

The payment to an emergency room physician for the screening and assessment of a patient who receives non-emergency care in the emergency room shall not exceed the payment for a problem focused history, examination, and straight forward medical decision making.

- (r) The upper limits on payments for all noninstitutional items and services shall be established by the department in accordance with section 346-59, HRS, and other applicable state statutes.

3. INTENTIONALLY BLANK, ~~renumbered as #2 in SPA 02-007.~~

4. PAYMENT FOR CERTAIN OTHER NON-INSTITUTIONAL ITEMS AND SERVICES:

a. Payment for ~~prescribed drugs~~ medications:

1. Payment for ingredient cost of prescription drugs:

~~4.~~ A. For single source drugs, shall not exceed the lower of:

~~A.~~ i. The billed charges;

~~B.~~ ii. The provider's usual and customary charge to the general public; ~~or~~

~~C.~~ iii. The estimated acquisition cost (EAC); ~~or the average wholesale price (AWP) when the AWP is the average selling price, plus a reasonable dispensing fee.~~

~~D.~~ iv. The actual acquisition cost (AAC).

~~2.~~ B. For multiple source drugs, shall not exceed the lower of:

~~A.~~ i. The billed charges;

~~B.~~ ii. The provider's usual and customary charge to the general public;

~~C.~~ iii. The ~~estimated acquisition cost (EAC); or the average wholesale price (AWP) when the AWP is the average selling price, plus a reasonable dispensing fee.~~

iv. The AAC;

~~D.~~ v. The Federal Upper Limit (FUL) price ~~plus a reasonable dispensing fee; or~~

~~E.~~ vi. The State Maximum Allowable Cost (SMAC) ~~plus a reasonable dispensing fee.~~

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3. ~~C.~~ C. ~~Over-The-Counter (OTC) drugs shall not exceed the lower of: Over-the-counter medications may be covered and, if covered, the payment shall be according to the methodology described in a.1.~~

A. The billed charges;

~~B.~~ The provider's usual and customary charge to the general public including any sale item which may be available on the day of service;

~~C.~~ The allowance set by the program (State maximum allowable costs);

~~D.~~ The estimated acquisition cost (EAC) or the average wholesale (AWP) when the AWP is the average selling price, plus a reasonable dispensing fee; or

~~E.~~ The Federal Upper Limit (FUL) price plus a reasonable dispensing fee;

Under no circumstances shall the program pay more than the general public for the same prescription or item.

~~4.~~ Payments for medical supplies shall be made as described in section 3 (1) above.

5. ~~D.~~ D. The Federal Upper Limit (FUL) price does not apply if a physician:

A. i. Certifies in his or her own handwriting, or by an electronic method approved by the State Agency, that a specific brand is medically necessary for a particular recipient. A check-off box on a form is not acceptable but a notation of "brand medically necessary" or "do not substitute" is allowable.

~~B.~~ ii. Obtains authorization for medical necessity from the state medical assistance program for specific brands of medication designated by the program.

iii. In such cases, the payment shall ~~not exceed the lower of:~~ be according to the methodology described in a.1.

~~A.~~ The billed charge;

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- B. ~~The provider's usual and customary charge to the general public; or~~
- C. ~~The estimated acquisition cost (EAC) of the ingredient plus a reasonable dispensing fee.~~
6. E. The estimated acquisition cost EAC, for the purpose of this section, is defined as the lesser of the Wholesale Average Cost (WAC) or the Suggested Wholesale Price (SWP) minus 17% average wholesale price minus 10.5%. Average wholesale price will be derived from the most commonly used packaged size listed in the Bluebook. The estimated acquisition cost means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers.
7. ~~For the purpose of this section, the reasonable dispensing fee is \$4.67 for claims submitted by hardcopy, electronic media claims (EMC) and Point-Of-Sale (POS).~~
8. F. The State maximum allowable cost (SMAC) for the purpose of this section is defined as the average of the estimated acquisition costs of the three least expensive generics available. At least one of the three products shall be provided by a manufacturer who participates in the Federal drug rebate program will be based on drug prices obtained from a nationally recognized comprehensive data file maintained by a vendor under contract with the Department agent. A generic drug may be considered SMAC for the pricing if there are two or more therapeutically equivalent, multi-source, non-innovator drugs with a cost difference. The SMAC will be based on drug status (including non-rebateable, rebateable, obsolete, therapeutic equivalency ratings, etc.), marketplace availability in Hawaii and cost. The obsolete drug status will be taken into account to ensure that the SMAC pricing is not influenced by the process listed for obsolete drugs.
9. G. Payment will not be made for innovator multiple source drugs subject to the Federal Upper Limits (42 C.F.R. 447.332(a)) when a less expensive non-innovator multiple source drug is available for dispensing from the pharmacy. Substitution may not be prohibited by Part VI, Drug Product Selection of

328 HRS.

40-2. Payment of dispensing fees for prescription drugs dispensed by a licensed pharmacy:

A. \$5.00 per prescription.

B. The dispensing fee for any maintenance or chronic medication shall be extended only once per thirty days without ~~medical~~ authorization from the medical assistance program. Other appropriate limits regarding the number of dispensing fees paid per interval of time shall be determined, as necessary, by the medical assistance program.

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3. Under no circumstances shall the program pay more than the general public for the same prescription or item.

4. Payments for medical supplies shall be made as described in section ~~3(f)~~ 2(k) above.

445. In compliance with section 1927(b)(2) of the Social Security Act, invoice reports will be submitted to each qualifying rebate manufacturer and the Department of Health and Human Services Secretary within sixty days after the end of each calendar quarter including information on the total number of dosage units of each covered outpatient drug dispensed under the rebate plan. This report will be consistent with the standard reporting format established by the Secretary and include the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter.

b. Payments for transportation services are limited as follows:

1. Payments for ground ambulance and air ambulance services are limited to billed charges, the rate negotiated by the Department or the Medicare reasonable charge, whichever is lower. In the case of neonatal ground transportation, the upper limit on payment shall be at a rate set by the Department;

- 2. Except for a recipient who is a stretcher patient, payment for air transportation shall not exceed the inter-island or out-of-state airfare charged the other persons on the recipient's flight, or a contracted amount previously agreed upon between the airlines and the Department for emergency chartered flights. For transportation of a stretcher patient by the scheduled carrier, payment shall not exceed the airfare charged for four seats on the recipient's flight.
  
- 3. A round trip airfare shall be paid for an attendant whose services are recommended by the attending physician or are required by the airline. Prior approval of the Department's medical consultant is necessary, except in emergency situations, when the attending physician's authorization is sufficient, subject to the Department's medical consultant's review. In addition, payment shall be made for the attendant's service, provided the attendant is unrelated to the patient. The amount of payment for the attendant's service shall not exceed the following applicable rates:

(a) Leave and return same day .....\$20

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