HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services hereby gives Notice of Intended Action to amend Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, " Amount, Duration and Scope of Medical and Remedial Services," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Services," Iowa Administrative Code.

The Federal Indian Health Service (IHS) approves encounter rates for inpatient and outpatient medical care provided by IHS and tribal facilities to American Indians or Alaskan natives who are beneficiaries of Medicare, Medicaid, or other federal programs. The Indian Health Facilities in Iowa requested that Iowa Medicaid adopt the encounter rate for prescribed drugs, in lieu of payment for the particular drugs provided.

The Centers for Medicare and Medicaid Services (CMS) released a final rule that implements provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) pertaining to Medicaid reimbursement for covered outpatient drugs. Key aspects of the final rule require Medicaid Agencies to comply by documenting the reimbursement methodology for specific entities in their State plan, no later than April 1, 2017. Specific entities that must be addressed include: (1) A covered entity described in section 1927(a)(5)(B) of the Social Security Act ("340B" entities), (2) A contract pharmacy under contract with a covered 340B entity, and (3) A facility authorized to purchase drugs through the Federal Supply Schedule (FSS). Corresponding clarifications are being made in the rules, which do not represent a change from current policy. Additionally, CMS has required that ingredient

cost reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" not exceed the provider's actual acquisition cost. A terminology clarification is also being made by changing the term "maximum allowable cost" (MAC) to "federal upper limit" (FUL) to conform to the Code of Federal Regulations (CFR). Lastly, the final rule indicates states may, at their option, provide coverage of and receive federal financial participation for investigational drugs, under specific conditions. The proposed rule clarifies that Iowa Medicaid does not cover investigational drugs that are the subject of an investigational new drug application (IND) that has been allowed to proceed by the Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug as set forth in 42 U.S.C. 1396r-8(k)(2)-(4).

These amendments change the outpatient prescribed drug reimbursement methodology for drugs provided to Medicaid recipients who are American Indians or Alaskan natives by health facilities that are operated by the United States Indian Health Service (IHS) or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an "Indian tribe," "tribal organization," or "Urban Indian organization," as those terms are defined in 25 USC 1603 (referred to as Indian Health Facilities). Such drugs will be reimbursed through an outpatient encounter rate per day rather than through reimbursement for each individual prescription provided. The amendments also clarify the facilities that will receive this encounter rate for drugs. Because Medicaid reimbursement for services provided to Medicaid recipients who are American Indians or Alaskan natives by these facilities are 100% federally funded, there is no state expenditure involved in this change of reimbursement methodology.

These amendments also change the outpatient prescribed drug reimbursement methodology for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR § 447.508. For such drugs, the ingredient cost may not exceed the provider's actual acquisition cost (not to exceed the nominal price paid).

Additionally, these amendments clarify the following:

- The current reimbursement methodology utilized for covered outpatient drugs for 340B Covered Entities, 340B Contract Pharmacies, and facilities (such as Department of Veterans Affairs facilities) purchasing through the Federal Supply Schedule (FSS) under the General Services Administration.
- The terminology of maximum allowable cost (MAC) by updating to the conventional label of federal upper limit (FUL) and maintaining the definition for the FUL in accordance with 42 Code of Federal Regulations (CFR) 447.514(a)-(c).
- Payment is not made for outpatient investigational drugs that are the subject of an investigational new drug application (IND) that has been allowed by the Food and Drug Administration (FDA) to proceed, which is optional with the state.
- Insertion of the word "state" in "average state actual acquisition cost (AAC)" to distinguish that limit from the provider-specific actual acquisition costs that also limit reimbursement of 340B covered entities and FSS facilities.
- Separation in the drug reimbursement methodology of "the submitted charge" and "the provider's usual and customary charge" to reflect that if the amounts are different, the lower of the two is utilized for reimbursement.

Any interested person may make written comments on the proposed amendments on or before December 13, 2016. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, 5th Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515) 281-4980 or by email to policyanalysis@dhs.state.ia.us.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A, 217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

The following amendments are proposed.

