ForwardHealth
Wisconsin serving you

Update
March 2017

No. 2017-07

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare, Wisconsin AIDS Drug Assistance Program, Wisconsin Chronic Disease Program
To: Federally Qualified Health Centers, Hospital Providers, Independent Labs, Narcotic Treatment Services Providers, Nurse Practitioners, Nurse Midwives, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Prenatal Care Coordination Providers, Rural Health Clinics, HMOs and Other Managed Care Programs

Changes to Billing and Reimbursement Policy for Covered Outpatient Drugs

This *ForwardHealth Update* provides information for providers who submit claims to ForwardHealth with National Drug Codes for covered outpatient drugs. ForwardHealth will be changing its billing and reimbursement policy for covered outpatient drugs, effective for dates of service on and after April 1, 2017. These changes are in compliance with the federal Covered Outpatient Drugs Final Rule (CMS-2345-FC) published by the Centers for Medicare and Medicaid Services on January 21, 2016. All policy and reimbursement changes impact BadgerCare Plus, Wisconsin Medicaid, and SeniorCare. The Wisconsin AIDS Drug Assistance Program and the Wisconsin Chronic Disease Program are impacted by the reimbursement changes; i.e., ingredient cost and professional dispensing fees.

Overview

Effective for dates of service (DOS) on and after April 1, 2017, ForwardHealth will be changing its billing and reimbursement policy for providers who submit claims to ForwardHealth with National Drug Codes (NDCs) for covered outpatient drugs. These changes are in compliance with the federal Covered Outpatient Drugs Final Rule (CMS-2345-FC) published by the Centers for Medicare and Medicaid Services (CMS) on January 21, 2016. All policy and reimbursement changes impact BadgerCare Plus, Wisconsin Medicaid, and SeniorCare. The Wisconsin AIDS Drugs Assistance Program (ADAP) and Wisconsin Chronic Disease Program (WCDP) are impacted by the reimbursement changes; i.e., ingredient cost and professional dispensing fees.

Note: Billing and reimbursement policies that affect Family Planning Clinics will be published in a separate *ForwardHealth Update*.

The intent of the Covered Outpatient Drugs Final Rule is to address the rise in prescription drug costs by ensuring that Medicaid programs reform payment methodologies for prescription drugs to accurately reflect market prices. All states are required to be in compliance with the reimbursement requirements of the rule by April 1, 2017.

As part of the Covered Outpatient Drugs Final Rule, CMS finalized payment upper limits for multiple source drugs available for purchase by retail community pharmacies. State payment for multiple source drugs must not exceed, in the aggregate, the federal upper limit (FUL). ForwardHealth will use an Actual Acquisition Cost (AAC) reimbursement methodology for ingredient cost reimbursement for DOS on and after April 1, 2017, which will ensure compliance with the FUL established by CMS. ForwardHealth will also move to a professional dispensing fee to comply with the reimbursement requirements of the Covered Outpatient Drugs Final Rule.

Throughout 2016 and early 2017, ForwardHealth conducted stakeholder meetings to inform providers of the Covered Outpatient Drugs Final Rule and to obtain feedback from providers on ForwardHealth's proposed reimbursement policies in response to the federal regulation. Additionally, ForwardHealth conducted a Professional Dispensing Fee Survey to obtain information from providers on the costs associated with dispensing covered outpatient drugs to ForwardHealth members. The ongoing collaboration with providers and associations was critical to ForwardHealth in determining the professional dispensing fee and other reimbursement policies.

As a reminder, providers are required to retain relevant documentation supporting adherence to the new program requirements outlined in the Online Handbook and the Wisconsin Administrative Code, and produce it for and/or submit it to ForwardHealth upon request. ForwardHealth may deny or recoup payment for services that fail to meet program requirements.

Definition of Covered Outpatient Drugs

Covered outpatient drugs are drugs that are treated as prescribed drugs for the purposes of § 1905(a)(12) of the Social Security Act (42 U.S.C. § 1396d[a][12]) and meet the definition of a covered outpatient drug as found in 42 C.F.R. § 447.502 (the Covered Outpatient Drugs Final Rule is available on the Federal Register website at *https://www.gpo.gov/fdsys/pkg/FR-2016-02-01/pdf/2016-01274.pdf*). The AAC reimbursement requirements for covered outpatient drugs set forth in the Code of Federal Regulations do **not** include, in part, diabetic supplies, provider-administered drugs, or specialty drugs not purchased through the federal 340B Drug Pricing Program (340B Program).

Covered Outpatient Drug Reimbursement — Ingredient Cost

In addition to BadgerCare Plus, Medicaid, and SeniorCare, ADAP and WCDP will be impacted by changes to ingredient cost reimbursement.

In order to comply with the Covered Outpatient Drugs Final Rule, ForwardHealth will reimburse covered outpatient drugs according to a separate ingredient cost and a professional dispensing fee. Ingredient cost reimbursement will move from Estimated Acquisition Cost (EAC) to AAC. As defined by 42 C.F.R. § 447.502, AAC is "the agency's determination of the pharmacy providers' actual prices paid to acquire drug products marketed or sold by specific manufacturers."

ForwardHealth will use the National Average Drug Acquisition Cost (NADAC) to reimburse ingredient cost for covered outpatient drugs, excluding drugs purchased through the federal 340B Program, drugs subject to the Federal Supply Schedule (FSS), or drugs acquired at a nominal price. The Centers for Medicare and Medicaid Services has stated the NADAC is an appropriate benchmark to establish AAC reimbursement. The NADAC is provided by CMS and calculated by a CMS vendor, Myers and Stauffer LC, a national certified public accounting firm. Myers and Stauffer LC conducts surveys of retail community pharmacy prices, including drug ingredient costs, to develop the NADAC pricing benchmark. The Medicaid website provides NADAC pricing at *https://www.medicaid.gov/medicaid/prescription-drugs/pharmacy-pricing/index.html*. The NADAC prices are updated on a weekly basis.

National Average Drug Acquisition Cost pricing review requests or notifications of recent drug price changes that may not be reflected in the posted NADAC file should be directed to the NADAC Help Desk. The NADAC Help Desk may be contacted through the following means:

- Telephone (toll-free): 855-457-5264
- Email: *info@mslcrps.com*
- Fax: 844-860-0236

ForwardHealth will not accept drug price review requests, disputes, or notifications of recent drug price changes for NADAC pricing.

