Ohio Administrative Code

Rule 5160-9-05 Pharmacy services: payment for prescribed drugs.

Effective: February 16, 2024

(A) Payment for prescribed drugs is the lesser of the provider's billed charges or the calculated allowable, after any coordination of benefits is applied as described in paragraph (E) of this rule. For prescribed drugs that are subject to a co-payment, the amount paid by the Ohio department of medicaid (ODM) is decreased by the amount equal to the co-payment billed to the recipient in accordance with rules 5160-1-09 and 5160-9-09 of the Administrative Code.

(B) The ingredient cost portion of the calculated allowable is determined in accordance with the following criteria:

(1) No ingredient cost is allowed for a pandemic vaccine or any other medication, provided by the Ohio department of health or other government entity at no cost to the provider.

(2) For any drug purchased under the 340B program, the ingredient cost is the lesser of submitted ingredient cost or the 340B ceiling price. If the 340B ceiling price is not available, the ingredient cost is the lesser of the submitted ingredient cost or fifty per cent of wholesale acquisition cost (WAC) If WAC is not available, the ingredient cost is the lesser of submitted ingredient cost or Ohio average acquisition cost (OAAC).

(3) For a clotting factor, the ingredient cost is the lesser of submitted ingredient cost or the payment limit shown in the current medicare part B drug pricing file, minus the furnishing fee assigned by medicare part B. The medicare part B pricing file is available at https://www.cms.gov.

(4) For all other ingredients not captured in paragraphs (B)(1) to (B)(3) of this rule the ingredient cost is the lesser of submitted ingredient cost or national average drug acquisition cost (NADAC). If the centers for medicare and medicaid services (CMS) has not published a NADAC for the ingredient for the date of service, the ingredient cost is the lesser of submitted ingredient cost, OAAC, or WAC.

(C) The administration fee portion of the calculated allowable for a vaccine, except for a vaccine for COVID-19, or other injectable drug administered at the pharmacy is nineteen dollars thirty-five cents. The administration fee for a vaccine for COVID-19 equals the medicare rate.

(D) The professional dispensing fee (PDF) portion of the calculated allowable is determined in accordance with the following criteria:

(1) The PDF to a provider for dispensing a non-compounded drug is assigned on the total number of prescriptions filled by the provider during the provider's last completed fiscal year prior to completing the required cost of dispensing survey and reported on the survey. The PDF is assigned in accordance with the following criteria:

(a) PDF payment amounts for dates of service prior to January 1, 2024:

(i) For providers reporting fewer than fifty thousand prescriptions, thirteen dollars and sixty-four cents.

(ii) For providers reporting between fifty thousand and seventy-four thousand nine hundred ninety-nine prescriptions, ten dollars and eighty cents.

(iii) For providers reporting between seventy-five thousand and ninety-nine thousand nine hundred ninety-nine prescriptions, nine dollars and fifty-one cents.

(iv) For providers reporting one hundred thousand or more prescriptions, eight dollars and thirty cents.

(v) For a provider who failed to submit a complete response to the required cost of dispensing fee survey for the previous reporting period, eight dollars and thirty cents.

(vi) For providers newly enrolled as medicaid providers as described in rule 5160-9-06 of the Administrative Code, the PDF is as follows:

(A) For a new provider located in Ohio, the provider is assigned a PDF of thirteen dollars and sixty-

four cents.

(B) For a new provider located outside of Ohio, the provider is assigned a PDF of eight dollars and thirty cents.

(b) PDF payment amounts for dates of service on or after January 1, 2024:

(i) For providers reporting fewer than fifty thousand prescriptions, fifteen dollars and forty-seven cents.

(ii) For providers reporting between fifty thousand and seventy-four thousand nine hundred ninety-nine prescriptions, eleven dollars and forty cents.

(iii) For providers reporting between seventy-five thousand and ninety-nine thousand nine hundred ninety-nine prescriptions, nine dollars and fifty-one cents.

(iv) For providers reporting one hundred thousand prescriptions or greater, eight dollars and thirty cents.

(v) For providers newly enrolled as medicaid providers as described in rule 5160-9-06 of the Administrative Code, the PDF is as follows:

(A) For a new provider located in Ohio, the provider is assigned a PDF of fifteen dollars and forty-seven cents.

(B) For a new provider located outside of Ohio, the provider is assigned a PDF of eight dollars and thirty cents.

(2) The PDF paid to a provider for dispensing compounded drugs is paid in accordance with the following criteria:

(a) The PDF for claims for dispensing total parenteral nutrition (TPN) is fifteen dollars per one-day supply on the claim, with a maximum total PDF of one hundred fifty dollars for the claim. To qualify

for the TPN PDF, the TPN compound must be mixed by the pharmacy to the final form under sterile conditions. If the products are mixed or activated at the point of administration by connecting components or breaking seals without the need for sterile conditions, the dispensing does not qualify for payment of the compounded PDF.

(b) The PDF for dispensing sterile compounds, other than TPN, that are required to be sterile for a route of administration including inhaled, infused, instilled, implanted or injected, is ten dollars per day's supply,a maximum of seventy dollars for the claim. To qualify for payment of the sterile compound PDF, the sterile compound must be mixed by the pharmacy to the final form under sterile conditions. Products mixed or activated at the point of administration by connecting components or breaking seals without the need for sterile conditions are not eligible for a sterile compound PDF.

(c) Compounded drugs that are not eligible for the TPN or sterile compound PDF will receive the PDF determined under paragraph (D) of this rule.

(3) Vaccine or injectable drug dispensing that qualifies for payment of an administration fee does not qualify for medicaid payment of a PDF.

(4) Notwithstanding paragraph (D)(1) of this rule, prescribed drugs, other than compounded drugs, dispensed to recipients residing in long term care facilities (LTCFs) are limited to one PDF per patient, per equivalent product, per month . If multiple supplies of an equivalent product are dispensed within the same month, only the ingredient cost will be paid. Exceptions to the one PDF per recipient, per product rule are:

(a) The prescriber ordered a second round of medication for an acute condition within the month.

(b) The prescriber changed the dosage.

(c) The drug was compromised by accident, including but not limited to being contaminated or destroyed.

(E) Coordination of benefits.

(1) Claims for medicare part B cost sharing as described in rule 5160-1-05 of the Administrative Code are submitted using the medical claim format and are not payable under this chapter.

(2) No payment will be made under this chapter for any drug that may be covered by medicare part D for an recipient who is eligible for coverage by medicare part D, regardless of whether the recipient is actually enrolled in a part D plan or the particular drug is covered by the recipient's part D plan.

(3) Cost-sharing for claims involving neither medicare part B nor medicare part D is determined in accordance with rule 5160-1-08 of the Administrative Code.