RULES OF

Department of Social Services

Division 70—MO HealthNet Division

Chapter 20—Pharmacy Program

TITLE 13 — DEPARTMENT OF SOCIAL SERVICES
Division 70 — MO HealthNet Division
Chapter 20 — Pharmacy Program

13 CSR 70-20.010 Participating Drug Vendors
(Rescinded September 30, 2018)

AUTHORITY: section 207.020, RSMo 1986. This rule was previously filed as 13 CSR 40-81.011. Original rule filed Nov. 13, 1978, effective Feb. 11, 1979. Rescinded: Filed March 2, 2018, effective Sept. 30, 2018.

13 CSR 70-20.030 Drugs Covered by the MO HealthNet Division

PURPOSE: This rule implements recent changes in drug coverage as mandated by the Centers for Medicare & Medicaid Services (CMS).

(1) Drugs covered under the MO HealthNet Division must meet the definition of a prescribed drug as defined in 42 CFR 440.120(a), as amended, or a covered outpatient drug as defined in the Social Security Act, section 1927(k)(2) and section 1927(k)(4), as amended.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and sections 208.152 and 208.153, RSMo Supp. 2024. This rule was previously filed as 13 CSR 40-81.010. Original rule filed Jan. 21, 1964, effective Jan. 31, 1964. Amended: Filed March 30, 1964, effective April 10, 1964. Amended: Filed April 27, 1965, effective May 7, 1965. Amended: Filed Dec. 7, 1966, effective Dec. 17, 1966. Amended: Filed Oct. 11, 1967, effective Oct. 21, 1967. Amended: Filed Oct. 19, 1967, effective Oct. 29, 1967. Amended: Filed Jan. 22, 1968, effective Feb. 2, 1968. Amended: Filed Aug. 24, 1968, effective Sept. 4, 1968. Amended: Filed April 16, 1970, effective April 26, 1970. Amended: Filed Feb. 16, 1971, effective Feb. 26, 1971. Amended: Filed Jan. 3, 1973, effective Jan. 13, 1973. Amended: Filed Feb. 6, 1975, effective Feb. 16, 1975. Amended: Filed March 9, 1977, effective June 11, 1977. Amended: Filed June 13, 1977, effective Oct. 1, 1977. Amended: Filed March 13, 1978, effective June 11, 1978. Amended: Filed Feb. 1, 1979, effective May 11, 1979. Emergency amendment filed July 26, 1979, effective Aug. 1, 1979, expired Oct. 10, 1979. Amended: Filed July 16, 1979, effective Oct. 11, 1979. Emergency amendment filed Aug. 11, 1981, effective Aug. 21, 1981, expired Nov. 11, 1981. Amended: Filed Aug. 11, 1981, effective Nov. 12, 1981. Emergency amendment filed Dec. 21, 1981, effective Jan. 1, 1982, expired April 10, 1982. Emergency amendment filed Jan. 21, 1982, effective Feb. 1, 1982, expired April 10, 1982. Amended: Filed Dec. 21, 1981, effective April 11, 1982. Emergency amendment filed July 22, 1982, effective Aug. 1, 1982, expired Nov. 10, 1982. Amended: Filed July 22, 1982, effective Nov. 11, 1982. Emergency amendment filed Sept. 30, 1982, effective Oct. 10, 1982, expired Jan. 28, 1983. Amended: Filed Jan. 14, 1983, effective May 12, 1983. Amended: Filed July 13, 1983, effective Oct. 13, 1983. Emergency amendment filed Dec. 21, 1983, effective Jan. 1, 1984, expired March 30, 1984. Emergency amendment filed March 21, 1984, effective March 31, 1984, expired July 11, 1984. Amended: Filed March 21, 1984, effective July 12, 1984. Emergency amendment filed April 20, 1984, effective May 1, 1984, expired July 11, 1984. Amended: Filed June 13, 1984, effective Sept. 14, 1984. Amended: Filed Sept. 12, 1984, effective Jan. 12, 1985. Amended: Filed Jan. 15, 1985, effective April 11, 1985. Amended: Filed April 16, 1985, effective July 11, 1985. Amended: Filed Oct. 2, 1985, effective Jan. 1, 1986. Amended: Filed April 16, 1986, effective July 1, 1986. Amended: Filed Sept. 17, 1986, effective Dec. 1, 1986. Amended: Filed Nov. 14, 1986, effective Feb. 12, 1987. Emergency amendment filed Dec. 18, 1986, effective Jan. 1, 1987, expired Feb. 11, 1987. Amended: Filed Feb. 18, 1987, effective May 1, 1987. Amended: Filed April 17, 1987, effective July 1, 1987. Amended: Filed June 16, 1987, effective Sept. 1, 1987. Amended: Filed Aug. 18, 1987, effective Nov. 12, 1987. Amended: Filed Dec. 1, 1987, effective Feb. 11, 1988. Amended: Filed April 4, 1988, effective July 1, 1988. Amended: Filed July 15, 1988, effective Oct. 13, 1988. Amended: Filed Sept. 15, 1988, effective Dec. 11, 1988. Amended: Filed April 4, 1989, effective July 1, 1989. Amended: Filed June 6, 1989, effective Sept. 1, 1989. Amended: Filed June 30, 1989, effective Oct. 1, 1989. Amended: Filed Nov. 15, 1989, effective Feb. 1, 1990. Amended: Filed Feb. 16, 1990, effective May 1, 1990. Amended: April 18, 1990, effective June 30, 1990. Amended: Filed Aug. 10, 1990, effective Dec. 31, 1990. Emergency amendment filed Dec. 21, 1990, effective Jan. 1, 1991, expired April 30, 1991. Emergency rescission and rule filed March 21, 1991, effective March 31, 1991, expired July 28, 1991. Emergency rescission filed April 2, 1991, effective April 12, 1991, expired Aug. 9, 1991. Emergency rule filed April 2, 1991, effective April 13, 1991, expired Aug. 10, 1991. Emergency amendment filed June 21, 1991, effective July 1, 1991, expired Aug. 10, 1991. Emergency rescission filed July 31, 1991, effective Aug. 11, 1991, expired Dec. 6, 1991. Rescinded: Filed March 21, 1991, effective Sept. 30, 1991. Emergency rule filed July 31, 1991, effective Aug. 11, 1991, expired Dec. 7, 1991. Readopted: Filed July 15, 1991, effective Jan. 13, 1992. Emergency amendment filed Sept. 23, 1991, effective Oct. 3, 1991, expired Dec. 7, 1991. Emergency rule filed Nov. 27, 1991, effective Dec. 8, 1991, expired April 5, 1992. Emergency amendment filed March 24, 1992, effective April 1, 1992, expired July 29, 1992. Emergency amendment filed June 16, 1992, effective July 1, 1992, expired Oct. 28, 1992. Amended: Filed March 24, 1992, effective Sept. 6, 1992. Emergency amendment filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency amendment filed Jan. 15, 1993, effective Jan. 29, 1993, expired May 28, 1993. Amended: Filed June 16, 1992, effective April 8, 1993. Emergency amendment filed March 19, 1993, effective April 1, 1993, expired July 29, 1993. Emergency amendment filed June 18, 1993, effective July 1, 1993, expired Oct. 28, 1993. Amended: Filed April 6, 1993, effective Dec. 9, 1993. Rescinded and readopted: Filed Oct. 15, 1993, effective June 6, 1994. Amended: Filed June 29, 2000, effective Dec. 30, 2000. Amended: Filed Aug. 28, 2018, effective April 30, 2019. Amended: Filed Aug. 16, 2024, effective April 30, 2025.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021, 2023, 2024; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.031 List of Drugs for Which Prior Authorization Is Required and Drugs Excluded from Coverage Under the MO HealthNet Pharmacy Program

PURPOSE: This rule establishes a listing of drugs and categories of drugs for which prior authorization is required in order for them to be reimbursable and for which reimbursement is not available under the MO HealthNet Pharmacy Program.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying

at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Exclusions — As used in section 208.152.1(12), RSMo, any "abortifacient drug or device" includes: mifepristone when used to induce an abortion; misoprostol when used to induce an abortion; manual vacuum aspirator (MVA) when used to induce an abortion; or any drug or device approved by the federal Food and Drug Administration (FDA) that the FDA has found on or after the effective date of section 208.152.1(12), RSMo, that is intended to cause the destruction of an unborn child as defined in section 188.015, RSMo.