Providers will be reimbursed at the lesser of the covered outpatient drug's NADAC rate or the billed amount. If a covered outpatient drug does not have a NADAC rate

available, then the provider will be reimbursed at the lesser of the drug's Wholesale Acquisition Cost (WAC), State Maximum Allowed Cost (SMAC), if available, or the billed amount.

As a reminder, providers are required to bill their usual and customary charges for pharmaceutical items and Medication Therapy Management (MTM) services provided. Covered services are reimbursed at the lower of the provider's usual and customary charge or the maximum allowable fee established by the Wisconsin Department of Health Services. For more information about usual and customary charges, providers may refer to the Usual and Customary Charges topic (topic #517) in the Responsibilities chapter of the Claims section of the Online Handbook.

340B Drug Pricing Program

Definition of the 340B Drug Pricing Program

The 340B Program is a federal program that requires drug manufacturers to provide outpatient drugs to eligible covered entities at significantly reduced prices. Section 340B(a)(4) of the Public Health Services Act specifies which covered entities are eligible to participate in the 340B Program. The 340B Program enables covered entities to fully utilize federal resources, reaching more eligible patients and providing more comprehensive services.

Providers may determine if they are an eligible organization/covered entity to participate in the 340B Program, and if so, may register with the 340B Program through the Health Resources & Services Administration (HRSA) website at *www.hrsa.gov/opa/index.html*. Upon enrollment in the 340B Program, covered entities must determine whether they will use drugs purchased through the 340B Program for their Medicaid members (carve-in) or purchase drugs for their Medicaid members through other mechanisms (carve-out). Covered entities who carve-in must be listed on the HRSA 340B Medicaid Exclusion File (MEF), which is used to assist states and manufacturers in determining which drugs are not subject to Medicaid rebates. Covered entity providers who carve-in will be subject to the 340B Program reimbursement changes as detailed in the 340B Ingredient Cost Reimbursement section of this *Update*.

Providers should refer to the Claims section of this *Update* for 340B Program claims submission requirements.

340B Ingredient Cost Reimbursement

The Covered Outpatient Drugs Final Rule requires state Medicaid programs to reimburse drugs acquired through the 340B Program at their AAC. Because NADAC pricing is not applicable for covered outpatient drugs purchased through the 340B Program, ForwardHealth will use calculated 340B ceiling prices to determine a maximum ingredient cost of drugs purchased through the 340B Program, including specialty drugs purchased through the 340B Program, and to comply with the 340B AAC requirements in the rule. The Centers for Medicare and Medicaid Services has stated that ceiling price is an appropriate AAC benchmark for drugs purchased through the 340B Program.

The 340B ceiling price refers to the maximum amount a manufacturer can charge a covered entity for the purchase of a covered outpatient drug through the 340B Program. The 340B ceiling price is statutorily defined as the Average Manufacturer Price (AMP) reduced by the rebate percentage, which is commonly referred to as the Unit Rebate Amount (URA). The Health Resources & Services Administration maintains the official 340B ceiling prices, which are not available to state Medicaid programs or the public due to confidentiality protections. However, CMS performs the URA calculations based on manufacturer-reported pricing data and specific methodology determined by law. The Centers for Medicare and Medicaid Services provides the URA and pricing data to states quarterly. ForwardHealth will use this information to determine the calculated 340B ceiling price. ForwardHealth will not adjust claims if manufacturers retroactively change AMP or URA.

Providers are required to submit their AAC when they dispense drugs purchased through the 340B Program to ForwardHealth members. Providers who dispense 340B inventory to ForwardHealth members will be reimbursed at

the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC.

When a calculated 340B ceiling price is not available for a drug, ForwardHealth will reimburse at the lesser of WAC minus 50 percent or the provider-submitted 340B AAC.

Contract Pharmacies

Effective for DOS on and after April 1, 2017, drugs acquired through the federal 340B Program and dispensed by 340B contract pharmacies will not be covered by ForwardHealth. A 340B contract pharmacy must carve-out ForwardHealth from its 340B operation and purchase all drugs billed to ForwardHealth outside of the 340B Program.

State and Specialty Maximum Allowed Cost Drug Pricing

Reimbursement for specialty drugs not purchased through the 340B Program does not need to meet the AAC requirements of the federal rule. States have the flexibility to determine separate reimbursement rates for specialty drugs; however, states must clearly define what drugs qualify as specialty drugs and will receive specialty drug reimbursement.

Specialty Drug Definition

ForwardHealth defines specialty drugs as drugs requiring comprehensive patient care services, clinical management, and product support services.

The definition includes criteria consistently included in other states' definitions of specialty drugs:

- Drugs prescribed for complex, chronic, or rare medical conditions
- Drugs not routinely stocked at a majority of retail community pharmacies
- Drugs that require special handling, storage, inventory, or distribution
- Drugs that require complex education and treatment maintenance

Per ForwardHealth's definition, some drugs that are currently classified as specialty drugs will no longer be classified as specialty drugs on and after April 1, 2017. The following drug classes will be removed from ForwardHealth's specialty drug list:

- Cytokine and cell adhesion molecule antagonists
- Human Immunodeficiency Virus
- Miscellaneous: antipsychotic injectable
- Miscellaneous: hyperparathyroidism
- Organ transplant/immunosuppressant
- Osteoporosis

To determine which drug classes meet the definition of specialty drugs, ForwardHealth reviewed the drug classes to determine whether the drugs within the drug classes had an available NADAC. Drug classes in which the majority of the drugs do not have an available NADAC will continue to be identified as specialty drugs. Drugs that may be dispensed by a retail community pharmacy and that belong to drug classes in which the majority of drugs within the therapeutic category have a NADAC will no longer be classified as specialty drugs.

Specialty Drug Reimbursement

Drugs that meet ForwardHealth's definition of specialty drugs are outside the scope of the AAC requirements of the federal rule and will continue to be reimbursed at an EAC of WAC plus or minus a specified percent. However, specialty drugs purchased through the 340B Program will be reimbursed according to the 340B ingredient cost reimbursement outlined above.

For more information about specialty drug reimbursement, providers may refer to the Wholesale Acquisition Cost topic (topic #12297) of the Amounts chapter of the Reimbursement section of the Pharmacy service area of the Online Handbook.

State Maximum Allowed Cost Drug Reimbursement

Existing SMAC rates will be end-dated March 31, 2017; however, ForwardHealth may use this reimbursement methodology in the future.

