

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

<u>CITATION</u> 42 CFR 447 Subpart D	Medical and Remedial Care and Services Item 12.a.	<u>Prescription drugs, dentures, and prosthetic devices and Eyeglasses</u> <u>Prescribed by a Physician Skilled in Diseases of the Eye, or by an</u> <u>Optometrist.</u>
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Prescribed Drugs are reimbursed as follows:

I. METHODS OF PAYMENT

Maximum and minimum payment rates for medications - pharmacy or dispensing physician are as follows:

A. Maximum Pharmaceutical Price Schedule

The Maximum payment for a prescription shall be no more than the cost of the drug established by the state plus the established dispensing fee.

B. Payment for Medications to Dispensing Physicians/Practitioners

Payment will be made for medications dispensed by a physician or other practitioner (within the scope of practice as prescribed by State Law) on a continuing basis only when his main office is more than five miles from a facility which dispenses drugs.

Under the above circumstances, vendor payment (when the treating prescriber dispenses his own medications and bills the Medicaid Program under his own name or the name of his own clinic or hospital) will be made on the same basis as a pharmacist as specified in Paragraph A. above.

II. STANDARDS FOR PAYMENT

A. Reimbursement will be made for medications following payment procedures for a Medicaid Program enrollee presenting proper identification.

B. The pharmacy must be licensed to operate in Louisiana, except:
1. as provided for a person residing near the state line; or
2. as provided for an enrollee visiting out-of-state.

C. Payment will be made only to providers whose records are subject to audit.

III. REIMBURSEMENT LIMITS

Payments shall be limited to Drugs covered by the Medicaid Program.

STATE <u>Louisiana</u>	
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DATE APP'VD <u>2-8-13</u>	A
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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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CITATION Medical and Remedial
42 CFR Care and Services
447 Subpart D Item 12.a.(Continued)

A. Definitions

340B Program - the federal drug discount program established under Section 340B of the Public Health Service Act and administered by the Office of Pharmacy Affairs within Health Resources and Services Administration.

Average Acquisition Cost (AAC) – the average of payments that pharmacists made to purchase a drug product as determined through the collection and review of pharmacy invoices and other information deemed necessary, in accordance with applicable state and Federal law.

Dispensing Fee - the fee paid by the Medicaid Program to reimburse for the overhead and labor expense incurred by pharmacy providers, such as professional services provided by a pharmacist when dispensing a prescription, including the provider fee assessed for each prescription filled in the state of Louisiana or shipped into the state of Louisiana per legislative mandate.

Estimated Acquisition Cost (EAC) - the Average Acquisition Cost (AAC) of the drug dispensed. If there is not an AAC available, the EAC is equal to the Wholesale Acquisition Cost (WAC), as reported in the drug pricing compendia utilized by the Department's fiscal intermediary.

Multiple Source Drug - a drug marketed or sold by two or more manufacturers or labelers or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name.

Provider Fee - The provider fee is a legislatively mandated fee that is assessed for each prescription filled. The amount of the provider fee is developed by the legislature.

Single Source Drug - a drug marketed or sold by one manufacturer or labeler.

Usual and Customary Charge – a pharmacy's charge to the general public that reflects all advertised savings, discounts, special promotions, or other programs, including membership-based discounts initiated to reduce prices for product costs available to the general public, a special population, or an inclusive category of customers.

Wholesale Acquisition Cost (WAC) – the manufacturer's published catalog price for a drug product to wholesalers as reported to the Department by one or more national compendia on a weekly basis.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION Medical and Remedial
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B. Federal Upper Limits (FUL) for Multiple Source Drugs

1. Except for drugs subject to "Physician Certification", Medicaid shall utilize listings established by CMS that identify and set upper limits for multiple source drugs that meet the following requirements:
 - a. All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the most current edition of their publication, Approved Drug Products with Therapeutic Equivalence Evaluations, including supplements or in-successor publications;
 - b. At least three suppliers list the drug, classified by the FDA as category "A", in published compendia of cost information for drugs available for sale nationally.
2. Medicaid shall utilize the maximum allowable cost established by CMS in determining Multiple Source Drug cost.

