



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**  
Division of Health Benefits

**ROY COOPER** • Governor  
**MANDY COHEN, MD, MPH** • Secretary  
**DAVE RICHARD** • Deputy Secretary, NC Medicaid

MEMORANDUM

TO: Mandy Cohen, MD, MPH  
Secretary

FROM: Dave Richard <sup>DS</sup>  
*DR*  
Deputy Secretary for NC Medicaid

SUBJECT: State Plan Amendment  
Title XIX, Social Security Act  
Transmittal #2020-0015

DATE: September 3, 2020

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected pages are Attachment 4.19-B, Section 5, Page 1g & Section 12 Pages 1, 1a, 1a.1, 1a.2, 1b.

This amendment aligns reimbursement with the actual system pricing logics, implements a new reimbursement methodology for Indian Health Services/Indian Tribal pharmacy facilities based on the OMB encounter rate and for drug delivery by mail, by courier or by person to person. It also outlines the proposal to enter into value/outcomes-based contracts with manufacturers on a voluntary basis. This change assists the EBCI health system achieve their goals of improving health care and delivery whole person care to their citizens.

This amendment is effective September 1, 2020.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Betty J. Staton at 919-527-7093.

**NC MEDICAID**  
**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH BENEFITS**

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MEDICAL ASSISTANCE  
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

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12. **Covered outpatient prescription drugs, dentures, prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.**

a.

- Legend and Non-legend drugs
- Drugs not Dispensed by a Retail Community Pharmacy, Long Term Care Pharmacy
- Specialty Drugs not Dispensed by a Retail Community Pharmacy and Dispensed Primarily through the Mail
- Payment for Drug Purchased Outside of the 340B Program by Covered Entities

Reimbursement for the above drugs dispensed to covered beneficiaries shall not exceed the federal upper limit defined as the lowest of:

1. The Actual Acquisition Cost (AAC) plus a professional dispensing fee;
2. The provider's usual and customary charge (U&C) to the general public;
3. The provider's gross amount due (GAD), or
4. The amount established by the State of North Carolina to determine the upper payment limit plus a professional dispensing fee.

In compliance with 42 Code of Federal Regulations 447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.

A professional dispensing fee will not be paid for covered outpatient prescriptions drugs refilled in the same month, whether it is the same drug or generic equivalent drug.

For blood clotting factor / hemophilia drugs reimbursement and professional dispensing fee see Section 12, Page 1a.1.

Multiple Source Drugs – North Carolina has implemented a State determined list of multiple source drugs. All drugs on this list are reimbursed at limits set by-the State unless the provider writes in their own handwriting, brand name drug is “medically necessary”.

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12. **Covered outpatient prescription drugs, dentures, prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.**

b. **North Carolina Actual Acquisition Cost (AAC) For Prescribed Drugs:**

Effective January 1, 2016, North Carolina will base brand and generic drug ingredient pricing on the actual acquisition cost (AAC). The National Average Drug Acquisition Cost (NADAC) pricing will be used for AAC when available. If NADAC is unavailable, then the AAC will be defined as Wholesale Acquisition Cost (WAC).

c. **Professional Dispensing Fee:**

The professional dispensing fee is paid to pharmacy providers for the initial dispensing and excludes refills within the same month for the same drug or generic equivalent.

The professional dispensing fee is \$3.98 for non-preferred brand drugs.

For blood clotting factor / hemophilia drugs professional dispensing fees see Section 12, Page 1a.1.

The generic and preferred brand professional dispensing fee will be based on an enrolled pharmacy's preferred brand and generic drugs during the previous quarter, as documented in the Medicaid Management Information System (MMIS). Based on the previous quarterly volume of an enrolled pharmacy, as documented in MMIS, the total number of generics and preferred brands is divided by the total number of prescriptions billed. Preferred brand drugs are brand drugs whose net cost to the State after consideration of all rebates is less than the cost of the generic equivalent.

The generic and preferred brand professional dispensing fee will be as follows:

- 85% or more claims per quarter - \$13.00
- Less than 85% claims per quarter - \$7.88

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d. **Payment for Clotting Factor / Hemophilia Drugs from Specialty Pharmacies, Hemophilia Treatment Centers (HTC), Centers of Excellence or any other pharmacy provider:**

Reimbursement for blood clotting factor / hemophilia drugs purchased through the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:

- 1) The 340B state maximum allowable cost, plus a per unit professional dispensing fee;
- 2) The provider's usual and customary charge (U&C) to the general public or their submitted charge plus a per unit professional dispensing fee, or
- 3) The provider's gross amount due (GAD).

Reimbursement for blood clotting factor / hemophilia drugs purchased outside of the 340B program and dispensed by specialty pharmacies, hemophilia treatment centers (HTC), Centers of Excellence or any other pharmacy provider will be reimbursed at the lesser of the following:

- 1) The state maximum allowable cost, plus a per unit professional dispensing fee;
- 2) The provider's usual and customary charge (U&C) to the general public or their submitted charge plus a per unit professional dispensing fee, or
- 3) The provider's gross amount due (GAD).

The above reimbursement methodology stated in Section 12.d is only applicable to pharmacy claims. For procedure coded professional / medical drug claims see Section 12, Page 1b.

The per unit professional dispensing fee for all units dispensed will be \$.04/unit for HTC pharmacies and \$.025/unit for all other pharmacies.