State and Specialty Pharmacy Drug Reimbursement Rates Table

Effective April 1, 2017, the State Maximum Allowed Cost List and Specialty Drug Reimbursement Rates list will be combined into the State and Specialty Pharmacy Drug Reimbursement Rates table. The State and Specialty Pharmacy Drug Reimbursement Rates table will be updated monthly. Providers should refer to the State and Specialty Pharmacy Drug Reimbursement Rates table on the Pharmacy Resources page of the Portal for a list of drugs that will receive specialty pharmacy drug reimbursement rates. If ForwardHealth uses SMAC reimbursement in the future, the SMAC reimbursement rates will be published in this table.

Revised State Maximum Allowed Cost Drug Pricing Review Request

ForwardHealth has revised and renamed the State Maximum Allowed Cost Drug Pricing Review Request form, F-00030 (10/13). The form has been renamed the State and Specialty Maximum Allowed Cost Drug Pricing Review Request form, F-00030 (04/2017). Beginning on April 1, 2017, providers may submit this form to request the review of SMAC pricing and specialty drug pricing in the ForwardHealth drug index.

The previous version of the form will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section of the Pharmacy Resources page of the Portal. Pricing review requests submitted on and after April 1, 2017, must be submitted on the revised form or the review request will be returned to the provider.

Federal Supply Schedule

The FSS program provides federal customers with access to commercial products and services through contracts awarded to pre-approved vendors using full and open competition and through negotiating firm-fixed pricing based on a commercial "most favored customer" pricing concept. The federal rule requires ForwardHealth to reimburse covered outpatient drugs purchased through the FSS program according to an AAC-based ingredient cost and a professional dispensing fee. Providers are required to bill their AAC plus a professional dispensing fee for these drugs.

Drugs Acquired at Nominal Price

Drugs acquired at a nominal price are drugs that cost less than 10 percent of the AMP in the same quarter for which the AMP is computed. The federal rule requires ForwardHealth to reimburse covered outpatient drugs purchased at a nominal price (not through the 340B Program) according to an AAC-based ingredient cost and a professional dispensing fee. Providers are required to bill their AAC plus a professional dispensing fee for these drugs.

Compound Drug Ingredient Cost Reimbursement

Compounded products are covered outpatient drugs and will be affected by the new reimbursement methodology. Compounded products will receive the aforementioned AAC pricing. If a covered outpatient drug NDC in the compound does not have a NADAC rate available, then the provider will be reimbursed at the lesser of the drug's WAC or SMAC, if available, or the billed amount. If a compounded product includes an ingredient purchased through the 340B Program, then all NDCs submitted in the entire compound will be considered as purchased through the 340B Program and will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC. If a calculated 340B ceiling price is not available for a drug, ForwardHealth will reimburse 340B ingredient cost at the lesser of WAC minus 50 percent or the provider-submitted 340B AAC.

Providers should refer to the Claims for Drugs Purchased Through the 340B Drug Pricing Program section of this *Update* for 340B Program claims submission information.

Covered Outpatient Drug Reimbursement — Professional Dispensing Fee

In addition to BadgerCare Plus, Medicaid, and SeniorCare, ADAP and WCDP will be impacted by changes to professional dispensing fee reimbursement rates.

In order to comply with the Covered Outpatient Drugs Final Rule, ForwardHealth will transition to a professional

dispensing fee. The professional dispensing fee is designed to reflect professional services and costs associated with delivering a covered outpatient drug to a ForwardHealth member.

The professional dispensing fee will also apply to drugs purchased through the 340B Program and specialty drugs listed on the State and Specialty Pharmacy Drug Reimbursement Rates table.

Professional Dispensing Fee Definition

As defined in 42 C.F.R. § 447.502:

> *Professional dispensing fee* means the professional fee which:
> **(1)** Is incurred at the point of sale or service and pays for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed;
> **(2)** Includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filling the container, beneficiary counseling, physically providing the completed prescription to the Medicaid beneficiary, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy; and
> **(3)** Does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including systems costs for interfacing with pharmacies.

Professional Dispensing Fee Survey

In June 2016, ForwardHealth conducted a mandatory Professional Dispensing Fee Survey to obtain information from providers on the costs associated with dispensing covered outpatient drugs to ForwardHealth members. Based on the data collected from the Professional Dispensing Fee Survey, ForwardHealth has established professional dispensing fee reimbursement rates based on a dispensing provider's annual prescription volume for DOS on and after April 1, 2017. Professional Dispensing Fee Survey findings and recommendations may be found in the Cost of Dispensing Report published on the Covered Outpatient Drug Pricing page of the Portal.

ForwardHealth will conduct mandatory professional dispensing fee surveys periodically as part of an ongoing process to ensure up-to-date professional dispensing fee reimbursement rates that accurately reflect the costs associated with dispensing covered outpatient drugs to ForwardHealth members.

Professional Dispensing Fee Reimbursement Rates

The following table lists the professional dispensing fee reimbursement rates for DOS on and after April 1, 2017, that include overall annual prescription volume and associated professional dispensing fees.

Total Annual Prescription Volume	Professional Dispensing Fee
0–34,999	$15.69
35,000+	$10.51

Prescription Volume Attestation

In January 2017, ForwardHealth conducted a mandatory Prescription Volume Attestation Survey to determine each dispensing provider's annual prescription volume for all prescriptions dispensed. Providers who submit claims to ForwardHealth with NDCs were required to attest to their annual prescription volume. Providers were identified for participation in the Prescription Volume Attestation Survey based on provider enrollment as of December 8, 2016, and billing ForwardHealth for a covered outpatient drug during calendar year 2016. ForwardHealth used providers' self-reported annual prescription volume to assign professional dispensing fee reimbursement rates.

A provider's assigned professional dispensing fee reimbursement rate will be effective until the next annual attestation process. Because prescription volume is self-reported, there will not be a dispute process for rate assignments. Providers who did not submit the Prescription Volume Attestation Survey will be assigned the professional dispensing fee reimbursement rate of $10.51.

Providers will be required to attest to their overall annual prescription volume on a yearly basis. The annual attestation process will be mandatory for all providers and organizations that dispense covered outpatient drugs. Providers will be subject to audits at ForwardHealth's discretion.

Newly Enrolled Providers

ForwardHealth will assign the professional dispensing fee reimbursement rate of $10.51 to newly enrolled providers who are newly enrolled after December 8, 2016. Providers will only be eligible for professional dispensing fee reimbursement rate reassignment during the annual prescription volume attestation process.

