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State/Territory Name: Mississippi

State Plan Amendment (SPA) #: 18-0011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303

Regional Operations Group

February 21, 2019

Drew L. Snyder, Executive Director
Office of the Governor, Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201

Attention: Margaret Wilson

Re: Mississippi Title XIX State Plan Amendment, Transmittal # 18-0011

Dear Mr. Snyder:

This is to affirm approval of the above referenced State Plan Amendment which was submitted to the Regional Office on August 23, 2018. The State's requested effective date of July 1, 2018 has been accepted.

Enclosed for your records are:

1. a copy of the approval letter dated February 14, 2019 that was submitted to the State by John M. Coster, Director, Division of Pharmacy;

2. the original signed 179; and

3. the approved plan pages.

If you have any additional questions regarding this amendment, please contact Tandra Hodges, State Coordinator for Mississippi, at 404-562-7409.

Sincerely,

//s//

Shantrina D. Roberts, MSN
Deputy Director
Division of Medicaid Field Operations South

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Disabled and Elderly Health Programs Group

February 14, 2019

Drew Snyder, Executive Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201-1399

Dear Mr. Snyder:

We have reviewed Mississippi State Plan Amendment (SPA) 18-0011, received in the Atlanta Regional Office on August 23, 2018. This amendment proposes to reimburse certain physician administered drugs (PAD), referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs), using the state's existing lesser of methodology under the pharmacy reimbursement methodology. That is, for these CADDs, providers will be reimbursed the lesser of the National Average Drug Acquisition Cost (NADAC), the Wholesale Acquisition Cost (WAC) + 2% or the providers' usual and customary charges to the general public.

In keeping with the requirements of section 1902 (a)(30)(A) of the Social Security Act, we believe the state has demonstrated that their reimbursement is consistent with efficiency, economy, and quality of care, and are sufficient to ensure that care and services are available to Medicaid beneficiaries at least to the extent they are available to the general population in the geographic area.

Therefore, based on the information provided, we are pleased to inform you that, consistent with the regulations at 42 CFR 430.20, SPA 18-0011 is approved with an effective date of July 1, 2018. A copy of the signed CMS-179 form, as well as the pages approved for incorporation into the Mississippi state plan will be forwarded by the Atlanta Regional Office.

If you have any questions regarding this amendment, please contact Mickey Morgan at (410) 786-4048 or mickey.morgan@cms.hhs.gov.

Sincerely,

/s/

John M. Coster, Ph.D., R.Ph.
Director
Division of Pharmacy

cc: Terri Kirby, Pharmacy Director, Mississippi Division of Medicaid
Margaret Wilson, Nurse Office Director, Office of Policy
Shantrina Robert, CMS Associate Regional Administrator
Tandra Hodges, CMS Regional Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES**	1. TRANSMITTAL NUMBER: **18-0011**	2. STATE **MS**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: **REGIONAL ADMINISTRATOR** **CENTERS FOR MEDICARE AND MEDICAID SERVICES** **DEPARTMENT OF HEALTH AND HUMAN SERVICES**	4. PROPOSED EFFECTIVE DATE **07/01/2018**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 C.F.R. §§ 447.518, 447.520	FFY 2018: ($35,052) FFY 2019: ($140,210)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, Exhibit 12a, Page 5 Attachment 4.19-B, Page 12a.1,12a.1.1(new), 12a.3	Attachment 3.1-A, Exhibit 12a, Page 5 Attachment 4.19-B, Page 12a.1, 12a.3

10. SUBJECT OF AMENDMENT:
State Plan Amendment (SPA) 18-0011 Physician Administered Drugs (PADs) is being submitted to allow the Division of Medicaid to reimburse for certain PADs under the pharmacy benefit to improve beneficiary access. These certain PADs are currently referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs) and include, but are not limited to, long-acting reversible contraceptives (LARCs), pregnancy maintaining agents, injectable atypical antipsychotic agents, and chemical dependency treatment agents. CADDs may be billed as either medical or pharmacy point-of-sale (POS) claims, effective July 1, 2018.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/	16. RETURN TO: **Drew L. Snyder** **Miss. Division of Medicaid** **Attn: Margaret Wilson** **550 High Street, Suite 1000** **Jackson, MS 39201-1399**
13. TYPED NAME: **Drew L. Snyder**	
14. TITLE: **Executive Director**	
15. DATE SUBMITTED: 8/23/2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08/23/18	18. DATE APPROVED: 02/14/19
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/18	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Shantrina D. Roberts	22. TITLE: Deputy Director Division of Medicaid Field Operations South