(2) Exclusions — As specified in the Social Security Act, Section 1927(d)(1)(B), states may exclude or otherwise restrict coverage of certain covered outpatient drugs. Section 1927(d)(2) of the Social Security Act provides a listing of the categories of drugs that states may exclude. Drugs included on this list may be excluded from coverage entirely or restricted by diagnosis as determined by the state.

(3) As specified in Section 1927(d)(1) of the Social Security Act, states may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of Section 1927(d)(5) of the Social Security Act.

(4) List of drugs or categories of drugs for which prior authorization is required for certain specified indications, and those which are excluded from reimbursement through the MO HealthNet Pharmacy Program shall be made available through —

(A) MO HealthNet provider manuals, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at http://manuals.momed.com/manuals/, September 27, 2018. This rule does not incorporate any subsequent amendments or additions;

(B) Provider Bulletins, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dss.mo.gov/mhd/providers/pages/bulletins.htm, September 27, 2018. This rule does not incorporate any subsequent amendments or additions; or

(C) Forms, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at http://manuals.momed.com/manuals/presentation/forms.jsp, September 27, 2018. This rule does not incorporate any subsequent amendments or additions.

(5) The division reserves the right to effect changes in the list of drugs for which prior authorization is required and for which reimbursement is not available by amending this rule.

AUTHORITY: sections 1.205, 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2021. Original rule filed Dec. 13, 1991, effective Aug. 6, 1992. Amended: Filed May 15, 1992, effective Jan. 15, 1993. Amended: Filed March 1, 1996, effective Oct. 30, 1996. Amended: Filed May 27, 1999, effective Dec. 30, 1999. Emergency amendment filed Nov. 21, 2000, effective Dec. 1, 2000, expired May 29, 2001. Amended: Filed June 29, 2000, effective Feb. 28, 2001. Emergency amendment filed June 7, 2002, effective July 1, 2002, expired Dec. 27, 2002. Amended: Filed June 11, 2002, effective Jan. 30, 2003. Amended: Filed Jan. 16, 2007, effective July 30, 2007. Amended: Filed Sept. 16, 2013, effective March 30, 2014. Amended: Filed Sept. 27, 2018, effective May 30, 2019. Emergency amendment filed Oct. 21, 2021, effective Nov. 4, 2021, expired May 2, 2022. Amended: Filed Oct. 21, 2021, effective April 30, 2022.*

**Original authority: 1.205, RSMo 1986; 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.032 List of Excludable Drugs Excluded From Coverage Under the MO HealthNet Pharmacy Program
(Rescinded January 30, 2019)

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2013. Original rule filed Dec. 13, 1991, effective Aug. 6, 1992. Amended: Filed June 30, 2000, effective Feb. 28, 2001. Emergency amendment filed June 7, 2002, effective July 1, 2002, expired Dec. 27, 2002. Amended: Filed June 11, 2002, effective Jan. 30, 2003. Amended: Filed Jan. 16, 2007, effective July 30, 2007. Amended: Filed Sept. 16, 2013, effective March 30, 2014. Rescinded: Filed June 8, 2018, effective Jan. 30, 2019.

13 CSR 70-20.033 Medicaid Program Coverage of Investigational Drugs Used in the Treatment of Acquired Immunodeficiency Syndrome (AIDS)
(Rescinded September 30, 2018)

AUTHORITY: sections 208.152, 208.153 and 208.201, RSMo 1994. Emergency rule filed Dec. 15, 1995, effective Jan. 1, 1996, expired June 28, 1996. Original rule filed Dec. 15, 1995, effective July 30, 1996. Rescinded: Filed March 2, 2018, effective Sept. 30, 2018.

13 CSR 70-20.034 List of Non-Excludable Drugs for Which Prior Authorization Is Required
(Rescinded May 30, 2019)

AUTHORITY: sections 208.152, 208.153, and 208.201, RSMo Supp. 2008. Emergency rule filed Nov. 21, 2000, effective Dec. 1, 2000, expired May 29, 2001. Original rule filed June 29, 2000, effective Feb. 28, 2001. Emergency amendment filed June 7, 2002, effective July 1, 2002, expired Dec. 27, 2002. Amended: Filed June 11, 2002, effective Jan. 30, 2003. Amended: Filed Jan. 16, 2007, effective July 30, 2007. Amended: Filed Aug. 17, 2009, effective Feb. 28, 2010. Rescinded: Filed Sept. 27, 2018, effective May 30, 2019.

13 CSR 70-20.040 Five Prescription Limit Per Month Per Recipient
(Rescinded January 30, 2019)

AUTHORITY: sections 208.153, RSMo Supp. 1991 and 208.201, RSMo Supp. 1987. This rule was previously filed as 13 CSR 40-81.012. Emergency rule filed Oct. 21, 1981, effective Nov. 1, 1981, expired Feb. 10, 1982. Original rule filed Oct. 21, 1981, effective Feb. 11, 1982. Amended: Filed March 14, 1984, effective June 11, 1984. Amended: Filed June 12, 1984, effective Sept. 14, 1984. Amended: Filed Jan. 15, 1985, effective April 11, 1985. Amended: Filed April 16, 1985, effective July 11, 1985. Amended: Filed Oct. 2, 1985, effective Jan. 1, 1986. Amended: Filed April 16, 1986,

effective July 1, 1986. Emergency amendment filed Dec. 18, 1986, effective Jan. 1, 1987, expired Feb. 11, 1987. Amended: Filed Sept. 17, 1986, effective Dec. 1, 1986. Amended: Filed Nov. 14, 1986, effective Feb. 12, 1987. Amended: Filed Feb. 18, 1987, effective May 1, 1987. Emergency amendment filed Dec. 18, 1986, effective Jan. 1, 1987, expired Feb. 11, 1987. Amended: Filed April 17, 1987, effective July 1, 1987. Amended: Filed June 16, 1987, effective Sept. 1, 1987. Amended: Filed Aug. 18, 1987, effective Nov. 12, 1987. Amended: Filed Dec. 1, 1987, effective Feb. 11, 1988. Amended: Filed April 15, 1988, effective July 1, 1988. Amended: Filed July 15, 1988, effective Oct. 13, 1988. Amended: Filed July 15, 1988, effective Oct. 13, 1988. Amended: Filed Sept. 15, 1988, effective Dec. 11, 1988. Amended: Filed April 4, 1989, effective July 1, 1989. Amended: Filed June 6, 1989, effective Sept. 1, 1989. Amended: Filed June 30, 1989, effective Oct. 1, 1989. Amended: Filed Nov. 15, 1989, effective Feb. 1, 1990. Amended: Filed Aug. 13, 1990, effective Dec. 31, 1990. Emergency amendment filed Dec. 21, 1990, effective Jan. 1, 1991, expired April 30, 1991. Emergency amendment filed March 21, 1991, effective April 1, 1991, expired July 29, 1991. Amended: Filed March 13, 1991, effective Oct. 31, 1991. Rescinded: Filed June 8, 2018, effective Jan. 30, 2019.

13 CSR 70-20.042 Automatic Refill Program

PURPOSE: This rule establishes the regulatory basis to prohibit automatic refill of prescriptions by providers for MO HealthNet participants.

(1) Automatic Refill Program.