ITEM 1. Amend rule 441—77.45(249A) as follows:

441—77.45(249A) Indian H~~h~~ealth ~~service 638~~ F~~f~~acilities. A health care facility ~~owned and~~ operated by the United States Indian Health Service or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an "Indian tribe," "tribal organization," or "Urban Indian organization," as those terms are defined in 25 USC 1603, ~~American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638)~~ is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) – 77.45(2) No change.

ITEM 2. Adopt the following **new** subparagrah **78.2(4)"b"(12)**:

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(3).

ITEM 3. Amend paragraph 79.1(1)"h" as follows:

h. Indian H~~h~~ealth ~~service 638~~ F~~f~~acilities. Indian H~~h~~ealth ~~service 638~~ F~~f~~acilities ~~as defined at~~ enrolled pursuant to rule 441—77.45(249A) are paid ~~a special daily base encounter rate~~ for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the United States Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. ~~This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget~~. For services provided to American Indians or Alaskan natives, Indian H~~h~~ealth ~~service 638~~ F~~f~~acilities may bill ~~only one charge~~ for one visit per patient per calendar day for medical services (at the "Outpatient per Visit Rate (Excluding Medicare)") ~~provided to American Indians or Alaskan natives~~, which shall ~~include~~ constitute payment in full for all medical services provided on that day, except as follows. For services provided to American Indians and Alaska Natives, Indian Health Facilities may bill for multiple visits per patient per calendar day for medical services (at the "Outpatient per Visit Rate (Excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services, dental services, mental health and addiction services, Early & Periodic Screening, Diagnosis, and Treatment services for children, other outpatient services, and other inpatient services. A visit is a face-to-face contact between a patient and a

health professional at or through the facility. For services provided to American Indians or Alaskan natives, Indian Health Facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "Outpatient per Visit Rate (Excluding Medicare)") which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the ~~fee schedule~~ reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

ITEM 4. Amend rule **441—79.1(2)** Basis of reimbursement of specific provider categories as follows:

Provider category	Basis of reimbursement	Upper Limit
Indian ~~h~~Health ~~service 638 f~~Facilities	1. ~~Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.~~ Daily visit rate approved by the United States Indian Health Service (IHS) for services provided to American Indian and Alaska native members. See 79.1(1)h.	1. ~~Office of Management and Budget rate~~ Indian Health Service (IHS) approved rate, published in the Federal Register as ~~for o~~Outpatient per ~~v~~Visit ~~r~~Rate (Excluding Medicare).
	2. Fee schedule for service	2. Fee schedule.

provided for all other
Medicaid members.

ITEM 5. Rescind subrule **79.1(8)** and adopt the following **new** rule in lieu thereof:

79.1(8) Drugs.

a. Except as provided below in paragraphs 79.1(8)"d" through "i," all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)"b," plus the professional dispensing fee determined pursuant to paragraph 79.1(8)"c."

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)"c."

3. Total submitted charge.

4. The providers' usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)"b," plus the professional dispensing fee determined pursuant to paragraph 79.1(8)"c."

2. Total submitted charge.

3. The providers' usual and customary charge to the general public.

b. For purposes of this subrule, 79.1(8), average state actual acquisition cost (AAC) is defined as retail pharmacies' average prices paid to acquire drug products. Average state AAC

shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

c. For purposes of this subrule, 79.1(8), the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries conducted every two years beginning in state fiscal year 2014-2015.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL.

e. 340B-Purchased Drugs.

(1) Notwithstanding paragraph 79.1(8)"a" above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. the submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price) plus the professional dispensing fee pursuant to paragraph 79.1(8)"c,"

2. the average state actual acquisition cost (AAC) determined pursuant to paragraph 79.1(8)"b" plus the professional dispensing fee pursuant to paragraph 79.1(8)"c,"

3. for generic prescription drugs and nonprescription drugs only, the federal upper limit

(FUL) pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c,”

4. total submitted charge, or

5. the providers’ usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8)“a”, as covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal Supply Schedule (FSS) Drugs. Notwithstanding paragraph 79.1(8)”a” above, reimbursement for drugs acquired by a provider through the Federal Supply Schedule (FFS) program managed by the federal General Services Administration will be the lowest of:

