

State of Mississippi

Methods and Standards For Establishing Payment Rates-Other Types of Care

Citation

42 CFR 434.6, 438.6, 447.26 and 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act

Payment Adjustment for Other Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for other provider preventable conditions.

Other Provider Preventable Conditions

The State identifies the following Other Provider Preventable Conditions for non-payment under Section 4.19(B) of this plan.

- Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Effective June 1, 2012, Medicaid will make zero payments to providers for Other Provider Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determinations (NCD). The Never Events (NE) as defined in the NCD include Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NEs. Practitioners are defined in Attachment 4.19 B-Pages 2b, 3, 5, 6b, 6d, 9, and 17 and 4.19E-Page 9.

Reimbursement for conditions described above is defined in Attachment 4.19-B, Page 1a.1, of this State Plan.

- Additional Other Provider Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied.)

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Payment for Other Provider Preventable Conditions to include the three Never Events:

Effective June 1, 2012, and in accordance with Title XIX of the Social Security Act-Sections 1902(a)(4), 1902(a)(6), and 1903 and 42 CFR's 434.6, 438.6, 447.26, Medicaid will make no payments to providers for services related to Other Provider Preventable Conditions (OPPC's) that at a minimum must include the Never Events (NE).

Never Events will be identified with the following ICD-9 or diagnosis codes or ICD-10 replacement diagnosis codes:

- E876.5-Performance of wrong operation (procedure) on correct patient
- E876.6-Performance of operation (procedure) on patient not scheduled for surgery
- E876.7-Performance of correct operation (procedure) on the wrong side/body part

No reduction in payment for the Other Provider Preventable Condition that include at a minimum the Never Events will be imposed on a provider when the surgery or procedure defined as a Never Event for a particular patient existed prior to the initiation of treatment for the patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

1. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the Other Provider Preventable Condition that include at a minimum the Never Events.

Non-payment of Other Provider Preventable Conditions that include at a minimum the Never Events shall not prevent access to services for Medicaid beneficiaries.

The following method will be used to determine the payment adjustment for Other Provider Preventable Conditions that at a minimum include the Never Events as defined by the National Coverage Determination:

- A. For dates of services beginning on or after June 1, 2012, through June 30, 2014, paid claims identified quarterly in the Mississippi Medicaid Information System (MMIS) with a diagnosis code for any of the three Never Events will be reviewed to ensure the State can reasonably isolate for non-payment the portion of the payment directly related to the treatment for, and related to, the Other Provider Preventable Condition that include at a minimum the Never Events.
- B. For dates of services beginning on or after July 1, 2014, once quarterly, claims identified in MMIS with a diagnosis code for any of the three Never Events will be denied, reviewed and adjusted to ensure no-payment is made for treatment directly related Other Provider Preventable Condition that include, at a minimum, the Never Events.

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

Citation- 42 CFR 447. 434. 438 and 1902(a)(4). 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B:

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below: Not applicable.

Section 2702 of the Patient Protection and Affordable Care Act of 2010 prohibits Federal payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for certain provider-preventable conditions (PPC) and health care-acquired conditions (HCAC) for dates of service effective October 1, 2011. This policy applies to all for individuals for which Medicaid is primary and those dually eligible for both the Medicare and Medicaid programs, and Mississippi Medicaid enrolled hospitals except for Indian Health Services. Reduced payment to providers is limited to the amounts directly identifiable as related to the PPC and the resulting treatment.

The following method will be used to determine the related reduction in payments for Other Provider-Preventable Conditions which includes Never Events as defined by the National Coverage Determination:

A. Dates of service beginning on or after October 1, 2011, through June 30, 2014:

1. The claims identified with a Present on Admission (POA) indicator of "Y" or "U" and provider-preventable conditions through the claims payment system will be reviewed.
2. When the review of claims indicates an increase of payment to the provider for an identified provider-preventable condition, the amount for the provider-preventable condition will be excluded from the providers' payment.

B. For dates of services beginning on or after July 1, 2014, claims identified in Medicaid Management Information System (MMIS) with a diagnosis code for any of the three Never Events will be denied, reviewed and adjusted to ensure no payment is made for treatment directly related to Other Provider Preventable Conditions that include, at a minimum, the three Never Events.

C. No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

D. Reductions in provider payment may be limited to the extent that the following apply:

1. The identified provider-preventable conditions would otherwise result in an increase in payment.
2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

E. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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Hospital Outpatient Services

A. Except as otherwise specified, outpatient hospital services for all hospitals except Indian Health Services will be reimbursed under a prospective payment methodology as follows:

1. Medicaid Outpatient Prospective Payment System (OPPS), Ambulatory Payment Classification (APC) Groups

Outpatient hospital services will be reimbursed on a predetermined fee-for-service basis. The parameters published annually in the Code of Federal Regulations (CFR) (national APC weights, APC group assignments and Medicare fees) and MS Medicaid OPPS status indicators, will be used by the Division of Medicaid (DOM) in calculating these predetermined rates and will be updated July 1 of each year.

- a. The Medicaid OPPS fees, including Clinical Diagnostic Laboratory OPPS fees, are calculated using 100% of the applicable APC relative weight or the payment rate for codes listed in the most current final Medicare outpatient Addendum B or C effective as of April 1st of each year as published by the Centers for Medicare and Medicaid Services (CMS). Codes with no applicable relative weight or payment rate in Addendum B or C are paid via a DOM published fee schedule based on 90% of the Medicare physician fee schedule or the Medicare Clinical Laboratory fee schedule of the current year. No retroactive adjustments will be made. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1st and is effective for services provided on or after that date. All fees are published on the agency's website at <http://www.medicaid.ms.gov/FeeScheduleLists.aspx>.
- b. The Medicaid conversion factor used by DOM is the current Jackson, MS Medicare conversion factor. This conversion factor is used for all APC groups and for all hospitals. Each APC rate equals the Medicare Addendum B specific relative weight at 100% multiplied by the Medicaid conversion factor, with the exception of observation fee which is paid using a MS Medicaid fee. Except as otherwise noted in the plan, MS Medicaid

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OPPS fee schedule rates are the same for both governmental and private providers of hospital outpatient services. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1 and is effective for services provided on or after that date.

- c. Subject to documentation of medical necessity, in addition to any Medicaid covered service received during observation in an outpatient hospital setting, DOM will pay an hourly fee for each hour of observation exceeding seven (7) hours, up to a maximum of twenty-three (23) hours (i.e., the maximum payment will be sixteen (16) hours times the hourly fee). Documentation requirements for medical necessity regarding observation services can be found in the MS Administrative Code Title 23 Medicaid, Part 202 Hospital Services, Chapter 2 Outpatient Hospital, Rule 2.4: Outpatient (23-Hour) Observation Services as of April 1, 2012, located at <https://medicaid.ms.gov/providers/administrative-code/>. The hourly fee for observation is calculated based on the relative weight for the Medicare APC which corresponds with an extended assessment and management encounter multiplied by the current Jackson, MS Medicare conversion factor divided by the twenty-three (23) maximum payable hours. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1 and is effective for services provided on or after that date. All fees are published on the agency's website at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/#>.
- d. The total claim allowed amount will be the lower of the provider's allowed billed charges or the calculated Medicaid OPPS allowed amount.
- e. A MS Medicaid OPPS status indicator is assigned to each procedure code determining payment under Medicaid OPPS. The full list of MS Medicaid OPPS status indicators and definitions is found on Attachment 4.19-B, page 2a.6.
- f. Claims with more than one (1) significant procedure, assigned a MS Medicaid OPPS status indicator "T" or "MT", are discounted. The line item with the highest allowed amount on the claim for certain significant procedures identified on the MS OPPS fee schedule

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assigned a MS Medicaid OPPS status indicator “T” or “MT” is paid at one hundred percent (100%). 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 paid at fifty percent (50%).

- 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 reimbursed as follows:

- a. For each outpatient service or procedure, the fee is 100% of the current Ambulatory Payment Classification (APC) rate multiplied by the units (when applicable).
- b. Where no APC relative weight has been assigned, outpatient services will be paid at 100% of any applicable Medicare payment rate in the most current final Medicare outpatient Addendum B or C as of April 1st of each year as published by the CMS multiplied by the units (when applicable).
- c. If there is no APC relative weight or Medicare payment rate established in the most current final Medicare outpatient Addendum B or C as of April 1st of each year as published by the CMS, payment will be made using the current applicable MS Medicaid fee multiplied by the units (when applicable).
- d. If there is (1) no APC relative weight, 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

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population or results in an access issue, a manual review of the claim will be made to determine an appropriate payment based on the resources used, cost of related equipment and supplies, complexity of the service and physician and staff time. The rate of reimbursement will be limited to (1) a MS Medicaid fee calculated as 90% of the Medicare rate of a comparable procedure or service or (2) the provider submitted invoice for a device, drug, biological or imaging agent

3. Five Percent (5%) Reduction

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 published fee does not include the five percent (5%) reduction. This provision is not applicable to Indian Health Services.

B. Miscellaneous

The topics listed below from Attachment 4.19-A will apply to hospital outpatient services:

1. Principles and Procedures
2. Availability of Hospital Records
3. Records of Related Organizations
4. Appeals and Sanctions.

