

PROVIDER BULLETIN

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Providers Billing Pharmacy Claims

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Covered Outpatient Drug Rule

The Centers for Medicare and Medicaid Services (CMS) published a final rule on January 1, 2016, pertaining to Medicaid reimbursement for covered outpatient drugs. The purpose of the final rule is to implement changes to the prescription drug reimbursement structure as enacted by the Affordable Care Act (ACA). States are required to establish actual acquisition cost (AAC) as the basis of ingredient cost reimbursement to providers as well as evaluate the professional dispensing fee reimbursement. With the final rule, States must also establish a payment methodology for 340B entities and 340B contract pharmacies.

Pharmacy Claim Reimbursement

Effective April 1, 2017, reimbursement for pharmacy claims will be determined by applying the following hierarchy methodology:

- Federal Upper Limit (FUL) price, plus professional dispensing fee; if there is no FUL,
- Missouri Maximum Allowed Cost (MAC), plus professional dispensing fee; if no FUL or MAC,
- Wholesale Acquisition Cost (WAC) minus 0.25%, plus professional dispensing fee, or
- The usual and customary (U&C) charge submitted by the provider IF it is lower than the chosen price (FUL, MAC, or WAC).

The MO HealthNet Division (MHD) may *not* be billed an amount in excess of the provider's U&C charge for a particular service.

***PLEASE NOTE:** The professional dispensing fee will only be added to prescriptions filled or refilled by a pharmacy provider. Rural Health Clinics (RHC), Federally Qualified Healthcare Centers (FQHC) and hospital providers will continue to be reimbursed at percent of billed charge.

Professional Dispensing and Enhanced Preferred Generic Incentive Fees

In 2014, MHD conducted a cost to dispense survey. As a result of the survey, the new base professional dispensing fee will be \$9.55. In-state providers only, will continue to get the enhanced dispensing fee of \$4.82. Using the reimbursement methodology above, the professional dispensing fee will be added to each reimbursable prescription filled or refilled by a pharmacy provider beginning April 1, 2017. Pharmacy providers supplying covered drugs to participants in long-term care (LTC) facilities shall receive an additional \$0.50 dispensing fee, provided the LTC dispensing fee requirements are met. See the [Pharmacy Manual](#) section 12.2.A for specific requirements.

The enhanced preferred generic product incentive fee will also be increased to \$5.00 effective April 1, 2017. Eligible generic products are identified as National Drug Codes (NDC) that have a First Data Bank Innovator Indicator of 0 and Generic Indicator of 1 (for Multi-Source Product). This enhanced fee will continue to be paid in addition to the professional dispensing fee(s). The preferred generic incentive payment is structured to reimburse in-state pharmacies only.

340B Providers

340B is a drug pricing program that resulted from the enactment of Public Law 102-585 and the Public Health Service Veterans Health Care Act of 1992. The 340B program limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes, and qualified hospitals. 340B also results in additional cost savings to 340B qualified participants. These providers purchase, dispense and/or administer pharmaceuticals at significantly discounted prices. The significant discount applied to the cost of these drugs makes these drugs ineligible for the Medicaid drug rebate.

To avoid duplicate discounts and ensure correct payment, 340B providers that choose to carve-in Medicaid must provide the Health Resources and Services Administration (HRSA) with their National Provider Identification (NPI) and/or MO HealthNet provider number for each site that carves in for the purpose of inclusion in the Medicaid Exclusion File.

340B contract pharmacies are **not** covered under this policy and must carve-out Medicaid from its 340B operation.

Covered entity providers that are reimbursed at a percent of billed charge – FQHC and hospital providers – may continue to bill MHD at the U&C rate and report AAC on their cost reports. These providers will continue to get reimbursed at percent of billed charge. All other covered entity providers submitting a claim to MHD must enter the lowest net charge a non-Medicaid 340B-eligible patient would pay for the prescription in the U&C Charge field (426-DQ). 340B claims will reimburse at the lower of WAC minus 35% plus professional dispensing fee or the U&C charge.

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.mo.gov/mhd/> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Managed Care Services

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the MO HealthNet card or by calling the Provider Communications Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the red or white card.

**Provider Communications Hotline
573-751-2896**