



Center for Medicaid and CHIP Services

Disabled and Elderly Health Programs Group

August 23, 2017

Cynthia E. Beane, MSW, LCSW
Commissioner
Bureau for Medical Services
350 Capitol Street Room 251
Charleston, West Virginia 25301-3706

Dear Commissioner Beane:

We have reviewed West Virginia's State Plan Amendment (SPA) 17-001 received in the Philadelphia Regional Office on June 1, 2017. This SPA proposes changes to comply with requirements of the Covered Outpatient Drug final rule with comment period (CMS-2345-FC).

The SPA proposes reimbursing a professional dispensing fee of \$10.49 plus the lowest of either the National Average Drug Acquisition Cost (NADAC), Wholesale Acquisition Cost (WAC), Federal Upper Limit (FUL), State Maximum Allowable Cost (SMAC), submitted ingredient cost, or the provider's usual and customary charge. The SPA also includes approved methodologies for how the state will reimburse for 340B drugs, physician administered drugs, clotting factor, federal supply schedule and drugs purchased at nominal price.

Please note that accompanying this approval of SPA 17-001 is a companion letter regarding the need for West Virginia to address issues related to the reimbursement of preventive services and rehabilitative services.

Based on the information provided and consistent with the regulations at 42 CFR 430.20, we are pleased to inform you that SPA 17-001 is approved with an effective date of April 08, 2017. A copy of the revised signed CMS-179 form, as well as the pages approved for incorporation into West Virginia's state plan will be forwarded by the Philadelphia Regional Office.

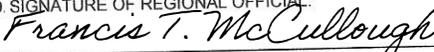
If you have any questions regarding this amendment, please contact Yolonda Williams at (410) 786-6618 or yolonda.williams@cms.hhs.gov.

Sincerely,

/s/

Meagan T. Khau
Deputy Director
Division of Pharmacy

CC: Francis T. McCullough, ARA, CMS, Philadelphia Regional Office
Vicki Cunningham, West Virginia Health and Social Services

<p align="center">TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION</p>		1. TRANSMITTAL NUMBER: 1 7 - 0 0 1	2. STATE: West Virginia
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 04-08-2017	
5. TYPE OF PLAN MATERIAL (Check One)			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 C.F.R 447.500 - 447.522		7. FEDERAL BUDGET IMPACT: a. FFY 2017 \$ 0 b. FFY 2018 \$ -24,400	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachmentbt 4.19-B, pages 8, 9, 9a, 10, 9b		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable). Attachmentbt 4.19-B, pages 8, 9, 9a, 10, 9b	
10. SUBJECT OF AMENDMENT: PAYMENT FOR PRESCRIPTION DRUGS			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input checked="" type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Bureau for Medical Services 350 Capitol Street Room 251 Charleston West Virginia 25301	
13. TYPED NAME: Cindy E. Beane, MSW			
14. TITLE: Commissioner, WV BMS			
15. DATE SUBMITTED: 8/21/2017			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED June 1, 2017		18. DATE APPROVED August 23, 2017	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 8, 2017		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Francis McCullough		22. TITLE Associate Regional Administrator	
23. REMARKS:			

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

c. Services for Individuals with Speech Hearing and Language Disorders
 Reimbursement for speech therapy is based on an:

Upper limit established using a resource-based relative value for the procedure times a conversion factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lesser of the upper limit or the providers customary charge for the service to the general public. Reimbursement for school-based speech therapy services is based on the Medicaid fee-for-service rate and apportioned based on a 15 minute unit of service. The rate assigned to the speech school-based 15 minute billing unit is one quarter of the total fee-for service rate calculated under the resource-based relative value scale.

The agency's fees were updated January 1, 2010 and are effective for services on or after that date Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private individual practitioners, and the fee schedule and any annual/periodic adjustments to the fee schedule are published in www.wvdhhr.org/bms.

Hearing Aids, Supplies and Repairs

Hearing aids and supplies are reimbursed at cost invoice plus 40%. Hearing Aid batteries are reimbursed at 80% of the Medicare fee schedule. Reimbursement for cost of repairs will be based upon an unaltered cost invoice.

If Medicare fees are available, reimbursement will be made at 80% of the fee schedule, otherwise, cost invoice plus 40%.

Cochlear Implants

Reimbursement for the cochlear implants, replacement processors and supplies are based on 80% of the Medicare fee schedule. Reimbursement for cost of processor repairs shall be based upon an unaltered cost invoice.

Augmentative/Alternative Communication Devices

Augmentative/Alternative Communication Devices: Reimbursement is based on 80% of the Medicare fee schedule. Reimbursement for cost of repairs shall be based upon an unaltered cost invoice. Reimbursement for services without a specific code or fee shall be based upon an unaltered cost invoice.

