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**State/Territory Name: IL**

**State Plan Amendment (SPA) #: 17-0006**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
233 N. Michigan Avenue, Suite 600  
Chicago, Illinois 60601-5519



## **Regional Operations Group**

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July 23, 2019

Theresa Eagleson, Director  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East, 3rd Floor  
Springfield, IL 62763-0001

Attn: Douglas Elwell

Dear Ms. Eagleson:

Enclosed for your records is an approved copy of the following State Plan Amendment.

|                      |                                          |
|----------------------|------------------------------------------|
| Transmittal #17-0006 | -Implements Covered Outpatient Drug Rule |
|                      | -Effective Date: July 15, 2019           |
|                      | -Approval Date: July 22, 2019            |

If you have any questions, please have a member of your staff contact Courtenay Savage at 312-353-3721 or via email at [Courtenay.Savage@cms.hhs.gov](mailto:Courtenay.Savage@cms.hhs.gov).

Sincerely,

/s/

Todd McMillion  
Acting Deputy Director  
Center for Medicaid & CHIP Services  
Regional Operations Group

Enclosure

cc: Sara Barger, HFS  
Mary Doran, HFS

|                                                                                                                        |                                                                                      |                              |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL<br/>OF STATE PLAN MATERIAL</b><br>FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES | 1. TRANSMITTAL NUMBER<br><b>17-0006</b>                                              | 2. STATE:<br><b>ILLINOIS</b> |
|                                                                                                                        | 3. PROGRAM IDENTIFICATION:<br><b>Title XIX of the Social Security Act (Medicaid)</b> |                              |
| TO: REGIONAL ADMINISTRATOR<br>CENTERS FOR MEDICARE AND MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES    | 4. PROPOSED EFFECTIVE DATE:<br><del>April 1, 2017</del><br><b>July 15, 2019</b>      |                              |

5. TYPE OF PLAN MATERIAL (Check One)

NEW STATE PLAN  AMENDMENT TO BE CONSIDERED AS NEW PLAN  AMENDMENT


COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

|                                                                                                                                                                         |                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 6. FEDERAL STATUTE/REGULATION CITATION:<br><b>Section 1902 of the Social Security Act</b>                                                                               | 7. FEDERAL BUDGET IMPACT<br>a. FFY 2017 - \$ 0<br>b. FFY 2018 - \$ 0                                                      |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><b>Attachment 4.19-B, Page 32 and 32A</b><br><i>ATTACHMENT 4.19-B, PAGE 32B, 32C &amp; 33C, 33</i><br>ces, 7/22/19 | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):<br><b>Attachment 4.19-B, Page 32 and 32A</b> |

10. SUBJECT OF AMENDMENT:  
**Revisions to pharmacy reimbursement methodology to comply with outpatient covered drug rule**

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  
 OTHER, AS SPECIFIED: Not submitted for review by prior approval.

|                                                                                                                          |                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 12. SIGNATURE OF AGENCY OFFICIAL:<br> | 16. RETURN TO:<br><b>Department of Healthcare and Family Services<br/>Bureau of Program and Reimbursement Analysis<br/>Attn: Mary Doran<br/>201 South Grand Avenue East<br/>Springfield, IL 62763-0001</b> |
| 13. TYPED NAME: <b>Felicia F. Norwood</b>                                                                                |                                                                                                                                                                                                            |
| 14. TITLE: <b>Director of Healthcare and Family Services</b>                                                             |                                                                                                                                                                                                            |
| 15. DATE SUBMITTED <b>6/30/17</b>                                                                                        |                                                                                                                                                                                                            |

**FOR REGIONAL OFFICE USE ONLY**

|                                         |                                         |
|-----------------------------------------|-----------------------------------------|
| 17. DATE RECEIVED: <b>June 30, 2017</b> | 18. DATE APPROVED: <b>July 22, 2019</b> |
|-----------------------------------------|-----------------------------------------|

PLAN APPROVED—ONE COPY ATTACHED

|                                                                  |                                                   |
|------------------------------------------------------------------|---------------------------------------------------|
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br><b>July 15, 2019</b> | 20. SIGNATURE OF REGIONAL OFFICIAL:<br><b>/s/</b> |
| 21. TYPED NAME <b>Todd McMillion</b>                             | 22. TITLE: <b>Acting Deputy Director</b>          |
| 23. REMARKS:                                                     |                                                   |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Illinois

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—  
OTHER TYPE OF CARE—BASIS FOR REIMBURSEMENT

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07/02 4. PRESCRIBED DRUGS:

~~07/12~~07/19 a. REIMBURSEMENT. Except for Critical Clinic Providers described in Chapter ~~130~~, subsection ~~(H)(e)(d)(i)(A)~~, pharmacies will be reimbursed for prescribed drugs at the lower of:

- i. The pharmacy's usual and customary charge to the general public.
- ii. The applicable methodology from among the following plus the applicable dispensing fee:

