**Table of Contents**

**State Plan Amendment (SPA) #: 15-005**

This file contains the following documents in 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

**Disabled & Elderly Health Programs Group**

February 6, 2017



Mrs. Jami Snyder
State Medicaid/CHIP Director
Health and Human Services Commission
Post Office Box 13247
Mail Code H100
Austin, Texas 78711

RE: Texas State Plan Amendment (SPA) Transmittal Number 15-005

Dear Mr. Jessee:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the Texas State Plan Amendment (SPA) 15-005 received in the Dallas Regional Office on August 14, 2015. This SPA proposes to revise Texas pharmacy reimbursement methodology for the Medicaid fee-for-service program from the current methodology to one that pays pharmacies based on the drug ingredient cost, defined as the acquisition cost (AC), plus a professional dispensing fee.

Based on the information provided, we are pleased to inform you that consistent with the regulations at 42 CFR 430.20, SPA 15-0005 is approved with an effective date of June 1, 2016. A copy of the signed CMS-179 form as well as the pages approved for incorporation into the Texas state plan will be forwarded by the Dallas Regional Office.

If you have any questions regarding this SPA, please contact Renee Hilliard at (410) 786-2991.

Sincerely,

/s/

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

cc: Bill Brooks, ARA, Dallas Regional Office
Ford Blunt, Dallas Regional Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL<br>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES | 1. TRANSMITTAL NUMBER: 15-005 | 2. STATE: TEXAS |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR<br>CENTERS FOR MEDICARE AND MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE: June 1, 2016 | |

5. TYPE OF PLAN MATERIAL *(Circle 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: | 7. FEDERAL BUDGET IMPACT: | SEE ATTACHMENT |
|---|---|---|
| 42 C.F.R. §§ 10.1-10.21, 447.502, 447.512, 447.514, and 447.518. | a. FFY 2016 | ($6,581,073) |
| | b. FFY 2017 | ($5,838,222) |
| | c. FFY 2018 | ($6,244,569) |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT TO BLOCKS 8 & 9 | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: SEE ATTACHMENT TO BLOCKS 8 & 9 | |

10. SUBJECT OF AMENDMENT:
**This proposed state plan amendment (SPA) modifies the reimbursement methodology for pharmacy services. The proposed SPA also includes language stating that Texas is in compliance with 42 Code of Federal Regulations (CFR.) § 447.512 and § 447.514, which requires that reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.**

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: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

| 12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted] | 16. RETURN TO: Jami Snyder<br>State Medicaid Director<br>Post Office Box 13247, MC: H-100<br>Austin, Texas 78711 |
|---|---|
| 13. TYPED NAME: Jami Snyder | |
| 14. TITLE: State Medicaid Director | |
| 15. DATE SUBMITTED: August 14, 2015 | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: 14 August, 2015 | 18. DATE APPROVED: 06 February, 2017 |
|---|---|
| PLAN APPROVED – ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 June, 2016 | 20. SIGNATURE OF REGIONAL OFFICIAL: [redacted] |
| 21. TYPED NAME: Bill Brooks | 22. TITLE: Associate Regional Administrator<br>Division of Medicaid & Children's Health |

23. REMARKS:

FORM CMS – 179 (07-92)

RECEIVED
FEB 0 9 2017
OFFICE OF THE STATE
MEDICAID DIRECTOR

**Attachment to Blocks 8 & 9 of CMS Form 179**

**Transmittal Number 15-005**

| **Number of the Plan Section or Attachment** | **Number of the Superseded Plan Section or Attachment** |
|---|---|
| Attachment 4.19-B | Attachment 4.19-B |
| Page 2b | Page 2b (TN 11-27) |
| Page 2c | Page 2c (TN 07-08) |
| Page 2c.1 | Page 2c.1 ~~(TN 01-19)~~ (TN 03-026) |
| Page 2d | Page 2d (TN 97-15) |

State: Texas
Date Received: 8-14-15
Date Approved: 2-6-17
Date Effective: 6-1-16
TN Number: 15-0005

**Pharmacy Reimbursement Methodology**

1. General

The upper limit for payment for prescribed drugs, whether legend or nonlegend items, will be based on the lower of cost, as defined by the Texas Health and Human Services Commission (HHSC) or its designee, plus a professional dispensing fee, as defined and determined by HHSC or its designee, or the usual and customary charge. Where a public agency makes bulk purchases of drugs, payment will be made in accordance with the governmental statutes and regulations governing such purchases in accordance with the agreement between such public agency and HHSC or its designee. These provisions do not apply to payment for drugs in hospitals and other institutions where drugs are included in the reimbursement formula and vendor payment to the institution.