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MS MEDICAID OPPTS STATUS INDICATORS

Status Indicator	MS Medicaid Definition
A, B, M	Miscellaneous codes priced by a Medicaid fee
C	Inpatient only services
D	Discontinued code
E	Non-covered code
G, K	Drugs & biologicals priced by a Medicare fee
M1	Mississippi Medicaid Specific Fee
N	Service is bundled into an APC (If all codes are N on a claim, the claim pays zero)
R	Blood products priced by a Medicare fee
S	Significant procedure priced by APC that the multiple procedure discount DOES NOT apply
T	Significant procedure priced by APC that the multiple procedure discount DOES apply
MT	MS Medicaid discounted services not covered under Medicare OPPTS
U	Brachytherapy
V	Medical visits in the clinic, critical care or emergency department (includes codes for direct admits)
X	Ancillary services paid by APC

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Enhanced Payment

Providers will receive a one (1) time enhanced payment of \$20,442,170.32 on or after April 1, 2013, for outpatient hospital services. See Appendix A for the amount of the enhanced payments for each provider. Payment will be made during the State Fiscal Year ending June 30, 2014. The enhanced payment estimate for each hospital is final and cannot be appealed.

TN No. 2013-012
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TN No. New

Date Received 07-12-13
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Appendix A
Enhanced Payment Per Provider

Medicaid Provider Number	Provider Name	Payment
00020149	UNIVERSITY OF MISS MED CENTER	\$3,897,683.96
00020229	TRI LAKES MEDICAL CENTER	\$1,023,637.17
00020081	NORTH MISSISSIPPI MEDICAL CENTER	\$902,903.71
00020469	METHODIST HOSPITALS OF MEMPHI	\$862,480.24
00220630	CENTRAL MISSISSIPPI MEDICAL CENTER	\$818,314.51
00220467	RIVER OAKS HOSPITAL	\$767,524.12
08087360	MADISON RIVER OAKS MEDICAL CENTER	\$717,313.53
00220462	WESLEY MEDICAL CENTER	\$712,350.96
00020027	MEMORIAL HOSPITAL AT GULFPORT	\$694,022.25
00020059	SINGING RIVER HEALTH SYSTEM	\$663,536.29
00220392	MISSISSIPPI BAPTIST MEDICAL CENTER	\$637,839.89
00220417	RANKIN MEDICAL CENTER	\$552,309.57
00220380	NORTHWEST MS REGIONAL MEDICAL CENTE	\$480,771.91
00220136	BMH GOLDEN TRIANGLE	\$443,579.55
00020182	BILOXI REGIONAL MEDICAL CENTER	\$385,589.68
00020143	BAPTIST MEMORIAL HOSPITALDESOTO	\$335,971.12
00020219	OCH REGIONAL MEDICAL CENTER	\$275,656.31
00020118	NORTH SUNFLOWER MEDICAL CENTER	\$267,214.37
00020026	GRENADA LAKE MEDICAL CENTER	\$243,149.44
00020010	BAPTIST MEMORIAL HOSPUNION COUNTY	\$234,384.89
00220609	HOLMES COUNTY HOSPITAL AND CLINICS	\$216,201.20
00220606	BOLIVAR MEDICAL CENTER	\$213,632.13
00020049	RUSH FOUNDATION HOSPITAL	\$210,176.48
00220571	RIVER REGION HEALTH SYSTEM	\$206,317.33
00020007	FORREST GENERAL HOSPITAL	\$201,379.59
00020079	CLAY COUNTY MEDICAL CENTER	\$188,598.66
00020046	ANDERSON REGIONAL MEDICAL CENTER	\$169,741.80
00020008	KINGS DAUGHTERS MEDICAL CENTER	\$169,318.84
00020082	KINGS DAUGHTERS HOSPITAL	\$167,633.97
00020145	DELTA REGIONAL MEDICAL CENTER	\$159,473.19
00020034	ST DOMINICJACKSON MEMORIAL HOSPITA	\$153,068.23
04125505	LAIRD HOSPITAL INC	\$152,786.19
00020214	H C WATKINS MEMORIAL HOSPITAL	\$149,038.10
00220734	GARDEN PARK MEDICAL CENTER	\$142,344.50
00220324	S E LACKEY MEMORIAL HOSPITAL	\$129,972.75
00220159	NATCHEZ COMMUNITY HOSPITAL	\$129,568.41
00020133	COVINGTON COUNTY HOSPITAL	\$123,637.02
00020124	PATIENTS CHOICE MEDICAL CENTER OF H	\$118,133.01
00220144	SCOTT REGIONAL MEDICAL CENTER	\$117,932.58
00020025	GREENWOOD LEFLORE HOSPITAL	\$107,534.44
00020003	GILMORE MEM REGIONAL MEDICAL CENTER	\$103,077.87
00220714	STONE COUNTY HOSPITAL INC	\$91,757.54
00220466	WOMANS HOSPITAL	\$90,711.64
00020141	SOUTH CENTRAL REG MED CTR	\$90,377.75
00220631	NORTH OAK REGIONAL MEDICAL CENTER	\$89,254.90
00020131	WAYNE GENERAL HOSPITAL	\$85,813.24
00020424	SLIDELL MEMORIAL HOSPITAL	\$74,746.19
00020207	SW MS REGIONAL MEDICAL CENTER	\$71,107.20

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Medicaid Provider Number	Provider Name	Payment
02934741	JOHN C STENNIS MEMORIAL HOSPITAL	\$68,821.57
00431215	PIONEER COMMUNITY HOSPITAL OF CHOCT	\$68,476.84
00020461	OCHSNER FOUNDATION HOSPITAL	\$63,793.57
00020140	CLAIBORNE COUNTY HOSPITAL	\$62,606.26
00220692	PIONEER COMM HOSPITAL OF ABERDEEN	\$62,094.10
00020065	ST JUDE CHILDRENS RESEARCH HOSPITA	\$58,631.33
00220230	PIONEER HEALTH SERVICES OF NEWTON C	\$56,773.54
00020111	TIPPAH COUNTY HOSPITAL	\$53,237.23
00020012	FIELD MEMORIAL COMMUNITY HOSPITAL	\$52,615.90
00020302	CHILDRENS HOSPITAL	\$51,445.49
00020042	MAGEE GENERAL HOSPITAL	\$50,852.54
00020156	TYLER HOLMES MEMORIAL HOSPITAL	\$49,617.97
00020130	FRANKLIN COUNTY MEMORIAL HOSPITAL	\$43,807.83
00220682	HIGHLAND COMMUNITY HOSPITAL	\$43,433.23
00020172	NATCHEZ REGIONAL MEDICAL CENTER	\$42,430.88
00020223	MS METHODIST REHAB CENTER	\$41,525.95
00220279	TULANE UNIVERSITY HOSPITAL	\$41,227.70
00020129	SHARKEYISSAQUENA COMMUNITY HOSPITA	\$40,158.89
00020084	BAPT MEM HOSP BOONEVILLE	\$39,816.72
00020170	LAWRENCE COUNTY HOSPITAL	\$37,907.51
00220213	SAINT FRANCIS HOSPITAL	\$37,152.30
00020020	MAGNOLIA REGIONAL HEALTH CENTER	\$36,248.00
00020208	WALTHALL CO GENERAL HOSPITAL	\$35,943.63
00020393	TISHOMINGO HEALTH SERVICES INC	\$35,831.95
00020193	JEFFERSON COUNTY HOSP	\$35,208.94
00020096	PONTOTOC HEALTH SERVICES INC	\$34,623.71
00220809	BAPTIST MEDICAL CENTER LEAKE	\$33,653.10
00220441	JEFFERSON DAVIS GENERAL HOSPITAL	\$32,651.73
00220297	PEARL RIVER COUNTY HOSPITAL	\$30,889.75
00020191	PERRY COUNTY GENERAL HOSPITAL	\$29,779.34
00220243	WINSTON MEDICAL CENTER	\$25,473.67
00095306	OCHSNER MEDICAL CENTER NORTHSHORE	\$24,952.37
00020374	BAPTIST MEMORIAL HOSPITAL	\$18,515.56
00020213	CALHOUN HEALTH SERVICES	\$15,266.52
00020041	NOXUBEE GENERAL CRITICAL ACCESS HOS	\$13,720.90
00097605	BAPTIST MEMORIAL HOSPITAL TIPTON	\$13,596.08
06200741	GREENE COUNTY HOSPITAL	\$11,838.85
00020408	RED BAY HOSPITAL	\$9,876.66
00220415	TRACE REGIONAL HOSPITAL	\$9,625.79
00220621	ALLIANCE HEALTHCARE SYSTEM	\$9,222.68
05432201	ST FRANCIS HOSPITAL BARTLETT	\$6,102.94
01687505	CHRISTUS SANTA ROSA HEALTHCARE	\$5,867.37
00020364	NORTH OAKS MEDICAL CENTER	\$5,222.27
02703888	MEMORIAL HERMANN HOSPITAL	\$5,087.93
00020427	LANE REGIONAL MEDICAL CENTER	\$4,428.58
00020395	UNIVERSITY OF ALABAMA HOSPITAL	\$4,366.31
04581000	LOUISIANA HEART HOSPITAL LLC	\$4,080.09
00220498	VANDERBILT UNIVERSITY HOSPITAL	\$2,872.44