C. Other Drug Cost Limits

1. Payments for Multiple Source Drugs not exempted by "physician certification" shall consider:
 - a. Medicaid's Estimated Acquisition Cost plus the established dispensing fee;
 - b. The provider's usual and customary charge to the general public; not to exceed Medicaid's "Maximum Pharmaceutical Price Schedule"; or
 - c. Any applicable Federal Upper Limit for Multiple Source Drugs plus the established dispensing fee.

Average acquisition cost will be determined through a collection and review of pharmacy invoices and other information deemed acceptable by the Department and in accordance with applicable State and Federal law. Other information deemed acceptable includes acquisition cost information provided by the pharmacy in a format other than an invoice, but in an acceptable form such as acquisition cost information from its wholesaler.

In addition to the review, the Department will evaluate the rates on an ongoing basis throughout the year and adjust them as necessary to reflect prevailing market conditions such as drug availability issues (e.g., shortages due to manufacturing or raw materials disruptions). Providers shall be given advance notice of any additions, deletions, or adjustments in price. A complete AAC rate listing will be available on the website to all providers and updated periodically.

The AAC rate will apply to all versions of a drug that share the same active ingredient combination, strength, dosage form, and route of administration. There will be a separate AAC rate for single source and multiple source drugs.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Attachment 4.19-B
Item 12a, Page 4

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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2. Payments for Drugs under the Public Health Service 340B Program

Effective September 5, 2012 and thereafter, payments for drugs obtained through 340B will include the acquisition cost plus a dispensing fee as specified in Section V.

D. Lower of Reimbursement for Single Source Drugs and Multiple Source Drugs

1. The agency shall make payments for Single Source Drugs based on the lower of:

- a. The Medicaid Estimated Acquisition Cost of the drug product, plus the established dispensing fee;
- b. The provider's usual and customary charges to the general public, not to exceed the "Maximum Pharmaceutical Price Schedule."

3. The agency shall make payments for Multiple Source Drugs other than drugs subject to "physician certification" based on the lower of:

- a. Any applicable Medicaid Estimated Acquisition Cost limit, plus the established dispensing fee;
- b. Any applicable Federal Upper Limit for multiple source drugs, plus the established dispensing fee;
- c. The provider's usual and customary charges to the general public, not to exceed the "Maximum Pharmaceutical Price Schedule."

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
 MEDICAL ASSISTANCE PROGRAM
 STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION Medical and Remedial
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E. Physician Certifications

Limits on payments for multiple source drugs shall not be applicable when the prescriber certifies in his own handwriting that a specified brand name drug is medically necessary for the care and treatment of a recipient. Such certification shall be written directly on the prescription or on a separate sheet which is attached to the prescription. The wording of the certification should testify to the medical necessity of the brand name drug by stating either “brand medically necessary” or “brand necessary”.

Any practice which precludes the prescriber’s handwritten statement shall not be accepted as valid certification. Such practices include, but are not limited to:

1. A printed box on the prescription blank that could be checked by the prescriber to indicate brand necessity.
2. A handwritten statement transferred to a rubber stamp and then stamped on the prescription blank.
3. Preprinted prescription forms using a facsimile of the prescriber’s handwritten statement.

F. Effective for dates of service on and after January 1, 2011, influenza vaccines shall be reimbursed at the following rates or billed charges, whichever is the lesser amount:

<u>Vaccine</u>	<u>Vaccine Reimbursement</u>
Influenza Vaccine, Preservative Free, IM	\$17.37
Influenza Vaccine, IM	\$13.22
Influenza Vaccine. Intranasal	\$22.03

