REIMBURSEMENT FOR PHARMACY SERVICES

This section describes the reimbursement methodologies used by Louisiana Medicaid for prescribed drugs.

Reimbursement Methodology

The amount of reimbursement to pharmacies is determined by federal regulations and state policy. A provider fee of $0.10 is added to reimbursement of all pharmacy claims. The fiscal intermediary has weekly check writes to reimburse the provider for those valid claims which are processed.

Medicaid reimburses the lowest of the:

1. National Drug Acquisition Cost (NADAC) plus the professional dispensing fee;
2. If NADAC is not available, use the Wholesale Acquisition Cost (WAC) plus the professional dispensing fee;
3. Federal Upper Limit (FUL) plus the professional dispensing fee; or
4. Providers' usual and customary charge to the general public.

340B Purchased Drugs

Payment for self-administered drugs purchased by a covered entity through the 340B program shall be made at the 340B actual acquisition cost, which can be no more than the 340B ceiling price, plus the professional dispensing fee.

Clotting Factor

Pharmacy claims for clotting factor, with the exception of Hemlibra, shall be reimbursed using the Louisiana clotting factor average acquisition cost (AAC) and a unit based professional dispensing fee reimbursement methodology. The clotting factor professional dispensing fee is $0.03500 per unit dispensed, up to a maximum amount of $1,676.22. Hemlibra shall be reimbursed using the "lower of" reimbursement methodology.

Investigational or Experimental Drugs

Louisiana Medicaid will not provide reimbursement for investigational or experimental drugs.

Mail Order, Long-Term Care and Specialty

Drugs not distributed by a retail community pharmacy e.g., drugs dispensed by mail order, long-term care (LTC) and/or specialty pharmacies, will be reimbursed using the "lower of" reimbursement methodology.

National Drug Code System

Drugs are identified by the National Drug Code (NDC). The NDC is an 11-digit number. The first five digits identify the manufacturer or supplier, the next four digits identify the product, and the last two digits identify the package size.

The provider must enter the entire 11-digit NDC for the actual product and package size dispensed on the claim as the NDC is critical for accurate reimbursement. Billing an NDC number other than the one for the product dispensed is a false claim, a violation of Medicaid policy and may be recouped.

Medicaid can only reimburse drugs whose NDC codes are on the Medicaid drug file.

Medicaid uses ingredient costs that are supplied and updated each week by a nationally recognized compendia.

Professional Dispensing Fee

The pharmacy provider will be reimbursed at the appropriate ingredient cost plus the professional dispensing fee or the usual and customary charge, whichever is less.

The professional dispensing fee for drugs dispensed to Louisiana Medicaid beneficiaries will not exceed $11.81 per prescription. The provider fee will be reimbursed separately, per legislative mandate.

The professional dispensing fee for drugs dispensed to Louisiana Medicaid beneficiaries and obtained through the Health Resources & Services Administration (HRSA) 340B Program will be $11.81 per prescription. The provider fee will be reimbursed separately, per legislative mandate.

Provider Fee

All pharmacy providers and dispensing physicians are responsible for paying a ten cent (10¢) provider fee to the Louisiana Department of Health (LDH) on **all** prescriptions they fill. The health insurance issuers shall reimburse pharmacists/pharmacies for payment of the provider fee in accordance with state legislation.

Usual and Customary Charges

Federal regulations governing the Medicaid Program require that participating providers agree to charge no more for services to eligible beneficiaries than they charge for similar services to the general public.

In implementing this regulation, the Medicaid Program states that providers in the Pharmacy Program may not charge a higher professional dispensing fee, on the average, for Medicaid beneficiary's prescriptions than is charged for non-beneficiary's prescriptions. Consequently, pharmacists are required to indicate their usual and customary charge on their claims for prescription services even if this charge exceeds the Medicaid maximum payment.

Federal Upper Limits Regulations

Federal Upper Limit (FUL) prices are established by the Centers for Medicare and Medicaid Services (CMS). Federal regulations prohibit Medicaid from reimbursing providers more than the FUL, except as instructed.

