IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201717 FEBRUARY 28, 2017

Changes to fee-for-service pharmacy benefit reimbursement methodology

On January 21, 2016, the Centers for Medicare & Medicaid Services (CMS) published its final Covered Outpatient Drugs rule, which became effective April 1, 2016. The rule contains provisions requiring state Medicaid agencies to modify their current methodologies used in reimbursing pharmacy providers for products dispensed to Medicaid members receiving pharmacy benefits under the fee-for-service (FFS) delivery system. Managed care Medicaid pharmacy benefits reimbursement methodologies are not affected by the changes noted in this bulletin.

This bulletin announces reimbursement changes that will be implemented by the Indiana Health Coverage Programs (IHCP) as a result of the CMS Covered Outpatient Drugs rule. These changes will be reflected in the Medicaid rule under *Indiana Administrative Code 405 IAC 5-24*. See the proposed rule at LSA Document No. 16-530.

Effective April 1, 2017, the following reimbursement methodology will apply to FFS pharmacy claims for legend and nonlegend products. The change in methodology applies to claims for dates of service (DOS) on or after April 1, 2017. The IHCP will reimburse pharmacy providers at the lowest of the following, as applicable:

(1) The National Average Drug Acquisition Cost (NADAC) as published by the CMS pursuant to *42 U.S.C 1396r-8 (f)*, as of the date of dispensing, plus any applicable professional dispensing fee.

(2) The state maximum allowable cost (MAC) as determined by the State as of the date of dispensing, plus any applicable professional dispensing fee.

(3) The provider's submitted charge, representing the provider's usual and customary charge for the service, as of the date of dispensing.

(4) The federal upper limit (FUL) as determined by the CMS pursuant to *42 CFR 447.514*, as of the date of dispensing, plus any applicable professional dispensing fee.

(5) The wholesale acquisition cost (WAC) according to the State's drug database file contracted from a nationally recognized source such as Medi-Span or First DataBank, minus a percentage as determined by the State through analysis of the dispensing cost survey or other methodology approved by the CMS, as of the date of dispensing, plus any applicable 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 only be considered if there is no applicable NADAC, FUL, or state MAC rate.

Effective April 1, 2017, the IHCP will increase the professional dispensing fee to $10.48. This change applies to FFS claims for DOS on or after April 1, 2017.

Please direct questions about this bulletin to the OptumRx Clinical and Technical Help Desk by calling toll-free 1-855-577-6317. Questions regarding pharmacy benefits for members in the Healthy Indiana Plan (HIP), Hoosier Healthwise, and Hoosier Care Connect should be referred to the managed care entity with which the member is enrolled.

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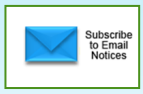

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