

MEDICAL ASSISTANCE PROGRAM

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.

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

- 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.

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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.