Blood clotting factor / hemophilia drugs per unit professional dispensing fees shall be established by a blood clotting factor / hemophilia dispensing fee survey.

e. **Payment for 340B Purchased Drugs Dispensed by a Covered Entity, a Contract Pharmacy Under Contract with a 340B Covered Entity, or an Indian Health Service, Tribal or Urban Indian Pharmacy:**

Reimbursement for 340B purchased drugs dispensed by 340B covered entities, contract pharmacies under contract with a 340B covered entity, and Indian health service, tribal, or urban Indian pharmacies will be reimbursed at no more than their 340B acquisition cost plus the professional dispensing fee as defined on Attachment 4.19-B, Section 12, Page 1a, Section c.

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- f. Reimbursement for drugs purchased through the Federal Supply Schedule will be reimbursed no more than the Federal Supply Schedule acquisition cost plus a professional dispensing fee, unless the reimbursement for covered outpatient prescription drugs are made through a bundled charge or all-inclusive encounter rate.
- g. Reimbursement for drugs purchased at Nominal Price (outside of 340B or FSS) will be reimbursed no more than the Nominal Price acquisition cost plus a professional dispensing fee.
- h. Covered outpatient prescription drugs dispensed by Indian Health Services/Tribal Facilities authorized under Public Law 93-638 will be reimbursed at OMB encounter rates. OMB encounter rates will be paid for encounter, as follows:
  - 1. Medicaid covered outpatient prescription drugs are dispensed to IHS eligible individuals (as defined at 42 CFR Section 447.51);
  - 2. Covered outpatient prescription drugs dispensed by I/T facilities as authorized by Public Law 93-638 Agreement (“I/T facilities”) will be reimbursed at the OMB encounter rates;

I/T facilities will receive one OMB encounter payment for each covered outpatient prescription drug filled or refilled; for a maximum of two (2) OMB encounter payments, per beneficiary, per day, per facility.

Non-covered under the OMB encounter rates:

- I. Specialty and high cost outpatient prescription drugs with acquisition costs greater than \$1,000. These covered outpatient prescription drugs will continue to be reimbursed at the lesser of the fee for service unit price or the actual acquisition costs, plus a professional dispensing fee;
  - II. Eyeglasses, prosthetic devices, hearing aids, diabetic testing equipment and supplies;
  - III. Drugs dispensed to beneficiaries assigned to the Health Choice or the Family Planning waiver benefit plans.
  - IV. Covered outpatient prescription drugs dispensed to non-IHS eligible individuals
- 3. Encounter is defined as a prescription, whether the prescription is for a single drug or compound drugs. No more than one OMB encounter rate payment is made per outpatient prescription drug filled whether the prescription is for a single ingredient drug or a compound drug;
  - 4. There will be no limit on the number of prescriptions filled per patient per day by an I/T facility, but an I/T facility will receive no more than two (2) OMB encounter payments per day per patient per facility for prescriptions filled or refilled, and these payments shall constitute payment in full for all covered outpatient prescription drugs dispensed for the patient on that day;

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12. **Covered outpatient prescription drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.**
- h.
5. The applicable encounter rate will be determined by the date of service submitted on the pharmacy claim; date of service is defined as the date the covered outpatient prescribed drug is dispensed.
6. I/T facilities receiving an OMB encounter payment for a covered outpatient prescription drug filled or refilled shall not be eligible to receive professional dispensing fees, delivery fees, ingredient costs and any necessary counseling.
- i. Investigational drugs are not covered.
- j. Reimbursement for drugs delivery by mail, courier or person to person delivery. Delivery payment will be for a single claim, once per day per beneficiary per pharmacy, unless the reimbursement for covered outpatient prescription drugs is made through a bundled charge or all-inclusive encounter rate.
- k. The State may enter into value/outcomes-based contracts with manufacturers on a voluntary basis. The contracts will be executed on the model agreement or contract entitled “Value/Outcome Based Supplemental Rebate Agreement approved by the Center of Medicaid and Medicare Services (CMS). The Value / Outcome Based Supplemental Rebate Agreement would apply to the drug benefits for both the fee-for-service and those paid by contracted managed care organization (MCOs).

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MEDICAL ASSISTANCE  
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12. **Covered outpatient prescription drugs, dentures, prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.**

Physician Administered Drug Program (PADP):

The agency's fee schedule rates for physician administered drugs were set as of January 1, 2015 and are effective for services provided on or after that date.

New physician administered drugs are reimbursed at the Average Sales Price (ASP) plus six percent (6%) to follow Medicare pricing. If there is no ASP value available from Medicare, fees shall be established based on the lower of vendor specific National Drug Code (NDC) Average Wholesale Price (AWP) less ten percent (10%) pricing as determined using lowest generic product NDC, lowest brand product NDC or a reasonable value compared to other physician drugs currently on North Carolina's physician drug program list.

Per approved Section 12, page 1a.1 d. effective April 1, 2017, procedure coded professional or medical drug claims for blood clotting factor / hemophilia drugs shall be reimbursed based on the State Maximum Allowable Cost (SMAC).

Effective July 1, 2017, physician administered vaccines are reimbursed at the Wholesale Acquisition Cost plus three percent (3%).

Effective July 1, 2017, physician administered contraceptive drugs are reimbursed at the Wholesale Acquisition Cost (WAC) plus six percent (6%).

Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers of the physician drug program and the fee schedule and any annual/periodic adjustments to the fee schedules are published on the NC Division of Health Benefits Website.