Connecticut Medical Assistance Program (CTMAP) Drug Rebate Policies

** **Please Note:** Effective November 1, 2018, the Connecticut AIDS Drug Assistance Program (CADAP) is administered by the Connecticut Department of Public Health. For current information regarding the Connecticut CADAP and CIPA programs please visit the following web location: https://ctdph.magellanrx.com; or email CTDPHMRXENROLL@magellanhealth.com with specific questions.

CTMAP POLICIES RELATED TO PHARMACY CLAIM PAYMENT

DISPENSING FEE

The CTMAP dispensing fee was updated as follows:

- $4.10 to $3.85 effective with scripts filled on or after Sept 1. 2002
- $3.85 to $3.60 effective with scripts filled on or after March 3, 2003
- $3.60 to $3.30 effective with scripts filled on or after October 1, 2003
- $3.30 to $3.15 effective with scripts filled on or after July 1, 2004
- $3.15 to $2.65 effective with scripts filled on or after October 1, 2009
- $2.65 to $2.90 effective with scripts filled on or after July 1, 2010
- $2.90 to $2.00 effective with scripts filled on or after July 1, 2011
- $2.00 to $1.70 effective with scripts filled on or after January 16, 2013
- $1.70 to $1.40 effective with scripts filled on or after July 1, 2015
- $1.40 to $10.75 effective with scripts filled on or after April 1, 2017

CO-PAY

- Effective October 1, 2016, all full dual eligible clients, covered by Medicare Part D and Medicaid will be financially responsible for the first seventeen dollars ($17.00) of co-pays imposed by their Medicare Part D Prescription Drug Plan (PDP) every calendar month.
- For Dispense Dates between July 1, 2015 and September 30, 2016, CMAP no longer paid for Medicare Part D co-pays for dual eligible clients.

Connecticut Federal (HUSKY A, HUSKY C and HUSKY D) co-pay is as follows:

- $0.00 co-pay effective date of 07/01/2004
- $1.50 co-pay effective date of 11/1/2003 to 06/30/2004
- $1.00 co-pay effective date of 04/15/2003 to 10/31/2003

The co-payment requirement shall not apply to the following exempt categories of HUSKY C and HUSKY D clients:

- Children under 21 years of age
- Women who are pregnant, including the postpartum period. The postpartum period is the immediate postpartum period, which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.
- Persons living in a nursing facility or chronic disease hospital
- Prescriptions for family planning drugs or supplies.
- Compounded prescriptions, as defined in the Medicaid Services Policy for Drugs, Section 174A, including parenteral nutritionals.

CADAP has never been subjected to co-pay.

HUSKY B co-pay is as follows:
• $10 for Brand name drugs effective July 1, 2010
• $5 for Generic name drugs effective July 1, 2010

OTHER CTMAP, CADAP AND ConnPACE POLICIES

- Effective April 1, 2017, reimbursement to pharmacies is based on NADAC (National Average Drug Acquisition Cost). Selected OTC's and Enteral Nutrition products are paid at AWP.
- Effective July 1, 2015, reimbursement to pharmacies decreases from AWP-16% to AWP-16.5% for brand name medications or payment subject to EAC (Estimated Acquisition Cost). Selected OTC's and Enteral Nutrition products are paid at AWP.
- CTMAP policy allows for multiple bottles/tubes/vials per prescription. Multiplying the number of scripts times the unit size is not valid for disputing claims.
- HUSKY Health (HUSKY A, HUSKY B, HUSKY C, HUSKY D), and CADAP have a limit of 240 units per prescription (or greater in some instances) for tablets and capsules.
- HUSKY Health and CADAP have a 30-day limit on non-maintenance drugs, as defined by First Databank. ConnPACE, terminated 12/31/13 paid for a 30-day supply or 240 tablets/capsules, whichever is greater.
- CTMAP policy covers only the amount prescribed. This results in partial bottles being dispensed. For example, a prescription written for 3 oz of a cough syrup results in only 90ml being dispensed and billed from a 120ml bottle.
- HUSKY Health and ConnPACE require mandatory substitution, unless prior authorization is obtained or the brand name product is listed as preferred on the Preferred Drug List (PDL). CADAP does not mandate generic substitution.
- Providers must bill CTMAP at their Usual and Customary. If a "loss leader" (for example, Walmart's $4.00 generic prescriptions) pricing methodology is used, this same pricing methodology must be applied to HUSKY Health claims.
- CTMAP never pays more than the billed amount. If the provider makes a billing error, HUSKY Health does not increase payment without intervention from the provider.
- CTMAP is the payer of last resort. If a client has other insurance, the other insurance must be billed prior to billing HUSKY Health. This can result in a reduced billed amount for products to Medicaid, thus lowering the price/prescription.
- CTMAP has a package size edit that requires providers to bill for quantities equal to the package size or a multiple of the package size. This is applied to topical, ophthalmic, otic, nasal, and inhalation products.