(1) the provider’s actual acquisition cost, not to exceed the Federal Supply Schedule (FSS) price, plus the professional dispensing fee pursuant to paragraph 79.1(8)“c,”

(2) the average state actual acquisition cost (AAC) determined pursuant to paragraph 79.1(8)“b” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c,”

(3) for generic prescription drugs and nonprescription drugs only, the federal upper limit (FUL) pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c,”

(4) total submitted charge, or

(5) the providers’ usual and customary charge to the general public.

g. Nominal Price Drugs. Notwithstanding paragraph 79.1(8)”a” above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug’s “best price” pursuant to 42 CFR § 447.508 will be the lowest of:

(1) the provider's actual acquisition cost (not to exceed the nominal price paid) plus the professional dispensing fee pursuant to paragraph 79.1(8)"c,"

(2) the average state actual acquisition cost (AAC) determined pursuant to paragraph 79.1(8)"b" plus the professional dispensing fee pursuant to paragraph 79.1(8)"c,"

(3) for generic prescription drugs and nonprescription drugs only, the federal upper limit (FUL) pursuant to 79.1(8)"a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)"c,"

(4) total submitted charge, or

(5) the providers' usual and customary charge to the general public.

h. Indian Health Facilities enrolled pursuant to rule 441-77.45. For all drugs provided to American Indians or Alaska Natives by Indian Health Facilities enrolled pursuant to rule 441-77.45, reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)"a"-"f." The pharmacy encounter rate is the current "Outpatient per Visit Rate (Excluding Medicare)" approved by the United States Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Vaccines for Children Program. All providers administering vaccines available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Providers may receive Medicaid reimbursement for the administration of vaccines to Medicaid members through the otherwise applicable reimbursement for inpatient or outpatient services.

j. Physician-administered drugs. Notwithstanding paragraphs 79.1(8) “a”-“f.”, payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).

k. Under this subrule, 79.1(8), no payment shall be made for sales tax.

l. For purposes of this subrule, 79.1(8), the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

Iowa Department of Human Services

Information on Proposed Rules

Name of Program Specialist	Telephone Number	Email Address
Susan Parker	256-4634	sparker2@dhs.state.ia.us

1. Give a brief summary of the rule changes:

   The rule changes the outpatient prescribed drug reimbursement methodology for drugs provided to Medicaid recipients who are American Indians or Alaskan natives by health facilities that are operated by the United States Indian Health Service (IHS) or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an "Indian tribe," "tribal organization," or "Urban Indian organization," as those terms are defined in 25 USC 1603 (referred to as Indian Health Facilities). Such drugs will be reimbursed through an outpatient encounter rate per day rather than through reimbursement for each individual prescription provided. The changes also clarify the facilities that will receive this encounter rate for drugs. Because Medicaid reimbursement for services provided to Medicaid recipients who are American Indians or Alaskan natives by these facilities are 100% federally funded, there is no state expenditure involved in this change of reimbursement methodology.

   The rule also changes the outpatient prescribed drug reimbursement methodology for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR § 447.508. For such drugs, the ingredient cost may not exceed the provider's actual acquisition cost (not to exceed the nominal price paid).

   Additionally, the rule clarifies the following:

   - The current reimbursement methodology utilized for covered outpatient drugs for 340B Covered Entities, 340B Contract Pharmacies, and facilities (such as Department of Veterans Affairs facilities) purchasing through the Federal Supply Schedule (FSS) under the General Services Administration.
   - The terminology of maximum allowable cost (MAC) by updating to the conventional label of federal upper limit (FUL) and maintaining the definition for the FUL in accordance with 42 Code of Federal Regulations (CFR) 447.514(a)-(c).
   - Payment is not made for outpatient investigational drugs that are the subject of an investigational new drug application (IND) that has been allowed by the Food and Drug Administration (FDA) to proceed, which is optional with the state.
   - Insertion of the word "state" in "average state actual acquisition cost (AAC)" to distinguish that limit from the provider-specific actual acquisition costs that also limit reimbursement of 340B covered entities and FSS facilities.
   - Separation in the drug reimbursement methodology of "the submitted charge" and "the provider's usual and customary charge" to reflect that if the amounts are different, the lower of the two is utilized for reimbursement.