(A) MO HealthNet does not allow automatic refills or automatic shipments of medications, devices, or supplies. MO HealthNet does not pay for any prescription without an explicit request from a participant or the participant's responsible party, such as a caregiver, for each refilling event. Participants and providers cannot waive the explicit refill request requirement and enroll in an automatic refill program.

(B) This ban on automatic refills shall include all MO HealthNet participants, including dual eligible participants and participants with other primary insurance.

(C) A nurse or other authorized agent of the facility may initiate a request for a refill for a participant residing in a skilled nursing facility, group home, or assisted living arrangement.

1. Cycle filling for a participant residing in a skilled nursing facility, group home, or assisted living arrangement does not constitute an automatic refill program as long as the pharmacy and facility staff have a policy and procedure in place to prevent medication that is discontinued or otherwise unneeded from being billed to MO HealthNet. Cycle-fill medication that does not follow the policy and procedure between the pharmacy and facility may be subject to administrative action.

(D) Any prescription filled without a request from a participant or the participant's responsible party may be subject to recoupment. Any provider who pursues an automatic refill policy may be subject to administrative action.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016. Original rule filed Dec. 15, 2022, effective July 30, 2023. Amended: Filed Nov. 6, 2023, effective May 30, 2024.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.045 Maximum Day Supply Limit on Prescriptions Reimbursed by the MO HealthNet Division

PURPOSE: This rule establishes a thirty-one- (31-) day supply maximum restriction per dispensing on prescriptions reimbursed by the MO HealthNet Division (MHD).

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) The maximum days' supply for prescriptions dispensed on behalf of a participant eligible for any fee-for-service programs is a maximum of thirty-one (31) days, except for those prescriptions under the provisions of this rule. MHD providers may dispense prescriptions in quantities less than a thirty-one- (31-) day supply if ordered by the prescriber, except as specified elsewhere in this rule.

(2) Prescriptions that are exempt from the thirty-one- (31-) day supply limit and therefore may be dispensed in quantities exceeding a thirty-one- (31-) day supply are made available in the MHD Pharmacy Manual. The MHD Pharmacy Manual is incorporated by reference in this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, April 15, 2024. This rule does not incorporate any subsequent amendments or additions. The division reserves the right to effectuate changes in the list of prescriptions and categories exempt from the thirty-one- (31-) day supply limit by amending this rule.

(3) All spend down participants are exempt from the MHD thirty-one- (31-) day supply limit on pharmacy services.

(4) Exemptions from the thirty-one- (31-) day supply limit may be given with prior authorization by the MHD to prevent a higher level of care.

(5) Prescriptions identified by 13 CSR 70-20.047 are exempt from the thirty-one- (31-) day supply limit.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and sections 208.152 and 208.153, RSMo Supp. 2024. Emergency rule filed Nov. 21, 2000, effective Dec. 1, 2000, expired May 29, 2001. Original rule filed June 29, 2000, effective Feb. 28, 2001. Amended: Filed Dec. 5, 2000, effective June 30, 2001. Amended: Filed April 18, 2018, effective Nov. 30, 2018. Amended: Filed Jan. 15, 2021, effective July 30, 2021. Amended: Filed Oct. 23, 2024, effective May 30, 2025.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021, 2023, 2024; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.047 Ninety-Day Supply Requirement for Select Prescriptions

PURPOSE: This rule establishes a ninety- (90-) day supply

requirement per dispensing on select prescriptions reimbursed by the MO HealthNet Division (MHD) on behalf of participants eligible for MO HealthNet.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) MHD participating pharmacies shall dispense a ninety- (90-) day supply of select prescriptions to a participant eligible for fee-for-service programs. Prescriptions subject to this ninety- (90-) day supply requirement are included in the *90-Day Supply Medication List*, and incorporated by reference and made part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://mydss.mo.gov/media/pdf/90-day-supply-medication-list-1, November 15, 2021. This rule does not incorporate any subsequent amendments or additions.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and sections 208.152 and 208.153, RSMo Supp. 2024. Original rule filed Jan. 15, 2021, effective July 30, 2021. Amended: Filed Sept. 9, 2024, effective April 30, 2025.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021, 2023, 2024; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.050 Return of Drugs

PURPOSE: This rule establishes that pharmacies must give the MO HealthNet Division credit for any unused portion of the drug that is reusable in accordance with applicable federal or state law.

(1) The return and reuse of drugs must follow guidelines set by the State Board of Pharmacy in 20 CSR 2220-3.040, as amended.

(2) The pharmacy must give the MO HealthNet Division credit for all reusable items (any unused portion) not taken by the MO HealthNet participant. In instances in which charges have been submitted prior to the return of an item, the pharmacy shall file an adjustment prorated to the quantity of the drug used by the MO HealthNet participant.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016. Original rule filed Dec. 15, 2000, effective July 30, 2001. Amended: Filed Sept. 16, 2013, effective March 30, 2014. Amended: Filed April 18, 2018, effective Nov. 30, 2018. Amended: Filed May 28, 2021, effective Nov. 30, 2021.*

**Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.060 Professional Dispensing Fee

PURPOSE: The MO HealthNet Division establishes the amount of the fee reimbursable for the professional dispensing of each MO HealthNet covered prescription by a pharmacy provider.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Between April 1, 2017 and January 31, 2021, a professional dispensing fee shall be added to the MO HealthNet maximum allowable payment for MO HealthNet reimbursable prescriptions filled or refilled by a pharmacy provider as follows:

(A) Out-of-state pharmacy providers receive a professional dispensing fee of nine dollars fifty-five cents ($9.55);

(B) In-state pharmacy providers receive a professional dispensing fee of fourteen dollars thirty-seven cents ($14.37);

(C) In-state pharmacy providers receive a preferred generic product incentive fee of five dollars zero cents ($5.00); and

(D) The professional dispensing fees as provided in this rule shall not be included in the computation of the MO HealthNet maximum allowable drug payment for participant cost-sharing purposes.

(2) Effective February 1, 2021, a professional dispensing fee shall be added to the MO HealthNet maximum allowable payment for MO HealthNet reimbursable prescriptions filled or refilled by a pharmacy provider as follows:

(A) Out-of-state pharmacy providers receive a professional dispensing fee of eight dollars and eighty-five cents ($8.85);

(B) In-state pharmacy providers receive a professional dispensing fee of twelve dollars and twenty-two cents ($12.22), plus an adjustment to account for the costs of the Missouri Pharmacy Reimbursement Allowance attributable to Medicaid-reimbursed prescriptions;

(C) The professional dispensing fee as provided in this rule shall not be added to prescriptions reimbursed at the usual and customary charge submitted by the provider; and

(D) The professional dispensing fees as provided in this rule shall not be included in the computation of the MO HealthNet maximum allowable drug payment for participant cost-sharing purposes.

(3) Effective April 1, 2017, all pharmacy providers supplying prescribed MO HealthNet covered drugs to participants in long-term care facilities shall receive an additional fifty cent (50¢) dispensing fee per claim provided they—

(A) Dispense medication in a drug distribution system(s) which meets minimum standards of container packaging (at least class B as defined in United States Pharmacopeia XXI);

(B) Certify to the MO HealthNet Division, on a form, and in the manner prescribed by the division, that they—

1. Provide this dispensing service to their long-term care facility resident patients;

2. Provide emergency services twenty-four (24) hours a day with seven (7) days a week availability; and

3. Have the ability and willingness to assist in accessing medications through the MO HealthNet Exception Process; and

(C) Indicate, as prescribed by the MO HealthNet Division, on each claim that the prescription was provided in packaging

qualifying for the dispensing fee add-on to a participant in a long-term care facility.

(4) A professional dispensing fee shall be added to maintenance medications no more frequently than once every twenty-five (25) days. "Maintenance medications" are defined as drugs that have a common indication for treatment of a chronic disease, and the therapeutic duration is expected to exceed one year. This is determined by a First DataBank drug code maintenance indicator of "1."

