STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Mississippi

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.	

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

12a. **Prescribed Drugs**: Covered outpatient drugs are those produced by any manufacturer which has entered into and complies with an agreement under Section 1927 (a) of the Act which are prescribed for a medically acceptable indication. Compounded prescriptions (mixtures of two or more ingredients) except for hyperalimentation are not covered.

All Medicaid beneficiaries age twenty-one and older are limited to five prescriptions per month with no more than two brand name (single source or innovator multiple source) drugs per month for each non-institutionalized Medicaid beneficiary.

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

As provided by Section 1927 (d) (2) and Section 1935 (d) (2) of the Act, the following drugs or classes of drugs, or their medical uses, are excluded from coverage or otherwise restricted.

The Medicaid agency will cover the following classes of excluded drugs as listed below:

- ☐ (a) Agents when used for anorexia, weight loss or weight gain.
- ☐ (b) Agents when used to promote fertility.
- ☐ (c) Agents when used for cosmetic purposes or hair growth.
- ☐ (d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
- ☐ (e) Those drugs designated less than effective by the FDA as a result of the Drug Efficacy Study Implementation (DESI) program.
- ☐ (f) Non-participating rebate manufacturers.
- ☒ (g) Agents when used for symptomatic relief of cough and colds:
  Brompheniramine/Pseudoephrine, Brompheniramine/Pseudoephrine/DM, Chlorpheniramine, Clemastine tablets, Dexbrompheniramine/Pseudoephrine, Dextromethorphan Polystirex Suspension, Dextromethorphan/Pseudoephrine, Diphenhydramine, Guaifenesin Syrup (AC, DAC, DM, Plain), Loratadine, Loratadine/Pseudoephrine, Promethazine with Codein, Pseudoephedrine, Triprolidine/Pseudoephrine.
- ☒ (h) Agents when used to promote smoking cessation; (Beginning January 1, 2006 for non Part D eligible individuals):
  Nicotine nasal spray, Nicotine oral inhaler.
- ☒ (i) Prescription vitamins and mineral products except prenatal vitamins (for OB patients only), fluoride preparations (for beneficiaries under age 21), and renal vitamins (for dialysis patients).

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

☒ (j) Non-prescription (OTC) drugs:
Acetaminophen, Al & Mg Hydroxide, Al & Mg Hydroxide plus Simethicone, Ammonium Lactate, Aspirin, Benzoyl Peroxide Gel, Brompheniramine/Pseudoephrine, Brompheniramine/Pseudoephrine/DM, Calcium Carbonate (for dialysis patients only), Chlorpheniramine, Clemastine tablets, Clotrimazole, Dexbrompheniramine/Pseudoephrine, Dextromethorphan Polystirex Suspension, Dextromethorphan/Pseudephrine, Diphenhydramine, Ferrous Sulfate, Guaifenesin Syrup (AC, DAC, DM, & Plain), Hydrocortisone Cream, Ibuprofen Suspension, Insulin, Loratadine, Loratadine/Pseudoephrine, Loperamide, Magnesium Gluconate, Magnesium Chloride, Miconazole, Naphazoline/Pheniramine Ophthalmic Drops, Niacin, Nicotine (for smoking cessation), Ocular Lubricant Ointment and Tears, Omeprazole, Oral Electrolyte Mixtures, Permethrin Cream Rinse, Phenazopyridine, Prenatal Vitamins (for OB patients only), Pseudoephedrine, Pyrantel Pamoate Suspension, Renal Vitamins (for dialysis patients only), Triple Antibiotic Ointment, Tolnaftate Cream And Powder, Triprolidine/Pseudoephrine.

☒ (k) Barbiturates, beginning January 1, 2006, only Phenobarbital and Mephobarbital are covered.

☒ (l) Benzodiazepines.

STATE PLAN UNDER TITLE X1X OF THE SOCIAL SECURITY ACT
State: MISSISSIPPI

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905 (a) (1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Ambulance			X	$3.00 per trip
Dental Visits			X	$3.00 per visit
Durable Medical Equipment, orthotics, and prostheticss (excludes medical supplies)			X	Up to $3.00 per item (varies per State payment for each item)
Eyeglasses			X	$3.00 per pair
Home Health Visits			X	$3.00 per visit
Hospital Inpatient Days			X	$10.00 per day up to one-half the hospital's first day per diem per admission
Hospital Outpatient Visits			X	$3.00 per hospital outpatient visit
Physician Visits: office, home, emergency room, ophthalmological			X	$3.00 per visit
Prescription drugs			X	$3.00 per prescription, including refills
Rural Health Clinic Visits, FQHC Visits, and MSDH clinic Vsits			X	$3.00 per visit

When the average or typical State payments for the above services are taken into consideration, all copayments are computed at a level to maximize the effectiveness without causing undue hardship on the recipients, assuring that they do not exceed the maximum permitted under 42 CFR 447.54

The basis for determining the charge of each co-payment for all services except in-patient hospital was the standard co-payment amount described in 42 CFR Section 447.55. The maximum co-payment amount in 42 CFR Section 447.54 was applied to the agency's average or typical payment for the particular service. For in-patient hospital services, the amount was calculated so as not to exceed one-half the first day's per diem for each hospital per admission.

