing survey may be paid a lower professional dispensing fee (PDF) in accordance with paragraph (E)(1) of rule 5160-9-05 of the Administrative Code.	Yes
Oklahoma Okla. Admin. Code 317:30-5-78 (c)	(c) Professional dispensing fee. The professional dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. **The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products.** Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.	Yes
Oregon Or. Admin. R. 410-121-0160	(2) **All Division enrolled independent pharmacies shall be required to complete an annual survey that collects claim volumes from enrolled pharmacies and other information from the previous 12-month period to determine the appropriate dispensing fee reimbursement:** . . . . (3) All chain affiliated pharmacies shall be exempt from completing the annual claims volume survey.	Yes
Pennsylvania 55 Pa. Code § 1121.55	(b) The Department will pay a pharmacy for a compensable compounded prescription at the lower of the cost of all ingredients plus a $3 dispensing fee or the provider's usual and customary charge to the general public. For MA recipients with a pharmacy benefit resource which is a primary third party payer to MA, the dispensing fee shall be $0.50.lic.	No
South Dakota S.D. Admin. R. 46:32:01:11	The HSC shall bill each patient for the pharmaceuticals used in the patient's course of treatment. The charge shall be the actual cost of the specific pharmaceutical and a dispensing fee. T**he dispensing fee is based upon the cost of filling the prescription and includes salaries, benefits, operating expenses, travel, contracted services, supplies and materials, grants and subsidies, and capital outlay** in accordance with BFM fixed assets and depreciation policy.	No

State and Code Citation	Full Provision *Emphasis added	Mandatory Language (Y/N)
Texas 1 Tex. Admin. Code § 355.8551 (b)	(b) The Texas Health and Human Services Commission (HHSC) reimburses contracted Medicaid pharmacy providers according to the following formula: Professional Dispensing Fee = (((AC + Fixed Component) divided by (1 - the percentage used to calculate the Variable Component)) - AC) + Delivery Incentive + Preferred Generic Incentive.	No
Virginia 12 Va. Admin. Code 30-80-40	I. Payment for pharmacy services are as described in subsections A through H of this section; however, they shall include the allowed cost of the drug plus only one professional dispensing fee, as defined at 42 CFR 447.502, per member per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The professional dispensing fee for all covered outpatient drugs shall be $10.65. **The professional dispensing fee shall be determined by a cost of dispensing survey conducted at least every five years.**	No
Washington Wash. Admin. Code 182-530-7050	(6) The agency determines a pharmacy's annual total prescription volume as follows: (a) **The agency sends out a prescription volume survey form to pharmacy providers during the first quarter of the calendar year;** (b) Pharmacies return completed prescription volume surveys to the agency each year. **Pharmacy providers not responding to the survey by the specified date are assigned to the high volume category;** (c) Pharmacies must include all prescriptions dispensed from the same physical location in the pharmacy's total prescription count; (d) The agency considers prescriptions dispensed to nursing facility clients as outpatient prescriptions; and (e) Assignment to a new dispensing fee tier is effective on the first of the month, following the date specified by the agency.	No
Wyoming Wyo. Admin. Code 048.0037.10 § 16	(d) Dispensing fee. Except as specified below, the dispensing fee shall be the lower of the provider's usual and customary dispensing fee or the dispensing fee specified in (i) or (ii) below. The dispensing fee shall be adjusted as specified in subsection (f). (i) Physicians. The dispensing fee for physicians who perform pharmacy services shall be two dollars ($2.00) per prescription. (ii) Pharmacies. The dispensing fee for pharmacies shall be ten dollars and sixty-five cents ($10.65) per prescription or compound. (e) Adjustment of dispensing fee. The dispensing fee shall be adjusted pursuant to subsection (f) when necessary to: (i) Enlist enough providers so that pharmaceutical services are available to clients to the extent that those services are available to the general population; and (ii) Ensure that payments are consistent with efficiency, economy, and quality of care. (f) Method of adjusting dispensing fee. The dispensing fee shall be adjusted as follows: **(i) The Department shall conduct a usual and customary survey which may include a review of other insurance payers in-state, and Medicaid pharmacy programs in surrounding areas.**	No