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016. Original rule filed Dec. 15, 1987, effective March 11, 1988. Amended: Filed Sept. 26, 2013, effective March 30, 2014. Emergency amendment filed Jan. 13, 2021, effective Feb. 1, 2021, expired July 30, 2021. Amended: Filed Jan. 13, 2021, effective July 30, 2021.*

**Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.070 Drug Reimbursement Methodology

PURPOSE: This rule establishes the basis and the method for pricing all drug claims in Missouri under the Title XIX Medicaid program. The purchase of a computer-generated tape, with weekly updates, will make it possible to utilize the computer for review purposes, which greatly increases the speed with which claims can be paid.

(1) The MO HealthNet Division will obtain, by contract with a reputable medical publishing company, a weekly computer-generated tape which will provide the information needed to price all fee-for-service Medicaid drug claims. The tape will contain National Drug Code (NDC), drug name, drug strength, dosage form, package size, the prices set by direct-selling manufacturers (direct prices), Wholesaler Acquisition Cost (WAC), federal Health and Human Services upper limits for specified multiple source drugs (FUL), and National Average Drug Acquisition Cost (NADAC). A multiple source drug is defined as a drug marketed or sold by two (2) or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two (2) or more different proprietary names or both under a proprietary name and without that name.

(2) The MO HealthNet Division will add the Missouri Maximum Allowable Cost (MMAC) limits, for multiple source drugs as defined, to the data shown on the tape described in section (1) of this rule.

(3) Effective December 16, 2018, reimbursement for covered drugs will be determined by applying the following hierarchy method:

(A) National Average Drug Acquisition Cost (NADAC); if there is no NADAC;

(B) Missouri Maximum Allowed Cost (MAC); if no NADAC or MAC;

(C) Wholesale Acquisition Cost (WAC); or

(D) The usual and customary (U&C) charge submitted by the provider if it is lower than the chosen price (NADAC, MAC, or WAC).

1. U&C is defined as the provider's charge to the general public that reflects all discounts or programs such as, but not limited to, discount programs, membership programs, price matching programs, or any other program offered by the provider to initiate a reduced price for product costs available to the general public, a special population, or an inclusive category of customers, on the date of service.

2. General public is defined as those patients that pay for their prescriptions and the prescription is not processed by a third-party which includes both governmental and non-governmental payers.

(4) Reimbursement for covered drugs for 340B providers as defined in 42 U.S.C. 256b(a)(4) and 42 U.S.C. 1396r-8(a)(5)(B) who carve-in for Medicaid will be calculated according to 13 CSR 70-20.075.

(5) The professional dispensing fee will be calculated according to 13 CSR 70-20.060.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2021. This rule was previously filed as 13 CSR 40-81.150. Original rule filed April 23, 1979, effective Aug. 11, 1979. Emergency amendment filed Sept. 9, 1981, effective Oct. 1, 1981, expired Dec. 10, 1981. Amended: Filed Sept. 9, 1981, effective Dec. 11, 1981. Emergency amendment filed Oct. 19, 1987, effective Oct. 29, 1987, expired Feb. 25, 1988. Amended: Filed Dec. 1, 1987, effective Feb. 11, 1988. Emergency amendment filed March 29, 1988, effective April 8, 1988, expired Aug. 5, 1988. Amended: Filed May 3, 1988, effective July 28, 1988. Emergency amendment filed Dec. 21, 1990, effective March 17, 1991, expired April 30, 1991. Emergency amendment filed March 6, 1991, effective March 17, 1991, expired July 14, 1991. Emergency amendment filed Sept. 4, 1991, effective Sept. 17, 1991, expired Jan. 14, 1992. Amended: Filed Sept. 4, 1991, effective Jan. 13, 1992. Amended: Filed Dec. 5, 2000, effective June 30, 2001. Amended: Filed July 19, 2018, effective March 30, 2019. Emergency amendment filed April 26, 2021, effective July 1, 2021, expired Feb. 24, 2022. Amended: Filed April 26, 2021, effective Nov. 30, 2021.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2015, 2018, 2021; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991, 2007, 2012; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.071 Multiple Source Drugs for Which There Exists a Federal Upper Limit on Reimbursement
(Rescinded September 30, 2018)

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2013. Emergency rule filed Oct. 19, 1987, effective Oct. 29, 1987, expired Feb. 25, 1988. Emergency amendment filed Oct. 29, 1987, effective Nov. 8, 1987, expired March 6, 1988. Original rule filed Dec. 1, 1987, effective Feb. 11, 1988. Emergency amendment filed June 21, 1988, effective July 1, 1988, expired Oct. 28, 1988. Amended: Filed Aug. 16, 1988, effective Oct. 29, 1988. Emergency amendment filed May 12, 1989, effective June 1, 1989, expired Sept. 23, 1989. Amended: Filed May 12, 1989, effective Aug. 11, 1989. Amended: Filed Nov. 15, 1989, effective Feb. 1, 1990. Amended: Filed April 18, 1990, effective June 30, 1990. Emergency amendment filed Aug. 20, 1990, effective Sept. 1, 1990, expired Dec. 30, 1990. Amended: Filed Sept. 5, 1990, effective Feb. 14, 1991. Emergency amendment filed Dec. 20, 1990, effective Dec. 31, 1990, expired April 29, 1991. Emergency amendment filed March 21, 1991, effective March 31, 1991, expired July 28, 1991. Amended: Filed April 2, 1991, effective Oct. 31, 1991. Emergency amendment filed Dec. 4, 1992, effective Dec. 15, 1992, expired April 13, 1993. Emergency rescission and emergency rule filed April 2, 1993, effective April 13, 1993, expired Aug. 10, 1993. Amended: Filed Aug. 27, 1993, effective May 9, 1994. Amended:

Filed Sept. 26, 2013, effective March 30, 2014. Rescinded: Filed March 2, 2018, effective Sept. 30, 2018.

13 CSR 70-20.075 340B Drug Pricing Program

PURPOSE: This rule establishes the payment methodology for 340B-covered entities as defined in section 1927(a)(5)(B) of the Social Security Act that choose to carve-in Medicaid.

(1) Covered entities that choose to carve-in Medicaid must provide the Health Resources and Services Administration (HRSA) with their National Provider Identification (NPI) and their MO HealthNet Division (MHD) provider number for each site that carves-in for inclusion in the HRSA Medicaid Exclusion File. MHD requires the MHD provider number to be included on the Medicaid Exclusion File to identify providers that carve-in Medicaid and to prevent duplicate discounts. A duplicate discount is defined as a covered entity receiving a discounted drug through the 340B program from the manufacturer, and MHD receives a rebate through the Medicaid Drug Rebate Program from the manufacturer for the same claim. Covered entity is defined in section 376.414.1(2), RSMo.

(2) Covered entities must identify 340B-purchased drugs using the Submission Clarification Code or modifier code on each claim that was 340B-purchased.

(3) Failure to include the appropriate identifier on a 340B-purchased drug will result in MHD collecting a rebate on the claim, resulting in a potential duplicate discount. A duplicate discount may subject the covered entity to audit penalties. MHD will deny claims identified as 340B-purchased drugs at the claim level from providers who have yet to notify HRSA of carve-in status.

(4) Reimbursement for 340B-identified covered drugs for 340B providers as defined in section 376.414.1(2), RSMo, who carve-in for Medicaid will be determined by applying the following method:

(A) MHD will reimburse 340B-purchased drugs dispensed by pharmacy providers at their actual acquisition cost, up to the 340B Maximum Allowable Cost (340B MAC) (calculated ceiling price) plus a professional dispensing fee. Covered entities must bill no more than their actual acquisition cost plus the professional dispensing fee.

1. MHD defines the 340B MAC (calculated ceiling price) as the Average Manufacturer Price (AMP) minus Unit Rebate Agreement (URA) as reported by the Centers for Medicare & Medicaid (CMS) quarterly.