IV. GENERAL REQUIREMENTS APPLICABLE TO ALL PRESCRIPTIONS

- A. For all prescriptions, the maximum quantity payable shall be a month’s supply or 100 unit doses, whichever is greater. The quantity billed shall be that prescribed, unless it exceeds the maximum quantity payable. In such cases, the maximum quantity payable shall be filled.
- B. When maintenance drugs are prescribed and dispensed for chronic illness, they shall be in quantities sufficient to effect economy in dispensing and yet be medically sound. Listed below are drugs considered maintenance type drugs and which should be prescribed and dispensed in a month’s supply:

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<u>CITATION</u> 42 CFR 447 Subpart D	Medical and Remedial Care and Services Item 12.a.(Continued)		
Anti-coagulants	Cardiovascular Drugs including:	Ferrous Sulfate	
Anti-convulsants	Diuretics	Folic Acid	
Anti-diabetics (Oral)	Antihypertensives	Nicotinic Acid	
Calcium Gluconate	Antihyperlipidemics	Potassium Supplements	
Calcium Lactate	Estrogens	Thyroid & Anti-thyroid drugs	
Calcium Phosphate	Ferrous Gluconate	Vitamin A, D, K, & B12 injection	

- C. For patients in nursing homes, the pharmacist shall bill for a minimum of a month's supply of medication unless the treating physician specifies a smaller quantity for a special medical reason.
- D. Payment will not be made for narcotics prescribed only for narcotic addiction.
- E. Enrollees shall have free choice of pharmacy unless subject to the agency's "lock-in" procedures.
- F. Vendor payments will not be made for medications which are included under another service (In-patient Hospital, LTC, etc.). The provisions applicable to such service plans shall apply during the time the service is provided.
- G. Payment will be made for prescriptions refilled for drugs other than controlled substances not more than eleven times or more than 1 year after issue date and only to the extent indicated by the prescriber on the original prescription, and is restricted by state and federal statutes. Payment will be made for prescriptions refilled for controlled substances in Schedule III, IV & V not more than five times or more than six months after issue date and only to the extent indicated by the prescriber on the original prescription, and is restricted by state and federal statutes. The prescriber is required to state on the prescription the number of times it may be refilled.
- H. Prescriptions for drugs other than controlled substances covered under the Medicaid Program shall expire one year after the date prescribed by a physician or other prescribing practitioner. A prescription for a controlled dangerous substance in Schedule II, III, IV, or V shall expire six months after the date written. Expired prescriptions shall not be refillable or renewable. Transfer of a prescription for drugs other than controlled substances from one pharmacy to another is allowed if less than one year has passed since the date prescribed. Transfer of a prescription for controlled substance in schedule III, IV & V from one pharmacy to another is allowed if less than six months has passed since the date prescribed, and transfer of prescription for controlled substance in Schedule II are not allowed. These transfers are allowed in accordance with the Louisiana Board of Pharmacy Regulations.
- I. A prescriber who has a sub office in an area more than five miles from a pharmacy or other facility dispensing medications shall not be paid for medication dispensed, if the main office is within five miles of a pharmacy or other facility dispensing medications.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1902(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

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447 Subpart D Item 12.a.(Continued)

- J. When a prescriber bills Medicaid for medications dispensed, he shall certify that he himself, another authorized prescriber, or pharmacist dispensed the medications and he shall maintain the same records as required of an enrolled pharmacy provider.

- K. The manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is purchased by a provider. Drug products supplied through repackaging into smaller quantities by chain drug store central purchasing shall be billed by the dispensing pharmacy using the manufacturer number, product number, and package size number of the package sized purchased by the central purchasing unit. If the package size is larger than the largest size listed by the Medicaid Program, then the package size billed shall be the largest size listed in the American Druggist Blue Book or other national compendia used by the state to update the Medicaid Management Information System. In instances where drugs are supplied in smaller quantities by a manufacturer or third party package size billed shall be the largest size listed in the American Druggist Blue Book or other national compendia utilized to update the Medicaid Management Information System (MMIS).