   Finally, the rule is also reorganized for clarity.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

Iowa Code 249A.4; The Indian Health Care Improvement Act of 1976 (25 U.S.C. 1601, et seq.); 42 CFR Part 447; and directives from the federal Centers for Medicare & Medicaid Services (CMS).

3. What is the reason for the Department requesting these changes?

   The federal Indian Health Service (IHS) approves encounter rates for inpatient and outpatient medical care provided by IHS and tribal facilities to American Indians or Alaskan natives who are beneficiaries of Medicare, Medicaid, or other federal programs. The Indian Health Facilities in Iowa requested that Iowa Medicaid adopt the encounter rate for prescribed drugs, in lieu of payment for the particular drugs provided.

   The Centers for Medicare and Medicaid Services (CMS) released a final rule that implements provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) pertaining to Medicaid reimbursement for covered outpatient drugs. Key aspects of the final rule require Medicaid Agencies to comply by documenting the reimbursement methodology for specific entities in their State plan, no later than April 1, 2017. Specific entities that must be addressed include: (1) A covered entity described in section 1927(a)(5)(B) of the Social Security Act ("340B" entities), (2) A contract pharmacy under contract with a covered 340B entity, and (3) A facility authorized to purchase drugs through the Federal Supply Schedule (FSS). Corresponding clarifications are being made in the rules, which do not represent a change from current policy. Additionally, CMS has required that ingredient cost reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" not exceed the provider's actual acquisition cost. A terminology clarification is also being made by changing the term "maximum allowable cost" (MAC) to "federal upper limit" (FUL) to conform to the Code of Federal Regulations (CFR). Lastly, the final rule indicates states may, at their option, provide coverage of and receive federal financial participation for investigational drugs, under specific conditions. The proposed rule clarifies that Iowa Medicaid does not cover investigational drugs that are the subject of an investigational new drug application (IND) that has been allowed to proceed by the Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug as set forth in 42 U.S.C. 1396r-8(k)(2)-(4).

4. What will be the effect of this rule making (who, what, when, how)?

   A maximum of one encounter payment per patient per date of service will be provided for outpatient prescribed drugs dispensed to Medicaid recipients who are American Indians or Alaskan natives by Indian Health Facilities. The pharmacy encounter rate includes reimbursement for the dispensing fee, ingredient cost, and any necessary counseling by the pharmacist.

   Ingredient cost reimbursement for drugs acquired by providers at nominal prices will not exceed the provider's actual acquisition cost (not to exceed the nominal price paid).

   The other changes clarify existing prescribed outpatient drug coverage and reimbursement policies currently in place.

5. Is the change mandated by State or Federal Law?

The change to an encounter payment for prescribed outpatient drugs provided to American Indians or Alaskan natives by Indian Health Facilities is not mandated by State or Federal Law, but is permitted by Federal Law.

The other reimbursement changes (340B Covered Entities, 340B Contract Pharmacies, facilities purchasing through the FSS, nominal price drugs, change of MAC to FUL, and investigational drug exclusion) are to implement state rule clarifications that correspond to the recently required state plan changes.

6. Will anyone be affected by this rule change? If yes, who will be affected and will it be to the person's (organization's) benefit or detriment?

   Yes, the change in reimbursement for outpatient prescribed drugs to an outpatient encounter rate will impact reimbursement to Indian Health Facilities for Medicaid recipients who are American Indians or Alaskan natives. These entities, as well as CMS, have encouraged the program to allow this reimbursement methodology and indicated the change would benefit the entities impacted.

   Ingredient cost reimbursement for drugs acquired by providers at nominal prices will not exceed the provider's actual acquisition cost (not to exceed the nominal price paid). It is unknown by the program what the volume of providers/prescriptions are that will fall in this category (providers will have to self-identify) and/or if there will be a financial impact, as the nominal price may be submitted as the usual and customary price already by these entities, if they exist as providers.