2. MHD defines actual acquisition cost as the invoice cost for the National Drug Code (NDC) per billing unit. This does not include timely pay discounts or discounts paid as a rebate on a separate invoice for volume-based purchases.

3. MHD calculates the professional dispensing fee according to 13 CSR 70-20.060; and

(B) MHD will reimburse physician-administered drugs purchased through the 340B program at the lesser of the Physician-Administered 340B MAC or the actual acquisition cost submitted by the provider. MHD does not apply a professional dispensing fee to physician-administered drugs.

1. MHD adds six percent (6%), up to six hundred dollars ($600), to the 340B MAC to calculate the physician-administered 340B MAC.

(5) MHD does not allow 340B contract pharmacies to carve-in under this policy.

(6) MHD may carve-out certain medications and categories of medications from 340B participation for MHD reimbursement. Medications subject to the carve-out will be reimbursed according to 13 CSR 70-20.070. The following medications and categories of medications are carved-out of reimbursement through the 340B program:

(A) Drugs approved by the FDA for the treatment of obesity; and

(B) Cell and gene therapies.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and section 208.153, RSMo Supp. 2024. Emergency rule filed April 26, 2021, effective July 1, 2021, expired Feb. 24, 2022. Original rule filed April 26, 2021, effective Nov. 30, 2021. Emergency amendment filed Nov. 21, 2024, effective Dec. 9, 2024, expired June 6, 2025. Amended: Filed Nov. 21, 2024, effective June 30, 2025.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.080 Labeling of Medicaid Prescriptions
(Rescinded December 9, 1993)

AUTHORITY: sections 207.020, RSMo 1986 and 208.153, RSMo Supp. 1991. This rule was previously filed as 13 CSR 40-81.030. Original rule file Oct. 24, 1974, effective Nov. 3, 1974. Rescinded: Filed April 6, 1993, effective Dec. 9, 1993.

13 CSR 70-20.100 Missouri Nonsteroidal Anti-Inflammatory Drug List
(Rescinded September 30, 1991)

AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 1989. This rule was previously filed as 13 CSR 40-81.013. Original rule filed Feb. 18, 1987, effective June 1, 1987. Amended: Filed April 4, 1989, effective July 1, 1989. Amended: Filed Aug. 13, 1990, effective Dec. 31, 1990. Emergency rescission filed March 21, 1991, effective March 31, 1991, expired July 28, 1991. Rescinded: Filed March 21, 1991, effective Sept. 30, 1991.

13 CSR 70-20.110 Medicaid Program Coverage of Approved Drugs for Treatment of Acquired Immunodeficiency Syndrome (AIDS)
(Rescinded September 30, 1991)

AUTHORITY: sections 208.153, RSMo 1986 and 208.201, RSMo Supp. 1988. Emergency rule filed July 9, 1987, effective July 19, 1987, expired Nov. 15, 1987. Original rule filed July 31, 1987, effective Nov. 12, 1987. Amended: Filed Nov. 15, 1989, effective Feb. 1, 1990. Emergency rescission filed March 21, 1991, effective March 31, 1991, expired July 28, 1991. Rescinded: Filed March 21, 1991, effective Sept. 30, 1991.

13 CSR 70-20.120 Medicaid Program Coverage of Anti-Ulcer Preparations
(Rescinded June 29, 1989)

AUTHORITY: sections 208.153, RSMo 1986 and 208.201, RSMo Supp. 1987. Original rule filed Oct. 18, 1988, effective Jan. 1, 1989.

Amended: Filed March 16, 1989. Emergency rescission filed April 7, 1989, effective April 20, 1989, expired Aug. 17, 1989. Rescinded: Filed April 7, 1989, effective June 29, 1989.

13 CSR 70-20.200 Prescription Prior Authorization Process

PURPOSE: This rule establishes the MO HealthNet Division (MHD) process by which drugs may be restricted under Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990) and is determined to be appropriate for inclusion as a regular benefit of the MHD or through prior authorization.

(1) All persons eligible for medical assistance benefits shall have access to all pharmaceutical products for which there is federal financial participation except those drugs that may be restricted under Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990). MHD shall review drugs that may be restricted and present to the Prior Authorization Committee for possible inclusion as a regular benefit of MHD program or through prior authorization.

(2) MHD may require prior authorization for pharmaceutical products. MHD bases any restriction on medical and clinical criteria and Missouri-specific data. MHD shall develop this medical and clinical criteria based on predetermined standards consistent with the following:

(A) The American Hospital Formulary Service Drug Information;

(B) The United States Pharmacopoeia Drug Information; and

(C) Peer-reviewed medical literature.

(3) MHD shall review drugs used to treat rare medical conditions with the Advisory Council on Rare Disease and Personalized Medicine. MHD shall develop medical and clinical criteria and make recommendations to the Advisory Council on Rare Disease and Personalized Medicine. MHD will present any proposals reviewed by the Advisory Council on Rare Disease and Personalized Medicine to the Prior Authorization Committee and Drug Utilization Review Board.

(4) The Prior Authorization Committee and Drug Utilization Review shall hold a public hearing at least once every quarter during which MHD shall make recommendations to the board and any final decision by MHD to require prior authorization for that pharmaceutical product, class, or category.

(5) MHD shall post the tentative meeting agenda on the MHD website (https://mydss.mo.gov/mhd/pharmacy-committees) at least seven (7) days before the meeting, and the agenda will include the therapeutic classes MHD plans to discuss.

(A) MHD shall place the specific preferred drug list classes to be considered at the next regularly scheduled Prior Authorization Committee meeting on the current agenda or posted on the website approximately seven (7) days before the next scheduled meeting.

(B) Any interested party shall be granted the opportunity for clinically relevant public comment for up to three (3) minutes per drug under review by the Prior Authorization Committee. The responsibility of scheduling the presentation shall rest with the interested party. Interested parties representing a manufacturer shall be granted three (3) minutes in the aggregate per therapeutic class under review by the Prior Authorization Committee.

(C) After considering all presented information, the Prior Authorization Committee may recommend alterations to the proposal. The committee shall make their final recommendation to the MHD by a majority vote of the committee members present thereto in a recorded roll call vote.

(6) MHD shall coordinate the implementation of any changes after all recommendations have been reviewed. All pertinent information relating to the edit implementation schedule and the edit criteria shall be made available to the public by reasonable means, including but not limited to posting on the MHD website following the Prior Authorization Committee meeting.

(7) On an annual basis, the Prior Authorization Committee shall review all prior authorization criteria in place quarterly and may schedule more frequently if new clinical or fiscal information is available.

(8) Unless MHD is addressing an urgent market change, MHD shall not otherwise restrict the prescribing and dispensing of covered outpatient prescription drugs under this rule without consulting the Prior Authorization Committee.

(9) When implementing the provisions of this rule, Missouri-specific data shall consider use and cost data, pharmacoeconomic information, and prudent utilization of state funds, and shall include medical and clinical criteria.

(10) MHD may impose limitations on the minimum or maximum quantities per prescription, early refill, or the number of refills if such limitations are necessary to discourage waste and may address instances of fraud or abuse by individuals.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and section 208.153, RSMo Supp. 2024. Original rule filed Feb. 3, 1992, effective Aug. 6, 1992. Emergency amendment filed May 22, 2002, effective June 1, 2002, expired Nov. 27, 2002. Amended: Filed June 3, 2002, effective Nov. 30, 2002. Amended: Filed Dec. 14, 2004, effective June 30, 2005. Amended: Filed Sept. 26, 2013, effective March 30, 2014. Amended: Filed Sept. 16, 2020, effective March 30, 2021. Amended: Filed Dec. 17, 2024, effective July 30, 2025.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.250 Prior Authorization of New Drug Entities or New Drug Dosage Form

PURPOSE: This rule outlines how new drugs or new drug dosage forms of existing drugs may be subject to prior authorization before payment by MO HealthNet Division (MHD).