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<u>CITATION</u>	Medical and Remedial	<u>Prescription drugs, dentures, and prosthetic devices and Eyeglasses</u>
42 CFR	Care and Services	<u>Prescribed by a Physician Skilled in Diseases of the Eye, or by an</u>
447	Item 12.a.	<u>Optometrist.</u>
Subpart D		

V. DISPENSING FEE

A. Establishment of Dispensing Fee

The dispensing fee shall be set by the Department and reviewed periodically for reasonableness and, when deemed appropriate by the Medicaid Program, may be adjusted considering such factors as fee studies or surveys.

Provider participation in the Louisiana Dispensing Fee Survey shall be mandatory. Failure to cooperate in the Louisiana Dispensing Fee Survey by a provider shall result in 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 dispensing fee survey document is properly completed and submitted to the Department.

B. Dispensing Fees

1. The dispensing fee for drugs dispensed to Louisiana Medicaid enrollees will be up to \$10.51 per prescription. This includes the provider fee assessed for each prescription filled in the state or shipped into the state, per legislative mandate.
2. The dispensing fee for drugs dispensed to Louisiana Medicaid enrollees and obtained through the Public Health Service 340B Program will be up to \$10.51 per prescription. This includes the provider fee assessed for each prescription filled in the state or shipped into the state.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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C. Parameters and Limitations

No downward adjustment in the dispensing fee shall be made in violation of 42 CFR 447 Subpart I.

D. Interim Changes to Dispensing Fees

Dispensing fee adjustment may be made when the event causing the adjustment is not one that would be reflected in fee studies or surveys. This would normally be a change in service requirements.

VI. PARENTERAL NUTRITION THERAPY

- A. Reimbursement for Parenteral Nutrition Therapy (TPN) formula is 80 percent of the Medicare Fee Schedule amount or billed charges, whichever is the lesser amount.
- B. Reimbursement for TPN supplies is 70 percent of the Medicare Fee Schedule amount or billed charges, whichever is the lesser amount.
- C. Reimbursement for TPN infusion pumps is 70 percent of the Medicare Fee Schedule amount or billed charges, whichever is the lesser amount.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

CITATION
42 CFR 447
Subpart D

MEDICAL AND REMEDIAL CARE AND SERVICES
Item 12.a. (cont'd.)

FCC is the fixed cost component which does not include prescription drug inventory. ROEF is the return on equity factor of 1.05 applied to all cost components except return on investment which is calculated separately.

After formal adoption of the first maximum allowable overhead cost limit, based upon the most recent overhead cost survey, the components computed above will become the base components used in calculating the next year's overhead maximum allowable effective for July 1, unless they are adjusted as provided in E below.

Parameters And Limitations

All calculations described herein shall be carried out algebraically. In all calculations the base maximum allowable and the base components will be rounded to the nearest one (1) cent (no less than two decimal places) and the Economic Adjustment Factors will be rounded to no less than four (4) decimal places. No downward adjustment in the maximum allowable overhead rate shall be made in violation of §1927(f)(1)(B).

The dispensing fee in effect and protected during the mandatory moratorium period shall be the lowest maximum allowable overhead rate which may be established by the Bureau of Health Services Financing during the moratorium period.

Cost Survey

Every three years a cost survey shall be conducted which includes cost data for all enrolled pharmacy providers. Participation shall be mandatory for continued enrollment as a provider. Cost data from providers who have less than 12 months of operating data shall not be utilized in determining average overhead cost or grouping providers by prescription volume. Predesk reviews shall be performed on all cost surveys to determine an average provider profile based upon total prescription volume. Through statistical analysis, minimum and maximum volume ranges shall be established which represent the majority of providers participating in Medicaid reimbursement. Cost data from providers whose prescription volume is above or below the volume range established shall not be utilized in calculating average overhead cost.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

CITATION MEDICAL AND REMEDIAL CARE AND SERVICES
42 CFR 447 Item 12.a. (Contd.)
Subpart D

Information submitted by participants shall be desk reviewed for accuracy and completeness. Field examination of a representative sample of participants shall be primarily random, but geographic location and type of operation shall be taken into consideration in order to ensure examination of pharmacies in various areas of the state and representative of various types of operations.

