Mississippi Medicaid Bulletin

Special Issue

March 2002

Medicaid Changes

This is a special issue of the Medicaid Provider Bulletin to notify providers of changes in the Medicaid program as a result of House Bill 1200. Below is a summary of the changes and the articles in this bulletin that provide details of the program changes.

- The number of prescriptions per month per beneficiary is reduced from 10 to 7 with prior approval after the 5th prescription.
- Prescriptions are limited to a 34-day supply based on the daily dosage.
- The dispensing fee is reduced from $4.91 to $3.91 for each new or refilled prescription.
- All prescriptions will be filled generically when equally effective generic equivalents exist. The Medicaid provider shall not prescribe a name brand drug, the Medicaid pharmacy will not bill a name brand drug, and the Division shall not reimburse for a name brand drug. Prior authorization must be obtained for any brand substitution for a generically equivalent drug.
- Applicable drug claims for dually eligible Medicare/Medicaid recipients must first be billed to Medicare for payment before Medicaid will process the drug claim.
- Medicaid is to develop pharmacy policy in accordance with the guidelines of the State Board of Pharmacy by which drugs in tamper-resistant packaging prescribed for residents in a nursing home but not dispensed to the resident shall be returned to the pharmacy and not billed to the Division.
- The "estimated acquisition cost" of drugs is to be average wholesale price minus 12%.
- Adult beneficiaries can receive one pair of eyeglasses every 5 years rather than every 3 years; children can receive 1 pair of eyeglasses per fiscal year, and any additional eyeglasses that are medically necessary will require prior authorization.
- The HealthMACS primary care case management program is eliminated.
- Medicaid with the State Department of Health will develop disease management programs for diabetes, hypertension, and asthma.
- Co-payments for services which are allowable under federal law are being maximized to the amount allowed under federal law.
- All provider reimbursement will be reduced by 5% except pharmacy, those

state facilities and agencies that provide their own state match, and those services for which the federal government mandates the reimbursement methodology and rates.

- The Drug Use Review (DUR) board is outlined with 12 members appointed by the Governor or his designee. The Board functions as outlined in federal law and is subject to the Open Meetings Act.

- The Pharmacy and Therapeutic Committee is established to oversee the drug prior authorization process of the Division. Its meetings are subject to the Open Meetings Act.

Five (5) Percent Reduction In Reimbursement Rates

Effective for dates of services on and after May 1, 2002 the Division of Medicaid will reduce the rate of reimbursement to providers for Medicaid services by 5% of the allowed amount for Medicaid services as authorized through legislation in House Bill 1200.

Providers will continue to submit their claims routinely. There will be no adjustments in the current fee schedules nor reimbursement rates because the reduction will be applied per claim line as the claim is being processed for payment. In addition, the Remittance Advice will include information regarding the reductions.

This legislation does not apply to pharmacy claims and services provided by a state agency, a state facility, a public agency, or the University of Mississippi Medical Center that either provides its own state match through inter-governmental transfer or certification of funds to the division or a service for which the federal government sets the reimbursement methodology and rate.

Home and Community-Based Wavier Services Providers

For the HCBS Waivers, the 5% cut will affect the Elderly and Disabled Waiver and the Assisted Living Waiver. Other waivers are exempt because they are funded by other state agencies. **Providers for the E&D Waiver and the Assisted Living Waiver do not have to do anything differently. Continue to file as you have been, the 5% will be deducted from the total amount of your payment.** Procedure codes that will be affected include: W3100, W3101, W3102, W3103, W3105, W3113, W3128, W9017 and W9018. This cut is effective for services on and after May 1, 2002.

Vision Providers

Children:
Effective May 1, 2002, the Division of Medicaid will reimburse for **one** (1) complete pair of eyeglasses per **fiscal year** for beneficiaries under the age of 21 years. Any **additional medically necessary eyeglasses** within the fiscal year will require **prior authorization.**

Adults:
Effective May1, 2002, the Division of Medicaid will reimburse for **one** (1) complete pair of eyeglasses per fiscal year for adult beneficiaries over the age of 21 years **every five years**.

If you have questions, please call 1-800-421-2408 or 601-359-6138. Thank you.

Medicare/Medicaid Dual Eligible Beneficiaries

As outlined in the February 2002 Bulletin, Volume 8, Issue 8, when a beneficiary is eligible under both Medicare and Medicaid, Medicare is responsible for primary coverage. There are several categories of drugs which are covered by Medicare for outpatients. These include (but may not be limited to:)

- Immunosuppressive agents for transplant recipients covered by Medicare
- Total Parenteral Nutrition
- Total Enteral Nutrition
- Oral Anti-Cancer Agents
- Oral Anti-Nausea Agents
- Inhalation Drugs.

