LOCAL COMMISSIONERS MEMORANDUM

DSS-4037EL (Rev. 9/89)

Transmittal No: 96 LCM-70

Date: August 9, 1996

Division: Health and Long Term Care

TO: Local District Commissioners

SUBJECT: Methodology For Reimbursement Of Pharmacy Services To Federally Qualified Health Centers When Drugs Are Outside The Clinic Rate

ATTACHMENTS: Proposed Changes To Title XIX Medicaid State Plan For New York State

A Public Notice has been filed with the Department of State by the Department of Social Services (Department) pertaining to a change in the way Federally Qualified Health Centers (FQHCs) may be reimbursed for pharmacy services when the pharmacy benefit is removed from the Medical Assistance clinic rate. The public notice was published on August 7, 1996 in the State Register.

Currently the Department pays FQHCs an all-inclusive rate for services provided to Medical Assistance recipients. If a FQHC provides pharmacy services in excess of that which is required by federal law, the State may then take steps to allow the FQHC to be paid on a fee for service basis for such pharmacy services. If the FQHC's all-inclusive rate includes such services, the FQHC could request that the New York State Department of Health remove such pharmacy services from its rate. If the request is granted, the FQHC could then apply to the Department to enroll as a pharmacy provider and be paid on a fee for service basis.

Copies of the proposed changes to the State Plan Amendment are enclosed and should be made available for public review. If you have any questions, please contact Mark Butt at (518) 486-3209.

Martin J. Conroy
Acting Deputy Commissioner
Division of Health and Long Term Care

capital cost component. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Payment rates for renal dialysis services of $150.00 per procedure are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. A single price per visit for day health care services rendered to patients with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses is determined based on reasonable projection of necessary costs and utilization and trended to later rate years. Price components may be adjusted for service capacity, urban or rural location and regional differences. Rates are subject to approval of the Division of the Budget.

If rates set by the State Department of Health for Federally Qualified Health Centers do not include pharmacy services, those services may be reimbursed in accordance with the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

Designated Preferred Primary Care Provider Freestanding Diagnostic and Treatment Centers

Freestanding diagnostic and treatment centers seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health.

Reimbursement for providers designated as preferred primary care providers is prospective and associated with resource use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system.

Under the reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service a rate is established to cover all labor, ancillary services, medical supplies, administrative overhead, general and capital costs. A supplemental capital add-on is available to facilities participating in the preferred primary care program which finance capital acquisitions through public authorities. The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor.

Prescribed Drugs

Reimbursement for pharmacy providers other than Federally Qualified Health Centers is the lowest of 1) the billing pharmacy's usual and customary price charged to the general public, 2) the upper limit if established by the Federal Government for specific multiple source drugs, plus a dispensing fee, or 3) the Estimated Acquisition Cost (EAC) established by State Social Services, plus a dispensing fee. EAC is average wholesale price less ten percent. The dispensing fee for generic prescription drugs is $5.50 per prescription and for brand name prescription drugs is $4.50. The State Social Services' prescription drug pricing service will determine whether a prescription drug is generic or brand name.

Exception: Physician Override: Reimbursement for those brand name drugs for which reimbursement is not to exceed the upper limit for the particular drug established by the Federal Government, will be paid at the lower of EAC, plus a dispensing fee, or at the billing pharmacy's usual and customary price charged to the general public when the prescriber indicates that the brand name drug is required by placing "daw" (dispense as written) in the box located on the prescription form and by writing "brand necessary" or "brand medically necessary" in his/her own handwriting on the face of the prescription.

Compound Drugs: Reimbursement is determined by the Department of Health at the cost of ingredients plus a dispensing fee of $4.50 with an additional amount of $0.75 as the compounding fee.

Federally Qualified Health Centers which provide pharmacy services on a fee for service basis will be reimbursed in accordance with the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Nonprescription Drugs	Reimbursement for pharmacy providers other than Federally Qualified Health Centers is the lowest of 1) the usual and customary price charged to the general public, 2) the price established by the Commissioner of Health as shown on the NYS List of Medicaid Reimbursable Drugs for that generic category and strength in the package size nearest to that ordered; or 3) Acquisition cost plus dispensing fee. Federally Qualified Health Centers which provide pharmacy services on a fee for service basis will be reimbursed in accordance with the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.
Private Duty Nursing	Fees determined by local districts and reviewed by the Department of Social Services.
Physical Therapy	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Occupational Therapy	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Speech Pathology	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Audiology	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Eyeglasses and Other Visual Services	Fee Schedule developed by Department of Health and approved by Division of the Budget.
Hearing Aid Supplies and Services	Fee Schedule developed by Department of Health and approved by Division of the Budget.

Prosthetic and Orthotic Appliances	Payments are limited to the lower of the usual and customary charge to the general public or fee schedule developed by Department of Health and approved by Division of the Budget.
Comprehensive Psychiatric Emergency Programs	Flat fee developed by OHM and approved by the Division of the Budget.