A. Single source ~~legend~~ drugs: Effective ~~July 21, 2012~~July 15, 2019, the rate shall be the lower of:

- National Average Drug Acquisition Cost, if available
- Wholesale acquisition cost of national drug code on claim minus 4.4%
- The State upper limit

B. Multiple source ~~legend~~ drugs: Effective ~~July 21, 2012~~July 15, 2019, the rate shall be the lower of:

- National Average Drug Acquisition Cost, if available
- Wholesale acquisition cost of national drug code on claim minus 17.5%
- The federal upper limit
- The State upper limit

C. 340B drugs: Effective July 15, 2019, the rate shall be the lower of:

- Actual Acquisition Cost of national drug code on claim
- 340B ceiling

D. Blood Clotting Factor (non-340B): Effective July 15, 2019, the rate shall be the lower of:

- WAC minus 10%
- The State upper limit

07/12 b. For multiple source legend and OTC drugs, the State upper limit reimbursement will apply to certain drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Agency. Multiple source drugs are subject to a State upper limit where the Food and Drug Administration (FDA) has rated at least two drug products pharmaceutically and therapeutically equivalent, including at least one non-innovator product. Single-source legend and OTC drugs will be subject to a State upper limit, on a case-by-case basis, where acquisition cost data demonstrates that acquisition cost is consistently and significantly lower than WAC for a particular drug.

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- ~~07/1207/19~~ c. PROFESSIONAL DISPENSING FEE. Effective ~~July 21, 2012~~ July 15, 2019, the professional dispensing fee for Illinois-based Critical Access Pharmacies shall be \$15.55 for both single source and multiple source drugs. For all other pharmacies, the professional dispensing fee shall be \$8.85 for both single source and multiple source drugs, and, Critical Access Pharmacies are defined as pharmacies physically located within Illinois in counties with less than 50,000 residents; and whose owner(s) do not have ownership or control interest in ten (10) or more pharmacies; and which are brick and mortar, meaning the pharmacy location is open to the public, recipients present at the pharmacy to fill prescriptions, and the majority of the pharmacy's business is not mail order based or through delivery to a residential facility and which is not owned/operated by a hospital or located within a hospital. ~~Effective~~ Effective February 1, 2013, the professional dispensing fee for 340B purchased drugs shall be \$12.00 for both single source and multiple source drugs. Only one professional dispensing fee shall be paid for each 30 or greater day supply of drugs dispensed.
- ~~05/15~~ Effective for dates of service May 1, 2015 through June 30, 2015, the dispensing fee shall be \$1.40 for single sourcee drugs, \$4.50 for multiple sourcee drugs, and \$11.00 for 340B purchased single sourcee and multiple sourcee drugs. Only one dispensing fee shall be paid for each 30 day supply of drugs dispensed.
- ~~07/19~~ d. CRITICAL CLINIC PROVIDERS. Reimbursement for prescribed drugs dispensed by Critical Clinic Providers shall be at the rate described in Chapter ~~430~~, subsection ~~(4)(e)(ii)~~ (d)(ii)(A) for that class of providers.
- 02/12 e. PRICING. Drug prices are updated no less frequently than monthly utilizing data procured from a national drug database source.
- 10/14 f. FQHC/RHC Long Acting Reversible Contraceptives (LARCs) and Non-surgical, Transcervical Permanent, Female Contraceptive Devices.
- Effective for dates of service on or after October 13, 2012, FQHCs and RHCs, as described in subsection (2)(a), may elect to receive reimbursement for LARCs (specifically intrauterine devices and single rod implantable devices) for contraceptive purposes.
- Effective for dates of service on or after October 1, 2014, FQHCs and RHCs, as described in subsection (2)(a), may elect to receive reimbursement for non-surgical transcervical permanent contraceptive devices.
- Reimbursement for the LARCs and transcervical permanent contraceptive devices shall be made in accordance with the following:
- i. To the extent that the LARCs or transcervical permanent contraceptive devices were purchased under the 340B Drug Pricing Program, the FQHC or RHC must bill the actual acquisition cost for the device.
  - ii. Reimbursement shall be made at the FQHC or RHC's actual 340B acquisition cost for LARCs and transcervical permanent contraceptive devices purchased through the 340B program. For LARCs and transcervical permanent contraceptive devices not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges, which shall be actual acquisition cost plus a \$12 administration fee, or the rate on the Department's practitioner fee schedule, ~~whichever is applicable~~.
  - iii. Reimbursement is separate from any encounter payment the FQHC or RHC may receive for LARCs or transcervical permanent contraceptive devices.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—  
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- 07/19 g. EXPERIMENTAL OR INVESTIGATIONAL DRUGS. Experimental or investigational drugs that are determined to be medically necessary through the Department's prior approval process, and are authorized for the specific member's use by the U.S. Food & Drug Administration, are reimbursed at invoice pricing which includes the cost of the drug, the international regulatory, shipping and handling fee, and the Professional Dispensing Fee in accordance with 4. c.
- 07/19 h. DRUGS DISPENSED BY 340B CONTRACT PHARMACIES. The Department does not reimburse for drugs acquired through the federal 340B drug pricing program and dispensed by 340B Contract Pharmacies.
- 07/19 i. NON-340B DRUGS BILLED BY COVERED ENTITIES. 340B covered entities dispensing drugs purchased outside the 340B program will be reimbursed in accordance with the payment methodology identified in 4.a. and 4.c.
- 07/19 j. FEDERAL SUPPLY SCHEDULE (FSS). For Federal Supply Schedule purchased drugs, reimbursement will be at their actual acquisition cost, plus the professional dispensing fee.
- 07/19 k. NOMINAL PRICE. Drugs acquired at Nominal Price (outside of 340B or FSS) will be reimbursed at their actual acquisition cost, plus the professional dispensing fee.
- 07/19 l. LONG TERM CARE AND SPECIALTY DRUGS. Long Term Care and Specialty Drugs that are distributed by a non-retail pharmacy will be reimbursed in accordance with the payment methodology identified in 4.a. and 4.c.
- 07/19 m. PHYSICIAN ADMINISTERED DRUGS. The reimbursement for the cost of drugs provided by a non-pharmacy provider shall be at a rate equal to the lowest of the provider's usual and customary charge to the public, or:
- The Average Sales Price (ASP) plus 6 percent; or
  - Beginning July 21, 2012, the state upper limit.
  - In cases in which ASP is not available, and no state upper limit has been developed, the Department's lowest maximum allowable price for all covered NDC's assigned to the HCPCS billing code determined in accordance with Section 4(a) of this attachment.