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00220742	CHILDRENS HOSP MEDICAL CENTER	\$2,713.51
07771013	MCNAIRY REGIONAL HOSPITAL	\$2,293.69
00020433	OUR LADY OF THE LAKE REGNL MED CTR	\$2,142.30
00020175	YALOBUSHA GEN HOSP NURSING HOME	\$1,917.48
00095136	HELENA REGIONAL MEDICAL CENTER	\$1,771.33
00020178	WEBSTER GENERAL HOSPITAL	\$1,678.44
00020177	JASPER GENERAL HOSPITAL	\$1,662.28
00220412	FLORIDA HOSPITAL MEDICAL CENTER	\$1,387.77
00220732	UAMS MEDICAL CENTER	\$1,333.96
00020186	OCHSNER MEDICAL CENTER KENNER LLC	\$1,323.96
00220712	SPRINGHILL MEMORIAL HOSPITAL	\$1,029.81
00098401	SOUTH BALDWIN HOSP	\$973.18
09573208	GULF BREEZE HOSPITAL	\$926.92
00220522	WEST JEFFERSON MEDICAL CENTER	\$922.85
04458031	MEDICAL CENTER OF ARLINGTON	\$888.74
01170370	HOUSTON NORTHWEST MEDICAL CENTER	\$702.51
01856833	CHOCTAW GENERAL HOSPITAL	\$685.89
08983376	GOOD SAMARITAN HOSPITAL	\$648.64
00097684	TEXAS CHILDRENS HOSPITAL	\$619.23
00220648	EAST ALABAMA MEDICAL CENTER	\$605.22
00220450	CHRIST HOSPITAL	\$599.06
03233717	MEMORIAL HERMANN NORTHWEST HOSPITAL	\$547.62
00220500	OCHSNER BAPTIST MEDICAL CENTER	\$535.92
00020421	REGIONAL MED CTR MEMPHIS	\$470.20
00095932	WESLEY MEDICAL CENTER	\$450.98
00020019	WEST FELICIANA PARISH HOSPITAL	\$447.80
05008049	BAPTIST HEALTH SYSTEM	\$446.96
07038885	NORTH FULTON REGIONAL HOSPITAL	\$441.05
00220616	WASHINGTON COUNTY HOSP ASSOC	\$432.01
00095485	NIAGARA FALLS MEM MED CTR	\$400.98
06048562	ST FRANCIS MEDICAL CENTER	\$351.38
00020459	ST HELENA PARISH HOSPITAL	\$344.09
06436004	SKYRIDGE MEDICAL CENTER	\$328.88
03152718	BAYLOR MEDICAL CENTER AT GRAPE VINE	\$327.24
00220754	ORLANDO REGIONAL MEDICAL CENTER	\$323.47
00220448	TOURO INFIRMARY	\$308.89
03126743	GLENWOOD REGIONAL MEDICAL CENTER	\$304.89
07386784	BOLIVAR GENERAL HOSPITAL	\$291.61
08227060	SKYLINE MEDICAL CENTER	\$286.70
00736327	BANNER DESERT MEDICAL CENTER	\$286.12
00220701	GATEWAY MEDICAL CENTER	\$267.39
02526776	BANNER GATEWAY MEDICAL CENTER	\$251.37
03920017	JEWISH HOSPITAL	\$250.65
00220489	RIVERSIDE MEDICAL CENTER	\$242.14
06409841	SOUTH FULTON MEDICAL CENTER	\$235.66
03024049	NORTHCREST MEDICAL CENTER	\$228.56
00220800	THE CHILDRENS HOSPITAL OF PHILADEL	\$226.77
08528720	LAKE POINTE MEDICAL CENTER	\$217.03

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Medicaid Provider Number	Provider Name	Payment
00097681	SINAI GRACE HOSPITAL	\$215.81
05703861	MEMORIAL HERMANN SOUTHEAST HOSPITAL	\$214.68
07832553	SUMMERLIN HOSPITAL MEDICAL CENTER	\$204.74
00097779	BAPTIST HOSPITAL	\$202.12
00220545	DOCTORS HOSPITAL OF AUGUSTA	\$183.64
00098297	ALEGENT HEALTH IMMANUEL MEDICAL CEN	\$180.87
00096346	JACKSON HEALTH SYSTEMS	\$172.82
02224822	STONECREST MEDICAL CENTER	\$170.99
06934870	FLORIDA HOSPITAL WATERMAN	\$170.73
00020441	BATON ROUGE GEN HOSP	\$165.39
00020238	ERLANGER HEALTH SYSTEM	\$155.44
00220601	EAST JEFFERSON GENERAL HOSPITAL	\$146.82
00095919	SAINT JOHNS HOSPITAL	\$143.21
00096445	SWEDISH AMERICAN HOSPITAL	\$136.80
08171261	SUMMIT MEDICAL CENTER	\$136.59
03578096	LAKEVIEW REGIONAL MEDICAL CENTER	\$128.38
00095348	ST LOUIS CHILDRENS HOSP	\$121.27
02653708	COLUMBIA MEDICAL CENTER OF DENTON S	\$119.65
01084764	JACKSON MADISON COUNTY GEN HOSPITAL	\$116.06
00020414	DCH REGIONAL MEDICAL CENTER	\$108.26
00220541	UNIVERSITY OF CHICAGO HOSPITAL	\$107.47
01832221	WOLFSON CHILDRENS HOSPITAL	\$104.87
00220512	JACKSON HOSPITAL CLINIC	\$98.78
00478748	DOCTORS HOSPITAL OF DALLAS	\$89.44
00888783	SHELBY BAPTIST MEDICAL CENTER	\$88.73
04436083	BAYLOR UNIVERSITY MEDICAL CENTER	\$85.18
00655066	THE CHILDRENS HOSPITAL ASSOCIATION	\$78.08
06473721	BAYLOR MEDICAL CENTER AT IRVING	\$73.57
08720011	FOSTER G MCGAW HOSPITAL	\$70.60
08123025	THE HEALTH CARE AUTHORITY FOR MEDIC	\$69.53
01188726	PHOENIX BAPTIST HOSPITAL	\$67.60
05804895	MEMORIAL HERMANN SOUTHWEST HOSPITAL	\$66.92
05420345	MEMORIAL HERMANN THE WOODLANDS HOSP	\$65.88
01651501	MEMORIAL HERMANN MEMORIAL CITY HOSP	\$65.88
00096548	CHILDRENS MERCY HOSPITAL	\$65.49
00097033	MARY WASHINGTON HOSPITAL	\$58.06
05729348	ATLANTA MEDICAL CENTER	\$53.07
03054203	NORTH BROWARD MEDICAL CENTER	\$52.09
00095450	CHILDRENS HOSPITAL OF MI	\$47.82
00096829	ST JOHNS REGIONAL HEALTH CENTER	\$47.45
05901737	MEDICAL CENTER OF SOUTHEAST TEXAS L	\$47.06
00096942	HARDIN MEMORIAL HOSPITAL	\$45.02
00095289	ST LUKES EPISCOPAL HOSPITAL	\$44.78
01500854	ST MARYS MEDICAL CENTER OF EVANSVIL	\$40.76
00220220	MARION REGIONAL MEDICAL CENTER	\$35.94
07184768	SSM DEPAUL HEALTH CENTER	\$35.75
05603861	THE TOLEDO HOSPITAL	\$30.14
00220559	CHILDRENS HOSPITAL MED CENTER	\$26.83

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

Appendix A
Enhanced Payment Per Provider

Medicaid Provider Number	Provider Name	Payment
09602562	SOUTHERN HILLS MEDICAL CENTER	\$26.59
00096517	BAYLOR MEDICAL CENTER AT GARLAND	\$21.07
07932018	EAST TEXAS MEDICAL CENTER	\$20.51
00220544	LAKELAND MED CENTERST JOSEPH	\$18.04
00020420	HUNTSVILLE HOSPITAL	\$17.32
06275818	TEXAS HEALTH HARRIS METHODIST HOSPI	\$17.17
02283343	UNIVERSITY OF TENNESSEE MEMORIAL HO	\$16.61
00020060	BRYAN W WHITFIELD MEM HOSP	\$13.88
00252002	WEST VALLEY HOSPITAL	\$13.41
00537300	WOMENS CHILDRENS HOSPITAL	\$9.85
00096867	LIMA MEMORIAL HOSPITAL	\$9.49
01634718	CHRISTIAN HOSPITAL NORTHEAST	\$7.34
00095319	LEESBURG REGIONAL MEDICAL CENTER	\$3.47
04102559	TRINITY MEDICAL CENTER	\$2.65
		<u>\$20,442,170.32</u>

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State of Mississippi

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

2b. RURAL HEALTH CLINICS (RHC)

I. Introduction

The purpose of this State Plan is to set forth policies and guidelines to be administered by the Mississippi Division of Medicaid (DOM) for Rural Health Clinics (RHCs) operating in the State of Mississippi. All RHCs shall be reimbursed in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) and the principles and procedures specified in this plan.

II. Payment Methodology

This state plan provides for reimbursement to RHC providers at a prospective payment rate per encounter. Reimbursement is limited to a single encounter, also referred to as a “visit”, per day except as described in Attachment 3.1-A exhibit 2b.