(1) New drug entities and new drug product dosage forms of existing drug entities are eligible to be covered, as defined in 13 CSR 70-20.030, and shall comply with prior authorization requirements imposed by MHD, in compliance with federal law.

(2) Prior authorization shall continue on new drug entities and new drug product dosage forms of existing drugs until reviewed by MHD and MHD eliminates the prior authorization or makes a final determination to require continued prior authorization. MHD shall consider known cost and utilization data, medical and clinical criteria, and prudent utilization

of state funds in the review. Interested parties may present clinical data to MHD.

(3) The review referenced in section (2) shall begin within thirty (30) business days after MHD receives notice through the weekly national compendia file of the availability of the drug entity on the market and if the drug is eligible to be covered as defined in 13 CSR 70-20.030, whichever is later. The review shall take no more than forty-five (45) business days from the start of the review. Upon completion of the review, MHD shall remove the prior authorization requirements or refer the new drug or new drug dosage form to the Prior Authorization Committee with a recommendation for continued prior authorization. MHD recommendations regarding continued prior authorization of a new drug or new drug dosage form shall be made in writing to the Prior Authorization Committee. A copy shall be available to the public before the Prior Authorization Committee meeting in which the continued prior authorization is to be discussed.

(4) The Prior Authorization Committee shall consider any recommendations related to continued prior authorization requirements of a new drug or new drug dosage form no later than one hundred ninety (190) calendar days after the new drug review is completed. The Prior Authorization Committee shall allow three (3) minutes for any interested parties who have notified MHD before the scheduled meeting to comment about such proposed prior authorization requirements.

(5) If the Prior Authorization Committee finds that utilization and cost data, pharmacoeconomic information, and medical and clinical implications of restriction are documented and prior authorization is warranted, the Prior Authorization Committee shall make a recommendation to MHD. Such recommendation shall be provided to MHD prior to MHD making a final determination. MHD shall provide notice of the final determination through the Department of Social Services, MHD website at https://mydss.mo.gov/mhd/pharmacy-clinical-edits-pdl.

(6) If, after the hearing referenced in section (5) above, prior authorization of the new drug or new drug dosage form is required, the prior authorization requirement shall be reviewed at least once every twelve (12) months by the Prior Authorization Committee.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and section 208.153, RSMo Supp. 2024. Emergency rule filed May 22, 2002, effective June 1, 2002, expired Nov. 27, 2002. Original rule filed June 3, 2002, effective Nov. 30, 2002. Amended: Filed Sept. 16, 2013, effective March 30, 2014. Amended: Filed Jan. 20, 2021, effective July 30, 2021. Amended: Filed Oct. 16, 2024, effective May 30, 2025.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.300 Retrospective Drug Use Review Process

PURPOSE: This rule establishes the MO HealthNet Division (MHD) process by which the Drug Utilization Review Board is established as required by Section 4401 of P.L. 101-508 (Omnibus Budget Reconciliation Act of 1990) and by section 208.175, RSMo.

(1) Drug Utilization Review (DUR) Board. This rule establishes a MO HealthNet DUR Board in the Department of Social Services, MO HealthNet Division. The board shall be composed as specified in section 208.175, RSMo.

(2) The board members shall elect a chairperson.

(3) The DUR Board shall meet at least once every ninety (90) days. A quorum of two-thirds (2/3) of the total members, including no fewer than three (3) physicians and three (3) pharmacists, is required for the board to act in its official capacity.

(4) Members shall serve four- (4-) year terms, except the terms of the original members, two (2) shall be appointed for a term of two (2) years, three (3) shall be appointed for a term of three (3) years, and three (3) shall be appointed for a term of four (4) years. Members may be reappointed, provided that minimum qualifications for membership continue to be met. Nominations shall be referred for final appointment by the governor subject to advice and consent of the senate. As vacancies occur, the DUR Board shall solicit and select a slate of nominees.

(5) The members of the DUR Board shall receive no compensation for their services other than reasonable expenses incurred in performing their official duties.

(6) The DUR Board shall hold a public hearing during which MHD shall make recommendations to the board.

(7) MHD shall make available any changes recommended by the DUR Board via the approved minutes of the DUR Board meeting in a timely fashion, at least thirty (30) days before the implementation of the recommendations.

(8) The DUR Board shall provide, either directly or through contracts between MHD and accredited health-care schools, state medical societies, or state pharmacist associations or societies, or other appropriate organizations, for educational outreach programs as required by P.L. 101-508, Section 4401, to educate practitioners on common drug therapy problems and improve prescribing and dispensing practices. This outreach shall include an educational newsletter to MHD providers including appropriate drug use guidelines and MHD utilization statistics. The board activities shall consist of —

(A) Establishment and implementation of medical standards and criteria for the prospective and retrospective DUR program;

(B) Development, selection, application, and assessment of educational interventions for physicians, pharmacists, and participants that improve care; and

(C) Administration of the Drug Prior Authorization Process as outlined in 13 CSR 70-20.200.

(9) As specified by P.L. 101-508, Section 4401, the DUR Board shall monitor drug use and prescribing and dispensing practices in the MHD program. This monitoring shall include reviewing and refining therapeutic criteria modules used in retrospective and prospective DUR and overseeing retrospective DUR intervention methods.

(10) The DUR Board shall advise MHD regarding all activities associated with the DUR process, including identifying types of intervention methods ranging from letters to physicians and pharmacists, face-to-face education, and educational

symposiums for targeted providers. The board shall provide educational support and guidance as needed by the review committees. The review committees, in turn, shall report intervention results and make recommendations to the board based on these results.

(11) Patterns of inappropriate or aberrant prescribing or dispensing shall be identified and referred to the board to formulate targeted education.

(12) Agency Responsibility Regarding Confidentiality of Information. All information concerning applicants and MHD participants shall be confidential, and any disclosure of this information shall be restricted to purposes directly related to the administration of the medical assistance program. Purposes directly related to administration of the medical assistance program include –

(A) Establishing eligibility;

(B) Determining the amount of medical assistance;

(C) Providing services for recipients; and

(D) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the program.

AUTHORITY: sections 208.175, 208.201, and 660.017, RSMo 2016, and section 208.153, RSMo Supp. 2024. Original rule filed Dec. 14, 1992, effective June 7, 1993. Amended: Filed Sept. 16, 2013, effective March 30, 2014. Amended: Filed Sept. 16, 2020, effective March 30, 2021. Amended: Filed Oct. 23, 2024, effective May 30, 2025.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.175, RSMo 1992, amended 1993, 2011, 2014; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.310 Prospective Drug Use Review Process and Patient Counseling

PURPOSE: This rule establishes provisions for prospective drug use review and patient counseling for MO HealthNet Division (MHD) participants, as required by Section 4401 or Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990) and by section 208.176, RSMo.

(1) Prospective Drug Use Review (DUR). This rule establishes a MHD prospective drug use review process within the Department of Social Services, MHD, as specified in section 208.176, RSMo.

(2) Electronic Point-of-Sale Review. MHD shall provide for electronic point-of-sale review before each prescription is dispensed to a MHD participant or MHD participant's responsible party on the date of service. MHD shall provide electronic point-of-sale screening for potential drug therapy problems using the approved clinical modules on the date of service.

(3) Electronic Point-of-Sale Review Available for MHD Participants. The pharmacy point of service system will provide the following reviews:

(A) Drug Disease Contraindications.

1. Drug (actual) disease precaution.

2. Inferred drug disease precaution;

(B) Drug to Drug Interactions;

(C) Side Effects.

1. Additive toxicity side effects.

2. Medical condition/additive side effect.

3. Side effect.

4. Drug indicated for the side effect of the previously prescribed drug;

(D) Dose Range Checking.

1. High dose alert.

2. Low dose alert;

(E) Minimum/Maximum Daily Dose.