When a prescriber indicates the brand name product is medically necessary for a particular beneficiary, and certifies that in his professional judgment the generic equivalent is not indicated, the FUL or LMAC limitations will not apply. The following procedure will apply in these cases:

1. Certification must be in the prescriber's handwriting and signed unless the prescription is submitted electronically;

2. Certification may be written either directly on the prescription or on a separate sheet which is attached to the prescription or submitted electronically with prescriber approval;

3. Standard phrases written by the prescriber on the prescription shall testify to the medical necessity of the brand name drug. The only acceptable phrases are "brand necessary" or "brand medically necessary";

4. If multiple prescriptions are written on the same prescription blank, the prescriber must certify which drugs require the brand name product, indicating "Brand Medically Necessary" for each prescription which requires the branded product;

5. Phrases such as *do not substitute, no generics* or *dispense as written* are not acceptable for overriding MAC limitations;

6. Providers should verify that the appropriate wording is properly documented at the time of dispensing; and

7. Checking a printed box on the prescription to indicate that the brand is necessary is unacceptable.

Co-Payments for Prescription Services

The co-payment will be paid by the beneficiary and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the co-payment amount for which the beneficiary is liable. Providers shall continue billing their usual and customary charges for prescription services. The fiscal intermediary will calculate and deduct the co-payment amount from the amount allowed.

Co-payment Schedule

The following is the prescription co-payment schedule:

Monthly Income	**Copayment**
when 5 percent of family's monthly income is spent on copays	$0.00
Medication Cost	**Copayment**
$5.00 or less	$0.00
$5.01 to $10.00	$0.50
$10.01 to 25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

Co-payment Exemptions

The following pharmacy services are exempt from the co-payment requirement:

1. Family planning services and supplies;
2. Emergency services;
3. Individuals younger than 21 years old;
4. Pregnant women;
5. Long-term care beneficiaries (residing in a nursing facility or ICG/IID);
6. Native Americans;
7. Alaskan Eskimos;
8. Women who are receiving services on the basis of breast and cervical cancer;
9. Beneficiaries receiving preventive services included in U.S. Preventive Services Task Force (USPSTF) A and B Recommendations, some examples are:
    a. Aspirin 81 mg for women ages 12-19 years of age and men ages 45-79 years of age;
    b. Folic acid 0.4mg and 0.8mg for women ages 12-54 years of age; and
    c. Vitamin D 400 IU for women and men ages 65 and older.
10. Beneficiaries receiving hospice services; and
11. Beneficiaries with waiver type cases.

NOTE: Refer to Section 37.5.4, Point of Sale (POS) User Guide for billing instructions.

Other Co-payment and Policies

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 co-payment amount. The beneficiary's assertion of their inability to pay the co-payment establishes the inability. Under 42 CFR §447.15, this

service statement does not apply to any individual who is able to pay, nor does an individual's inability to pay eliminate their liability for the co-payment.

Providers shall not waive the beneficiary's co-payment liability.

The pharmacy provider shall collect a co-payment for each drug dispensed and covered by Medicaid excluding some pharmacy services/populations. **This co-payment is NOT taxable**. Providers should not collect tax on the co-payment.

Quantities dispensed by pharmacists shall not be adjusted to reflect the co-payment amounts paid by the beneficiary. By participation in the Pharmacy Program, providers have agreed to accept, as payment in full, the amounts paid by the agency plus any deductible, co-insurance or co-payment.

In accordance with 42 CFR §447.56, co-payments of Medicaid household members are not to exceed five percent of the family income.

Department monitoring and auditing will be conducted to determine provider policies and compliance. Violators of this policy will be subject to penalty such as suspension from the program for one year.

Medicare Crossover Claims

Refer to Section 37.5.7 Medicare Prescription Drug Coverage regarding payment of services for which Medicaid reimburses providers for participants' responsibilities of coinsurance and deductible payments.

Third Party Liability Claims

Refer to Section 37.5.15 Third Party Liability/Coordination of Benefits, regarding services which must be billed to Medicaid as the payor of last resort.