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State/Territory Name: Mississippi

State Plan Amendment (SPA) #: MS 22-0018-A

This file contains the following documents in the order listed:

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

August 24, 2022

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

Dear Drew Snyder:

The CMS Division of Pharmacy team has reviewed Mississippi's State Plan Amendment (SPA) 21-0018-A received in the CMS Division of Program Operations on April 22, 2022. This SPA approves the removal of the five percent (5%) reimbursement reduction for physician administered drugs.

Based on the information provided and consistent with the regulations at 42 CFR 430.20, we are pleased to inform you that SPA 21-0018-A is approved with an effective date of July 1, 2021. Our review was limited to the materials necessary to evaluate the SPA under applicable federal laws and regulations.

We are attaching a copy of the signed CMS-179 form, as well as the pages approved for incorporation into Mississippi's state plan. If you have any questions regarding this amendment, please contact Charlotte Amponsah at (410) 786-1092 or charlotte.amponsah@cms.hhs.gov.

Sincerely,

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

cc: Robin Bradshaw, State of Mississippi, Division of Medicaid
Margaret Wilson, State of Mississippi, Division of Medicai
Etta Hawkins, CMS Division of Program Operations - South Branch

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: **21-0018a**

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
July 1, 2021

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:
42 C.F.R. § 447.201

7. FEDERAL BUDGET IMPACT:
FFY 2020: $0 ~~22,729~~
FFY 2021: $0 ~~$22,729~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

- Attachment 4.19-B, 12a-12a.4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

- Attachment 4.19-B, 12a-12a.4

10. SUBJECT OF AMENDMENT:
State Plan Amendment (SPA) 21-0018a is being submitted to allow the Division of Medicaid (DOM) to ~~1) set a ceiling for the blood factor professional dispensing fee of $260.00, and 2)~~ remove the five percent (5%) reimbursement reduction for physician administered drugs effective July 1, 2021.

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/

13. TYPED NAME: **Drew L. Snyder**

14. TITLE: **Executive Director**

15. DATE SUBMITTED: April 22, 2022

16. RETURN TO:

Drew L. Snyder
Miss. Division of Medicaid
Attn: Margaret Wilson
550 High Street, Suite 1000
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
APRIL 22, 2022

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATUR

21. TYPED NAME: JOHN M. COSTER

22. TITLE: DIRECTOR, DIVISION OF PHARMACY

23. REMARKS:

THE MISSISSIPPI DIVISION OF MEDICAID AUTHORIZES CMS TO DO A PEN AND INK CHANGE AT BOX 7 TO CHANGE FEDERAL IMPACT BUDGET TO $0 FROM $22,729 AND AT BOX 10 TO REMOVE ITEM #1

State of Mississippi

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –OTHER TYPES OF CARE

Prescribed Drugs

The Division of Medicaid reimburses for certain legend and non-legend drugs, as authorized under the State Plan, prescribed by a Mississippi enrolled Medicaid prescribing provider licensed to prescribe drugs and dispensed by a Mississippi enrolled Medicaid pharmacy in accordance with Federal and State laws.

The Division of Medicaid Prescription Drug Program conforms to the Medicaid Prudent Pharmaceutical Purchasing Program as set forth in the Omnibus Budget Reconciliation Act of 1990 (OBRA'90) and complies with the Centers for Medicare and Medicaid (CMS) Covered Outpatient Drug Final Rule in accordance with 42 C.F.R. Part 447.

The Division of Medicaid reimburses the following drugs as described below:

A. Brand Name drugs – Ingredient cost based on actual acquisition cost (AAC) which is defined as the lesser of:
   1. National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee of $11.29, or
   2. Wholesale Acquisition Cost (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.

B. Generic drugs – 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.

C. Reimbursement for 340B covered entities as described in section 1927(a)(5)(B) of the Act, including an Indian Health Service, tribal and urban Indian pharmacy as follows:
   1. 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 covered outpatient drug plus a professional dispensing fee of $11.29.
   2. Drugs purchased outside of the 340B program by covered entities – Ingredient cost based on AAC which is defined as the lesser of:
      a. NADAC plus a professional dispensing fee of $11.29, or
      b. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
      c. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no WAC is available, or
      d. The provider's usual and customary charge.
   3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

D. Drugs acquired via the Federal Supply Schedule (FSS) – Ingredient cost based on AAC plus a professional dispensing fee of $11.29.

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. For drugs purchased outside of the 340B program by covered entities reimbursement is the lesser of the provider's total usual and customary charge or the ingredient cost as defined in the hierarchy below :
         1) WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit. If there is no WAC available, then
         2) A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02.

2. For a non-340B covered entity reimbursement for prescribed drugs is the lesser of the provider's total usual and customary charge or an ingredient cost as defined in the hierarchy below:
   a. WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit. If there is no WAC available, then
   b. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02.

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 - F above, or
   2. As described in Attachment 4.19-B, pages 12a.3-12a.4.