Out-of-State Providers and In-State Emergency Providers

For DOS on and after April 1, 2017, out-of-state providers and in-state emergency providers will be assigned the professional dispensing fee reimbursement rate of $10.51.

Federally Qualified Health Centers

Tribal Federally Qualified Health Centers (FQHCs) will receive an interim professional dispensing fee reimbursement rate of $24.92, which will be reconciled to approved federal encounter rates.

Non-tribal FQHCs, also known as Community Health Centers (CHCs), will receive an interim professional dispensing fee of $24.92 for SeniorCare members. For non-SeniorCare members, CHCs will not receive an interim professional dispensing fee because the professional dispensing fee is incorporated into the approved rate process.

Claims submission and billing requirements for tribal and non-tribal FQHCs will remain the same, with the exception of claims for drugs purchased through the 340B Program, which will be subject to the claims submission and billing requirements for the 340B Program. Providers should refer to the Claims section of this *Update* for 340B Program claims submission requirements.

Compound Drug Professional Dispensing Fee Reimbursement

The aforementioned professional dispensing fee reimbursement rates will be used to reimburse providers for the dispensing of compound drugs. Providers will be reimbursed the assigned professional dispensing fee reimbursement rate plus a compound add-on of $7.79. Level of effort will be discontinued, effective for DOS on and after April 1, 2017; providers will no longer be reimbursed according to time spent compounding a prescription.

Other Reimbursement

Medication Therapy Management

Effective for DOS on and after April 1, 2017, MTM intervention-based services (IBS) will no longer be a separately reimbursable service. The professional dispensing fee incorporates MTM IBS reimbursement. As a reminder, providers are required to submit the associated documentation for MTM services within 365 days of the DOS.

Effective for DOS on and after April 1, 2017, comprehensive medication review/assessments (CMR/As) will continue to be a billable service. Reimbursement for CMR/As will increase to the following amounts:

- $85.00 for initial assessments
- $40.00 for follow-up assessments

Repackaging Allowance

Repackaging will continue to be a separately reimbursed service. Repackaging will only be allowable for oral drugs in a solid form. For these drugs, ForwardHealth will continue to reimburse a repackaging allowance of $0.015 per unit. The billing requirements for repackaging will remain the same.

For more information about submitting claims for repackaging, providers may refer to the Repackaging topic (topic #1954) in the Submission chapter of the Claims section of the Pharmacy service area of the Online Handbook.

Drug Search Tool

The Drug Search Tool on the Portal will be updated to reflect covered outpatient drug reimbursement policy changes, effective April 1, 2017. Additional enhancements to the Drug Search Tool will also be implemented at a later date.

Reimbursement information for drugs purchased through the 340B Program will not be available on the Drug Search Tool. The Health Resources & Services Administration maintains the official 340B ceiling prices, which are not available to the public due to confidentiality protections.

Terms of Reimbursement

ForwardHealth has revised the Pharmacy Terms of Reimbursement, P-01673 (04/2017), to reflect the reimbursement policy changes in this *Update*, effective for DOS on and after April 1, 2017. The conditions outlined in the revised terms of reimbursement will automatically take effect; providers do not need to resubmit enrollment materials.

Refer to the Attachment of this *Update* for the revised Pharmacy Terms of Reimbursement. This document will be available on the Terms of Reimbursement Provider Enrollment page of the Portal on April 3, 2017.

Brand or Generic Status of a National Drug Code

Effective for DOS on and after April 1, 2017, the brand or generic status of some drugs may change. ForwardHealth will use the following information to determine the brand or generic status of an NDC:

- National Average Drug Acquisition Cost file
- Manufacturer's label name of the product

Brand Status of a National Drug Code

Effective for DOS on and after April 1, 2017, an NDC's brand status will be assigned using the Classification for Rate Setting field on the NADAC file. An NDC with a value of "B" or "B-ANDA" will be assigned a brand status. If an NDC is not on the NADAC file, brand status will be determined by the market or label name. If the NDC market or label name is different than the active ingredient(s), the NDC will be considered a brand; e.g., Adderall® (active ingredients amphetamine and dextroamphetamine) and Norco® (active ingredients acetaminophen and hydrocodone) would have a brand status.

Generic Status of a National Drug Code

Effective for DOS on and after April 1, 2017, an NDC's generic status will be assigned using the Classification for Rate Setting field on the NADAC file. An NDC with a value of "G" will be assigned a generic status. If an NDC is not on the NADAC file, generic status will be determined by the market or label name. If the NDC market or label name is based on the active ingredient(s), the NDC will be considered a generic; e.g., digoxin and omeprazole would have a generic status.

Copayment

ForwardHealth copayments for NDCs are not changing. For BadgerCare Plus and Wisconsin Medicaid, ForwardHealth will continue to assign a $3.00 copayment to a legend NDC with a brand status and a $1.00 copayment to a legend NDC with a generic status. ForwardHealth will continue to assign a $1.00 copayment to compounded products. ForwardHealth will continue to assign a $0.50 copayment to an over-the-counter NDC or diabetic supply NDC regardless of brand or generic status.

In certain situations, ForwardHealth will continue to assign a $1.00 generic copayment for an NDC with a brand name.

For SeniorCare, ForwardHealth will continue to assign a $5.00 copayment to a legend NDC with a generic status or a compound drug and a $15.00 copayment to a legend NDC with a brand status; however, copayments for tablet splitting

for SeniorCare members will be discontinued, effective for DOS on and after April 1, 2017.

For WCDP, ForwardHealth will continue to assign a $7.50 copayment to a legend NDC with a generic status and a $15.00 copayment to a legend NDC with a brand status.

For more information about copayment policies, providers may refer to the Copayment chapter of the Reimbursement section of the Online Handbook.

Copayment for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copayment to a brand name drug when a drug that previously required brand medically necessary (BMN) prior authorization (PA) becomes a preferred drug on the Preferred Drug List (PDL) and the available generic equivalents are non-preferred drugs.

This does not include brand name drugs that were preferred over generic equivalents because the generic equivalents are new to the marketplace and are not yet cost-effective when compared to brand pricing.

For drugs determined to be included in this policy, ForwardHealth will automatically apply the generic copayment when a specific brand name drug is preferred over a generic equivalent. Providers do not need to indicate a National Council for Prescription Drug Programs (NCPDP) Dispense As Written (DAW)/Product Selection code on claims to ensure the generic copayment deduction.

