WAC 182-530-7000 Reimbursement. (1) The medicaid agency's reimbursement for a prescription drug dispensed through point-of-sale (POS) must not exceed the lesser of actual acquisition cost (AAC) plus a professional dispensing fee or the provider's usual and customary charge.

(2) The agency selects the sources for pricing information used to set AAC.

(3) The AAC is calculated as the lowest of:

(a) National average drug acquisition cost (NADAC);

(b) Maximum allowable cost (MAC);

(c) Federal upper limit (FUL);

(d) 340B MAC for covered outpatient drugs purchased, dispensed, or administered under section 340B of the Public Health Service (PHS) Act (see WAC 182-530-7900 for exceptions); or

(e) Submitted ingredient cost.

(4) Where NADAC does not exist, other available reference prices from national sources such as wholesale acquisition cost, or average manufacturer price may be used as the basis of the reimbursement.

(5) Where NADAC does not accurately reflect the actual acquisition costs in Washington state, a percentage adjustment to NADAC will be made to the reimbursement.

(6) The agency may set AAC for specified drugs, drug categories, or providers at a maximum allowable cost other than that determined in subsection (2) of this section based on specific product acquisition costs. The agency considers product acquisition costs in setting a rate for a drug or a class of drugs.

(7) The agency bases AAC drug reimbursement on the actual package size dispensed.

(8) The agency reimburses a pharmacy for the least costly dosage form of a drug within the same route of administration, unless the prescriber has designated a medically necessary specific dosage form or the agency has selected the more expensive dosage form as a preferred drug.

(9) If the pharmacy provider offers a discount, rebate, promotion, or other incentive which directly relates to the reduction of the price of a prescription to the individual nonmedicaid customer, the provider must similarly reduce its charge to the agency for the prescription.

(10) If the pharmacy provider gives an otherwise covered product for free to the general public, the pharmacy must not submit a claim to the agency.

(11) The agency does not reimburse for:

(a) Prescriptions written on presigned prescription blanks filled out by nursing facility operators or pharmacists;

(b) Prescriptions without the date of the original order;

(c) Drugs used to replace those taken from a nursing facility emergency kit;

(d) Drugs used to replace a physician's stock supply;

(e) Outpatient drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:

(i) Diagnosis-related group (DRG);

(ii) Ratio of costs-to-charges (RCC);

(iii) Nursing facility daily rates;

(iv) Managed care capitation rates;

(v) Block grants; or

(vi) Drugs prescribed for clients who are on the agency's hospice program when the drugs are related to the client's terminal illness and related condition.

(f) Hemophilia and von Willebrand related products shipped to clients for administration in the home unless the products are provided through a qualified hemophilia treatment center of excellence (COE) as defined in WAC 182-531-1625.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 24-08-061, § 182-530-7000, filed 3/29/24, effective 5/1/24; WSR 17-07-001, § 182-530-7000, filed 3/1/17, effective 4/1/17. Statutory Authority: RCW 41.05.021. WSR 12-16-061, § 182-530-7000, filed 7/30/12, effective 11/1/12. WSR 11-14-075, recodified as § 182-530-7000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 07-20-049, § 388-530-7000, filed 9/26/07, effective 11/1/07.]