§ 250. Reimbursement to participating provider pharmacies. 1. The amount of reimbursement which shall be paid by the state to a participating provider pharmacy for any covered drug filled or refilled for any eligible program participant shall be equal to the allowed amount defined as follows, minus the point of sale co-payment as required by sections two hundred forty-seven and two hundred forty-eight of this title:

(a) Multiple source covered drugs. Except for brand name drugs that are required by the prescriber to be dispensed as written, the allowed amount for a multiple source covered drug shall equal the lower of:

(1) The pharmacy's usual and customary charge to the general public, taking into consideration any quantity and promotional discounts to the general public at the time of purchase, or

(2) The upper limit, if any, set by the centers for medicare and medicaid services for such multiple source drug, or

(3) Average wholesale price discounted by twenty-five percent, or

(4) The maximum allowable cost, if any, established by the commissioner of health pursuant to paragraph (e) of subdivision nine of section three hundred sixty-seven-a of the social services law.

Plus a dispensing fee for drugs reimbursed pursuant to subparagraphs two, three, and four of this paragraph, as defined in paragraph (c) of this subdivision.

(b) Other covered drugs. The allowed amount for brand name drugs required by the prescriber to be dispensed as written and for covered drugs other than multiple source drugs shall be determined by applying the lower of:

(1) Average wholesale price discounted by sixteen and twenty-five one hundredths percent, plus a dispensing fee as defined in paragraph (c) of this subdivision, or

(2) The pharmacy's usual and customary charge to the general public, taking into consideration any quantity and promotional discounts to the general public at the time of purchase.

(c) As required by paragraphs (a) and (b) of this subdivision, a dispensing fee of four dollars fifty cents will apply to generic drugs and a dispensing fee of three dollars fifty cents will apply to brand name drugs.

2. For purposes of determining the amount of reimbursement which shall be paid to a participating provider pharmacy, the commissioner of health shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug that participating provider pharmacies buy most frequently. Using the result of this survey, the contractor shall update every thirty days the list of average wholesale prices upon which such reimbursement is determined using nationally recognized and most recently revised sources. Such price revisions shall be made available to all participating provider pharmacies. The pharmacist shall be reimbursed based on the price in effect at the time the covered drug is dispensed.

3. (a) Notwithstanding any inconsistent provision of law, the program for elderly pharmaceutical insurance coverage shall reimburse for covered drugs which are dispensed under the program by a provider pharmacy only pursuant to the terms of a rebate agreement between the program and the manufacturer (as defined under section 1927 of the federal social security act) of such covered drugs; provided, however, that:

(1) any agreement between the program and a manufacturer entered into before August first, nineteen hundred ninety-one, shall be deemed to have been entered into on April first, nineteen hundred ninety-one; and provided further, that if a manufacturer has not entered into an agreement with the department before August first, nineteen hundred ninety-one, such agreement shall not be effective until April first, nineteen hundred ninety-two, unless such agreement provides that rebates will be retroactively calculated as if the agreement had been in effect on April first, nineteen hundred ninety-one; and

(2) the program may reimburse for any covered drugs pursuant to subdivisions one and two of this section, for which a rebate agreement does not exist and which are determined by the commissioner to be essential to the health of persons participating in the program; and likely to provide effective therapy or diagnosis for a disease not adequately treated or diagnosed by any other covered drug.

(b) The rebate agreement between such manufacturer and the program for elderly pharmaceutical insurance coverage shall utilize for covered

drugs the identical formula used to determine the rebate for federal financial participation for drugs, pursuant to section 1927(c) of the federal social security act, to determine the amount of the rebate pursuant to this subdivision.

(c) The amount of rebate pursuant to paragraph (b) of this subdivision shall be calculated by multiplying the required rebate formulas by the total number of units of each dosage form and strength dispensed. The rebate agreement shall also provide for periodic payment of the rebate, provision of information to the program, audits, verification of data, damages to the program for any delay or non-production of necessary data by the manufacturer and for the confidentiality of information.

(d) The program in providing utilization data to a manufacturer (as provided for under section 1927 (b) of the federal social security act) shall provide such data by zip code, if requested, for the top three hundred most commonly used drugs by volume covered under a rebate agreement.

(e) Any funds collected pursuant to any rebate agreements entered into with a manufacturer pursuant to this subdivision, shall be deposited into the elderly pharmaceutical insurance coverage program premium account.

4. Notwithstanding any other provision of law, entities which offer insurance coverage for provision of and/or reimbursement for pharmaceutical expenses, including but not limited to, entities licensed/certified pursuant to article thirty-two, forty-two, forty-three or forty-four of the insurance law (employees welfare funds) or article forty-four of the public health law, shall participate in a benefit recovery program with the elderly pharmaceutical insurance coverage (EPIC) program which includes, but is not limited to, a semi-annual match of EPIC's file of enrollees against the entity's file of insured to identify individuals enrolled in both plans with claims paid within the twenty-four months preceding the date the entity receives the match request information from EPIC. Such entity shall indicate if pharmaceutical coverage is available from the entity for the insured persons, list the copayment or other payment obligations of the insured persons applicable to the pharmaceutical coverage, and (after receiving necessary claim information from EPIC) list the amounts which

the entity would have paid for the pharmaceutical claims for those identified individuals and the entity shall reimburse EPIC for pharmaceutical expenses paid by EPIC that are covered under the contract between the entity and its insured in only those instances where the entity has not already made payment of the claim. Reimbursement of the net amount payable (after rebates and discounts) that would have been paid under the coverage issued by the entity will be made by the entity to EPIC within sixty days of receipt from EPIC of the standard data in electronic format necessary for the entity to adjudicate the claim and if the standard data is provided to the entity by EPIC in paper format payment by the entity shall be made within one hundred eighty days. After completing at least one match process with EPIC in electronic format, an entity shall be entitled to elect a monthly or bi-monthly match process rather than a semi-annual match process.

5. Notwithstanding any other provision of law, the commissioner of health shall maximize the coordination of benefits for persons enrolled under Title XVIII of the federal social security act (medicare) and enrolled under this title in order to facilitate medicare payment of claims. The commissioner of health may select an independent contractor, through a request-for-proposal process, to implement a centralized coordination of benefits system under this subdivision for individuals qualified in both the elderly pharmaceutical insurance coverage (EPIC) program and medicare programs who receive medications or other covered products from a pharmacy provider currently enrolled in the elderly pharmaceutical insurance coverage (EPIC) program.

6. The EPIC program shall be the payor of last resort for individuals qualified in both the EPIC program and title XVIII of the federal social security act (Medicare).