Claims

Effective for claims received on and after April 1, 2017, ForwardHealth will revise claim formats and billing instructions to be in accordance with the covered outpatient drug pricing changes. All providers who submit compound, noncompound, or professional claims to ForwardHealth for drugs should be aware of the changes to ensure they are using the most current claim formats and billing instructions.

The following will be revised:

- The ForwardHealth Payer Sheet: National Council for Prescription Drug Programs (NCPDP) Version D.0, P-00272, will identify additional submission clarification values and address new payer situations to accommodate claim submission requirements when submitting a claim for a drug purchased through the 340B Program. Currently, the Submission Clarification Code field (420-DK) of the NCPDP Version D.0 transaction only accepts a value of "8." For DOS on and after April 1, 2017, this field will be revised to accept additional values. Providers should refer to the updated NCPDP Version D.0 Payer Sheet (dated 04/2017) by clicking the Companion Guides link from the Trading Partners box on the Portal home page.
- The Portal Direct Data Entry Compound/ Noncompound Claim formats will add a Submission Clarification Code field. Providers should refer to the updated ForwardHealth Portal Compound and Noncompound Drug Claim User Guide by clicking the Companion Guides link from the Trading Partners box on the Portal home page.
- The Provider Electronic Solutions (PES) NCPDP Pharmacy claim form will have additional values for the Submission Clarification Code field. The PES software will be upgraded to version 3.10. Users will be notified when the upgraded PES software is available for mandatory download. The PES Manual will be revised and published to the Portal in coordination with the upgraded software release.
- The paper Compound Drug Claim form, F-13073 (04/2017), and corresponding Compound Drug Claim Completion Instructions, F-13073A (04/2017), have:
  - ✓ Added Element 18 – Submission Clarification Code
  - ✓ Removed Element 23 – Level of Effort
- The paper Noncompound Drug Claim form, F-13072 (04/2017), and corresponding Noncompound Drug Claim Completion Instructions, F-13072A (04/2017), have:
  - ✓ Added Element 21 – Submission Clarification Code
  - ✓ Removed Element 23 – Level of Effort
  - ✓ Removed Element 24 – Reason for Service
  - ✓ Removed Element 25 – Professional Service

- ✓ Removed Element 26 – Result of Service

The previous versions of the Compound Drug Claim form and Noncompound Drug Claim form will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section of the Pharmacy Resources page of the Portal. Paper Compound Drug Claim and Noncompound Drug Claim forms received by ForwardHealth from April 1–30, 2017, will be accepted on the previous and revised form versions to allow a transition period. Providers should allow four to five days for mail delivery of their paper forms. Paper compound and noncompound drug claims submitted on and after May 1, 2017, must be submitted on the appropriate revised form or the claim will be denied.

Claims for Drugs Purchased Through the 340B Drug Pricing Program

Providers who submit compound, noncompound, and professional claims to ForwardHealth for drugs purchased through the 340B Program for DOS on and after April 1, 2017, must comply with revised billing instructions. ForwardHealth will use submission clarification codes on compound and noncompound drug claims and a modifier on professional claims to identify claims for drugs purchased through the 340B Program. Additionally, ForwardHealth will monitor claims for the appropriate submission clarification code or modifier based on whether or not providers have designated themselves on the HRSA 340B MEF.

ForwardHealth will use claim level identifiers to identify claims for drugs purchased through the 340B Program in order to exclude these claims from the drug rebate invoicing process. It is the responsibility of the 340B covered entity to indicate the AAC and to correctly report claims filled with 340B inventory for 340B-eligible patients to ensure rebates are not collected for these drugs. If a rebate is received by ForwardHealth for a drug purchased through the 340B Program due to incorrect claim level identifiers, the 340B covered entity will be responsible to reimburse the manufacturer the 340B discount.

As a reminder, ADAP and WCDP providers are not allowed to dispense drugs purchased through the 340B Program to ADAP and WCDP members; therefore, the billing instructions for drugs purchased through the 340B Program do not apply.

Compound and Noncompound Claim Requirements for Drugs Purchased Through the 340B Drug Pricing Program

Effective for DOS on and after April 1, 2017, the compound and noncompound drug claim formats will require submission clarification codes in order to identify claims for drugs purchased through the 340B Program. ForwardHealth will use the submission clarification code value to ensure appropriate rebate processes and avoid duplicate discounts. Providers should only submit claims for drugs purchased through the 340B Program if the provider is present on the HRSA 340B MEF.

ForwardHealth will rely solely on these claim level identifiers to identify claims for drugs purchased through the 340B Program. If a 340B claim level identifier is present, then the claim will be excluded from the drug rebate invoicing process.

The following submission clarification codes will be applicable to compound and noncompound drug claims submitted by 340B providers:

- "20" (340B) — Providers who submit a compound or noncompound drug claim for a drug purchased through the 340B Program will be required to enter submission clarification code "20" to indicate that the provider determined the drug being billed on the claim was purchased pursuant to rights available under Section 340B of the Public Health Act of 1992. ForwardHealth will use the submission clarification code value of "20" to apply 340B reimbursement and to ensure that only eligible claims are being used to obtain drug manufacturer rebates. The claim will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC.
- "99" (Other) — If a provider who is listed on the HRSA 340B MEF submits a compound or

noncompound drug claim without submission clarification code "20," the claim will be denied with an Explanation of Benefits (EOB) code stating he or she is a 340B provider submitting a claim for a drug not purchased through the 340B Program. Once a provider has verified that the claim is not for a drug purchased through the 340B Program, he or she should resubmit the claim with submission clarification code "99" to verify that the claim was submitted as intended and is not a claim for a drug purchased through the 340B Program. A claim with a submission clarification code of "99" will be reimbursed at the lesser of the current ForwardHealth reimbursement rate plus a professional dispensing fee or the billed amount. 340B reimbursement will not be applied.

- "2" (Other Override) — If a submitting provider is not listed on the HRSA 340B MEF but submits a compound or noncompound drug claim for a drug purchased through the 340B Program (by indicating a submission clarification code of "20"), the claim will be denied with an EOB code stating he or she is not on the HRSA 340B MEF. If the provider believes he or she is or should be on the HRSA 340B MEF as a 340B covered entity choosing to carve-in for Wisconsin Medicaid, the provider should resubmit the claim with submission clarification code "2" to indicate that the claim is for a drug purchased through the 340B Program. The provider should also contact HRSA to update the HRSA 340B MEF with the provider's information. Covered entities are responsible for the accuracy of the information in the HRSA 340B MEF. A claim with a submission clarification code of "2" will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted 340B AAC. If a calculated 340B ceiling price is not available for a drug, ForwardHealth will reimburse 340B ingredient cost at the lesser of WAC minus 50 percent or the provider-submitted 340B AAC.

