

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
Medical Assistance Program

State/Territory: OREGON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL  
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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LIMITATIONS ON SERVICES (Cont.)

12.a. Prescribed Drugs

**Rebate Agreement:**

The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of manufacturers participating in the Medicaid Drug Rebate Program. The state has the following policies for drug rebate agreements:

- Manufacturers are allowed to audit utilization rates;
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D);
- The state is in compliance with reporting requirements for utilization and restrictions to coverage;
- All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement;
- Funds received from supplemental rebates will be reported to CMS;
- The state will remit the federal portion of any supplemental rebates collected at the same percentage basis as applied under the national rebate agreement.

**Supplemental Rebate Agreement:**

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX under the national rebate program. Supplemental rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates received under the national rebate program.

CMS has authorized Oregon to enter into "The Sovereign States Drug Consortium (SSDC)" Medicaid Multi-State purchasing pool in relation to supplemental rebates.

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LIMITATIONS ON SERVICES (Cont.)

12.a. Prescribed Drugs

**Supplemental Rebate Agreement (Cont):**

The Centers for Medicare and Medicaid Services (CMS) has authorized a rebate agreement between the state and a drug manufacturer that provides supplemental rebates for drugs provided to the Oregon Medicaid program as follows:

- A supplemental rebate agreement submitted to CMS on 6/19/2003 and entitled, "State of Oregon, Supplemental Rebate Agreement" has been authorized by CMS.
- A supplemental rebate agreement submitted to CMS on 7/15/09, amended the 6/19/03 version of the "State of Oregon, Supplemental Rebate Agreement" under Transmittal 03-02, has been authorized by CMS.
- A supplemental rebate agreement submitted to CMS on 8/2/10 amended the 7/15/09 version of the "State of Oregon, Supplemental Rebate Agreement" authorized under Transmittal 09-05, has been authorized by CMS.

The state will maintain the flexibility to negotiate supplemental rebate payments by manufacturers for Medicaid Managed Care Organization (MCO) utilization of products on the PDL regardless if the products are on the Medicaid MCO formularies (Version 1 of Attachment A, Transmittal 10-13).

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TN No. 10-13  
Supersedes TN No. 09-11

Approval Date:

Effective Date: 1/1/11

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

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12. Prescribed Drugs

A. General

- (1) The Division of Medical Assistance will pay the lesser of the provider's usual charge to the general public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee. The EAC is defined by the Division as the lesser of:
  - a. The Average Acquisition Cost (AAC) of the drug. The AAC will be established by the Division or its contractor by rolling surveys of enrolled pharmacies to verify the actual invoice amount paid by the pharmacy for the product and as such will serve as the basis for reimbursement;
  - b. In cases where no AAC is available, reimbursement will be Wholesale Acquisition Cost (WAC) . WAC shall mean the price, paid by a wholesaler for the drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug as published by a recognized compendia of drug pricing on the last day of the calendar quarter that corresponds to the calendar quarter;
  - c. The Division determines usual charge to be the lesser of the following unless prohibited from billing by federal statute or regulation:
    - i. The provider's charge per unit of service for the majority of non-Medical Assistance users of the same service based on the preceding month's charges;
    - ii. The provider's lowest charge per unit of service on the same date that is advertised quoted or posted. The lesser of these applies regardless of the payment source or means of payment;
    - iii. Where the provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to third party resources are to be considered.

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12. Prescribed Drugs (continued)

- (2) The Division requires prior authorization of payment for selected therapeutic classes of drugs. These drug classes are listed in the Oregon Administrative Rules, Pharmaceutical Services Program. Exception to the prior authorization requirement may be made in medical emergencies.
- (3) The Division will reimburse providers only for drugs supplied from pharmaceutical manufacturers or labelers who have signed an agreement with CMS or who have a CMS approved agreement to provide drug price rebates to the Oregon Medicaid program.
- (4) The Division utilizes a contracted mail order vendor, the program is voluntary for the enrollees. The vendor is selected via a standard invitation to bid process. All Medicaid program rules apply to the vendor contract, payment rates are established during the bid process.

B. Payment Limits for Multiple Source Drugs

- (1) Reimbursement for multiple source drugs in the Medicaid Program shall not exceed the lowest of:
  - a. The federally mandated upper limit (FUL) for certain multiple source drugs as established and published by CMS plus a dispensing fee;
  - b. The Estimated Acquisition Cost (EAC) defined by the Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, Wholesale Acquisition Cost (WAC) plus a dispensing fee ; or
  - c. The provider's Usual and Customary charge to the general public for the drug.
- (2) Payment for multiple-source drugs for which CMS has established upper limits will not exceed, in the aggregate, the set upper limits plus a dispensing fee.
- (3) Oregon state law requires that no payment shall be made for a multiple source drug having a federal upper limit (FUL) for payment if a less expensive multiple source drug could have been dispensed, unless the physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient.

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12. Prescribed Drugs (continued)

C. Payment Limits for Single-Source Drugs

- (1) The Division established the payment amount for single-source drugs shall not exceed the lowest of:
  - a. The Estimated Acquisition Cost (EAC) defined by the Medicaid as the Average Acquisition Cost (AAC) of the drug; or
  - b. In cases where no AAC is available, Wholesale Acquisition Cost (WAC) plus a dispensing fee; or
  - c. The provider's Usual and Customary charge to the general public for the drug.
- (2) The upper payment limit established by the State EAC listing does not apply if a prescriber certifies that an innovator multi-source drug is medically necessary.
- (3) Payments for single-source drugs shall not exceed, in the aggregate, the lesser of the estimated acquisition cost plus a reasonable dispensing fee or the provider's usual charge to the general public.

D. Payment limit for 340B entity

- (1) The Division established the payment amount for 340B entities shall not exceed the entity's actual acquisition cost plus a dispensing fee.

E. Dispensing or Professional Fees

- (1) The Division establishes pharmacy dispensing fee payments based on the results of surveys of pharmacies. The dispensing fee structure will be one of 3 rate tiers. The Division or its designated representative will conduct an annual survey of every enrolled pharmacy to determine which tier the pharmacy will be paid.

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12. Prescribed Drugs (continued)

(2) Based upon the annual volume of the enrolled pharmacy, the dispensing fee will be as follows:

- Less than 49,999 claims a year = \$14.01
- Between 50,00 and 69,999 claims per year = \$10.14
- 70,000 or more claims per year = \$9.68

(3) Pharmacies that fail to respond to the annual survey will default to the \$9.68 dispensing fee.

(4) Pharmacies dispensing through a unit dose or 30-day card system must bill the Division only one dispensing fee per medication dispensed in a 30-day period.

(5) Dispensing fee tiers are applicable to all retail (chain and independent), Institutional, mail order, compounding and 340 programs.

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TN No. 10-13  
Supersedes TN No. 09-01

Approval Date:

Effective Date: 1/1/11