

## **Table of Contents**

**State/Territory Name: Nevada**

**State Plan Amendment (SPA) #: 17-014**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-14-26  
Baltimore, Maryland 21244-1850



**Center for Medicaid and CHIP Services**

**Disabled and Elderly Health Programs Group**

January 25, 2018

Mr. Richard Whitley, Director  
Nevada Department of Health and Human Services  
4126 Technology Way, Suite 100  
Carson City, Nevada 89706

Dear Mr. Whitley:

We have reviewed Nevada's State Plan Amendment (SPA) 17-0014, Prescribed Drugs, received in the San Francisco Regional Office on October 31, 2017. This SPA proposes to add the maximum quantity of medication per prescription for maintenance medications as a 100-day (3 month) supply, and the maximum quantity of medication for contraceptives as a 12-month supply.

Based on the information provided and consistent with the regulations at 42 CFR 430.20, we are pleased to inform you that SPA 17-0014 is approved with an effective date of January 1, 2018. A copy of the signed CMS-179 form, as well as the pages approved for incorporation into Nevada's state plan will be forwarded by the San Francisco Regional Office.

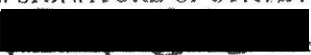

If you have any questions regarding this amendment, please contact Lisa Shochet at (410) 786-5445 or [lisa.shochet@cms.hhs.gov](mailto:lisa.shochet@cms.hhs.gov).

Sincerely,

/s/

Meagan Khau  
Deputy Director, Division of Pharmacy

cc: Lynne Foster, Chief of Division Compliance, NV DHCFP/Medicaid  
Holly Long, Policy Development & Program Management, NV DHCFP  
Henrietta Sam-Louie, ARA, CMS, San Francisco Regional Office  
Peter Banks, San Francisco Regional Office  
Kitaho Kato, San Francisco Regional Office  
Kathleen Creggett, San Francisco Regional Office

|                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                 |                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF<br/>STATE PLAN MATERIAL</b><br><br><b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b><br><br>TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES                                                      |  | 1. TRANSMITTAL NUMBER:<br><br><p style="text-align: center;"><b>17-014</b></p>                                                                                                                                  | 2. STATE:<br><br><p style="text-align: center;"><b>NEVADA</b></p> |
|                                                                                                                                                                                                                                                                                                        |  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE<br>SOCIAL SECURITY ACT (MEDICAID) SECTION 1927.                                                                                                                     |                                                                   |
|                                                                                                                                                                                                                                                                                                        |  | 4. PROPOSED EFFECTIVE DATE<br><br><p style="text-align: center;"><b>January 1, 2018</b></p>                                                                                                                     |                                                                   |
| 5. TYPE OF PLAN MATERIAL (Check One):<br><br><input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT<br>COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT <i>Seperate Transmittal for each amendment</i> |  |                                                                                                                                                                                                                 |                                                                   |
| 6. FEDERAL STATUTE/REGULATION CITATION:<br><br>Sect ion 1927(d)(6) of the Soci al Security Act                                                                                                                                                                                                         |  | 7. FEDERAL BUDGET IMPACT:<br>a. FFY 2018                                      \$0<br>b. FFY 2019                                      \$0                                                                       |                                                                   |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br><p style="text-align: center;"><b>Attachment 3.1-A, Page 5b #6, and Page 5c #9</b></p>                                                                                                                                                        |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION<br>OR ATTACHMENT (If Applicable):<br><br><p style="text-align: center;"><b>Attachment 3.1-A, Pages 5b and 5c</b></p>                                              |                                                                   |
| 10. SUBJECT OF AMENDMENT:<br><br><p style="text-align: center;"><b>Updating the State Plan to allow for a 100-day supply per prescription for maintenance drugs and a 12-month supply per prescription for contraceptives.</b></p>                                                                     |  |                                                                                                                                                                                                                 |                                                                   |
| 11. GOVERNOR'S REVIEW (Check One):<br><input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL.                                                     |  | <input checked="" type="checkbox"/> OTHER, AS SPECIFIED:<br>The Governor's Office does not wish to review the State Plan Amendment.                                                                             |                                                                   |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br><br><br>13. TYPED NAME:<br><b>Richard Whitley</b>                                                                                                                        |  | 16. RETURN TO:<br><br><b>Lynne Foster, Chief of Division Compliance<br/>                 DHCFP/Medicaid<br/>                 1100 East William Street, Suite 101<br/>                 Carson City, NV 89701</b> |                                                                   |
| 14. TITLE:<br><b>Director, Department of Health and Human Services</b>                                                                                                                                                                                                                                 |  | 15. DATE SUBMITTED: <b>10/31/17</b>                                                                                                                                                                             |                                                                   |
| <b>FOR REGIONAL OFFICE USE ONLY</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                 |                                                                   |
| 17. DATE RECEIVED: <b>9/1/2017</b>                                                                                                                                                                                                                                                                     |  | 18. DATE APPROVED:<br>January 25, 2018                                                                                                                                                                          |                                                                   |
| <b>PLAN APPROVED - ONE COPY ATTACHED</b>                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                 |                                                                   |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>1/1/2018</b>                                                                                                                                                                                                                                               |  | 20. SIGNATURE OF REGIONAL OFFICIAL:<br><br>                                                                                 |                                                                   |
| 21. TYPED NAME: <b>Henrietta Sam-Louie</b>                                                                                                                                                                                                                                                             |  | 22. TITLE:<br><b>Associate Regional Administrator</b>                                                                                                                                                           |                                                                   |
| 23. REMARKS:                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                 |                                                                   |