12. a. Prescribed Drugs

Professional Dispensing Fee=\$10.49 per prescription
 Reimbursement for covered outpatient drugs is based on the following methodology:

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Supersedes:	09-04				

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

- A. Brand Name (single source) and Generic (multiple source) Drugs**
Reimbursement for brand and generic drugs shall be the lower of:
1. NADAC plus the professional dispensing fee
 2. If no NADAC is available, then WAC + 0% plus the professional dispensing
 3. The Federal Upper Limit (FUL) as supplied by CMS plus the professional dispensing fee
 4. The State Maximum Allowable Cost (SMAC) plus the professional dispensing fee
 5. The submitted ingredient cost plus the professional dispensing fee
 6. The provider's usual and customary charges to the general public, including any sale price which may be in effect on the date of dispensing
- B. 340B Purchased Drugs-Drugs purchased by covered entities described in section 1927 (a)(5)(B) (340B covered entity pharmacies) shall be reimbursed at the lower of:**
1. AAC, which shall not exceed the 340B ceiling price, plus the professional dispensing fee.
- C. Drug Purchased outside of the 340B Program by covered entities-Drugs purchased outside of the 340B Program by covered entities shall be reimbursed at the lower of:**
1. NADAC plus the professional dispensing fee.
 2. If no NADAC is available, then WAC + 0% plus the professional dispensing fee
 3. The Federal Upper Limit (FUL) plus the professional dispensing fee
 4. Maximum Allowable Cost (SMAC) plus the professional dispensing fee
 5. The submitted ingredient cost plus the professional dispensing fee
 6. The provider's usual and customary charges to the public, including any sale price which may be in effect at the time
- D. Drugs dispensed by 340B Contract Pharmacies:**
 Drugs acquired through the 340B program and dispensed by 340B contract pharmacies are not covered.
- E. Drugs acquired via the Federal Supply Schedule**
 Facilities purchasing drugs through the Federal Supply Schedule (FSS) will be reimbursed no more than their actual acquisition cost, plus the professional dispensing fee.
- F. Drugs acquired at Nominal Price-(outside of 340B or FSS)**
 Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) shall be reimbursed by their actual acquisition cost plus the professional dispensing fee.

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PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

G. Specialty Drugs

Specialty drugs not dispensed by a retail community pharmacy and dispensed primarily through the mail will be reimbursed at the lower of:

1. NADAC plus the professional dispensing fee
2. If no NADAC is available, then WAC + 0% plus the professional dispensing fee
3. The Federal Upper Limit as provided by CMS plus the professional dispensing fee
4. The State Maximum Allowable Cost (SMAC) plus the professional dispensing fee
5. The submitted ingredient cost plus the professional dispensing fee
6. The provider's usual and customary charges to the public, including any sale price which may be in effect at the time

H. Drugs Not Dispensed by a retail community pharmacy

Drugs not dispensed by a retail community pharmacy (long term care or institutional pharmacy when not included as part of an inpatient stay) will be reimbursed at the lower of:

1. NADAC plus the professional dispensing fee.
2. If no NADAC is available, then WAC + 0% plus the professional dispensing fee
3. Federal Upper Limit as provided by CMS plus the professional dispensing fee
4. The State Maximum Allowable Cost (SMAC) plus the professional dispensing fee
5. The submitted ingredient cost plus the professional dispensing fee
6. The provider's usual and customary charges to the public, including any sale price which may be in effect at the time

A one-time monthly dispensing fee per drug will apply to maintenance drugs dispensed in long term care or other institutions.

I. Physician Administered Drugs

Drugs that have a Healthcare Common Procedure Code System (HCPCS) code will be reimbursed at:

1. The Medicare reference price file, 106% of the Average Sales Price (ASP) or
2. In the absence of a fee on the Medicare reference price, the drug will be priced at WAC
3. Covered entities using drugs purchased under the 340B Program for Medicaid members must bill no more than their actual acquisition cost (AAC).

J. Clotting Factor

Clotting Factor from specialty pharmacies, hemophilia treatment centers and Centers of Excellence will be reimbursed at:

1. Wholesale Acquisition Cost (WAC) plus 0% plus the professional dispensing fee of \$10.49

K. Investigational Drugs:

Investigational drugs are not covered by West Virginia Medicaid.

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PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

L. Compounded Prescriptions

Payment for legend ingredients will be based on the lower of NADAC, or WAC +0% if NADAC is not available, FUL, SMAC, submitted ingredient cost or Usual & Customary charges to the public, including any sale price which may be in effect at the same time plus the dispensing fee. A fee of \$6.00 will be added to the dispensing fee for extra compounding time required by the pharmacist. The \$6.00 compounding fee does not apply to the Usual and Customary reimbursement.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: West Virginia

Attachment 4.19-B

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PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12. b. Dentures
 Payment for dentures is included in item 10.
1. Prosthetic Devices
 Payment is based on the upper limit established for the service by Medicare.
2. Eyeglasses
 Payment will not exceed an upper limit established considering cost information from national sources; i.e., Optometry Today and Review of Optometry; a survey of practitioners in the State; and the upper limits established by Medicare adjusted to reflect complexity of material.
- An upper limit is established for each lens code. The upper limit for frame is wholesale cost up to \$40.00 multiplied by a factor 2.5. Payment for low vision aids may not exceed invoice cost plus 30 percent.
- Reimbursement may not exceed the provider's customary charge for the service for the general public.
13. c. Preventive Services
 Disease State Management
1. The state developed fee schedule rates are the same for both public and private providers of these 1905(a) services. The fee schedule and any annual/period adjustments to the fee schedule are published.
- d. Rehabilitative Services
 Behavioral Health Services
1. Reimbursement to those agencies licensed as behavioral

(continued next page)

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