Software is being put into place which will identify dual eligible beneficiaries and reject claims for drugs which should be billed to Medicare.

Please refer to the February 2002 bulletin for information about applying to become a Medicare DMEPOS supplier.

Any questions about Medicare and the DEMPOS supplier requirements should be directed to the National Supplier Clearing House at the toll free number 1-866-238-9652 or by accessing the Palmetto GBA web site at www.palmettogba.com

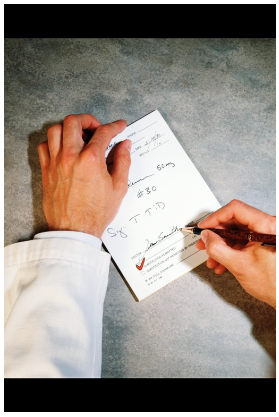
HealthMACS

Effective April 1, 2002 HealthMACS primary care providers (PCPs) will no longer receive monthly case management fees nor report information specific for HealthMACS. The HealthMACS PCP will be responsible for approving or denying HealthMACS authorization requests for services provided on or before March 31, 2002. A letter is being sent to HealthMACS beneficiaries reassuring them that the termination of the HealthMACS program does not in any way impact their Medicaid eligibility or entitled benefits.

Medicaid providers no longer need to verify managed care status or obtain HealthMACS authorization for services provided on or after April 1, 2002. Providers in need of HealthMACS claims assistance may contact the Managed Care Division at 1-800-421-2408 or 601-359-6133.

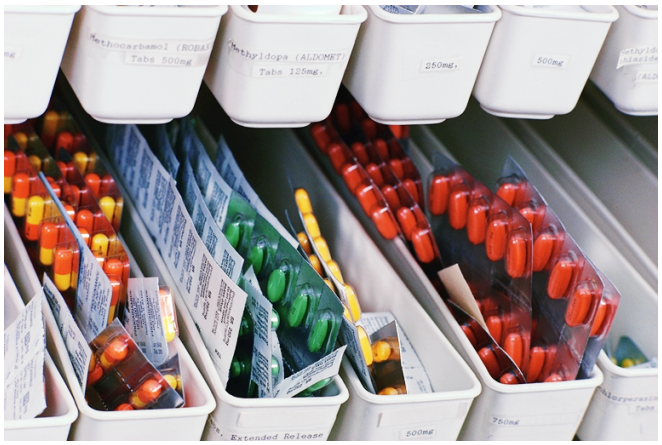
Maximum Prescriptions Per Beneficiary

Adults :
Effective May 1, 2002 the maximum number of prescriptions allowed per beneficiary is being reduced from 10 per month to 7 per month. However, prescriptions over 5 per beneficiary will require prior authorization. The practitioner's office will be required to submit a letter of medical necessity for the additional two prescriptions. This letter must include diagnosis and be signed by the physician. If approved, the indicated pharmacy will be given a PA number which will allow the two additional prescriptions to be entered.



Children:
Requests for extended prescriptions (i.e., more than five prescriptions per month) for beneficiaries under 21 years of age should be submitted to the Bureau of Maternal & Child Health on Form MA-1148 (MS Medical Assistance Program Plan of Care Authorization Request). This form may be obtained by calling ACS at 1-800-884-3222 or (601) 206-3000. Please ensure that all prescriptions under the service limit file have been exhausted before submitting a request for extended prescriptions on the MA-1148 form.

For more information you may call 1-800-421-2408 or 601 359-6150.



Returned Medications From Long Term Care Facilities

Effective May 1, 2002 drugs in tamper-resistant packaging that are prescribed for a resident of a nursing facility but are not dispensed to the resident shall be returned to the pharmacy and not billed to Medicaid in accordance with guidelines of the Mississippi State Board of Pharmacy.

Drug Use Review Board

A Drug Use Review Board (DUR Board) will meet quarterly. Written notice will be furnished at least 10 days before the date of the meeting. The meeting is open to the public, members of the press, legislatures, and consumers.

Generic Drugs Mandated

Effective June 1, 2002 the Medicaid prescriber shall not prescribe a name brand drug, the Medicaid pharmacy shall not bill for a name brand drug, and the Division of Medicaid shall not reimburse for a name brand drug if an equally effective and less expensive generic equivalent drug is available.

