CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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March 27, 2017

Dear Pharmacy Provider

The Cabinet for Health and Family Services, Department for Medicaid Services (DMS), is sending this letter to inform you of some necessary changes for covered outpatient drug reimbursement. Pursuant to the requirements of 42 CFR § 447.205, effective April 1, 2017, DMS will be transitioning to the following actions regarding pharmacy reimbursement.

Fee-for-Service Only
The reimbursement transition applies to the dispensing or administration of covered outpatient drugs rendered to Medicaid "fee-for-service" recipients who are not enrolled with a Medicaid managed care organization. Managed care organizations are not required to reimburse for pharmacy services in this manner.

Effective April 1, 2017, DMS will implement an actual acquisition cost-based reimbursement model for pharmacy drug cost and implement a professional dispensing fee. Drug cost reimbursement will utilize the following methodology:

Drug Cost Reimbursement for Point of Sale
Effective for services provided on or after April 1, 2017, DMS shall reimburse for covered outpatient drug cost by the lowest of:

- National Average Drug Acquisition Cost (NADAC)
- Federal upper limit (FUL)
- Wholesale acquisition cost (WAC)
- State maximum allowable cost (MAC)
- Usual and customary charge
- 340B ceiling price

Drug Cost Reimbursement for Physician Administered Drugs
Effective for services provided on or after April 1, 2017, DMS shall alter reimbursement for physician administered covered outpatient drugs billed through the medical benefit from Average Wholesale Price (AWP) minus 10% to the following lowest of:

- National Average Drug Acquisition Cost (NADAC)
- Federal upper limit (FUL)
- Wholesale acquisition cost (WAC)
- State maximum allowable cost (MAC)

- Usual and customary charge
- 340B ceiling price
- Average sales price (ASP) plus 6.0%

Dispensing Fee

Effective for services provided on or after April 1, 2017, DMS shall pay a professional dispensing fee of $10.64 per provider per recipient per drug per month for any point of sale qualifying dispense.

Physician Administered Drugs billed through the medical benefit shall be reimbursed for drug cost only and no professional dispense fee shall be paid.

DMS is establishing this new reimbursement model in response to CMS; Medicaid Program; Covered Outpatient Drug; Final Rule (FC-2345), published on February 1, 2016, which requires drug pricing reductions related to actual acquisition cost (AAC) pricing. The changes ensure Medicaid recipients have continued access to prescription drugs, particularly those residing in rural areas. It also establishes a professional dispensing fee that is aligned and appropriate to compensate for the reasonable costs associated with a pharmacist's time and duties in delivering medication to a Medicaid recipient as defined by 42 CFR § 447.502. The new reimbursement model incorporates a more reliable and widely accepted drug pricing benchmark through the incorporation of NADAC.

DMS anticipates that the changes to the drug cost reimbursement and dispensing fees will be budget neutral. The increased professional dispense fee should offset any reduction in drug cost from the "lowest of" reimbursement methodology. An affected providers' net reimbursement should remain stable as a result of the changes rather than realizing a reduction. The change in pharmacy reimbursement methodology is intended to neither increase nor adversely affect overall pharmacy reimbursement. DMS anticipates some claims will require reprocessing once the new reimbursement and professional dispensing fee structure is fully implemented.

A public notice has been published regarding these changes. A copy of this notice is available for public review at the Department for Medicaid Services at the address listed below and http://www.chfs.ky.gov/dms/public+notices.htm.

Thank You,

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