3. The State will not pay for covered outpatients drugs of a non-participating manufacturer, except for drugs rated "1-A" by the FDA. If such a medication is essential to the health of a recipient and a physician has obtained approval for use of the drugs in advance of its dispensing, it may be covered by the program pursuant to section 1927(a)(3).
4. The Medicaid program restricts coverage of certain covered outpatient drugs through the operation of a prior authorization program. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two-hour supply of medication in accordance with the provisions of §1927 (d)(5) of the Social Security Act.
5. Pursuant to 42 U.S.C. Section 1396r-8, the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. The state, or the state in consultation with a contractor, may negotiate supplemental rebate agreements that will reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect.
6. Pursuant to Section 1927(d)(6), the State has established a maximum quantity of medication per prescription as a 34-day supply; maintenance drugs per prescription as a 100-day (3 month) supply; and contraceptives per prescription as a 12-month supply.
  - a) In those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the professional fee may be disallowed.
  - b) In nursing facilities if the prescriber fails to indicate the duration of therapy for maintenance drug, the pharmacy must estimate and provide at least a 30-day supply.
7. The state will meet the requirements of Section 1927 of the Social Security Act. Based on the requirements for Section 1927 of the act, the state has the following policies for the supplemental rebate program for Medicaid recipients:
  - a) CMS has authorized the State of Nevada to enter into direct agreements with pharmaceutical manufacturers for a supplemental drug rebate program. The supplemental rebate agreement effective July 1, 2014 amends the original, January 1, 2012 version, which is effective through their expiration dates.
  - b) Supplemental rebates received by the State under these agreements by the State that are in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.
  - c) All drugs covered by the program, irrespective of a supplemental agreement, will comply with provisions of the national drug rebate agreement.

8. The Medicaid program restricts coverage of certain covered outpatient drugs through the operation of a prior authorization program. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within 24 hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a 72-hour supply of medication in accordance with the provisions of §1927 (d)(5) of the Social Security Act.
9. Pursuant to Section 1927(d)(6), the State has established a maximum quantity of medication per prescription as a 34-day supply; maintenance drugs per prescription as a 100-day (3 month) supply; and contraceptives per prescription as a 12-month supply.
  - a) In those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the professional fee may be disallowed.
  - b) In nursing facilities if the prescriber fails to indicate the duration of therapy for maintenance drug, the pharmacy must estimate and provide at least a 30-day supply.
12.
  - b. Dentures are allowed every five years.
  - c. Prosthetic devices must be prescribed by a physician or osteopath and must be prior authorized by the Nevada Medicaid Office on Form NMO-3.
  - d. Eyeglasses are limited to those prescribed to correct a visual defect of at least 0.5 diopters or 10 degrees in axis deviation for recipients for recipients of all ages once in 12 months, or with prior authorization if program limitations are exceeded. In addition, they are available on the periodicity schedule established for EPSDT.