DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

Pharmacy Reimbursement at Actual Acquisition Cost (SPA17-O)

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services.

Changes to Medicaid State Plan

Effective April 1, 2017, SPA 17-O will amend Attachment 4.19-B of the Medicaid State Plan to change the reimbursement methodology for covered outpatient drugs from an estimated acquisition cost (EAC) basis to an actual acquisition cost basis (AAC). This Amendment is necessary to comply with federal regulations that require states' reimbursement for ingredient costs for brand and certain multiple source drugs (that do not have a Federal Upper Limit calculated) to be based on AAC. Connecticut will base its ingredient cost on the National Average Drug Acquisition Cost (NADAC) file, a current national survey of retail community pharmacies' acquisition costs maintained by CMS. Brand name single source and multisource drugs will reimburse at the Brand NADAC price while generic drugs will reimburse at the generic NADAC price. Claims for drugs without a NADAC price will reimburse at the lesser of the Federal Upper Limit (FUL) or the Wholesale Acquisition Cost (WAC). Certain drugs, however, will always be reimbursed at WAC, including preferred brand name medication and medications for which the prescriber has complied with the Department's "dispense as written" requirements.

DSS will discontinue the State of CT Maximum Allowable Cost (MAC), effective April 1, 2017.

This amendment will establish a new professional dispensing fee for each prescription paid on behalf of Medicaid clients. The dispensing fee will change from one dollar and forty cents ($1.40) to ten dollars and seventy five cents ($10.75). The professional dispensing fee was based upon an extensive survey of retail pharmacy providers, conducted as part of a regional collaboration with other states.

Over-the-counter medications will continue to be reimbursed at Average Wholesale Price (AWP) and will continue to have no dispensing fee.

The professional dispensing fee for pharmacies enrolled with DSS as 340B pharmacies will be reduced from thirteen dollars ($13.00) to $10.75.

Claims for drugs purchased at Nominal Price and through the Federal Supply Schedule will also be reimbursed at AAC plus the $10.75 dispensing fee.

The dispensing fee for compound prescriptions, defined as two or more drugs mixed together where at least one ingredient is a legend drug, will also be $10.75.

Effective April 1, 2017, Factor VII, VIII, IX, and X drugs will be reimbursed based on the actual acquisition cost from the submitted manufacturer's invoice, plus 8 percent and the dispensing fee of $10.75.

The amendment will also reflect DSS reimbursement for 340B entities, which is not changing at this time. Similarly, the amendment will reflect, but not change, DSS reimbursement for physician-administered drugs and clinics, which is primarily based on the Medicare April 2013 Average Sales Price. Also, the amendment will reflect, but not change, DSS reimbursement to outpatient hospitals, which is largely based on the ambulatory payment classification system.

Fiscal Impact

This SPA is anticipated to increase annual aggregate expenditures by approximately $3.8 million in State Fiscal Year 2017 and by approximately $15.6 million in State Fiscal Year 2018.

Compliance with Federal Access Regulations

In accordance with federal regulations at 42 CFR §§ 447.203 and 447.204, DSS is required to ensure that there is sufficient access to Medicaid services, including services where payment rates are going to be reduced. These federal regulations also require DSS to have ongoing mechanisms for Medicaid members, providers, other stakeholders, and the public to provide DSS with feedback about access. In addition to other available procedures, anyone may send DSS comments about the potential impact of this SPA on access to covered outpatient drugs under the Medicaid program as part of the public comment process. Contact information and the deadline for submitting comments are listed below.

Information on obtaining SPA language and Submitting Comments.

The proposed SPA is posted on the DSS website at this link: http://www.ct.gov/dss. Go to "Publications" and then "Updates." The proposed SPA may also be obtained at any DSS field office and upon request from DSS.

To request a copy of the SPA or send comments about the SPA, please email: ginny.mahoney@ct.gov or write to Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford CT 06105 (Phone: 860-424-5145, Fax: 860-424-5799) Please reference SPA 17-O Pharmacy Reimbursement.

Anyone may send written comments about this SPA, including comments about access to services affected by this SPA. Written comments must be received at the above contact information no later than April 14, 2017.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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(12) Prescribed drugs, prosthetic devices and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.

A. Prescribed Drugs – ingredient cost methodology in accordance with the Actual Acquisition Cost (AAC) methodology.

1. Brand Name and Generic Drugs - Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a $10.75 professional dispensing fee. Reimbursement for the drug ingredient shall be the lowest of:
    a. The usual and customary charge to the public or the pharmacy's actual submitted ingredient cost;
    b. The National Average Drug Acquisition Cost (NADAC) established by CMS;
    c. The Affordable Care Act Federal Upper Limit (FUL); or
    d. Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for a specific drug

    No professional dispensing fee will be paid for non-legend or over-the-counter drugs.

2. Compound Drugs - Claims for compound prescriptions, defined as two or more drugs mixed together where at least one ingredient is a legend drug, will receive a professional dispensing fee of $10.75.

3. 340B Drug Pricing Program - Covered legend and non-legend drugs, purchased through the Federal Public Health Service's 340B Drug Pricing Program (340B) by pharmacies that carve Medicaid into the 340B Drug Pricing Program shall be reimbursed at the 340B actual invoice price but no more than the 340B ceiling price plus a professional dispensing fee of $10.75. Pharmacies contracting with a 340B entity shall be reimbursed at the lesser of methodology described in 12(A), above, plus a dispensing fee of $10.75

4. Federal Supply Schedule (FSS) and Federally Qualified Health Centers (FQHC) - Facilities purchasing drugs through the Federal Supply Schedule (FSS) shall be reimbursed by the lesser of methodology, described in (12)(A), above, plus the established professional dispensing fee of $10.75.

5. Drugs Purchased at Nominal Price - Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) shall be reimbursed at their actual acquisition cost.

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B. Payment for the following drugs that do not need to meet the Actual Acquisition Cost (AAC) definition.

1. Clotting Factors - Pharmacies and other entities dispensing Antihemophilic Factor products (Factor VII, VIII IX and X products) will be reimbursed at the Actual Acquisition Cost plus 8 percent as reflected on the invoice submitted with the claim to the Department plus a professional dispensing fee of $10.75.

2. Specialty Drugs - Specialty drugs, if not on the NADAC file, are reimbursed at WAC plus zero (0) percent plus a professional dispensing fee of $10.75.

3. Physician Administered Drugs (Physicians and other prescribers and Clinics- Reimbursement rates for Physician Administered Drugs (administered by physicians and other prescribers and at Clinics) are set forth on the physician and clinic fee schedules, effective for services provided on or after that date, except that procedure codes may be deleted or added and priced in order to remain compliant with HIPAA. The physician and clinic fee schedules can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page go to "Provider Services" then to "Fee Schedule Download". All governmental and private providers are reimbursed according to the same fee schedule.

   The majority of physician administered drugs are based on the Medicare April 2013 Average Sales Price Drug Pricing File

4. Investigational Drugs - Investigational drugs are not covered.

5. Outpatient Hospitals – The majority of codes for drugs provided in outpatient hospitals settings are reimbursed through the ambulatory payment classification system (APC).

6. IHS Tribal Facilities – Only one IHS facility is enrolled as a provider. The Department and this facility are finalizing the clinic's rates and the state plan will be amended at a future date to reflect the reimbursement methodology for the clinic.

7. Institutional or Long Term Care pharmacies – are reimbursed at the lesser of methodology for retail community pharmacies described in 12(A).