A. Prospective Payment System

In accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, the state plan shall provide for payment for core services and other ambulatory services provided by RHCs at a prospective payment rate per encounter. The rate shall be calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the RHCs reasonable costs of providing Medicaid covered services provided during fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during fiscal year 2001. For RHCs that qualified for Medicaid participation during fiscal year 2000, their prospective payment rate for fiscal year 2001 shall be calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the RHCs reasonable costs of Medicaid covered services provided during fiscal year 2000.

For services furnished during calendar year 2002 and each subsequent calendar year, the payment rate shall be equal to the rate established in the preceding calendar year increased by the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year. Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

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B. New Clinics

For new clinics that qualify for the RHC program after January 1, 2001, the initial prospective payment system (PPS) rate shall be based on the rates established for other RHCs located in the same or adjacent area with a similar caseload. In the absence of such RHCs, the rate for the new provider will be based on projected costs.

The RHC's Medicare final settlement cost report for the initial cost report period year will be used to calculate a PPS base rate that is equal to one hundred percent (100%) of the RHC's reasonable costs of providing Medicaid covered services. If the initial cost report period represents a full year of RHC services, this final settlement rate will be considered the base rate. If the initial RHC cost report period does not represent a full year, then the rate from the first full year cost report will be used as the clinic's base rate.

For each subsequent calendar year, the payment rate shall be equal to the rate established in the preceding calendar year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year.

C. Alternative Payment Methodology

1. The Division of Medicaid reimburses an RHC a fee in addition to the encounter rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the RHC's established office hours but before or after the Division of Medicaid's office hours, or (2) outside of the Division of Medicaid's office hours or the RHC established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or the RHC established office hours. The Division of Medicaid's office hours are defined as the hours between 8:00 a.m. and 5 p.m., Monday through Friday, excluding Saturday, Sunday, and federal and state holidays. These codes will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.
2. The Division of Medicaid reimburses an RHC an additional fee for telehealth services provided by the RHC as the originating site provider. The RHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The RHC may not bill for an encounter visit unless a separately identifiable service is performed. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/#>.
3. If an RHC's base year cost report is amended, the clinic's PPS base rate will be adjusted based

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on the Medicare final settlement amended cost report. The RHC's original PPS base rate and the rates for each subsequent fiscal year will be recalculated per the payment methodology outlined above. Claims payments will be adjusted retroactive to the effective date of the original rate. The amended PPS base rate will be no less than the original base rate.

D. Fee-For-Service

RHCs acting in the role of a telehealth originating site provider with no other separately identifiable service being provided will only be paid the telehealth originating site fee per completed transmission and will not receive reimbursement for an encounter. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

E. Change of Ownership

When an RHC undergoes a change of ownership, the PPS rate of the new owner will be equal to the PPS rate of the old owner. There will be no change to the RHC's PPS rate as a result of a change of ownership.

F. Change in Scope of Services

A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services occurs if: (1) the clinic RHC has added or has dropped any services that meets the definition of an RHC service as provided in section 1905(a)(2)(B) and (C), and (2) the service is included as a covered Medicaid service under the Mississippi Medicaid state plan. A change in intensity could be a change in the amount of health care services provided by the RHC in an average encounter.

A change in the scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not generally constitute a change in the scope of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

An RHC must notify the Division of Medicaid in writing of any change in the scope of services by the end of the calendar year in which the change occurred, including decreases in scope of services. The Division of Medicaid will adjust an RHC's PPS rate if the following criteria are met: (1) The RHC can demonstrate that there is a valid and documented change in the scope of services, and (2) The change in scope of services results in at least a five percent (5%) increase or decrease in the RHC's PPS rate for the calendar year in which the change in scope of service took place.

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

An RHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of the RHC's Medicare final settlement cost report for the RHC's first full fiscal year of operation with the change in scope of services. The request must include the first final settlement cost report that includes twelve (12) months of costs for the new service. The adjustment will be granted only if the cost related to the change in scope of services results in at least a five percent (5%) increase or decrease in the RHC's PPS rate for the calendar year in which the change in scope of services took place. The cost related to a change in scope of services will be subject to reasonable cost criteria identified in accordance with 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 C.F.R. Part 413 Principles of Reasonable Cost Reimbursement.

It is the responsibility of the RHC to notify the Division of Medicaid of any change in the scope of services and provide proper and valid documentation to support the rate change. Such required documentation must include, at a minimum, a detailed working trial balance demonstrating the increase or decrease in the RHC's PPS rate as a result of the change in scope of services. The Division of Medicaid will require the RHC to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid will also request additional information as it sees fit in order to sufficiently determine whether any change in scope of services has occurred. The instructions and forms for submitting a request due to a change in scope of services can be found at <http://www.medicaid.ms.gov/resources/forms/>.

Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place. The revised PPS rate generally cannot exceed the cost per visit from the most recent audited cost report.

G. Change in Ownership Status

The RHC's PPS rate will not be adjusted solely for a change in ownership status between freestanding and provider-based.

H. Allowable Costs

Allowable costs are those costs that result from providing covered services. They are reasonable in amount and are necessary for the efficient delivery of those services. Allowable costs include the direct cost center component (i.e., salaries and supplies) of providing the covered services and an allocated portion of overhead (i.e., administration and facility).

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

Federally Qualified Health Centers (FQHCs)

I. Introduction

The purpose of this State Plan is to set forth policies and guidelines to be administered by the Mississippi Division of Medicaid (DOM) for Federally Qualified Health Centers (FQHCs) operating in the State of Mississippi. All FQHCs shall be reimbursed in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) and the principles and procedures specified in this plan.

II. Payment Methodology

This state plan provides for reimbursement to FQHC providers at a prospective payment rate per encounter. Reimbursement is limited to a single encounter, also referred to as a “visit”, per day except as described in Attachment 3.1-A exhibit 2c.

A. Prospective Payment System

In accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, the state plan shall provide for payment for core services and other ambulatory services provided by FQHCs at a prospective payment rate per encounter. The rate shall be calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the FQHC’s reasonable costs of providing Medicaid covered services provided during fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during fiscal year 2001. The average rate will be computed from FQHC Medicaid cost reports by applying a forty percent (40%) weight to fiscal year 1999 and a sixty percent (60%) weight to fiscal year 2000 and adding those rates together. For FQHC’s that qualified for Medicaid participation during fiscal year 2000, their prospective payment rate will only be computed from the fiscal year 2000 Medicaid cost report.

For services furnished during calendar year 2002 and each subsequent calendar year, the payment rate shall be equal to the rate established in the preceding calendar year increased by the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year. Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

B. New Centers

For new centers that qualify for the FQHC program after January 1, 2001, the initial prospective payment system (PPS) rate shall be based on the rates established for other centers located in the same or adjacent area with a similar caseload. In the absence of such an FQHC, the rate for the new provider will be based on projected costs. After the FQHC initial year, a Medicaid cost report

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must be filed in accordance with this plan. The cost report will be desk reviewed and a rate shall be calculated in an amount equal to one hundred percent (100%) of the FQHC reasonable costs of providing Medicaid covered services. The FQHC may be subject to a retroactive adjustment based on the difference between projected and actual allowable costs. Claims payments will be adjusted retroactive to the effective date of the original rate.

For each subsequent calendar year, the payment rate shall be equal to the rate established in the preceding calendar year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year.

C. Alternative Payment Methodology

1. The Division of Medicaid reimburses an FQHC a fee in addition to the encounter rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the FQHC's established office hours but before or after the Division of Medicaid's office hours, or (2) outside of the Division of Medicaid's office hours or the FQHC established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or FQHC established office hours. The Division of Medicaid's office hours are defined as the hours between 8:00 a.m. and 5 p.m., Monday through Friday, excluding Saturday, Sunday, and federal and state holidays. These codes will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.
2. The Division of Medicaid reimburses an FQHC an additional fee for telehealth services provided by the FQHC as the originating site provider. The FQHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The FQHC may not bill for an encounter visit unless a separately identifiable service is performed. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/#>.

D. Fee-For-Service

FQHCs acting in the role of an originating site provider with no other separately identifiable service being provided will only be paid the telehealth originating site fee per completed transmission and will not receive reimbursement for an encounter. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/#>.

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E. Change in Scope of Services

A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services shall occur if: (1) the clinic RHC has added or has dropped any services that meets the definition of an RHC service as provided in section 1905(a)(2)(B) and (C) of the SSA; and, (2) the service is included as a covered Medicaid service under the Mississippi Medicaid state plan. A change in intensity could be a change in the amount of health care services provided by the RHC in an average encounter.

A change in the scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not generally constitute a change in the scope of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

An FQHC must notify the Division of Medicaid in writing of any change in the scope of services by the end of the calendar year in which the change occurred, including decreases in scope of services. The Division of Medicaid will adjust an FQHC PPS rate if the following criteria are met: (1) the FQHC can demonstrate that there is a valid and documented change in the scope of services, and (2) the change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC PPS rate for the calendar year in which the change in scope of service took place.

A change in the scope of services generally does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters generally does not constitute a change in the scope of services. Also, a change in the cost of a service is not considered in and of itself a change in the scope of services.

An FQHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of FQHC Medicare final settlement cost report for the FQHC's first full fiscal year of operation with the change in scope of services. The request must include the first final settlement cost report that includes twelve (12) months of costs for the new service. The adjustment will be granted only if the cost related to the change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC PPS rate for the calendar year in which the change in scope of services took place. The cost related to a change in scope of services will be subject to reasonable cost criteria identified in accordance with 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 C.F.R. Part 413 Principles of Reasonable Cost Reimbursement.

It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of services and provide proper and valid documentation to support the rate change. Such required documentation must include, at a minimum, a detailed working trial balance demonstrating the increase or decrease in the FQHC PPS rate as a result of the change in scope of services. The Division of Medicaid will require the FQHC to provide such documentation in a format acceptable

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to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid will also request additional information as it sees fit in order to sufficiently determine whether any change in scope of services has occurred. The instructions and forms for submitting a request due to a change in scope of services can be found at www.medicaid.ms.gov/resources/forms/.

Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place. The revised PPS rate generally cannot exceed the cost per visit from the most recent audited cost report.

F. Allowable Costs

Allowable costs are those costs that result from providing covered services. They are reasonable in amount and are necessary for the efficient delivery of those services. Allowable costs include the direct cost center component (i.e., salaries and supplies) of providing the covered services and an allocated portion of overhead (i.e., administration and facility).

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

Independent Laboratory and X-Ray Services - Payment is made from a statewide uniform fee schedule based on 90 percent of the current Medicare fee schedule and is updated each year as of July 1st and is effective for services provided on or after that date. All fees are published on the agency's website at <http://www.medicaid.ms.gov/FeeScheduleLists.aspx>.

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.

TN# 2013-007
Supersedes
TN# 2002-06

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State of Mississippi

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under the Age of Twenty-one (21): Limited to Federal Requirements.

(a) EPSDT Screenings -

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of EPSDT screenings. All rates are published on the agency's website at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

- (1) The screening fee will be reimbursed using the Current Procedural Terminology (CPT) codes based on CMS methodology for determining Medicare preventive medicine service fees and applying the state law of 90% in accordance with nationally recognized evidence-based principles of preventive health care services periodicity schedule as set forth by the American Academy of Pediatrics (AAP) Bright Futures. The screening fee for an EPSDT psychosocial and/or behavioral health, vision, hearing, adolescent and developmental screen will be reimbursed using the CPT codes based on the American Medical Association (AMA) methodology for determining medicine services and applying the state law of 90% of the Medicare fee and are updated January 1 of each year and are done in conjunction with the age appropriate comprehensive physical assessment. These reimbursement rates will be paid only to Mississippi Medicaid enrolled EPSDT providers. Age appropriate laboratory testing fees are reimbursed according to applicable state plan reimbursement methodologies.
- (2) Interperiodic screenings are visits provided for other medically necessary health care, screens, diagnosis, treatment and/or other measures to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions. Such services are covered whether or not they are included elsewhere in the State Plan provided they are described in Section 1905(a) of the Social Security Act. These services will be reimbursed using the CPT codes based on the AMA methodology for Evaluation and Management (E&M) and applying the state law of 90% of the Medicare fee and updated January 1 of each year.
- (3) Dental screen: Dental screening services are furnished by a direct referral to a Dentist. Payment for the comprehensive oral evaluation will be reimbursed using the Healthcare Common Procedure Coding System (HCPCS) codes as provided by the Centers for Medicare and Medicaid Services (CMS) based on a statewide fixed fee schedule to comply with Miss. Code Ann. § 43-13-117. These reimbursement rates will be paid according to the periodicity schedule and when medically necessary to dentists only.

STATE: Mississippi

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER
TYPES OF CARE**

Early and Periodic Screening, Diagnosis, and Treatment and Extended EPSDT Services.

(4) Interperiodic Dental Screens: Between periodic screens, coverage is provided for other medically necessary services. Payment for problem focused evaluation will be reimbursed using the Healthcare Common Procedure Coding System (HCPCS) codes as provided by the Centers for Medicare and Medicaid based on a statewide fixed fee schedule authorized by MS State Legislation. These reimbursement rates will be paid to dentists only.

(b) High-Risk assessment - Reimbursement is based on 75% of the current Medicaid allowable for an antepartum visit. These reimbursement rates will be paid to Perinatal High Risk Management (PHRM) providers only.

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.

TN No. 2003-03
Superseded ~~99-08~~

New

Date Approved 04/23/03
Dated Effective 03/01/03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE MISSISSIPPI

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

Family Planning Services and Supplies for Individuals – Payment is made from a statewide uniform fee schedule based on at ninety percent (90%) of the Medicare fee schedule.

Payment to providers, such as federally qualified health center and rural health clinics, do not exceed the reasonable costs of providing services. Payments to health departments are on an encounter rate and are determined annually.

Family planning services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

TN No. 2010-019
Supersedes:
TN #06-005

Date Received March 31, 2010
Date Effective January 1, 2010
Date Approved June 28, 2010

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

Physicians' services – Fees for Medicaid physician services are updated July 1 of each year and are reimbursed at ninety percent (90%) of the Medicare Physician Fee Schedule in effect as of January 1 of each year. All rates are published at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/#>.

Primary Care Physician Payment:

The Division of Medicaid will continue to reimburse for services provided by physicians who self-attest as having a primary specialty designation of family medicine, pediatric medicine or internal medicine formerly authorized by 42 C.F.R. § 447.400(a).

Effective July 1, 2016, the Division of Medicaid will reimburse for services provided by obstetricians and gynecologists (OB/GYNs) with a primary specialty/subspecialty designation in obstetric/gynecologic medicine who attest to one (1) of the following:

- 1) Physician is board certified by the American Congress of Obstetricians and Gynecologists (ACOG) as a specialist or subspecialist in obstetric/gynecologic medicine, or
- 2) Physician with a primary specialty/subspecialty designation in obstetric/gynecologic medicine and has furnished the evaluation and management services and vaccines administration services listed below that equal at least sixty percent (60%) of the Medicaid codes they have billed during the most recently completed calendar year but does not have an ACOG certification, or
- 3) Physician, newly enrolled as a Medicaid provider, with a primary specialty/subspecialty designation in obstetric/gynecologic medicine and attests that the evaluation and management services and vaccines administration services listed below will equal at least sixty percent (60%) of the Medicaid codes they will bill during the attestation period, or
- 4) Non-physician practitioner providing primary care services in a Practice Agreement with a qualified physician enrolled for increased primary care services.

Primary Care Services' reimbursement applies to the Evaluation and Management (E&M) codes 99201 through 99499 except: 99224, 99225, 99226, 99239, 99288, 99316, 99339, 99340, 99358, 99359, 99360, 99363, 99364, 99366, 99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99466, 99467, 99485, 99486, 99487, 99488, 99489, 99495, 99496.

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

Primary Care Services' reimbursement applies to the following Vaccine Administration Codes: 90460 and 90471 through 90474. The state reimburses vaccine administration services at the Mississippi regional maximum administration fee set by the Vaccines for Children (VFC) program for self-attested primary care physicians and self-attested primary care OB/GYN physicians. To receive reimbursement for vaccine administration to a VFC-eligible beneficiary, a self-attested primary care physician or self-attested primary care OB/GYN physician provider must also be enrolled as a VFC provider.

Primary Care Services' fees are updated July 1 of each year and are reimbursed at one hundred percent (100%) of the Medicare Physician Fee Schedule in effect as of January 1 of each year. All rates are published at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/#>.

Physician services not otherwise covered by the State Plan but determined to be medically necessary for EPSDT beneficiaries are reimbursed according to the methodology described above.

TN No. 16-0008
Supersedes
TN No. New

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Date Effective 07/01/2016

State of Mississippi

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

**Supplemental Payments for Physician and Professional Services Practitioners
at Qualifying Hospitals**

Effective for dates of service on or after January 1, 2015, the Division of Medicaid will make supplemental payments for physicians and other professional services practitioners who are employed by or contracted with a qualifying hospital for services rendered to Medicaid beneficiaries. These supplemental payments will be equal to the difference between the average commercial payment rate and the amount otherwise paid pursuant to the fee schedule for physicians' services under Attachment 4.19-B.

1. Qualifying Criteria

Physicians and other eligible professional service practitioners as specified in 2. below who are employed by a qualifying hospital or who assigned Mississippi Medicaid payments to a qualifying hospital. The term "qualifying hospital" means a Mississippi state-owned academic health science center with a Level 1 trauma center, Level 4 neonatal intensive care nursery, an organ transplant program, and more than a four hundred (400) physician multispecialty practice group. To qualify for the supplemental payment, the physician or professional service practitioner must be:

- a. Licensed by the State of Mississippi, and
- b. Enrolled as a Mississippi Medicaid provider.

2. Qualifying Provider Types

For purposes of qualifying for supplemental payments under this section, services provided by the following professional practitioners will be included:

- a. Physicians,
- b. Physician Assistants,
- c. Nurse Practitioners,
- d. Certified Registered Nurse Anesthetists,
- e. Certified Nurse Midwives,
- f. Clinical Social Workers,
- g. Clinical Psychologists,
- h. Dentists, and
- i. Optometrists.