Note: The compound drug claim format only accepts one submission clarification code value. If a compound drug includes an ingredient that was purchased through the 340B Program, the provider should use the appropriate submission clarification code to identify the claim is for a drug purchased through the 340B Program, and ForwardHealth will assume the submission clarification code "8" (Process Compound for Approved Ingredients) applies to all ingredients of the compound drug claim.

Professional Claim Requirements for Drugs Purchased Through the 340B Drug Pricing Program

Effective for DOS on and after April 1, 2017, professional claim formats will require a "UD" modifier in order to identify claims for drugs purchased through the 340B Program. Providers who submit professional claims for provider-administered drugs purchased through the 340B Program to ForwardHealth for DOS on and after April 1, 2017, will be required to indicate a "UD" modifier for each Healthcare Common Procedure Coding System procedure code to indicate the provider determined that the product being billed on the claim detail was purchased pursuant to rights available under Section 340B of the Public Health Act of 1992. ForwardHealth will use the "UD" modifier to identify that a claim is for a provider-administered drug purchased through the 340B Program and to ensure that only eligible claims are being used to obtain drug manufacturer rebates. Providers should only submit claims for drugs purchased through the 340B Program if the provider is present on the HRSA 340B MEF.

ForwardHealth will rely solely on the "UD" modifier to identify professional claims for drugs purchased through the 340B Program. If a "UD" modifier is present, then the claim will be excluded from the drug rebate invoicing process.

In addition, providers are required to submit their AAC when they dispense drugs purchased through the 340B Program to ForwardHealth members. Providers who dispense 340B inventory to ForwardHealth members will be reimbursed at the lesser of the calculated 340B ceiling price or the provider-submitted AAC.

For more information about how to bill claims for provider-administered drugs purchased through the 340B Program, providers should refer to the Provider-Administered Drugs

topic (topic #4382) in the Submission chapter of the Claims section of the Online Handbook.

Explanation of Benefits

Explanation of Benefits codes will be updated, as applicable, to reflect changes to covered outpatient drug reimbursement policy. Additionally, for DOS on and after April 1, 2017, ForwardHealth will be assigning compound and noncompound drug claims through new reimbursement EOB codes. The following EOB codes will apply:

- 9949 (NDC was reimbursed at the SMAC rate.)
- 9951 (NDC was reimbursed at the brand WAC rate.)
- 9952 (NDC was reimbursed at the generic WAC rate.)
- 9960 (NDC was reimbursed at the NADAC rate.)
- 9961 (NDC was reimbursed at the Calculated 340B Ceiling Price.)

Additional changes to the EOB codes will be implemented in the future. Providers should refer to the Explanation of Benefits list linked from the Provider home page of the Portal for current EOB codes and descriptions.

Pharmacy Policy Changes

Prior Authorization

Brand Medically Necessary Drugs and Brand Before Generic Drugs

ForwardHealth requires PA for the coverage of certain drugs. For DOS on and after April 1, 2017, providers should refer to the new Brand Medically Necessary Drugs and Brand Before Generic Drugs data table on the Pharmacy Resources page of the Providers area of the Portal for a list of drugs that require these types of PA. This table will list the drugs that have specific PA or policy requirements for BMN drugs or Brand Before Generic (BBG) drugs. The Brand Medically Necessary Drugs and Brand Before Generic Drugs data table will be available on the Pharmacy Resources page of the Portal and will be updated monthly.

Brand Medically Necessary Drugs Prior Authorization and Policy

ForwardHealth has revised the Prior Authorization/Brand Medically Necessary Attachment (PA/BMNA) form, F-11083 (04/2017). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received on and after April 1, 2017, must be submitted on the revised form or they will be returned to the provider.

Effective for DOS on and after April 1, 2017, the following drugs will be subject to BMN policy but will not require PA:

- Anticonvulsants — included on the PDL Quick Reference in the anticonvulsants drug class
- CellCept®
- Certain thyroid hormones
- Contraceptives
- Coumadin®
- Lanoxin®
- Neoral®
- Prograf®

Prescribers will continue to be required to handwrite "brand medically necessary" on the prescription for the above drugs either directly on the prescription or on a separate order attached to the original prescription, and pharmacy providers will be required to submit a DAW/Product Selection Code 1 (Substitution not allowed by prescriber) for the above drugs. The completion of the PA/BMNA form for the drugs listed above is no longer required.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Providers may refer to the Brand Medically Necessary Drugs and Brand Before Generic Drugs data table located on the Pharmacy Resources page of the Portal for the most current list of BMN drugs that require PA.

Brand Medically Necessary Drugs: A Prescriber's Responsibilities

As required in Wis. Admin. Code § DHS 107.10(3)(c), when a prescription is for a BMN drug, the prescriber is required to handwrite "brand medically necessary" directly on the prescription. ForwardHealth also allows the required statement to be handwritten on a separate order attached to the original prescription. Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement. Blanket authorization for an individual member, drug, or prescriber is not acceptable documentation.

Prescribers are also required to complete a PA/BMNA form for BMN drugs that require PA. The PA/BMNA form must include accurate and complete answers and clinical information about the member's medical history and must include the prescriber's handwritten signature and date.

The PA/BMNA form may be faxed or mailed to the pharmacy, or the member may carry the form with the prescription to the pharmacy. The pharmacy provider will use the completed PA/BMNA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA/BMNA form to ForwardHealth.

Prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation.

ForwardHealth has revised the clinical criteria for BMN drugs.

Clinical Criteria for Brand Medically Necessary Drugs That Require Prior Authorization

Clinical criteria for approval of a BMN drug that requires PA are **all** of the following:

- The drug has been defined by ForwardHealth as a brand drug that requires BMN PA.
- The member satisfies established coverage and PA policy for the generic equivalent drug.
- The prescriber submits detailed documentation of the member's relevant medication treatment history.
- The member has taken the requested BMN drug for at least 30 consecutive days and had a measurable therapeutic response. (*Note:* Documentation of approximate dates taken may come from the pharmacy or the prescriber.)
- The prescriber has indicated how the BMN drug will prevent recurrence of an unsatisfactory therapeutic response or clinically significant adverse drug reaction.
- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to the generic equivalent drug from at least two different manufacturers.

