Table of Contents

State Name: Virginia

State Plan Amendment (SPA) #: 16-002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT #051320164036

October 20, 2016

Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Jones:

The Centers for Medicare & Medicaid Services (CMS) has reviewed Virginia's State Plan Amendment (SPA) 16-002, Pharmacy Fee-for Service Reimbursement. This SPA proposes to revise Virginia's pharmacy reimbursement methodology for the Medicaid fee-for-service program from the current methodology to one that meets the drug pricing definition described in the Final Rule that was published in the Federal Register on February 1, 2016. The rules requires States to pay pharmacies based on the drug ingredient cost, defined as the actual acquisition cost (AAC) plus a "professional dispensing fee." Virginia has determined that the weighted average cost of dispensing prescriptions to Virginia Medicaid members is $10.65.

This SPA is acceptable. Therefore, we are approving SPA 16-002 with an effective date of January 9, 2017. Enclosed is the approved SPA page and signed CMS-179 form.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 16 — 002

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

J: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: ~~July 1, 2016~~ 1/9/2017 pen & ink EM 10/6/2016

5. TYPE OF PLAN MATERIAL *(Check One)* September pen & ink EM 6/23/2016

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ -0-
b. FFY 2017 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
EM pen & ink 5/12/16
Attachment 4.19-B, page 7.3 - revised
Attachment 4.19-B, page 7.4, 7.5, and 7.6 - ~~deleted~~ revised
revised EM pen & ink 8/30/2016

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Same pages

10. SUBJECT OF AMENDMENT
Pharmacy Fee-for-Service Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT 2016
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED
Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL
/S/ [redacted]

13. TYPED NAME: Cynthia B. Jones

14. TITLE: Director

15. DATE SUBMITTED: 4/25/16

16. RETURN TO
Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond VA 23219

Attn: Regulatory Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: May 12, 2016

18. DATE APPROVED: October 19, 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 9, 2017

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Francis McCullough

22. TITLE: Associate Regional Administrator

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Save

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

§7. Fee-for-service providers: pharmacy. (12VAC30-80-40)

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

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%; or
c) The Federal Upper Limit (FUL); or
d) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge.

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

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%; or
c) The Federal Upper Limit (FUL); or
d) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge.

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

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%; or
c) The Federal Upper Limit (FUL); or
d) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DMAS shall reimburse at Wholesale Acquisition Cost (WAC) + 0%; or
c) The provider's usual and customary (U & C) charge to the public, as identified by the claim charge.

5. 340B covered entities and Federally Qualified Health Centers (FQHCs) that fill Medicaid member prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Services Act will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee. 340B covered entities that fill Medicaid member prescriptions with drugs not purchased under the Section 340B of the Public Health Services Act will be reimbursed in accordance to section 7.1 plus the $10.65 professional dispensing fee as described in section 7.8.

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

6. Facilities purchasing drugs through the Federal Supply Scheduled (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 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

8. Payment for pharmacy services will be as described above in sections 7.1 - 7.7; however, shall include the allowed cost of the drug plus only one professional dispensing fee, as defined at 42 CFR 447.502, 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 (5) years.

9. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 106 percent of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at the provider's acquisition cost. Covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act for Medicaid members must bill Medicaid their actual acquisition cost (AAC).

10. Payment to Indian Health Service, tribal, and urban Indian pharmacies. DMAS does not have any Indian Health Service, tribal or urban Indian pharmacies enrolled at this time. Payment for pharmacy services will be defined in a state plan amendment if such entity enrolls with DMAS.

11. Investigational drugs are not a covered service under the DMAS pharmacy program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE-
OTHER TYPES OF CARE

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