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

3. Payment Methodology

The supplemental payment will be determined in a manner to bring payments for these services up to the average commercial rate level. The average commercial rate level is defined as the rates paid by commercial payers for the same service. Under this methodology the terms physician and physician services include services provided by all qualifying provider types as set forth in 2. above.

The specific methodology to be used in establishing the supplemental payment for physician services is as follows:

- a. For services provided by physicians at a qualifying hospital, the Division of Medicaid will collect from the hospital its current commercial physician fees by CPT code for the hospital's top five (5) commercial payers by volume.
- b. The Division of Medicaid will calculate the average commercial fee for each CPT code for each physician practice plan or physician that provides services at the qualifying hospital.
- c. The Division of Medicaid will extract from its paid claims history file for the preceding fiscal year all paid claims for those physicians who will qualify for a supplemental payment. The Division of Medicaid will align the average commercial fee for each CPT code as determined in 3.b. above to each Medicaid claim for that physician or physician practice plan and calculate the average commercial payments for the claims.
- d. The Division of Medicaid will also align the same paid Medicaid claims with the Medicare fees for each CPT code for the physician or physician practice plan and calculate the Medicare payment amounts for those claims. The Medicare fees will be the most currently available national non-facility fees.
- e. The Division of Medicaid will then calculate an overall Medicare to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio will be re-determined every three (3) years.

State of Mississippi

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

- f. For each quarter the Division of Medicaid will extract paid Medicaid claims for each qualifying provider types for that quarter.
- g. The Division of Medicaid will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the most currently available national non-facility fees.
- h. The total amount that Medicare would have paid for those claims is then multiplied by the Medicare to commercial conversion factor and the amount Medicaid actually paid for those claims is subtracted to establish the supplemental payment amount for the qualifying provider types for that quarter.

The supplemental payments will be made on a quarterly basis and the Medicare equivalent of the average commercial rate of 159.14% factor will be rebased/updated every three (3) years by the Division of Medicaid. Supplemental payments will be directly remitted to the qualifying hospital or the physician practice plan to which participating physicians have assigned the Mississippi Medicaid payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 4.19-B

Page 5.14

State Mississippi

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

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Supersedes TN 96-06
TN 97-01

Date Received 4/1/97
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State of Mississippi
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

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

Podiatry services are reimbursed from the same fee schedule as physicians' services.

Podiatrists' services for EPSDT recipients, if medically necessary, include those services that would be covered as physicians' services when performed by a doctor of medicine for osteopathy and are reimbursed as physicians' services, Attachment 4.19-B, Page 5.

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.

TN # 2002-06

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

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

Chiropractic services are reimbursed from the same fee schedule based on 70 percent of Medicare as authorized by the Legislature

Chiropractors' services for EPSDT recipients, if medically necessary, are reimbursed from the fee schedule based on 70 percent of Medicare as authorized by the Legislature.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers by five percent (5%) of the allowed amount for that service.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

6d. Other Practitioners' Services:

Nurse Practitioner and Physician Assistant Services: Reimbursement for nurse practitioner and physician assistant services shall be at 90% of the fee for reimbursement paid to licensed physicians under the statewide physician fee schedule for comparable services under comparable circumstances.

Nurse practitioner and physician assistant services 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 above paragraph.

Pharmacy Disease Management Services: The pharmacy disease management services are reimbursed on a per encounter basis with an encounter averaging between fifteen and thirty minutes. The reimbursement is a flat fee established after reviewing Medicaid's physician fee schedule and reimbursement methodologies and fees of other states and third party payers.

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.

TN No. 2002-29
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

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

Orthotics and Prosthetics for children under age 21, if medically necessary, are reimbursed as follows:

- A. The payment for purchase of Orthotics and Prosthetics is made from a statewide uniform fee schedule not to exceed 80 percent of the rate established annually under Medicare (Title XVIII of the Social Security Act), as amended.
- B. The payment for repair of Orthotics and Prosthetics is the cost, not to exceed 50 percent of the purchase amount.
- C. The payment for other individual consideration items must receive prior approval from the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Orthotics and Prosthetics Reimbursement and Coverage Criteria are applicable.

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.

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METHODS AND STANDARDS FOR ESTABLISHING RATES – OTHER TYPES OF CARE

Home Health Care Services- Payment for home health services shall be on the basis of cost or charges, whichever is less, as determined under standards and principles applicable to Title XVIII, not to exceed in cost the prevailing cost of skilled nursing home services under Medicaid. Effective July 1, 1981, payment for Home Health Services is in accordance with the Mississippi Title XIX Home Health Agency Reimbursement Plan (see Exhibit "A" pages 1-9c, attached); however, under no circumstances will the cost of Home Health Services exceed the cost of skilled nursing home services per month under the Medicaid Program.

Home Health care services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph and in Exhibit A of Attachment 4.19-B.

Durable Medical Equipment Services- Payment for Durable Medical Equipment (DME) is in accordance with the Mississippi Title XIX Durable Medical Equipment Reimbursement Plan at Exhibit "A", page 10.

Medical Supplies- Payment for medical supplies is in accordance with Mississippi Title XIX Medical Supply Reimbursement at Exhibit "A", page 11.

TN# 2003-07
Superseded TN# 2002-06

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Date Received SEP 11 2003

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

Private Duty Nursing Services for EPSDT recipients, if medically necessary, reimbursed on a fee for service basis.

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.

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State of Mississippi

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

Clinic Services

Reimbursement is for services rendered by the Mississippi State Department of Health (MSDH) clinics. Reimbursement is based on cost reports submitted by the provider. In order to be reimbursed at cost, the provider must demonstrate its cost finding methodology and use a cost report approved by CMS. The provider is required to submit a cost report for each clinic type using the Medicare Cost Report Form 222. The encounter rate will be determined by dividing total reasonable cost by total encounters but will not exceed the upper limits specified in 42 CFR §§ 447.321 through 447.325. The rate for an encounter is limited to one (1) visit per day per beneficiary. An encounter is defined as services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers. A clinic's encounter rate covers the beneficiary's visit to the clinic, including all services and supplies, such as drugs and biologicals that are not usually self-administered by the patient, furnished as an incident to a professional service. The established rate setting period is July 1 to June 30. The Division of Medicaid requires the MSDH to submit the cost report by November 30 of each year, five (5) calendar months after the close of the cost reporting period. An interim rate is paid until the end of the reporting period when there is a retrospective cost settlement. The interim rate is the established rate for the prior fiscal year. Actual reasonable costs reported on the cost report are divided by actual encounters by clinic type to determine the actual cost per encounter. Overpayments will be recouped from the provider, and underpayments will be paid to the provider.

The encounter rates are updated annually on July 1 and are effective for services provided on or after July 1. Rates for the MSDH clinics are published on the Division of Medicaid's website at www.medicaid.ms.gov/FeeScheduleLists.aspx.

The Division of Medicaid covers for all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

State of Mississippi

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES —
OTHER TYPES OF CARE**

Ambulatory Surgical Center Facility Services

Reimbursement of ambulatory surgical center (ASC) services is calculated at eighty percent (80%) of the current Medicare Ambulatory Surgical Center Payment System.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental, if any, and non-governmental providers of ambulatory surgical center services. Mississippi Medicaid's fee schedule for ambulatory surgical center services is updated annually with an effective date of October 1 for services provided on or after that date. All rates may be viewed at www.medicaid.ms.gov/FeeScheduleLists.aspx.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to both governmental and non-governmental providers for any service by five percent (5%) of the allowed amount for that service. The published fee does not include the five percent (5%) reduction.

State of Mississippi

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

Dialysis Center Services

A. Payment Methodology

Effective January 1, 2014, dialysis centers shall be reimbursed at a bundled end-stage renal disease (ESRD) prospective payment system (PPS) rate. The ESRD PPS rate is equal to the Medicare ESRD bundled PPS rate as of January 1, published in the Federal Register in the fourth (4th) quarter of the preceding calendar year. The ESRD PPS rate provides a single payment to freestanding and hospital-based dialysis centers -covering all resources used in providing dialysis treatment in the centers or at a beneficiary's home, including supplies, equipment, drugs, biologicals, laboratory services, and support services. A complete listing of drugs, biologicals and lab services included in the ESRD PPS rate can be viewed at www.medicaid.ms.gov/FeeScheduleLists.aspx.

B. Rate Setting

New dialysis centers are assigned an ESRD PPS rate equal to the prevailing Medicare bundled ESRD base PPS rate, adjusted by the ESRD PPS Wage Index for the provider's Core-Based Statistical Area (CBSA) labor market area.

For each subsequent year, the dialysis center's ESRD PPS rate shall be equal to the bundled ESRD base PPS rate established by Medicare as of January 1, for that year, adjusted by the ESRD PPS Wage Index.

MEDICAL ASSISTANCE PROGRAM

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

Dental Services –Effective for dates of service beginning July 1, 2007, the fee schedule shall provide for a fee for each dental service that is equal to a percentile of normal and customary private provider fees, as defined by the Ingenix[®] Customized Fee Analyzer Report, which percentile shall be determined by the Division. The fee schedule shall be reviewed annually by the Division, and dental fees shall be adjusted each July based on service utilization data for the previous fiscal year, an updated Ingenix[®] Customized Fee Analyzer Report, and state budgeted amounts in order to meet requirements for a balanced budget. Dental providers will be reimbursed the provider's charge or the allowed fee for the procedure, whichever is less.