7. What are the potential benefits of this rule?

   The benefit of this change is that Indian Health Facility reimbursement will be consistent in that all services provided at such facilities will be reimbursed through the encounter rate for Medicaid recipients who are American Indians or Alaskan natives. Additionally the rule provides clarification of current reimbursement methodology for specific entities and methodologies, consistent with federal requirements for the state plan.

8. What are the potential costs, to the regulated community or the state of Iowa as a whole, of this rule?

   The Medicaid program will require programming changes to allow this change in reimbursement methodology to an encounter payment for Indian Health Facilities, however this will not result in a charge as the programming hours will be part of the annual development hours built into the contract.

9. Do any other agencies regulate in this area? If so, what agencies and what Administrative Code sections apply?

   The federal government regulates and has oversight over the Indian Health Facilities and there will be a federal fiscal impact. There should be no effects on any other governmental agencies.

10. What alternatives to direct regulation in this area are available to the agency? Why were other alternatives not used?

    No alternatives to direct regulation are available to the agency in this area, as the agency must set some Medicaid reimbursement policy for drugs.

11. Does this rule contain a waiver provision? If not, why?

This amendment does not provide for waiver in specified situations because the policies addressed should apply in all cases and because a waiver can be requested under the Department's general rule on exceptions at Iowa Admin. Code r. 441--1.8.

12. What are the likely areas of public comment?

None are anticipated.

13. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee)

No.

ADMINISTRATIVE RULE
FISCAL IMPACT STATEMENT

Date: 8/17/16

Agency: Human Services

IAC citation: 441 IAC - 77.45 ,78.2 and 79.1

Agency contact: Susan Parker

Summary of the rule:

To reimburse for prescribed outpatient drugs provided to Medicaid members who are American Indians or Alaskan natives through an all-inclusive outpatient encounter rate per day rather than through reimbursement for each individual prescription provided. Because Medicaid reimbursement of an Indian Health Facility for services provided to Medicaid members who are American Indians or Alaskan natives are 100% federally funded, there is no state expenditure involved in this change of reimbursement methodology.

Additionally clarifications only are provided for outpatient pharmacy reimbursement for specific entities and drugs, consistent with the current reimbursement process.

Fill in this box if the impact meets these criteria:

_X_ No fiscal impact to the state.

___ Fiscal impact of less than $100,000 annually or $500,000 over 5 years.

___ Fiscal impact cannot be determined.

Brief explanation:

This change is expected to increase the amount paid to Indian Health Facilities for prescription drugs. However, Indian Health Facility expenditures are 100% federally funded, and therefore, there is no state fund expenditure for the prescription drug services. Based on SFY16 units, annual federal spending is expected to increase by $1,361,890.

It is estimated that Pharmacy Point of Sale programming to complete this change will be approximately 120 programming hours, which will not result in a charge as the programming hours will be part of the annual development hours built into the contract.

All other components of this rule are expected to be budget neutral.

Fill in the form below if the impact does not fit the criteria above:

___ Fiscal impact of $100,000 annually or $500,000 over 5 years.

Fill in the rest of the *Fiscal Impact Statement* form.

Assumptions:

Describe how estimates were derived:

Estimated Impact to the State by Fiscal Year		
	Year 1 (SFY17)	**Year 2 (SFY18)**
Revenue by each source:		
General fund		
Federal funds		
Other (specify):		
TOTAL REVENUE		
Expenditures:		
General fund		
Federal funds		
Other (specify):		
TOTAL EXPENDITURES		
NET IMPACT	No State Impact	No State Impact

____ This rule is required by state law or federal mandate.
Please identify the state or federal law:

____ Funding has been provided for the rule change.
Please identify the amount provided and the funding source:

_X_ Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
There is no fiscal impact to the state.

Fiscal impact to persons affected by the rule:

Indian Health Facilities will no longer be reimbursed on an individual outpatient per drug basis but rather though an all-inclusive rate. There is the potential for this all-inclusive rate to overpay or underpay the facility depending on the drugs received each day the rate is reimbursed.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

None anticipated.

Agency representative preparing estimate: Jason Buls
Telephone number: 515-281-5764