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State/Territory Name: Indiana

State Plan Amendment (SPA) #: 17-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Center for Medicaid and CHIP Services

Disabled and Elderly Health Programs Group

July 21, 2017

Mr. Joseph Moser
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204

Dear Mr. Moser:

We have reviewed Indiana's State Plan Amendment (SPA) 17-0002, Prescribed Drugs, received in the Chicago Regional Office on April 28th, 2017. This SPA proposes to bring Indiana into compliance with the reimbursement requirements in the Covered Outpatient Drug final rule with comment (CMS-2345-FC).

SPA 17-0002 establishes reimbursement for covered outpatient drugs using an actual acquisition cost methodology and implements a professional dispensing fee of $10.48. This SPA also includes reimbursement for 340B drugs, physician-administered drugs, clotting factor, federal supply schedule, and drugs purchased at nominal price.

Based on the information provided and consistent with the regulations at 42 CFR 430.20, we are pleased to inform you that SPA 17-0002 is approved with an effective date of April 1, 2017. A copy of the signed CMS-179 form, as well as the pages approved for incorporation into the Indiana state plan will be forwarded by the Chicago Regional Office.

If you have any questions regarding this amendment, please contact Mickey Morgan at (410) 786-4048 or Mickey.morgan@cms.hhs.gov.

Sincerely,

[redacted]

John M. Coster, Ph.D., R.Ph.
Director
Division of Pharmacy

CC: Timothy Hawkins, Indiana, Federal Relations Lead
Ruth Hughes, CMS Associate Regional Administrator
Jennifer Maslowski, CMS Regional Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 17-002

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2017

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:
42 CFR 440.120

7. FEDERAL BUDGET IMPACT: (in millions)
a. FFY 2017 ($3.90)
b. FFY 2018 ($7.81)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Pages 1d & 1e

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, Pages 1d & 1e

10. SUBJECT OF AMENDMENT: OMPP proposes to change reimbursement methodology by which the Indiana Medicaid fee-for-service pharmacy benefit reimburses for covered legend and non-legend ('over-the-counter', or OTC) drugs. This State Plan Amendment (SPA) also adds other information requested by the Centers for Medicare and Medicaid Services (CMS) for inclusion in the pharmacy state plan. These changes are required by federal law (CMS Covered Outpatient Drugs final rule, published January 21, 2016).

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:

Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Joseph Moser

14. TITLE: Medicaid Director

15. DATE SUBMITTED: 4.28.17

16. RETURN TO:
Joseph Moser
Medicaid Director
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W374
Indianapolis, IN 46204
ATTN: Tim Hawkins, Federal Relations Lead

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: April 28, 2017

18. DATE APPROVED: July 21, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Ruth A. Hughes

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

Pharmacy Services

Reimbursement for covered federal legend drugs and for covered non-legend (OTC) drugs is at acquisition cost plus professional dispensing fee, as follows:

Federal legend Drugs

Payment is based on the lowest of:

(A) The National Average Drug Acquisition Cost (NADAC) as published by CMS pursuant to 42 U.S.C 1396r-8(f) plus the professional dispensing fee;

(B) The state maximum allowable cost (MAC) as determined by the office plus the professional dispensing fee;

(C) The federal upper limit (FUL) as determined by CMS pursuant to 42 C.F.R. 447.514 plus the professional dispensing fee;

(D) The wholesale acquisition cost (WAC) according to the office's drug database file contracted from a nationally recognized source such as Medi-Span or First DataBank, minus a percentage as determined by the office through analysis of the dispensing cost survey or other methodology approved by CMS, plus the professional dispensing fee. The purpose of the percentage is to ensure that the applicable WAC rate sufficiently reflects the actual acquisition cost of the provider. The WAC shall be considered only if there is no applicable NADAC, FUL, or state MAC rate;

(E) The provider's submitted charge, representing the provider's usual and customary charge for the service.

Non-legend (OTC) Drugs

Payment is based on the lowest of:

(A) State OTC MAC plus professional dispensing fee;

(B) The provider's submitted charge, representing the provider's usual and customary charge for the service.

The professional dispensing fee that is reimbursed to pharmacy providers is determined based on a cost of dispensing survey that is performed every two years. The survey identifies costs associated with the dispensing function of prescription services, regardless of product or setting. Indiana Medicaid has selected a single dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to Indiana Medicaid members, inclusive of both specialty and non-specialty pharmacies.

Indiana Medicaid 340B Policy For Indiana Health Coverage Programs:

For drugs purchased through the 340B program, reimbursement will be at the provider's actual acquisition cost plus the professional dispensing fee.

For drugs purchased outside the 340B program, reimbursement will be as described under the heading "Federal Legend Drugs", above

Drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

Drugs Acquired at the Federal Supply Schedule (FSS):

If providers obtain drugs acquired at the federal supply fee schedule, Indiana Medicaid will reimburse at no more than the actual acquisition cost plus the professional dispensing fee.

Drugs Acquired at Nominal Price (Outside of 340B or FSS):

If providers obtain drugs acquired at nominal cost, Indiana Medicaid will reimburse at no more than the actual acquisition cost plus the professional dispensing fee. .

Encounter Rates (Drugs Dispensed by IHS/Tribal Facilities Under Encounter Rates):

All Indian Health Service, tribal and urban Indian pharmacies would be reimbursed an applicable encounter rate by Indiana Medicaid, regardless of their method of purchasing. Indiana does not have any Tribal Facilities billing for pharmacy services at this time.

Drugs Not Distributed by a Retail Community Pharmacy and Distributed Primarily Through the Mail (Such as Specialty Drugs):

Same policy as applies to drugs distributed by a retail community pharmacy. Indiana Medicaid has selected a single dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to Indiana Medicaid members, inclusive of both specialty and non-specialty pharmacy services.

Drugs Not Distributed by a Retail Community Pharmacy (Such as a Long-Term Care Facility):

Same policy as applies to drugs distributed by a retail community pharmacy. Indiana Medicaid has selected a single dispensing fee of $10.48, which is the weighted mean cost of dispensing prescriptions to Indiana Medicaid members, inclusive of both specialty and non-specialty pharmacy services.

Physician Administered Drugs

Physician-administered drugs are considered a physician service under Indiana Medicaid; as such, information regarding physician–administered drugs is contained in the physician services section of the state plan. Please refer to Attachment 4.19-B page 1f.

Blood Factor / Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers, Centers of Excellence:

Indiana Medicaid will reimburse for blood factor / clotting factor products using the same methodology as for federal legend drugs.

Investigational Drugs:

Investigational drugs, when deemed medically necessary on a case-by-case review basis, will be reimbursed at the actual acquisition cost plus the professional dispensing fee.