TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #18-482(F)

DIGEST

Amends 405 IAC 5-24-4, 405 IAC 5-24-5, 405 IAC 5-24-6, and 405 IAC 5-24-7 to correct the professional dispensing fees as approved by the Centers for Medicare and Medicaid Services (CMS) and to correct current terminology and policies. Effective 30 days after filing with the Publisher.

405 IAC 5-24-4; 405 IAC 5-24-5; 405 IAC 5-24-6; 405 IAC 5-24-7

SECTION 1. 405 IAC 5-24-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-4 Reimbursement for legend drugs

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. (a) The office shall reimburse pharmacy providers for covered legend drugs at the lowest of the following, as applicable:
(1) The National Average Drug Acquisition Cost (NADAC) of the drug as published by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 U.S.C. 1396r-8(f), as of the date of dispensing, plus any applicable Medicaid professional dispensing fee.
(2) The state maximum allowable cost (MAC) of the drug as determined by the office as of the date of dispensing, plus any applicable Medicaid professional dispensing fee.
~~(3) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.~~
~~(4)~~ **(3)** The federal upper limit (FUL) of the drug as determined by CMS pursuant to 42 CFR 447.514, as of the date of dispensing, plus any applicable Medicaid professional dispensing fee.
~~(5)~~ **(4)** The wholesale acquisition cost (WAC) of the drug according to the office's drug database file contracted from a nationally recognized source such as Medi-Span or First DataBank, adjusted by a percentage as determined by the office through analysis of the dispensing cost survey or other methodology approved by CMS, as of the date of dispensing, plus any applicable Medicaid 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.
(5) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

(b) The state MAC is equal to the average actual acquisition cost per drug adjusted by a multiplier of at least 1.0. The actual acquisition cost will be determined using pharmacy invoices and other information that the office determines is necessary. The purpose of the multiplier is to ensure that the applicable state MAC rate is sufficient to allow reasonable access by providers to the drug at or below the established state MAC rate.

(c) OMPP will review state MAC rates on an ongoing basis and adjust the rates as necessary to:
(1) reflect prevailing market conditions; and
(2) ensure reasonable access by providers to drugs at or below the applicable state MAC rate.

(d) Pharmacies and providers that are enrolled in Medicaid are required, as a condition of participation, to make available and submit to the office acquisition cost information, product availability information, or other information deemed necessary by the office for the efficient operation of the pharmacy benefit in the format requested by the office. Providers will:
(1) not be reimbursed for this information; and
(2) submit information to the office or its designee within thirty (30) days following a request for such information unless the office or its designee grants an extension upon written request of the pharmacy or provider.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2001, 9:50 a.m.: 25 IR 60 [NOTE: On October

9, 2001, the Marion Superior Court issued an Order in Cause No. 49D05-0109-CP-1480, enjoining the Family and Social Services Administration from implementing LSA Document #01-22(F), published at 25 IR 60.]; filed Apr 30, 2002, 10:59 a.m.: 25 IR 2727; errata filed Aug 22, 2002, 3:11 p.m.: 26 IR 35; filed Nov 23, 2005, 11:30 a.m.: 29 IR 1212; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jan 23, 2008, 1:42 p.m.: 20080220-IR-405070547FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA; filed Mar 2, 2017, 3:39 p.m.: 20170329-IR-405160530FRA; filed Apr 29, 2019, 10:35 a.m.: 20190529-IR-405180482FRA)

SECTION 2. 405 IAC 5-24-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-5 Reimbursement for nonlegend drugs

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 5. (a) The office shall reimburse pharmacy providers for ~~the cost and dispensation of~~ nonlegend (over-the-counter or OTC) drugs ~~included on the Medicaid nonlegend drug formulary as provided for in this section.~~ **at the lower of the following:**

~~(b) The office shall reimburse for nonlegend drugs at the lowest of the following rates:~~

~~(1) One hundred fifty percent (150%) of the state maximum allowable cost, as set out in the Medicaid Pharmacy Provider Manual and amendments thereto, for the drug in the quantity dispensed, as of the date dispensed.~~

(1) the state over-the-counter maximum allowable cost plus professional dispensing fee; or

(2) the provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

(b) Only those nonlegend drugs that are included on the OTC drug formulary are covered by Indiana health coverage programs (IHCP).

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; filed Sep 27, 1999, 8:55 a.m.: 23 IR 319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Nov 23, 2005, 11:30 a.m.: 29 IR 1212; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA; filed Mar 2, 2017, 3:39 p.m.: 20170329-IR-405160530FRA; filed Apr 29, 2019, 10:35 a.m.: 20190529-IR-405180482FRA)

SECTION 3. 405 IAC 5-24-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-6 Professional dispensing fee

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 6. (a) For purposes of this rule, the Medicaid professional dispensing fee maximum is ten dollars and ~~fifty-seven~~ **forty-eight** cents ~~($10.57) per legend drug.~~ **($10.48).**

(b) A maximum of one (1) Medicaid professional dispensing fee per month is allowable per member per drug order for legend **or nonlegend** drugs provided to members residing in Medicaid certified long-term care facilities.

(c) The practice of split billing of legend **or nonlegend** drugs, defined as the dispensing of less than the prescribed amount of drug solely for the purpose of collecting more Medicaid professional dispensing fees than would otherwise be allowed, **or to circumvent prior authorization criteria,** is prohibited. In cases in which the pharmacist's professional judgment dictates that a quantity less than the amount prescribed be dispensed, the pharmacist should contact the prescribing practitioner for authorization to dispense a lesser quantity. The pharmacist must document the result of the contact and the pharmacist's rationale for dispensing less than the amount prescribed on the prescription or in the pharmacist's records.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345;

readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2001, 9:50 a.m.: 25 IR 60 [NOTE: On October 9, 2001, the Marion Superior Court issued an Order in Cause No. 49D05-0109-CP-1480, enjoining the Family and Social Services Administration from implementing LSA Document #01-22(F), published at 25 IR 60.]; filed Apr 30, 2002, 10:59 a.m.: 25 IR 2727; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Nov 8, 2013, 2:56 p.m.: 20131204-IR-405130422FRA; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; filed Mar 2, 2017, 3:39 p.m.: 20170329-IR-405160530FRA; filed Apr 29, 2019, 10:35 a.m.: 20190529-IR-405180482FRA)

SECTION 4. 405 IAC 5-24-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-24-7 Copayment for legend and nonlegend drugs

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 7. (a) Under IC 12-15-6, a copayment is required for legend and nonlegend drugs ~~and insulin~~ in accordance with the following:

(1) The copayment shall be paid by the member and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the member is liable.
(2) In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under 42 CFR 447.15, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.
(3) The amount of the copayment will be three dollars ($3) for each covered drug dispensed.

The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid.

(b) The following pharmacy services are exempt from the copayment requirement:
(1) Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.
(2) Services furnished to individuals less than eighteen (18) years of age.
(3) Services furnished to pregnant women if such services are related to the pregnancy or any other medical condition that may complicate the pregnancy.
(4) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, or other medical institutions.
(5) Family planning services and supplies furnished to individuals of child bearing age.
~~(6) Health maintenance organization (HMO) pharmacy services.~~

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Nov 4, 2002, 12:16 p.m.: 26 IR 732; filed Feb 24, 2004, 10:45 a.m.: 27 IR 2252; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; filed Apr 29, 2019, 10:35 a.m.: 20190529-IR-405180482FRA)

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