- Effective August 1, 2004, Hewlett Packard Enterprise stopped processing claims for the State Administered General Assistance Program (SAGA). Providers have one year for timely filing so manufacturers may be invoiced by Hewlett Packard Enterprise for rebate on all claims up through August 1, 2005. Community Health Network of Connecticut (CHNCT) became the Administrative Services Organization for the State Administered General Assistance Medical Program effective August 1, 2004 through January 31, 2007.

- Effective February 1, 2008, Hewlett Packard Enterprise began processing claims for the State Administered General Assistance Program (SAGA).

- Effective April 1, 2010, the State Administered General Assistance Program (SAGA) was discontinued. Providers had one year for timely filing so manufacturers would be invoiced by Hewlett Packard Enterprise for rebate on all claims up through April 1, 2011. Pursuant to section 2001 (a) (40) (A) of the Patient Protection and Affordable Care Act, individuals formerly covered

under SAGA were covered under Medicaid effective April 1, 2010. The program name for this new Medicaid population was “Medicaid for Low Income Adults”, which was referred to as “Medicaid LIA”. Effective January 1, 2012 this population is referred to as Husky D.

NDC BILLING

- Effective March 1, 2005, providers are required to submit the corresponding 11-digit National Drug Code (NDC) when billing a HCPCS drug procedure code in the J, S or Q series.
- Effective July 1, 2008. Providers are required to submit a HCPCS and NDC on outpatient claims when billing for Revenue Center Codes (RCC) 250-253, 258-260, 273, or 634-637 electronically or using UB-04 forms.

APPLYING DIFFERENT DRUG FORMS TO BILLING UNITS

In general, **each** should be applied to the unit or lowest denominator, not the total package. Each packet, each syringe, each suppository, each patch and each tablet in a birth control package are examples of correct billing units. Each package and each box are examples of improper billing units according to the NCPDP standard. For the dose forms of ampules, syringes, and vials to be recognized as each, the container should be empty or contain a dry powder for reconstitution. If an ampule, syringe or vial is liquid-filled, the correct billing unit of ML is used instead.

Unit Dose Exception

Billing units used to represent unit-of-use packages are sometimes classified as each. For example, packets, drops, ointments, creams, and vials containing less than one gram or one milliliter are always categorized as each. Ophthalmic drops containing 0.4ml of liquid and Bacitracin ointment in 0.9gm packets are examples of dose forms that require each to be used in place of ML

Milliliter (ML) or Gram (GM) Exception

NCPDP states that inhaler, aerosols and topical products (except ointments) can be correctly classified as either ml or gm. When there is not a one-gram-one-milliliter relationship, the use of a gm versus ml can cause billing quantity discrepancies for both the provider and the Department. Special attention should be given to those drugs that fall within this group. Billing of multi-dose inhalers, creams, gels and lotions should be given close scrutiny.

Unit of Measure

In addition to the 11-digit NDC, the NDC quantity administered and the NDC Unit of Measure (UOM) must also be submitted.

- UN (Unit) would be utilized in conjunction with NDCs considered as individual or ‘Each’ unit ; for example, one tablet would be billed as 1 UN.
- GR (Gram) would be utilized in conjunction with NDCs measured by weight; for example, 15 grams of ointment would be billed as 15 GR.
- ML (Milliliter) would be utilized in conjunction with NDCs of liquids billed by volume; for example, 100 ml of Normal Saline would be billed as 100 ML.
- F2 (International Units) should be reserved for billing of Antihemophilic Factor medications which are billed by the number of units administered.