PUBLIC NOTICE

December 20, 2024

Pursuant to 42 C.F.R. Section 447.205, public notice is hereby given for the submission of a Medicaid State Plan Amendment (SPA) 25-0006 High-Cost 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 January 1, 2025, contingent upon approval from CMS, our Transmittal #25-0006.

1. This SPA being is being submitted to allow the Division of Medicaid (DOM) to reimburse certain high-cost drugs outside of the All-Patient Refined Diagnosis Related Group (APR-DRG) reimbursement system, effective January 1, 2025.

2. The expected annual impact is $4,075,700. The federal annual aggregate expenditure is $0.00 for Federal Fiscal Year (FFY25) and $3,148,478 for FFY26. The expected increase in state annual aggregate expenditure is $0.00 for FFY 25 and $927,222 for FFY26.

3. The Division of Medicaid is submitting this proposed SPA to be in compliance with 42 C.F.R. § 447.201 which requires all policy and methods used in setting payment rates for services be included in the 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 601-359-3984 or by emailing at DOMPolicy@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 DOMPolicy@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.

R. Long-term Ventilator-dependent Patients Admitted Prior to October 1, 2012

Payment for ventilator-dependent patients admitted to the hospital prior to October 1, 2012 will continue to be reimbursed on a per diem basis until they are discharged from the hospital, the per diem in effect in the preceding year will be increased by the percentage increase. For hospitals with these patients, for rate years beginning October 1, 2012, and thereafter of the most recent Medicare Inpatient Hospital PPS Market Basket Update as of October 1 of each year as published in the Federal Register. All patients admitted to a hospital on or after October 1, 2012 will be reimbursed under the APR-DRG methodology.

S. Post-Payment Review

All claims paid under the APR-DRG payment methodology are subject to post-payment review.

T. Payments Outside of the DRG Base Payment

The following payments are made outside of, and in addition to, the DRG base payment:

1. Long Acting Reversible Contraceptives (LARCs) and their insertion at the time of delivery will be reimbursed separately from the APR-DRG payment. A separate outpatient claim may be submitted by the hospital for reimbursement for LARCs and their insertion at the time of delivery. Reimbursement for the insertion of LARCs at the time of delivery will be based on the Physician Fee Schedule effective July 1, 2023, and updated annually as described in Attachment 4.19-B. The LARC will be reimbursed at the lesser of the provider's usual and customary charge or the fee listed on the Physician Administered Drugs and Implantable Drug System Devices Fee Schedule effective July 1, 2023, and updated quarterly as described in Attachment 4.19-B. All fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

~~1.~~2. Effective January 1, 2025, certain high-cost drugs provided in an inpatient hospital setting will be reimbursed separately from the APR-DRG payment. A separate outpatient hospital claim may be submitted by the hospital to receive reimbursement for certain high-cost drugs during the time of inpatient services. High-cost drugs will be reimbursed using the provider’s invoice price. Invoice price must be the actual net price paid by the hospital. The list of high-cost drugs is maintained on the Division of Medicaid’s website at https://medicaid.ms.gov/pharmacy/ .

assigned a MS Medicaid OPPS status indicator "T" or "MT" is priced at one hundred percent (100%) of the allowed amount or published fee. All other lines with significant procedures identified on the MS OPPS fee schedule assigned a MS Medicaid OPPS status indicator of "T" or "MT" is priced at fifty percent (50%) of the allowed amount or published fee.

Effective July 1, 2019, claims with more than one (1) significant dental procedure code, assigned a MS Medicaid OPPS status indicator "T" or "MT" are discounted. The dental procedure code line item with the highest allowed amount on the claim assigned a MS Medicaid OPPS status indicator "T" or "MT" is priced at one hundred percent (100%) of the allowed amount or published fee. All other lines with significant dental procedures identified on the MS OPPS fee schedule assigned a MS Medicaid OPPS status indicator of "T" or "MT" are priced at twenty-five percent (25%) of the allowed amount or published fee.

g. Medicare has set guidelines for procedures it has determined should be performed in an inpatient setting only. The DOM follows Medicare guidelines for procedures defined as "inpatient only".

2. Outpatient Payment Methodology Paid Under Medicaid OPPS

Except in cases where the service is non-covered by DOM, outpatient services will be priced as follows:

a. For each outpatient service or procedure, the fee is no more than 100% of the Ambulatory Payment Classification (APC) rate multiplied by the units (when applicable).

b. Where no APC rate has been assigned, the outpatient services fee will be no more than 100% of any applicable Medicare payment rate in the Medicare outpatient Addendum B as of January 1 of each year as published by the CMS multiplied by the units (when applicable).

c. If there is no APC rate or Medicare payment rate established in the Medicare outpatient Addendum B as of January 1 of each year as published by the CMS, payment will be made using the applicable MS Medicaid fee multiplied by the units (when applicable).

d. If there is (1) no APC rate, Medicare payment rate, or MS Medicaid fee for a procedure or service, or a device, drug, biological or imaging agent, or (2) when it is determined, based on documentation, that a procedure or service, or device, drug, biological or imaging agent reimbursement is insufficient for the Mississippi Medicaid

~~d.~~e. Effective January 1, 2025, certain high-cost drugs provided in an inpatient hospital setting will be reimbursed separately from the APR-DRG payment. A separate outpatient hospital claim may be submitted by the hospital to receive reimbursement for certain high-cost drugs during a time of inpatient services. Reimbursement for high-cost drugs will be priced using the provider's invoice price. Invoice price must be the actual net price paid by the hospital. The list of high-cost drugs is maintained on the Division of Medicaid's website located at https://medicaid.ms.gov/pharmacy/.

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.

~~K.~~ Certain high-cost drugs provided in an inpatient hospital setting will be reimbursed separately from the APR-DRG payment. A separate outpatient hospital claim may be submitted by the hospital to receive reimbursement for certain high-cost drugs during a time of inpatient services. Reimbursement for high-cost drugs will be priced using the provider's invoice price. The invoice price must be the actual net price paid by the hospital. The list of high-cost drugs is maintained on the Division of Medicaid's website at https://medicaid.ms.gov/pharmacy/.

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~~[Reserved]

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

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