Payment to 340B providers will be the 340B actual acquisition cost for the drug, plus a \$12.00 administration fee.

All rates are published on the Department's website in the Practitioner Fee Schedule located at <http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/FeeSchedule/>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—  
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- ~~07/19~~ 5. ~~RESERVED OVER THE COUNTER DRUGS: Effective February 1, 2012, pharmacies will be reimbursed for over the counter drugs at the lower of:~~  
~~The pharmacy's usual and customary charge to the general public.~~  
~~The wholesale acquisition cost plus 25 percent.~~  
~~The State upper limit.~~
- 07/12 6. OTHER LABORATORY AND X-RAY SERVICES: Lesser of the usual and customary charge to the general public or statewide maximums established by the Department not to exceed the upper limits specified in federal regulations. Reimbursement is based upon the applicable modifier billed by the provider, and will be either for the technical component, the professional component or a global amount.
- 05/15 Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Other Laboratory and X-ray services. The agency's fee schedule rate was set as of July 1, 2012, and is effective for services provided on or after that date. All rates are published on the Department's website in Practitioner Fee Schedule located at <http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/>
- Clinic diagnostic laboratory services comply with Section 1903(i)(7) of the Social Security Act, which limits Medicaid payments for clinical diagnostic lab services to the amount paid by Medicare for those services on a per test basis.
- 05/15 Effective for dates of service May 1, 2015 through June 30, 2015, laboratory reimbursement rates are reduced by 16.75% with the exception of governmental providers.
- 05/15 Effective for dates of service May 2, 2015 through June 30, 2015, x-ray services reimbursement rates are reduced by 16.75% with the exception of governmental providers.
- 04/09 7. PHYSICIAN'S SERVICES: Reimbursement for physician services are at the physician's usual and customary charges, not to exceed the maximum established by the Department.
- 05/15 Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician services. The agency's fee schedule rate was set as of July 1, 2012, and is effective for services provided on or after that date. All rates are published on the Department's website in the Practitioner Fee Schedule located at <http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/>.
- Providers, including practitioners working under the supervision of the physician and billing under the physician's name and provider number, statewide who meet the participation requirements for the Maternal and Child Health Program receive enhanced reimbursement rates for services provided to pregnant women and children through age 20 who are participants in the MCH Program. The enhanced rates, which are detailed on the practitioner fee schedule and paid in combination with the maximum fee-for-service rates, include:

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—  
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7. Physician Services, Continued:

~~04/12 Effective April 1, 2012, the reimbursement for the cost of drugs provided by a non-pharmacy provider shall be at a rate equal to the lowest of the provider's usual and customary charge to the public, or:~~

- ~~• The Average Sales Price (ASP) plus 6 percent; or~~
- ~~• Beginning July 21, 2012, the state upper limit.~~
- ~~• In cases in which ASP is not available, and beginning July 21, 2012, no state upper limit has been developed, the Department's lowest maximum allowable price for all covered NDC's assigned to the HCPCS billing code determined in accordance with Section 4(a) of this attachment.~~

~~All rates are published on the Department's website in the Practitioner Fee Schedule located at <http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/FeeSchedule/>~~

07/18 Effective for dates of service July 1, 2018 through June 30, 2019, physicians and APNs partnering with participating providers of Mental Health Rehabilitative Services and who bill the Mental Health Rehabilitative service provider's National Provider Identification (NPI) as their payee will receive an add-on payment. The procedure codes and reimbursement rates subject to the add-on payment are published on the Practitioner Fee Schedule located at <http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/FeeSchedule/>