

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment

Pharmacy Services Reimbursement and Coverage of Over-the-Counter Medications (SPA 15-036)

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

Changes to Medicaid State Plan

Pursuant to Public Act 15-41, effective on or after July 1, 2015, SPA 15-036 will amend Attachments 3.1-A and 3.1-B of the Medicaid State Plan implement coverage of over-the-counter medications and products determined by the Commissioner of Social Services to be appropriate for coverage based on clinical efficacy, safety and cost effectiveness.

Additionally, effective on or after July 1, 2015, SPA 15-036 will amend Attachment 4.19-B of the Medicaid State Plan to decrease reimbursement to pharmacies for dispensing drugs (other than drugs subject to a different reimbursement methodology as set forth in the State Plan) based on average wholesale price (AWP) minus a set percentage. Based on the current version of the budget adopted by the General Assembly, the reduction is currently proposed to be changing the reimbursement to AWP minus 16.5%, which is subject to change based on legislative adjustments that may occur in the upcoming special legislative session.

This SPA will also amend Attachment 4.19-B of the Medicaid State Plan to reduce the professional fee to licensed pharmacies for each prescription. Based on the current version of the budget adopted by the General Assembly, the reduction is currently proposed to be changing the dispensing fee to one dollar and forty cents (\$1.40) for each prescription, which is subject to change based on legislative adjustments that may occur in the upcoming special legislative session.

Pursuant to federal regulations at 42 C.F.R. § 447.205, public notice is required at this time. Accordingly, this public notice reflects proposed changes that are currently available based on the state budget (Public Act 15-244) adopted by the General Assembly during the 2015 regular legislative session. However, this SPA is subject to change based on legislative adjustments that may occur in the upcoming special legislative session.

Fiscal Information

Based on information that is available at this time, it is estimated that this SPA will reduce annual aggregate expenditures by approximately \$5.4 million in State Fiscal Year 2015 and \$5.6 million in State Fiscal Year 2016.

Information on Obtaining SPA Language and Submitting Comments

In accordance with federal Medicaid requirements, upon request, DSS will provide copies of the proposed SPA. Copies of the proposed SPA may also be obtained at any DSS regional office and on the DSS website: <http://www.ct.gov/dss>. Go to “Publications” and then “Updates”.

Written, phone, and email requests should be sent to Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105, Telephone: 860-424-5145, Email: ginny.mahoney@ct.gov. Please reference “SPA 15-036: Pharmacy Services Reimbursement”. Written comments may be submitted in the same manner as requests no later than July 14, 2015.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO THE
CATEGORICALLY NEEDY GROUP (S): ALL

- (4) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The following drugs or classes of drugs are excluded from coverage by the Medicaid agency, except the drugs checked, for which the Medicaid agency provides coverage, as described below, to ALL Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D:

- Agents when used for anorexia, weight loss, weight gain
(Weight gain medications, anabolic steroids, growth hormones only)
 - Agents when used to promote fertility
 - Agents when used for cosmetic purposes or hair growth
 - Agents when used for the symptomatic relief of cough and colds
 - Prescription vitamins and mineral products, except prenatal vitamins and fluoride
 - Nonprescription drugs on the OTC formulary covered for clients under the age of 21; those drugs determined by the Department to be appropriate for coverage based on clinical efficacy, safety and cost are covered for all clients; low-dose aspirin covered for men ages 45 to 79 years and women ages 55 to 79 years when the potential benefit outweighs the potential harm; and folic acid covered for women planning or capable of pregnancy.
(OTC formulary includes: Antacids, H2 antacids, spermicidal foam and jelly, cough, cold and allergy, nasal mast stabilizer, laxatives, antihistamines, decongestants, topical Antifungals, vaginal Antifungals).
 - Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- (5) Certification of Brand Name Drugs
Reimbursement for multiple-source drugs for which CMS has designated a FUL is not limited to the FUL if a licensed authorized practitioner determines that a specific brand is medically necessary for a particular patient provided the requirements noted in section 5(a) are met.
- (6) Prior Authorization Requirements:
PA shall be available in accordance with 1927(d)(5) of the Social Security Act. The state shall provide a response within two (2) hours upon a request for prior authorization. An automatic fourteen (14) day supply of medication shall be made available if no prior authorization has been requested and granted. In addition, a one-time five (5) day emergency supply shall be made available when the department representative has been contacted and no prior authorization has been requested and granted.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State CONNECTICUT**

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO THE
MEDICALLY NEEDY GROUP (S): ALL**

- (5) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The following drugs or classes of drugs are excluded from coverage by the Medicaid agency, except the drugs checked, for which the Medicaid agency provides coverage, as described below, to ALL Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D:

- Agents when used for anorexia, weight loss, weight gain
(Weight gain medications, anabolic steroids, growth hormones only)
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- (12) Prescribed drugs and 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
1. With the exception of (a)2 and (a)3 below the cost of drugs is determined by the drug product allowance established by the Federal Upper Limit plus a professional Dispensing Fee of \$1.40; The State's estimated acquisition cost (E.A.C.) which is AWP –16.5% plus the professional Dispensing Fee of \$1.40; or the usual and customary charge to the general public, whichever is lower.
 2. The maximum allowable cost paid for selected multi-source brand and generic drugs meeting the following criteria shall be the Average Wholesale Price (AWP) minus 72% plus the professional Dispensing Fee. If providers are not able to purchase such drugs at this rate, a stepped down maximum allowable cost tiered approach will be enforced with the maximum reimbursement set at AWP minus 20% plus the professional Dispensing Fee:
 - at least two suppliers of the generic product are available,
 - drug is not on the Federal Upper Limit (FUL) list or, and
 - all dosage forms (including tablets, capsules, eye drops, inhalers, topicals and liquids).
 - The Department uses a MAC Pricing Inquiry Worksheet for drugs on the MAC list. This worksheet allows providers to document difficulty in obtaining a specific drug for the MAC price set in this section. The MAC Pricing Inquiry Worksheet requires the provider to submit certain information to the Department, including the actual purchase invoice for the drug. If the information submitted demonstrates a provider's inability to purchase a drug for the MAC price using the tiered approach described above, the Department removes the drug from the MAC list and the price for that drug is based on the EAC, as described in (a)(1), above.
 3. The maximum allowable cost paid for Factor VIII (Factorate, Antihemophilic Factor, AHF) pharmaceuticals shall be the Actual Acquisition Cost (AAC) plus eight per cent.

TN# 15-036
Supersedes
TN # 14-038

Approval Date _____

Effective Date: 7/01/2015