Providers are required by the agency's provider agreements and policy manuals to assume the responsibility for collecting the co-payment amounts from those beneficiaries who are required to pay co-payments. Providers are required to make the determination as to whether or not a Medicaid beneficiary is able to pay required co-payment amounts Providers are prohibited by the agency's provider agreements and policy manuals from denying services to Medicaid beneficiaries because of inability to pay the co-payment, in compliance with 42 CFR Section 447.15.

Providers are prohibited by the agency's provider agreements and policy manuals from charging co-payment amounts for those services and beneficiaries found in 42 CFR Section 447.53(b). Beneficiaries are educated regarding co-payment amounts and regarding those services and beneficiaries that are exempt from co-payments. The agency's claims payment system contains an edit that prohibits the reduction of the co-payment amount from an excluded service or beneficiary category.

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

Prescribed Drugs

Medicaid pays for certain legend and non-legend drugs prescribed by a physician or other prescribing provider licensed to prescribe drugs as authorized under the program and dispensed by a licensed pharmacist in accordance with Federal and State laws.

The Mississippi 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).

For beneficiaries under age 21, special exceptions for the use of non-covered drug items may be made in unusual circumstances when prior authorization is given by Medicaid.

1. **Reimbursement Methodology**

MEAC is defined as the Division's best estimate of the actual purchase price generally and currently paid by providers for a drug, identified by NDC number, marketed or sold by a particular manufacturer or labeler.

A. **Brand Name** (Single source, Innovator multiple source) **and Single Source Generic Drugs** - Single Source generic drugs are defined as those drugs going off patent and a single source generic house has exclusivity for a period of time. Reimbursement methodology for brand name drugs and single source generic drugs is:

1. The lesser of:
   - The usual and customary charge; or
   - The Federal Upper Limit (FUL), for certain multiple source drugs, and a dispensing fee of $3.91; or
   - Average Wholesale Price (AWP) less 12% and a dispensing fee of $3.91; or
   - Wholesale Net Unit Price/Wholesale Acquisition Cost (WAC) plus 9% and a dispensing fee of $3.91.
2. Less the applicable co-payment.

B. **Multiple Source Generic Drugs**- CMS defines multiple source generic drugs as a product with three or more versions of the product related therapeutically equivalent (A-rated) regardless of the ratings of other versions (B-rated) and at least three suppliers are listed in the current editions of published national compendia. Reimbursement methodology for multiple source generic drugs is:

1. The lesser of:
   - The usual and customary charge; or
   - The Federal Upper Limit (FUL), if applicable, and a dispensing fee of $4.91*; or

- Average Wholesale Price (AWP) less 25% and a dispensing fee of $4.91*;

2. Less the applicable co-payment.

*The dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to $3.91.

C. Other Drugs

1. Reimbursement for covered drugs other than the multiple-source drugs with CMS upper limits shall not exceed the lower of:

   - The Mississippi Estimated Acquisition Cost for the drug plus a reasonable dispensing fee; or
   - The provider's usual and customary charge to the general public.

2. Reimbursement for covered non-legend products or over-the-counter products is limited to the lower of the Division's estimated shelf price for the drug plus a reasonable dispensing fee or the charge to the general public for the drug.

2. Dispensing Fee

Dispensing fees are determined on the basis of surveys that are conducted periodically by the Division of Medicaid and take into account various pharmacy operational costs. Between surveys, the dispensing fee may be adjusted based on various factors (i.e., CPT, etc.). The dispensing fee of $3.91 for sole source drugs and $4.91 for multi-source drugs is paid for non-institutionalized beneficiaries. The dispensing fee paid for institutionalized beneficiaries is $3.91.

3. Usual and Customary Charges

The provider's usual and customary charge is defined as the charge to the non-Medicaid patient. The state agency obtains the provider's usual and customary charge from the pharmacy invoice. The accuracy of the usual and customary charge is validated by Division staff in the field who conducts on-site audits. Audits of prescription files and usual and customary fee schedules will be the means by which compliance with this stipulation is assured.

4. EPSDT Beneficiaries

Prescribed drugs for EPSDT beneficiaries, if medically necessary, which exceed the limitations and scope for Medicaid beneficiaries, as covered in this Plan, are reimbursed according to the methodology in the paragraphs above.