23. REMARKS:

Approved with pen and changes authorized by the state on email dated 10/17/18 Attachment 4.19-B, page 12a.3 should be removed for block 8 and 9.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

12a. **Physician Administered Drugs and Implantable Drug System Devices:**

The Division of Medicaid defines Physician Administered Drugs and Implantable Drug System Devices as any covered diagnostic or therapeutic radiopharmaceutical, contrast imaging agent, drug, biological or implantable drug system device that is administered in a clinically appropriate manner to a beneficiary by a Mississippi Medicaid provider other than a pharmacy provider. Physician Administered Drugs and Implantable Drug System Devices are not counted toward the beneficiary's monthly prescription limit.

The Division of Medicaid covers Physician Administered Drugs and Implantable Drug System Devices as listed on the Physician's Fee Schedule located at www.medicaid.ms.gov/FeeScheduleLists.aspx.

E. Drugs acquired at Nominal Price (outside of 340B or FSS) – Ingredient cost based on AAC plus a professional dispensing fee of $11.29.

F. Specialty drugs are defined by the Division of Medicaid, updated no less than monthly, and listed at https://medicaid.ms.gov/providers/pharmacy/pharmacy-reimbursement/. Ingredient cost is defined as the lesser of:
   1. For a 340B covered entity:
      a. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the outpatient drug plus a professional dispensing fee of $61.14.
      b. Drugs purchased outside of the 340B program by covered entities – Ingredient cost is defined as the lesser of:
         1) WAC plus zero percent (0%) plus a professional dispensing fee of $61.14, or
         2) A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $61.14 when no WAC is available, or
         3) The provider's usual and customary charge.
   2. For a non-340B covered entity:
      a. WAC plus zero percent (0%) plus a professional dispensing fee of $61.14, or
      b. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $61.14 when no WAC is available, or
      c. The provider's usual and customary charge.

G. Drugs not dispensed by a retail community pharmacy (e.g., institutional or long-term care pharmacy when not included as part of an inpatient stay) – Ingredient cost based on AAC which is defined as the lesser of:
   1. NADAC plus a professional dispensing fee of $11.29, or
   2. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
   3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
   4. The provider's usual and customary charge.

H. Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers (HTCs), or Centers of Excellence – Ingredient cost defined as:
   1. For a 340B covered entity:
      a. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the clotting factor product plus a professional dispensing fee of $0.02 per Unit.
      b. Drugs purchased outside of the 340B program by covered entities – Ingredient cost which is defined as the lesser of:
         1) WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit, or
         2) A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02 when no WAC is available, or
         3) The provider's usual and customary charge.

2. For a non-340B covered entity – Ingredient cost is defined as the lesser of:
   a. WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit, or
   b. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02 when
   c. The provider's usual and customary charge.

I. Physician Administered Drugs and Implantable Drug System Devices as defined in Attachment 3.1-A, Exhibit 12a, Page 5 and reimbursed:
   1. Using the lesser of methodology under the pharmacy benefit as described in A - H above, or
   2. As described in Attachment 4.19-B, pages 12a.3-12a.4.

II. The Division of Medicaid does not reimburse for Investigational Drugs.

III. Usual and Customary Charges

The Division of Medicaid defines usual and customary charge as the lowest price the pharmacy would charge to a particular customer if such customer were paying cash for the identical prescription drug services on the date dispensed. This includes any applicable discounts including, but not limited to, senior discounts, frequent shopper discounts, and other special discounts offered to attract customers such as four dollar ($4.00) flat rate generic price lists. A pharmacy cannot have a usual and customary charge for prescription drug programs that differs from either cash customers or other third-party programs. The pharmacy must submit the accurate usual and customary charge with respect to all claims for prescription drug services.

IV. Overall, the Division of Medicaid's payment will not exceed the federal upper limit (FUL) based on the NADAC for ingredient reimbursement in the aggregate for multiple source drugs.