J. Prescribed drugs dispensed by Indian Health Services are reimbursed the current Federal Register encounter rate for outpatient hospital. Refer to Attachment 4.19-B, Supplement 3, Page 1.

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.

State of Mississippi
Methods and Standards For Establishing Payment Rates-Other Types of Care

Hospital Outpatient Drugs

a. Drugs paid outside the Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC) rate will be reimbursed by a Medicare fee. If there is no Medicare fee the drug will be reimbursed using a MS Medicaid OPPS Chemotherapy fee.

b. The APC and the Medicare fees on the MS Medicaid OPPS fee schedule will be calculated based on the Medicare outpatient Addendum B published by the Centers for Medicare and Medicaid Services (CMS) as of January 1 of each year. The MS Medicaid OPPS fee schedule is updated and effective July 1 of each year with no retroactive adjustments.

c. Chemotherapy drugs and concomitant non-chemotherapy drugs administered during the chemotherapy treatment billed on the same claim as the chemotherapy treatment will be paid a MS Medicaid OPPS Chemotherapy fee. The MS Medicaid OPPS Chemotherapy fee will be the amount listed on the Medicare Average Sales Price (ASP) Drug Pricing File, titled Payment Allowance Limits for Medicare Part B, published by CMS as of January 1 of each year. The ASP files are one-hundred six percent (106%) of the ASP calculated from data submitted by drug manufacturers. The MS Medicaid OPPS Chemotherapy fee is updated and effective July 1 of each year with no retroactive adjustments.

d. If there is no APC relative weight, Medicare payment rate, MS Medicaid OPPS Chemotherapy fee or ASP for a drug, reimbursement is made at no more than one-hundred percent (100%) of the provider's acquisition cost.

e. All rates are published at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

Physician Administered Drugs and Implantable Drug System Devices

Drugs and Biologicals

Drugs and Biologicals are reimbursed at the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using the April 1 Medicare Part B Drug Fee Schedule of each year.

1) If there is no Medicare Part B Drug Fee Schedule a fee will be calculated at one hundred percent (100%) of the current April 1 Medicare Addendum B Outpatient Prospective Payment System (OPPS) Fee Schedule updated July 1 of each year and effective for services provided on or after that date.

2) If there is no Medicare Part B Drug Fee Schedule or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using Wholesale Acquisition Cost (WAC) + 0% in effect on April 1 of each year and updated July 1 of each year and effective for services provided on or after that date.

3) If there is no (a) Medicare Part B Drug Fee Schedule, Medicare Addendum B OPPS Fee or WAC + 0% or (b) when it is determined, based on documentation, that a drug or biological fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, the price will be one hundred percent (100%) of the current invoice submitted by the provider including:

   (1) A matching National Drug Code (NDC) as the product provided, and

   (2) Medical documentation of the dosage administered.

Implantable Drug System Devices

Implantable drug system devices are reimbursed at the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using the April 1 Medicare Part B Drug Fee Schedule of each year.

1) If there is no Medicare Part B Drug Fee Schedule a fee will be calculated at one hundred percent (100%) of the current April 1 Medicare Addendum B OPPS Fee Schedule updated July 1 of each year and effective for services provided on or after that date.

2) If there is no Medicare Part B Drug Fee Schedule or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using WAC + 0% in effect on April 1 of each year and updated July 1 of each year and effective for services provided on or after that date.

3) If there is no (a) Medicare Part B Drug Fee Schedule, Medicare Addendum B OPPS Fee Schedule or WAC + 0% or (b) when it is determined, based on documentation, that an implantable drug device system fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, the price will be one hundred percent (100%) of the current invoice submitted by the provider including:

   (1) A matching National Drug Code (NDC) as the product provided, and

   (2) Medical documentation of the dosage administered.

Diagnostic or Therapeutic Radiopharmaceuticals and Contrast Imaging Agents

Diagnostic or therapeutic radiopharmaceuticals and contrast imaging agents are reimbursed at the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using one hundred percent (100%) of the April Medicare Radiopharmaceutical Fee Schedule.

1) If there is no Medicare Radiopharmaceutical Fee a fee will be calculated at one hundred percent (100%) of the current April 1 Medicare Addendum B OPPS Fee Schedule updated July 1 of each year and effective for services provided on or after that date.

2) If there is no Medicare Radiopharmaceutical Fee or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using WAC + 0% in effect on April 1 of each year and updated July 1 of each year and effective for services provided on or after that date.

3) If there is no (a) Medicare Radiopharmaceutical Fee, Medicare Addendum B OPPS Fee Schedule or WAC + 0% or (b) when it is determined, based on documentation, that a diagnostic or therapeutic radiopharmaceuticals and contrast imaging agent fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, the price will be one hundred percent (100%) of the current invoice submitted by the provider including:

   (1) A matching National Drug Code (NDC) as the product provided, and

   (2) Medical documentation of the dosage administered.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician Administered Drugs and Implantable Drug System Devices. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.