  For each generic trial, the following must be documented:

  - ✓ Generic drug manufacturer or NDC (*Note:* Documentation may come from the pharmacy or the prescriber.)
  - ✓ Approximate dates taken (*Note:* Documentation may come from the pharmacy or the prescriber.)
  - ✓ A description of the unsatisfactory therapeutic response or clinically significant adverse drug reaction that can be directly attributed to the generic equivalent drug

Note: Member or prescriber preference for the use of a BMN drug will not be considered as criteria to support the need for a BMN drug.

Brand Medically Necessary Drugs with Generic Equivalents on the Preferred Drug List

In addition to meeting the clinical criteria for BMN drugs that require PA, all existing PDL policies will apply to BMN drugs with generic equivalents on the PDL. This includes, but is not limited to, policy pertaining to drug classes that require step therapy, drugs that require clinical PA, and drugs that have non-preferred generic equivalents.

In addition to completing the PA/BMNA form for BMN drugs requiring PA, the prescriber is required to complete any other required drug- or drug-class-specific PA form and provide any medical records and/or documentation required

for the generic equivalent drug or applicable drug class. Examples include, but are not limited to, the following:

- A BMN drug, where its non-preferred generic equivalent requires a specific PA form
- A drug or drug class that requires specific medical records and/or documentation to be submitted with the PA request

For example, if a prescriber requests BMN PA for a brand drug and the non-preferred generic equivalent drug's PDL PA criteria requires the use of at least two PDL preferred drugs in the same drug class with an unsatisfactory therapeutic response or clinically significant adverse drug reaction, this requirement must also be met before a PA request can be approved for the brand name drug.

Brand Medically Necessary Drugs: A Pharmacy Provider's Responsibilities

Pharmacy providers are required to submit the completed PA/BMNA form received from the prescriber for BMN drugs requiring PA and a completed Prior Authorization Request Form (PA/RF), F-11018 (05/13), to ForwardHealth. Pharmacy providers may submit PA requests for BMN drugs requiring PA on the Portal, by fax, or by mail (but **not** using the Specialized Transmission Approval Technology-Prior Authorization [STAT-PA] system).

To obtain BMN PA, pharmacies are required to do the following:

- Obtain a prescription with "brand medically necessary" written in the prescriber's own handwriting either directly on the prescription or on a separate order attached to the original prescription.
- Receive the completed, signed, and dated PA/BMNA form from the prescriber.
- Complete a PA/RF to be submitted with the PA/BMNA form.

Documentation on the PA/BMNA form regarding the following may come from the pharmacy or the prescriber:

- The names of the manufacturers of the generic drugs that were taken
- The NDCs for the generic drugs that were taken
- The approximate dates the generic and brand drugs were taken

Note: For appropriate reimbursement, pharmacy providers are required to submit claims with a "1" in the DAW/Product Selection Code, as appropriate.

Certain BMN drugs are available through expedited emergency supply. Providers may refer to the Expedited Emergency Supply Request Drugs data table on the Pharmacy Resources page of the Providers area of the Portal or the Emergency Medication Dispensing topic (topic #1399) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook.

ForwardHealth does not require pharmacy providers to submit a copy of the BMN prescription or order attachment with the PA request. Pharmacy providers should retain the prescription, and if applicable, the order attachment, for all BMN drugs with the prescriber's handwritten certification of "brand medically necessary" in their pharmacy records. Pharmacy providers are required to ensure all necessary documentation is obtained before submission of the PA request. Pharmacy providers who receive BMN PA for brand name drugs requiring PA or for drugs subject to BMN policy may be subject to audits at any time. Pharmacy providers are also required to retain a completed, signed, and dated copy of the PA forms and any additional supporting documentation received from the prescriber and produce it for and/or submit it to ForwardHealth upon request. ForwardHealth may deny or recoup payment for claims submitted that do not meet BMN PA or policy requirements.

For information about amending a BMN PA request, pharmacy providers should refer to the Amendments topic (topic #431) in the Follow-Up to Decisions chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Titration

A prescriber who titrates a BMN drug requiring PA for a member may request more than one strength of the drug on a PA/BMNA form. The prescriber should handwrite "brand medically necessary" on each prescription for each strength of the titrated BMN drug requiring PA directly on the prescription or on a separate order attached to the original prescription sent to the pharmacy with the PA/BMNA form. Pharmacy providers should include the NDCs of all requested strengths of the drug on the PA/RF.

Brand Before Generic Drugs

Effective for DOS on and after April 1, 2017, most drugs that are listed on the Brand Medically Necessary Drugs and Brand Before Generic Drugs data table will require PA. Certain BBG drugs with previously published individual clinical criteria will be moved to the Brand Medically Necessary Drugs and Brand Before Generic Drugs data table and will now require PA under the new clinical criteria established for BBG drugs; e.g., imatinib.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Providers may refer to the Brand Medically Necessary Drugs and Brand Before Generic Drugs data table located on the Pharmacy Resources page of the Portal for the most current list of BBG drugs that require PA.

ForwardHealth has established clinical criteria for BBG drugs.

Clinical Criteria for Brand Before Generic Drugs

Clinical criteria for approval of a BBG drug that requires PA are **all** of the following:

- The drug has been defined by ForwardHealth as a generic drug that requires BBG PA.
- The member satisfies established coverage and PA policy for the brand equivalent drug.
- The prescriber submits detailed documentation of the member's relevant medication treatment history.
- The member has taken the requested generic drug for at least 30 consecutive days and had a measurable therapeutic response. (*Note:* Documentation of approximate dates taken may come from the pharmacy or the prescriber.)
- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction to the brand equivalent drug. (*Note:* Documentation of approximate dates taken may come from the pharmacy or the prescriber.)
- The prescriber includes a description of the unsatisfactory therapeutic response or clinically significant adverse drug reaction that can be directly attributed to the brand equivalent drug.
- The prescriber has indicated how the generic drug will prevent recurrence of an unsatisfactory therapeutic response or clinically significant adverse drug reaction.

Note: Member or prescriber preference for the use of a BBG drug will not be considered as criteria to support the need for a BBG drug.