Maximum Days Supply

Effective May 1, 2002 all prescriptions will be filled for a maximum 34-day supply

Pharmacy and Therapeutic Committee

A Pharmacy and Therapeutic (P and T Committee) will meet quarterly. Written notice will be furnished at least 10 days before the date of the meeting. The meeting is open to the public, members of the press, legislatures and consumers

Dispensing Fee Reduced

Effective April 1, 2002 the dispensing fee for all legend drugs will be reduced from $4.91 to $3.91 per prescription.

Drug Reimbursement Rate

Effective April 1, 2002 the reimbursement rate on claims is being reduced from AWP minus 10% to AWP minus 12%. This is for all drugs. Federal Upper Limits (FUL or MAC) will still be in place. Reimbursement for legend drugs is the lesser of the AWP minus 12% plus $3.91 dispensing fee OR the usual and customary charge. All claims are to be billed at the usual and customary charge. Over the counter (OTC) drugs are paid at the lesser of AWP plus 3.91, AWP + 50% or the shelf price. All OTC drugs are to be billed at shelf price.

Co-Payments

Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services, such as enrollment fee payments, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges.

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House Bill 1200 legislates that "the division shall establish co-payments for all Medicaid services for which co-payments are allowable under federal law or regulation, and shall set the amount of the co-payment for each of those services at the maximum amount allowable under federal law or regulation."

For dates of service on and after May 1, 2002, providers are responsible for collecting the following co-payments for the following Medicaid services.

Service	Co-payment For Date(s) Of Services Prior To May 1, 2002	Co-payment For Date(s) Of Services On And After May 1, 2002
Ambulance	**$2.00 Per Trip**	**$ 3.00 Per Trip**
Dental	**$2.00 Per Visit**	**$ 3.00 Per Visit**
FQHC	**$1.00 Per Visit**	**$ 3. 00 Per Visit**
Home Health	**$2.00 Per Visit**	**$ 3.00 Per Visit**
Hospital Inpatient	**$5.00 Per Day**	**$10.00 Per Day**
Hospital Outpatient	**$2.00 Per Visit**	**$3.00 Per Visit**
Physician (any setting)	**$1.00 Per Visit**	**$3.00 Per Visit**
Prescription	**$1.00 Per Prescription**	**$1.00 Per Prescription for Generic Drugs $3.00 Per Prescription for Brand Name Drugs**
Rural Health Clinic	**$2.00 Per Visit**	**$3.00 Per Visit**
Vision	**$2.00 Per Pair of Eyeglasses**	**$3.00 Per Pair of Eyeglasses**
Durable Medical Equipment Orthotics Prosthetics (Not Applicable to Medical Supplies)	**None**	**Up to $3.00 (Will vary Based on state payment for each Durable Medical Equipment, Orthotic or Prosthetic Item) Providers will be further notified when co-payments are assigned to the individual HCPCS codes.**
Non-Emergency Transportation	**None**	**$2.00 Per Round Trip**

The following beneficiaries and services do not require co-payments:

Infant Exception Code (For newborn only)

K Infant

Co-Payment Exception Codes

C Children under age 18
P Pregnant Women
N Nursing Facility
F Family Planning Services
E Emergency Room Services**

** Certified by the physician as true emergencies and so recorded in the medical record.

Collection of Co-Payment

Collecting the co-payment amount from the beneficiary is the responsibility of the provider. In cases of claims adjustments, the responsibility of refunding or collecting additional cost sharing co-payments from the beneficiary remains the responsibility of the provider.

The provider may not deny services to any eligible Medicaid individual due to the individual's inability to pay the cost of the co-payment. However, the individual's inability to pay the co-payment amount does not alter the Medicaid reimbursement amount for the claim.

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If you have any questions related to the topics in this bulletin, please contact ACS at 1-800 -884 -3222 or 601 -206 -3000

Mississippi Medicaid Bulletins and Manuals are on the Web www.dom.state.ms.us

For your convenience we have included a Quick Contact Guide for commonly used numbers. If you have any questions or concerns please refer to the following:

Quick Contact Guide	
ACS Provider and Beneficiary Services	1-800-884-3222 or 1- 601-206-3000
ACS Provider and Beneficiary Fax Number	1-601-206-3059
EDI	1-866-225-2502
AVRS	1-866-597-2675 or 1-601-206-3090
Division of Medicaid	1-601-359-6050