Reimbursement Requirements for Drugs Used to Treat Sickle Cell Disease

Beginning September 1, 2025, Texas will participate in the Cell and Gene Therapy (CGT) Access Model n fee-for-service and managed care. CGT treatments have been developed to treat rare and severe diseases, and these one-time treatments have the potential to improve the lives of people living with rare and often debilitating diseases.

As part of this model, Providers are required to adhere to the billing requirements outlined in the Outpatient Drug Services Handbook of the Texas Medicaid Provider Procedures Manual (TMPPM) for Separate Reimbursement of Certain Inpatient High-Cost Clinician-Administered Drugs (HCCAD) when submitting claims for the following drugs when used to treat sickle cell disease:

- CASGEVY
- LYFGENIA

Claims Processing Requirements

HCCAD are drugs or biologics that HHSC has approved to be "carved out" of the All-Patient Refined Diagnosis Related Group (APR-DRG) and can be billed on an outpatient claim.
The following billing guidelines apply to outpatient claims of HCCAD.

Special requirements for transmitting claims for HCCAD

1. The hospital must claim **separate payment** for the HCCAD on an **outpatient claim**. MCOs must ensure that payment to the hospital is direct reimbursement for the HCCAD. Payment for the HCCAD must not be bundled with any other service.
2. The claim for the HCCAD must be **separate** from any facility/institutional claim the hospital submits for **all other** hospital services delivered to the member during the same visit. The associated inpatient or outpatient charges with the same date(s) of service are billed separately and remain part of the APR-DRG.
3. The date of administration of the drug should be used on the HCCAD outpatient claim.
4. Along with the members name, date(s) of service, and other required information, the HCCAD claim **must** include:
    a. The **NDC qualifier** of N4
    b. The appropriate 11-digit **National Drug Code (NDC)** and corresponding **HCPCS code** for the drug; and

c. The **number of units** of the drug administered to the member that is covered by the claim; and

d. The **NDC unit of measurement.** There are five allowed values: F2, GR, ML, UN or ME.

5. MCOs should reimburse the hospital at the FFS rate or the actual acquisition cost from the invoice, whichever is less. MCOs must require the hospital to submit an invoice of the **actual acquisition cost** of the drug.

Additional instructions for MCOs

1. The HHSC-approved prior authorization criteria for HCCAD is **mandatory** and can be found in the Outpatient Drugs Handbook of the Texas Medicaid Provider Procedure Manual.
2. MCOs will be reimbursed non-risk for the HCCAD. The medical encounters must contain the **Financial Arrangement Code value of "20".**
3. HHSC limits the non-risk payment to the actual amounts paid to providers for the drug's ingredient cost (up to the fee-for-service reimbursement amount).
4. **Drugs administered in an inpatient setting do not qualify for 340B discounts.**

For questions related to this change, contact Provider Relations at MHTXProviderServices@MolinaHealthcare.com

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