1. High dose alert.

2. Low dose alert;

(F) Duplicate Therapy Checking.

1. Therapeutic duplication.

2. Ingredient duplication; and

(G) Duration of Therapy.

1. Excessive duration alert.

(4) MHD Patient Counseling. As part of the prospective DUR program, participating pharmacies shall perform patient counseling according to the standards established by the Board of Pharmacy under 20 CSR 2220-2.190.

(5) MHD Patient Profiles. The term "reasonable effort" means that each time a MO HealthNet patient or caregiver presents a prescription, the pharmacist or pharmacist's designee should request profile information verbally or in writing. Pharmacies must make a reasonable effort to obtain records and maintain patient profiles containing, at a minimum:

(A) The name, address, telephone number, date of birth (or age), and gender of the patient;

(B) Individual medical history, if significant, including disease states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices; and

(C) Pharmacist's comments relevant to the individual's drug therapy.

(6) Documentation of Offer to Counsel. The pharmacist shall document for each MHD patient's prescription uniformly whether the offer to counsel was accepted or refused by the patient or the patient's agent.

(7) Provider Responsibility Regarding Confidentiality of MO HealthNet Beneficiary Information. All information concerning applicants and participants of medical services shall be confidential. Any disclosure of this information by the pharmacy provider shall be restricted to purposes directly related to the treatment of the patient and promotion of improved quality of care or conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the program. The confidential information includes –

(A) Names and addresses;

(B) Social Security number;

(C) Medical services provided;

(D) Social and economic conditions or circumstances;

(E) Medical data, including diagnosis and history of disease or disability;

(F) Any information received for verifying income eligibility; and

(G) Any information received in connection with the identification of legally liable third-party resources.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and section 208.153, RSMo Supp. 2024. Original rule filed June 3, 1993, effective Dec. 9, 1993. Amended: Filed Sept. 16, 2013, effective March 30, 2014. Amended: Filed Nov. 27, 2019, effective June 30, 2020. Amended: Filed Dec. 17, 2024, effective July 30, 2025.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.320 Pharmacy Reimbursement Allowance

PURPOSE: This rule establishes a Pharmacy Federal Reimbursement Allowance and the methodologies to determine the formula for the amount of allowance each pharmacy is required to pay for the privilege of providing outpatient prescription drugs.

(1) Pharmacy Reimbursement Allowance (PRA). PRA shall be assessed as described in this section.

(A) Definitions.

1. Department — Department of Social Services.
2. Director — Director of Department of Social Services.
3. Division — MO HealthNet Division.
4. Gross retail prescription receipts — For ease of administration for the department as well as the industry, this shall be an annual amount. The basis of tax in any fiscal year will be the gross prescription sales of the last calendar year prior to the previous fiscal year.

(B) Each pharmacy engaging in the business of providing outpatient prescription drugs in Missouri to the general public shall pay a PRA.

1. The PRA owed for existing pharmacies shall be calculated by multiplying the pharmacy's total gross retail prescription receipts by the tax rate determined by the department. Subject to the limitations established in section 338.520, RSMo, such said tax rate shall be uniform and shall not exceed five percent (5%).
2. The PRA shall be divided by and collected over the number of months for which the PRA is effective.
3. The initial PRA owed by a newly licensed pharmacy shall be calculated by estimating the total prescription sales and multiplying the estimate by the rate determined by the department, as described in paragraph (1)(B)1.
4. If a pharmacy ceases to provide outpatient prescription drugs to the general public, the pharmacy is not required to pay the PRA during the time it did not provide outpatient prescription drugs.
5. If the pharmacy reopens, it shall resume paying the PRA. It shall owe the same PRA as it did prior to closing, if the PRA has not changed per paragraph (1)(B)1.

(C) Each pharmacy shall submit an affidavit to the department with the following information:

1. Pharmacy name;
2. Contact;
3. Telephone number;
4. Address;
5. Federal tax ID number;
6. MO HealthNet pharmacy number (if applicable);
7. Pharmacy sales (total);
8. MO HealthNet pharmacy sales;
9. Number of paid MO HealthNet prescriptions; and
10. Gross receipts attributable to prescription drugs that are delivered directly to the patient via common carrier, by mail, or a courier service.

(D) The department shall prepare a confirmation schedule of the information provided by each pharmacy and the amount of PRA that is due from the pharmacy.

(E) Each pharmacy shall review the information prepared by the department and the amount of PRA calculated by the department to verify that the information is correct.

1. If the information supplied by the department is incorrect, the facility within thirty (30) calendar days of receiving the confirmation schedule must notify the division and explain the correction.
2. If the division does not receive corrected information within thirty (30) calendar days, it will be assumed to be correct, unless the pharmacy files a protest in accordance with subsection (2)(D) of this regulation.

(2) Payment of the PRA.

(A) Offset.

1. Each pharmacy may request that its PRA offset against any MO HealthNet payment due to that pharmacy.

A. A statement authorizing the offset must be on file with the division before any offset may be made relative to the PRA by the pharmacy.

B. Assessments shall be allocated and deducted over the applicable service period.

C. Any balance due after the offset shall be remitted to the director of the Department of Revenue and be deposited in the state treasury to the credit of the Pharmacy Reimbursement Allowance Fund.

D. If the remittance is not received before the next MO HealthNet payment cycle, the division shall offset the balance due from that check.

(B) Check.

1. If no offset has been authorized by the pharmacy, the division will begin collecting the pharmacy reimbursement allowance on the first day of each month for the preceding months.
2. The PRA shall be remitted by the pharmacy to the department. The remittance shall be made payable to the director of the Department of Revenue and be deposited in the state treasury to the credit of the Pharmacy Reimbursement Allowance Fund.

(C) Failure to comply with this request for information or failure to pay the PRA.

1. If a pharmacy fails to comply with a request for information from the MO HealthNet Division or fails to pay its PRA within thirty (30) days of notice, the PRA shall be delinquent.
2. For any delinquent PRA, the department may —

A. Proceed to enforce the state's lien of the property of the pharmacy;

B. Cancel or refuse to issue, extend, or reinstate the MO HealthNet provider agreement; or

C. Seek denial, suspension, or revocation of license granted under Chapter 338, RSMo.

3. The new owner, as a result of a change in ownership, shall have his/her PRA paid by the same method the previous owner elected.

(D) Each pharmacy, upon receiving written notice of the final determination of its PRA, may file a protest with the director of the department setting forth the grounds on which the protest is based, within thirty (30) days from the date of receipt of written notice from the department. The director of the department shall reconsider the determination and, if the pharmacy so requested, grant the pharmacy a hearing to be held within forty-five (45) days after the protest was filed, unless extended by agreement between the pharmacy and the director. The director shall issue a final decision within forty-five (45) days of the completion of the hearing. After a final decision by the director, a pharmacy's appeal of the director's final decision shall be to the Administrative Hearing Commission in accordance with section 208.156, RSMo, and section 621.055, RSMo.

(E) PRA Rates.

1. The PRA tax rate will be a uniform effective rate of one and twenty hundredths percent (1.20%) with an aggregate annual adjustment, by the MO HealthNet Division, not to exceed five hundredths percent (.05%) based on the pharmacy's total prescription volume.

2. Beginning January 1, 2019, the PRA tax rate will be a uniform effective rate of one and forty-three hundredths percent (1.43%) with an aggregate quarterly adjustment, by the MO HealthNet Division, not to exceed one and five-tenths percent (1.5%) based on the pharmacy's total prescription volume.

3. Beginning July 1, 2022, the PRA tax rate will be a uniform effective rate of thirty-seven hundredths percent (0.37%) with an aggregate quarterly adjustment, by the MO HealthNet Division, not to exceed one and five-tenths percent (1.5%) based on the pharmacy's total prescription volume.

4. Beginning July 1, 2023, the PRA tax rate will be a uniform effective rate of fifty-two hundredths percent (0.52%) with an aggregate quarterly adjustment, by the MO HealthNet Division, not to exceed one and five-tenths percent (1.5%) based on the pharmacy's total prescription volume.