The Ingenix[®] Customized Fee Analyzer Report is a commercially available product produced by Ingenix[®], a health care industry information company located at 2525 Lake Park Boulevard, West Valley City, Utah 84120. The Ingenix[®] Dental Customized Fee Analyzer Report is compiled by the company through collecting charge data from insurance payer clients across the country. The Report then organizes the data into percentiles – 50th, 60th, 75th, 80th, and 95th. A fee at the 50th percentile indicates that 50 percent of submitted charges for that service in the database are equal to or higher than the fee listed. The Report is also customized by arraying the data by geozips. Comparing a fee or charge in the Report indicates how that amount stands in relation to fees from other providers in the geozip area.

Use of the Ingenix[®] Customized Fee Analyzer Report is intended to provide a benchmark for dental charges in Mississippi in order to set fair and reasonable fees for dental services. Mississippi Medicaid purchased the Report for geozip 392xx, which includes the Hinds and Rankin County areas that constitute the largest metropolitan area in the state and the largest number of dental providers. All dental fees will be set based on this Report and dentists statewide would be reimbursed using the same fee methodology.

The state will use the following process to determine the percentile and percentage reduction on an annual basis:

- The annual fee determination will be done each July, consistent with the state's fiscal year;
- The state will determine the total expenditures for dental services from the previous fiscal year;
- The portion of state funds from the total expenditures will be calculated based on the FFP rate for the previous fiscal year;
- The amount of state funds will be increased by ten percent (10%) and this amount will be added to the previous fiscal year dental expenditure total to give the expenditure total expected to be paid for the upcoming fiscal year;

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- The percentile and percentage reduction will be determined by adjusting the allowed fee for each dental procedure code so that expected expenditures will equal approximately the total expenditures plus a ten percent increase over the state's share for the previous fiscal year.

The state will publish the annual percentile and annual percentage amount of the reduction for dental fees on the DOM web site at www.dom.state.ms.us. The dental fee schedule will be posted on the DOM web site and the fiscal agent web portal for providers.

Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services.

Dental services for EPSDT beneficiaries (beneficiaries under age twenty-one (21)) which exceed the limitations and scope for Medicaid beneficiaries as covered in this Plan are reimbursed according to the methodology in the above paragraphs, if medically necessary.

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 total allowed amount for all services on a claim.

State of Mississippi

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

Therapy Services (provided in a non-hospital setting)

Physical therapy services – Fees for physical therapy services are updated July of each year for services rendered on or after that date and are reimbursed at ninety percent (90%) of the current Medicare rate.

Occupational therapy services – Fees for occupational therapy services are updated July of each year for services rendered on or after that date and are reimbursed at ninety percent (90%) of the current Medicare rate.

Speech-language pathology services – Fees for speech-language pathology services are updated July of each year for services rendered on or after that date and are reimbursed at ninety percent (90%) of the current Medicare rate.

Physical therapy, occupational therapy, and speech-language pathology services for EPSDT beneficiaries, if medically necessary, which exceed the limitations and scope for Medicaid beneficiaries, as covered in the Plan are reimbursed according to the methodology described above.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of physical therapy, occupational therapy, and speech-language pathology services in a non-hospital setting. Mississippi Medicaid's fee schedule for physical therapy, occupational therapy, and speech-language pathology services is updated annually with an effective date of July 1 for services provided on or after that date. All rates may be viewed at <http://www.medicaid.ms.gov/Providers.aspx>.

Notwithstanding any other provision of the Plan, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service as noted above by five percent (5%) of the allowed amount for that service.

State of Mississippi

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

EAC (Estimated Acquisition Cost) is defined as the Division's estimate of the price generally paid by pharmacies for pharmaceutical products. EAC may be based on the Average Wholesale Price (AWP) or the Wholesale Acquisition Cost (WAC) or the State Maximum Allowable Cost (SMAC) as described below. The EAC will not be based on the SMAC unless the State prevails in Mississippi Independent Pharmacies Association, et al. v. Division of Medicaid, et.al; Hinds County Chancery Court No. G2008-704 S/2.

SMAC reimbursement will apply to certain multi-source drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Division of Medicaid. Actual acquisition cost will be determined through the collection and review of pharmacy invoices and other information deemed necessary by the Division and in accordance with applicable State and Federal law. SMAC rates are based on the average actual acquisition cost per drug of pharmacy providers enrolled in the Medicaid Program, adjusted by a multiplier that is 1.3, which ensures that each rate is sufficient to allow reasonable access by providers to the drug at or below the established SMAC rate. The Division will review the rates on no less than an annual basis and adjust them as necessary to reflect prevailing market conditions and to assure reasonable access by providers.

- A. **Brand Name Drugs** (single source, innovator multiple – source) - In reimbursing for brand name drugs Medicaid shall pay for:
 - 1.) The lesser of:
 - a.) The provider's usual and customary charge; or
 - b.) The EAC for brand name drugs which is defined as the lesser of:
 - i.) AWP minus 12% plus a dispensing fee of \$3.91; or
 - ii.) WAC plus 9% plus a dispensing fee of \$3.91.
 - 2.) Less the applicable co-payment.

- B. **Multiple Source Generic Drugs** – In reimbursing for multiple-source generic drugs, as defined by CMS, Medicaid shall pay:
 - 1.) The lesser of:
 - a) The provider's usual and customary charge; or
 - b) The Federal Upper Limit (FUL), if applicable, plus a dispensing fee of \$5.50*; or
 - c) The EAC for multiple source drugs which is defined as the lesser of:
 - i) AWP minus 25% plus a dispensing fee of \$5.50 or
 - ii) SMAC rate and a dispensing fee of \$5.50* (except \$4.91 unless the State prevails in Mississippi Independent Pharmacies Association, et al. v. Division of Medicaid, et.al.; Hinds County Chancery Court No. G2008-704 S/2..

State of Mississippi

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

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 lesser of:
 - a) The provider's usual and customary charge; or
 - b) The EAC for other than multiple-source drugs which is defined as the lesser of:
 - i) AWP minus 12% plus a dispensing fee of \$3.91; or
 - ii) WAC plus 9% plus a dispensing fee of \$3.91; or
 - iii) SMAC rate and a dispensing fee of \$3.91.
 - c) Less the applicable co-payment
- 2.) Reimbursement for covered non-legend products or over-the-counter products is the less of:
 - a) The provider's usual and customary charge; or
 - b) The EAC for multiple source drugs which is defined as the lesser of:
 - i) AWP minus 25% plus a dispensing fee of \$3.91 or
 - ii) SMAC rate and a dispensing fee of \$3.91.
 - c) Less the applicable co-payment

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 \$5.50 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.

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

Hospital Outpatient Drugs

- 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 most recent final Medicare outpatient Addendum B and C published by the Centers for Medicare and Medicaid Services (CMS) as of April 1 of each year. The MS Medicaid OPPS fee schedule is effective July 1 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 most recent final Medicare Average Sales Price (ASP) Drug Pricing File, titled Payment Allowance Limits for Medicare Part B, published by CMS as of April 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 effective July 1 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 one-hundred percent (100%) of the provider's acquisition cost.
- e. All fees are published on the agency's website at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/#>.

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 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 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 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 OPSS Fee Schedule a fee will be calculated using 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 OPSS Fee or RED BOOK™ fee 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 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 Medicare Addendum B OPSS 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 OPSS Fee Schedule a fee will be calculated using 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.

State of Mississippi
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 RED BOOK™ fee 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 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™ 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 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

Dentures for EPSDT recipients, if medically necessary, are reimbursed according to the fee schedule for dental services.

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.

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

Hearing Aids - Payment is from a statewide uniform fixed fee schedule based on actual acquisition cost, plus a professional and fitting cost of \$80.00.

Hearing aids for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

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.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
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Eyeglasses - Payment is made from a statewide uniform fixed fee schedule for the professional services of the eye doctor plus actual acquisition cost for the frames and lenses. Effective

Eyeglasses for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

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.

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13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services: Mental Health Services described in Attachment 3.1-A, Exhibit 13.d are reimbursed as follows:

Covered services billed using Current Procedural Terminology (CPT) codes for psychiatric therapeutic procedures are reimbursed based on ninety percent (90%) of the most recent final Medicare fee schedule published by the Centers for Medicare and Medicaid Services (CMS) as of April 1 each year and effective July 1 and updated annually.

Covered services billed using Healthcare Common Procedure Coding System (HCPCS) are reimbursed according to a statewide uniform fixed fee schedule. In establishing the fee schedule, the Division of Medicaid (DOM) engaged an actuarial firm to establish fees. DOM provided service descriptions and other information for the existing mental health services offered and the proposed new services. The relationships between comparable services for Medicaid programs in other states were examined to develop factors to apply to existing Mississippi fees to calculate the new service group fees with the fees for the existing mental health services. Consideration was given to the service descriptions, required provider credentials and current costs associated with services. Preliminary fees were modified to better reflect the expected provider cost relative to other mental health services. The agency's state developed fee schedule rate is set as of July 1, 2012, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, state-developed uniform fixed fee schedule rates are the same for both governmental and private providers of mental health rehabilitative services as described in Attachment 3.1-A, Exhibit 13.d. All rates are published on the agency's website at <http://www.medicaid.ms.gov/FeeScheduleLists.aspx>.