1. Cost Finding Procedures

The basic analytical rationale used for cost finding procedures shall be that of full costing. Under full costing, all costs associated with a particular operation are summed to find the total cost. The objective of cost finding shall be to estimate the cost of dispensing prescriptions through generally accepted accounting principals (GAAP).

2. Inflation Adjustment

Where data collected from participating pharmacies represents varying periods of time, cost and price data may be adjusted for the inflation that occurred over the relevant period. The appropriate Consumer Price Index indicator (Table 12, Southern Region, Urban Consumer) and wage indicator produced by the U.S. Department of Labor Statistics shall be utilized.

3. In addition to cost finding procedures, a usual and customary survey shall be included in the survey instrument. This instrument shall be used to determine the following:

- (a) An average usual and customary charge, or gross margin for each pharmacy.
- (b) The computation of the net margin per prescription (gross margin less computed dispensing cost per prescription) in order to approximate the average profit per prescription.
- (c) Computation of the average percentage of markup per prescription.
- (d) The computation of average usual and customary charges shall include adjustments to allow comparability with upper limits for prescription reimbursement utilized by the Bureau of Health Services Financing.

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Louisiana	OCT 03 1995	NOV 27 1995	JUL 07 1995	

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

CITATION MEDICAL AND REMEDIAL CARE AND SERVICES
42 CFR 447 Item 12.a. (Contd.)
Subpart D

4. Statistical Analysis

Statistical analysis shall be undertaken to estimate the cost to pharmacies of dispensing prescriptions. Such analysis shall include, but not be limited to:

- (a) An average dispensing cost of pharmacies.
- (b) Analysis of the correlations among overhead costs and parameters deemed relevant to pharmacy cost.
- (c) The statistical relationship between independent variables and the cost to dispense prescriptions shall be analyzed using the techniques of simple linear and stepwise regression. Independent variables may include annual volume of prescriptions filled, pharmacy location, type of ownership, and number of Medicaid claims paid.

Survey Results

The Bureau of Health Service Financing shall consider survey results in determining whether the maximum allowable overhead cost should be rebased. Where the overhead cost survey findings demonstrate the current maximum allowable is below average cost or above the 80th percentile of cost, rebasing shall be required. The Bureau may review the survey data and establish a new overhead cost utilizing the cost survey findings and any other pertinent factors, including but not limited to: inflation adjustment; application of return on equity; recognition of inventory investment; etc.

E. Interim Adjustment to Overhead Cost

If an unanticipated change in conditions occurs which affects the overhead costs of at least fifty percent(50%) of the enrolled provider by an average of five (5%) per cent or more, the maximum allowable overhead cost may be adjusted. The Bureau determine whether or not the maximum allowable overhead cost limit should be changed when requested to do so by at least ten (10%) per cent of the enrolled pharmacies. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. The Bureau, however, may initiate an adjustment without a request to do so. Changes to overhead cost may be one of two types:

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ENSURING PAYMENT RATES

CITATION MEDICAL AND REMEDIAL CARE AND SERVICES
42 CFR 447 Item 12.a. (cont'd.)
Subpart D

1. Temporary Adjustments

Temporary adjustments do not affect the base cost used to calculate a new maximum allowable overhead cost limit. Temporary adjustments may be made in the rate when changes which will eventually be reflected in the Economic Indices, such as a change in the minimum wage, occur after the end of the period covered by the index, i.e., after the December preceding the limit calculation. Temporary adjustments are effective only until the next overhead cost limit calculation which uses Economic Adjustment Factors based on index values computed after the change causing the adjustment.

2. Base Rate Adjustments

Base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the Indices. This would normally be a change in service requirements. Base rate adjustment will result in a new base rate component value(s) which will be used to calculate the maximum allowable overhead cost for the next year.

F. Effective July 1, 1995 and thereafter, the Maximum Allowable Overhead Cost will remain at the level established for state fiscal year 1994-95.

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