HHSC or its designee will advise the Centers for Medicare & Medicaid Services (CMS) in writing of the uniform, reasonable dispensing fee, which will be used to establish how the state is in compliance with the upper limit, as specified in the regulations and as determined by the methodology described in this plan. Such notice will specify the time period for which it is effective.



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**Pharmacy Reimbursement Methodology (continued)**

2. Reimbursement Methodology

HHSC or its designee reimburses contracted Medicaid pharmacy providers according to the professional dispensing fee formula defined in this section. The dispensing fee is determined by the following formula: Professional Dispensing Fee = (((Acquisition Cost + Fixed Component) divided by (1 – the percentage used to calculate the Variable Component)) - Acquisition Cost) + Delivery Incentive + Preferred Generic Incentive.

(a) Drug Ingredient Cost

The acquisition costs are defined in Section IIC (Legend and Nonlegend Medications).

(b) Dispensing Fee Determination

(1) The fixed component is $7.93.

(2) The variable component is 1.96%.

(3) The total dispensing fee shall not exceed $200 per prescription.

(4) A delivery incentive shall be paid to approved providers who certify a form prescribed by HHSC or its designee that the delivery services meet minimum conditions for payment of the incentive. These conditions include: making deliveries to individuals rather than just to institutions, such as nursing homes; offering no-charge prescription delivery to all Medicaid recipients requesting delivery in the same manner as to the general public; and publicly displaying the availability of prescription delivery services at no charge. The delivery incentive is $0.15 per prescription and is to be paid on all Medicaid prescriptions filled. This delivery incentive is not to be paid for over-the-counter drugs, which are prescribed as a benefit of this program.

(5) A preferred generic incentive of $0.50 per prescription shall be paid on all Medicaid prescriptions filled for preferred generic drugs for which a manufacturer has agreed to pay a supplemental rebate. Preferred generic drugs are subject to the requirements for placement on the Preferred Drug List (PDL).



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## Pharmacy Reimbursement Methodology (continued)

(c) Legend and Nonlegend Medications

For all medications, legend and nonlegend, covered by the Vendor Drug Program (VDP) and appearing in the Texas Drug Code Index (TDCI) and updates, the following requirements must be met.

(1) A pharmaceutical provider is reimbursed based on the lesser of the acquisition cost (AC) plus HHSC's currently established professional dispensing fee per prescription, or the usual and customary price charged the general public.

(2) AC is defined as the Texas Retail Pharmacy Acquisition cost (RetailPAC); long-term care pharmacy acquisition cost (LTCPAC); specialty pharmacy acquisition cost (SPAC); or 340B price. Pharmacies subject to LTCPAC are "Long-term care (LTC) pharmacies." LTC Pharmacies serve LTC Patients, as determined by the Single State Agency, and must be "closed door pharmacies." Closed door pharmacies do not have public-facing operations and do not accept outpatient walk-in patients.

(A) AC is verifiable by invoice audit conducted by HHSC to include necessary supporting documentation that will verify the final cost to the provider.

(B) The RetailPAC, LTCPAC, and SPAC will be based on the National Average Drug Acquisition Cost (NADAC) as defined here:

RetailPAC: Ingredient cost = NADAC

LTCPAC: Ingredient cost = (NADAC - 2.4%)

SPAC: Ingredient cost = (NADAC - 1.7%)

(C) If NADAC is not available for a specific drug, the RetailPAC, LTCPAC, and SPAC will be defined as follows:

RetailPAC: Ingredient cost = (WAC - 2%)

LTCPAC: Ingredient cost = (WAC - 3.4%)

SPAC: Ingredient cost = (WAC - 8%)

(D) If NADAC or WAC is not available for a specific drug, reimbursement will be based on market sources, which include, but are not limited to: the current Redbook; Redbook Update; First Databank; First Alert; or reported manufacturer pricing; or reported pharmacy acquisition costs.

(E) In compliance with 42 Code of Federal Regulations (C.F.R.) 447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.

(F) HHSC reimburses a 340B covered entity for a 340B covered outpatient drug purchased through the 340B program and dispensed to a patient of a 340B covered entity based on HHSC's estimate of the CMS 340B ceiling price.



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**Pharmacy Reimbursement Methodology (continued)**

**2. Reimbursement Methodology**

**(c) Legend and Nonlegend Medications (continued)**

(3) Notice of a public hearing to receive comments on proposed changes to general pricing determinations derived under these policies shall be published in the Texas Register.

(4) Definitions. As used in Section IIC, these terms shall be defined as follows:

(A) Reported Manufacturer Price–Information on pricing submitted to VDP by the manufacturer, including Average Wholesale Prices, Average Manufacturer Price, wholesaler costs, direct prices and institutional or contract prices.

(B) Wholesale Costs–The net cost of a product to a drug wholesaler or distributor.



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