

PUBLIC NOTICE

June 30, 2020

Pursuant to 42 C.F.R. Section 447.205, public notice is hereby given for the submission of a Medicaid State Plan Amendment (SPA) 20-0005 Physician Administered Drugs. The Division of Medicaid, in the Office of the Governor, will submit this proposed SPA to the Centers for Medicare and Medicaid Services (CMS) effective July 1, 2020, contingent upon approval from CMS, our Transmittal #20-0005.

1. Mississippi Medicaid SPA 20-0005 proposes to change the physician administered drug payment methodology by revising the fee schedule update from quarterly to annually. Physician administered drugs will be updated annually on July 1st calculated based on the current January 1 hierarchy below:
 - a. Medicare Part B Drug Average Sales Price (ASP),
 - b. Medicare Addendum B Outpatient Prospective Payment System (OPPS) Fee Schedule, or
 - c. Wholesale Acquisition Cost (WAC) pricing.
2. The expected annual aggregate expenditures is \$0.00.
3. The Division of Medicaid is submitting this proposed SPA in order to comply with federal Medicaid regulations. 42 C.F.R. § 447.201 requires the Division of Medicaid to submit a SPA describing the policy and methods used in setting payment rates for each type of service included in the Mississippi State Plan.
4. A copy of the proposed SPA will be available in each county health department office and in the Department of Human Services office in Issaquena County for review. A hard copy can be downloaded and printed from www.medicaid.ms.gov, or requested at 601-359-2081 or by emailing at Margaret.Wilson@medicaid.ms.gov.
5. Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or Margaret.Wilson@medicaid.ms.gov for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.
6. A public hearing on this SPA will not be held.

State of Mississippi
Methods and Standards for Establishing Payment Rates – Other Types of Care

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 January 1 Medicare Part B Drug Average Sales Price (ASP) of each year.

- 1) If there is no ASP a fee will be calculated at one hundred percent (100%) of the current January 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 ASP or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using Wholesale Acquisition Cost (WAC) pricing in effect on January 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) ASP, Medicare Addendum B OPPS Fee or WAC pricing 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 January 1 Medicare Part B Drug ASP of each year.

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

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Methods and Standards for Establishing Payment Rates – Other Types of Care

- 3) If there is no (a) ASP, Medicare Addendum B OPPS Fee Schedule or WAC pricing 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 January 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 January 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 pricing in effect on January 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 pricing 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/#. Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The federal match will be paid based on the reduced amount.

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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 ~~quarterly (July 1 of each year, October 1, January 1, April 1) of each year~~ and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using the ~~Quarterly January 1 Medicare Part B Drug Average Sales Price (ASP) plus six percent (6%) in effect quarterly (July 1, October 1, January 1, April 1)~~ of each year.

- 1) If there is no ASP a fee will be calculated at one hundred percent (100%) of the current ~~April January 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 ASP or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using Wholesale Acquisition Cost (WAC) pricing ~~RED BOOK™~~ in effect on January 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) ASP, Medicare Addendum B OPPS Fee or ~~RED BOOK™ WAC fee pricing~~ 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 ~~quarterly (July 1, October 1, January 1, April 1)~~ of each year and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using the ~~Quarterly January 1 Medicare Part B Drug ASP plus six percent (6%) in effect quarterly (July 1, October 1, January 1, April 1)~~ of each year.

- 1) If there is no ASP a fee will be calculated at one hundred percent (100%) of the current ~~April January 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 ASP or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using ~~RED BOOK™ WAC pricing~~ in effect on January 1 of each year and updated July 1 of each year and effective for services provided on or after that date.

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- 3) If there is no (a) ASP, Medicare Addendum B OPPS Fee Schedule or ~~RED BOOK™ fee~~ WAC pricing 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 January 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~~ January 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 ~~RED BOOK™ fee~~ WAC pricing in effect on January 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 ~~RED BOOK™ fee~~ WAC pricing 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:
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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/#. Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The federal match will be paid based on the reduced amount.