Submitting Prior Authorization Requests for Brand Before Generic Drugs

Prior authorization requests for BBG drugs must be completed and signed by the prescriber and must be submitted using **both** of the following forms:

- Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form, F-11049 (07/2016)
- The PA/RF

Pharmacy providers may submit PA requests for BBG drugs on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Brand Before Generic Drugs on the Preferred Drug List

In addition to meeting the clinical criteria for BBG drugs, all existing PDL policies will apply to BBG drugs on the PDL. This includes, but is not limited to, policy pertaining to drug classes that require step therapy, drugs that require clinical PA, and drugs that have non-preferred brand equivalents.

In addition to completing the PA/DGA form for BBG drugs, the prescriber is required to complete any other required drug- or drug-class-specific PA form and provide any medical records and/or documentation required for the brand drug or applicable drug class. Examples include, but are not limited to, the following:

- A BBG drug, where its non-preferred brand requires a specific PA form
- A drug or drug class that requires specific medical records and/or documentation to be submitted with the PA request

For example, if a prescriber requests BBG PA for a generic drug and the non-preferred brand drug's PDL PA criteria requires the use of at least two PDL preferred drugs in the same drug class with an unsatisfactory therapeutic response or clinically significant adverse drug reaction, this requirement must also be met before a PA request can be approved for the generic drug.

Submitting Prior Authorization Requests for Brand Before Generic Drugs on the Preferred Drug List

Prior authorization requests for BBG drugs on the PDL must be completed and signed by the prescriber and must be submitted using **all** of the following forms:

- Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form
- The PA/RF
- Any other drug- or drug class-specific PA request form that would be required for the brand equivalent drug or applicable drug class

Pharmacy providers may submit PA requests for BBG drugs on the PDL on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Expedited Emergency Supply

As a result of the PA changes announced in this *Update*, the Expedited Emergency Supply Request Drugs data table on the Pharmacy Resources page of the Providers area of the Portal has been updated. The Emergency Medication Dispensing topic (topic #1399) includes more information about dispensing an emergency supply of medication.

Grandfathering Overview

If a BadgerCare Plus, Medicaid, or SeniorCare member is grandfathered on a brand name drug and a generic equivalent is available, grandfathering of the brand name drug for the member will be discontinued once the brand name drug is added to the BMN list on the Brand Medically Necessary Drugs and Brand Before Generic Drugs data table.

If medically appropriate for the member, providers should request BMN PA for the member to continue taking the brand name drug.

If a BadgerCare Plus, Medicaid, or SeniorCare member is grandfathered on a generic drug, PA is not required until further notice.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy for members enrolled in Medicaid and BadgerCare Plus who receive pharmacy services on a fee-for-service basis only. Pharmacy services for Medicaid members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and the Family Care Partnership are provided by the member's managed care organization (MCO). Members who are enrolled in the WCDP only are not enrolled in MCOs.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Medicaid Services, the Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at *www.forwardhealth.wi.gov/*.

P-1250

This *Update* was issued on 03/15/2017 and information contained in this *Update* was incorporated into the Online Handbook on 04/12/2017.

ATTACHMENT
Revised Pharmacy Terms of Reimbursement

(A copy of the "Pharmacy Terms of Reimbursement" is located on the following pages.)

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PHARMACY
TERMS OF REIMBURSEMENT

The Wisconsin Department of Health Services (DHS) will establish maximum allowable fees for all covered pharmaceutical items, disposable medical supplies (DMS), and Medication Therapy Management (MTM) services provided to Wisconsin Medicaid members eligible on the date of service. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law (42 C.F.R. § 447.512).

All covered legend and over-the-counter drugs will be reimbursed at the lower of the Actual Acquisition Cost (AAC) of the drug, plus a professional dispensing fee, or the provider's usual and customary charge.

The AAC of legend drugs and over-the-counter drugs will be determined based on the following:

- The actual prices currently and generally paid for pharmaceuticals.
- Individual drug cost will be based on either the National Average Drug Acquisition Cost (NADAC), or if NADAC is not available, the published Wholesale Acquisition Cost (WAC) or State Maximum Allowed Cost (SMAC), if available.

The following will also be reimbursed at AAC and providers are required to bill their AAC when they submit claims for these drugs:

- Drugs purchased through the 340B Drug Pricing Program
- Drugs purchased through the Federal Supply Schedule program
- Drugs purchased at nominal price

Diabetic supplies and specialty drugs not purchased through the 340B Drug Pricing Program will not be reimbursed at AAC, and will be reimbursed at the lower of the Estimated Acquisition Cost, plus a professional dispensing fee, or the provider's usual and customary charge.

Drug costs will be calculated based on the package size from which the prescription was dispensed, as indicated by the National Drug Code. The only exceptions are those drugs for which quantity minimums are specified by federal regulations and those drugs listed on the Wisconsin SMAC list.

The maximum allowable professional dispensing fee shall be based on a variety of factors, including data from the cost of dispensing surveys, the Wisconsin state legislature's Medicaid budgetary constraints, federal law, and other relevant economic limitations. Provider participation in ongoing cost of dispensing surveys is mandatory, including annual attestations. Newly enrolled providers will automatically be assigned a professional dispensing fee reimbursement rate until the next annual attestation survey.

The maximum allowable fees for DMS and MTM services shall be established upon a review of various factors. These factors include a review of usual and customary charges submitted to Wisconsin Medicaid; cost, payment, and charge information from companies that provide DMS and MTM services; Medicaid payment rates from other states; and the current Medicare fee schedule. Other factors taken into consideration include the Wisconsin state legislature's Medicaid budget constraints, limits on the availability of federal funding as specified in federal law, and other relevant economic and reimbursement limitations. Maximum allowable fees may be adjusted periodically.

Providers are required to bill their usual and customary charges for pharmaceutical items and for DMS and MTM services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. Covered services shall be reimbursed at the lower of the provider's usual and customary charge or the maximum allowable fee established by DHS. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers are required to bill their AAC when they submit claims for drugs purchased through the 340B Drug Pricing Program, drugs purchased through the Federal Supply Schedule program, or drugs purchased at nominal price. 340B covered outpatient drugs shall be reimbursed at the lower of the provider-submitted 340B AAC or the calculated 340B ceiling price.

Wisconsin Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department of Health Services will adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to Wis. Stat. ch. 49.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Wis. Stat. § 49.46(2)(c).

In accordance with federal regulations contained in 42 C.F.R. § 447.205, DHS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

P-01673 (04/2017)

Wisconsin
Department of Health Services