5. Beginning January 1, 2024, the PRA tax rate will be a uniform effective rate of forty-nine hundredths percent (0.49%) with an aggregate quarterly adjustment, by the MO HealthNet Division, not to exceed one and five-tenths percent (1.5%) based on the pharmacy's total prescription volume.

6. Beginning July 1, 2025, the PRA tax rate will be a uniform effective rate of two percent (2%) with an aggregate quarterly adjustment, by the MO HealthNet Division, not to exceed two percent (2%) based on the pharmacy's total prescription volume.

7. The maximum rate shall be five percent (5%).

AUTHORITY: sections 208.201, 338.505, and 660.017, RSMo 2016. Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed July 15, 2002, effective Feb. 28, 2003. Amended: Filed Feb. 3, 2003, effective Aug. 30, 2003. Amended: Filed Nov. 3, 2003, effective April 30, 2004. Emergency amendment filed Sept. 12, 2008, effective Sept. 22, 2008, expired March 20, 2009. Amended: Filed Sept. 12, 2008, effective April 30, 2009. Amended: Filed July 1, 2009, effective Jan. 30, 2010. Emergency amendment filed Dec. 1, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Dec. 1, 2009, effective June 30, 2010. Emergency amendment filed June 17, 2010, effective July 1, 2010, expired Dec. 27, 2010. Amended: Filed April 26, 2019, effective Nov. 30, 2019. Amended: Filed March 2, 2023, effective Oct. 30, 2023. Amended: Filed Feb. 21, 2024, effective Aug. 30, 2024. Emergency amendment filed June 23, 2025, effective July 8, 2025, expired Feb. 26, 2026. Amended: Filed June 23, 2025, effective Jan. 30, 2026.*

**Original authority: 208.201, RSMo 1987, amended 2007; 338.505, RSMo 2002; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-20.330 Medication Therapy Management (MTM) Program

PURPOSE: This rule establishes the regulatory basis for the administration of the MO HealthNet Medication Therapy Management (MTM) program, including designation of professional persons who may perform medication therapy management services and defined covered services within the program.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The Medication Therapy Management (MTM) program shall be administered by the Department of Social Services, MO HealthNet Division. The MTM services covered, the program limitations, and the maximum allowable fees for all covered services shall be determined by the Department of Social Services, MO HealthNet Division, and shall be included in the pharmacy provider manual and provider bulletins, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at dss.mo.gov/mhd/index.htm, September 1, 2015. This rule does not incorporate any subsequent amendments or additions.

(2) Persons Eligible. A person who is eligible for Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) or Blind Pension and who meets certain disease-based criteria included in their health profile.

(3) Provider Participation. To be eligible for participation in the MO HealthNet MTM program, a provider must be a qualified Missouri licensed pharmacist and have an active MO HealthNet provider status, and must have successfully completed two (2) hours of ACPE (Accreditation Counsel for Pharmacy Education) accredited continuing education focused on the administration of MTM approved by the MO HealthNet Division.

(4) Medication Therapy Management Services. MTM Services are available to any currently eligible non-managed care MO HealthNet participant for whom the qualifying pharmacist receives a MO HealthNet directed electronic drug utilization review (DUR) message through a Point-of-Sale transaction. MO HealthNet uses a clinically based rules engine that juries which participants require MTM interventions based on nationally accepted evidence-based guidelines. Pharmacists are then messaged about only those participants who are identified for one (1) or more issues pertinent to the evidence-based criteria. The rules engine uses current nationally accepted evidence-based guidelines for clinically appropriate drug therapy, and applies this criteria to thirty-six (36) months of paid participant claims data which includes drugs, diagnoses, and procedures. When an eligible participant meets certain disease-based criteria a pharmacist may perform a wide variety of MTM services directed by MO HealthNet to address specific treatment needs, such as:

(A) Counseling participants on the importance of medication adherence (alerting participants to missed dosages and refills);

(B) Providing medication education;

(C) Providing self-care education for specific chronic conditions;

(D) Contacting physicians to schedule diagnostic testing;

(E) Contacting physicians to make drug therapy recommendations; or

(F) Connecting participants with other community-based resources as needed.

(5) The service is comprised of the following components:
(A) Assessing a participant's health status;
(B) Developing a medication treatment plan;
(C) Monitoring and evaluating a participant's response to therapy;
(D) Providing a comprehensive medication review to identify, resolve, and prevent medication-related problems;
(E) Documenting the care provided and communicating essential information to a participant's primary care providers;
(F) Providing oral education and training to enhance participant understanding and appropriate use of medications;
(G) Providing information, support services, and resources to enhance participant adherence to therapeutic regimens; and
(H) Coordinating and integrating MTM services within the broader health care services provided to a participant.

(6) Reimbursement. Pharmacists will receive the payment for participating in MTM. The payment is contingent upon the provider logging on to the electronic web tool to view, reserve, and complete interventions. Once an intervention is complete, providers will submit an electronic medical claim to MO HealthNet. The payment status of these claims will be reflected on the provider's remittance advice. The fee schedule is available at dss.mo.gov/mhd/providers/pages/cptagree.htm.

AUTHORITY: section 208.201, RSMo Supp 2013. Original rule filed July 30, 2015, effective Jan. 30, 2016.*

**Original authority: 208.201, RSMo 1987, amended 2007.*

13 CSR 70-20.340 National Drug Code Requirement

PURPOSE: This rule implements the National Drug Code (NDC) requirement for all medications administered in the clinic or outpatient hospital setting. The Deficit Reduction Act of 2005 (DRA) requires states to collect rebates for certain physician-administered drugs.

(1) Drug charges submitted by providers on an electronic Professional or Institutional ASC X12 837 Health Care claim transaction or manually entered on a medical or outpatient claim into the MO HealthNet Division's (MHD) billing website eMOMED (www.emomed.com) must be billed with a valid Healthcare Common Procedure Coding System (HCPCS) procedure code and a valid NDC for all medications administered to MHD participants in the clinic or outpatient hospital setting. MHD must collect the eleven- (11-) digit NDC on all outpatient drug claims submitted to MHD from all providers for rebate purposes to receive federal financial participation. Providers can find the NDC on the medication's packaging, and must submit the NDC in the five (5) digit – four (4) digit – two (2) digit format. If the NDC does not appear in the five (5) digit – four (4) digit – two (2) digit format on the packaging, zero(s) (0) may be entered in front of the section that does not have the required number of digits. The MHD denies medical or outpatient claim lines submitted with a HCPCS procedure code without the corresponding NDC. For medical or outpatient claims correctly submitted with the appropriate HCPCS procedure code and the corresponding NDC, the system automatically generates a separate drug claim for the NDC to process as a pharmacy claim. It will appear as a separate claim on your Remittance Advice. The MHD will drop the corresponding line with the HCPCS procedure code and NDC from the medical or outpatient claim. If an NDC is not provided, the HCPCS procedure code will remain on the claim to report the denied line. All claims must be billed with the proper NDC quantities, not the HCPCS quantities. For drugs without a valid HCPCS procedure code, revenue code 0250, "General Classification: Pharmacy," must be used with the appropriate NDC. Only drugs and items used during outpatient care in the hospital are covered. MHD does not cover take-home medications and supplies under the Hospital Program.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Emergency rule filed June 19, 2015, effective July 1, 2015, expired Dec. 28, 2015. Original rule filed July 1, 2015, effective Feb. 29, 2016. Amended: Filed Sept. 27, 2018, effective May 30, 2019. Amended: Filed Jan. 16, 2020, effective Aug. 30, 2020. Amended: Filed Oct. 20, 2023, effective May 30, 2024.*

**Original authority: 208.201, RSMo 1987, amended 2007, and 660.017, RSMo 1993, amended 1995.*