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 five percent (5%) reduction in reimbursement is made after the published rate is applied. This provision is not applicable to Indian Health Services or for services provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate.

TN# 2012-003

Supersedes

TN # 2003-004

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Date Effective 07/01/2012

STATE PLAN UNDER TITLE XIX OF THE SOCIAL-SECURITY ACT

State Mississippi

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

17. Nurse-midwife services

The reimbursement for certified nurse midwifery services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

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.

State of Mississippi

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

Hospice

Mississippi Medicaid's hospice fee schedule is updated annually with an effective date of October 1 for services provided on or after that date. All rates may be viewed at <http://www.medicaid.ms.gov/HospiceFees.aspx>.

The fee schedule reimburses for the hospice benefit, including routine home care, continuous home care, inpatient respite care and general inpatient care. These rates are authorized by section 1814(i)(c)(ii) of the Social Security Act, which also provides for annual increases in payment rates for hospice care services.

If a Medicaid beneficiary elects the Hospice Program and is admitted to nursing facility as an individual on hospice at the same time or while residing in a nursing facility when the hospice election is made, the State pays the hospice provider a room and board rate that is 95% of the Medicaid Nursing Facility per diem rate for each Medicaid or dually eligible individual on hospice residing in a nursing facility. This rate is required by Section 1902 (a)(13)(B) of the Social Security Act and is an additional per diem rate paid on routine home care and continuous home care days. Any Medicaid payment to the nursing facility ceases when the rate is paid to the hospice provider. The hospice provider pays the 95% rate to the nursing facility for room and board. All nursing facility rates may be viewed at <http://www.medicaid.ms.gov/Providers.aspx>.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Mississippi

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

Transportation - Ambulance Services - The reimbursement methodology for ambulance services is a statewide fee schedule. Payment is made from a statewide uniform fee schedule based on 70 percent of the rate established under Medicare (Title XVIII of the Social Security Act), as amended.

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.

TN # 2002-06
Supersedes TN # 94-03

Date Effective MAY 01 2002
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

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

Targeted Case Management

1. Targeted Case Management for High-Risk Pregnant Women - The case management fee is a negotiated rate of payment. Potential providers indicated participation was contingent upon establishing a fee that allowed them to recover the cost of providing the services recognizing the additional effort required to initialize each case. The rate will be evaluated annually.
2. Targeted Case Management for High-Risk Infants - The case management fee is based upon the current negotiated fee of:

\$12.00 for open and ongoing EPSDT case management contracts

\$6.00 for closure of EPSDT case management
3. All services - In the case of a public agency, reimbursement determined to be in excess of cost will be recouped by means of a rate adjustment for the next year.

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.

TN # 2002-06

Supercedes TN # 92-11

Date Received MAY 02 2002

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STATE Mississippi

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

Targeted Case Management:

Targeted case management for chronically mentally ill community based recipients is reimbursed on a fee-for-service basis based on the number of units provided on behalf of the recipient.

TN No.	<u>92-17</u>	Date Received	<u>12-23-92</u>
Supersedes		Date Approved	<u>8-16-93</u>
TN No.	<u>NEW</u>	Date Effective	<u>10-01-92</u>

State of Mississippi

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

Targeted Case Management:

Targeted Case Management services for beneficiaries with Intellectual and/or Developmental Disabilities (IDD) in community-based settings are billed using Current Procedural Terminology (CPT) codes according to a statewide uniform fixed fee schedule. The Division of Medicaid engaged an actuarial firm to establish fees.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Targeted Case Management as described in Supplement 1C to Attachment 3.1-A. The agency's fee schedule rate was set as of July 1, 2012, and is effective for services provided on or after that date. All rates are published on the agency's website at www.medicaid.ms.gov/FeeScheduleLists.aspx.

Targeted Case Management is billed using the Healthcare Common Procedure Coding System (HCPCS) and reimbursed according to a statewide uniform fixed fee schedule. In establishing the fee schedule, the Division of Medicaid engaged an actuarial firm to establish fees. DOM provided a service description and other information for Targeted Case Management. The relationships between a comparable service for Medicaid programs in other states was examined to develop factors to apply to existing Mississippi fees to calculate the fee. Consideration was given to the service description, required provider credentials and current costs associated with the service. The preliminary fee was modified to better reflect the expected provider cost relative to other Targeted Case Management services. The agency's state developed fee schedule rate is set as of July 1, 2012, and is effective for services provided on or after that date.

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 five percent (5%) reduction in reimbursement is made after the published rate is applied. This provision is not applicable to Indian Health Services or for services provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate.

Payment for targeted case management for IDD beneficiaries in community-based settings do not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 4.19-B

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State Mississippi

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER TYPES OF CARE

Targeted Case Management Services for children birth to three participating in the Mississippi Early Intervention Program

Payment for Targeted Case Management (TCM) Services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TCM Services by Public Providers

TCM for children, ages birth to three years of age, provided by public providers will be reimbursed through an encounter fee. The TCM encounter fee will be based on the actual costs associated with allowable case management service delivery.

Reimbursement is based on cost reports submitted by the provider. The rate will be determined by dividing total reasonable cost by total encounters but will not exceed the upper limits specified in 42 CFR 447.321 through 447.325. The established rate setting period is July 1 to June 30. The TCM encounter fee will be prospectively determined for an interim period until the end of the reporting period when there is a retrospective cost settlement. The cost report will include both the direct and indirect costs of providing case management services and statistical information regarding the number of children served, including the number of encounters. The cost report will include allocations between the different programs administered by the provider and the computation of the actual cost of case management. The provider must submit a copy of the two most current Random Moment Time Studies (RMTS) with each cost report. The RMTS must show the times allocated to each program administered by the provider.

TCM Services for Non-Public Providers

TCM for children, ages birth to three years of age, provided by non-public providers are reimbursed on a fee-for-services basis.

TN # 2001-22
Superseded TN # NEW

Date Effective JAN 01 2002
Date Approved JUN 12 2002

STATE : Mississippi

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

Extended Services for Pregnant Women

1. Reimbursement- Reimbursement will be on a fee-for-service basis, billed monthly on the HCFA-1500 form. Payment will be the lesser of the charge or the established fee.

The established fees were based on like procedures and services currently paid in the Medicaid program.

Examples are:

- a. In-home visits pay the rate of the visits in the home by a physician plus estimated travel costs.
 - b. High-risk assessment reimbursement is based on physician office visits reimbursement, currently in Mississippi.
2. All Services- In the case of a public agency, reimbursement determined to be in excess of cost will be recouped by means of a rate adjustment for the next year.

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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Mississippi

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

Item 1. Payment of Title XVIII Part A and Part B Deductible/ Coinsurance

The Medicaid agency uses the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/ QMB Individual	Medicare-QMB Individual
Part A Deductible Inpatient Hospital	<input type="checkbox"/> limited to State Plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount
Part A Coinsurance Inpatient Hospital	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount
Part A Deductible Nursing Facility Hospice Home Health	<input checked="" type="checkbox"/> limited to State plan rates* <input type="checkbox"/> full amount	<input checked="" type="checkbox"/> limited to State plan rates <input type="checkbox"/> full amount	<input checked="" type="checkbox"/> limited to State plan rates <input type="checkbox"/> full amount
Part A Coinsurance Nursing Facility Hospice Home Health	<input checked="" type="checkbox"/> limited to State plan rates* <input type="checkbox"/> full amount	<input checked="" type="checkbox"/> limited to State plan rates <input type="checkbox"/> full amount	<input checked="" type="checkbox"/> limited to State plan rates <input type="checkbox"/> full amount
Part B Deductible	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount
Part B Coinsurance	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount	<input type="checkbox"/> limited to State plan rates <input checked="" type="checkbox"/> full amount

*The Medicaid agency will not reimburse for services that are not covered under the Medicaid State Plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 4.19-B
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STATE: Mississippi

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

Respiratory Care Services for EPSDT recipients, if medically necessary, reimbursed on a fee for service scale.

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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 4.19-B
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STATE: Mississippi

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

Christian Science Nurses for EPSDT recipients, if medically necessary, are reimbursed according to an established fee for service scale.

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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 4.19-B

STATE: Mississippi

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

Christian Science Sanatoria Services for EPSDT recipients, if medically necessary, reimbursed according to an established reimbursement rate.

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.

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STATE : Mississippi

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

Personal Care Services for EPSDT recipients, if medically necessary, reimbursed on a fee for service scale.

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.

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State of Mississippi

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

24a. Transportation – The State Agency will assure necessary transportation of recipients to and from providers of services through the following methods:

Ambulance Services – The reimbursement methodology for ambulance services is a statewide fee schedule. Payment is made from a statewide uniform fee schedule based on 70 percent of the rate established under Medicare (Title XVIII of the Social Security act), as amended.

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

Notwithstanding any other provision of the ambulance 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.

Non-emergency Transportation Services – Costs for non-emergency transportation services are reimbursed per the 1915(b)(4) Initial Selective Contracting Waiver for the NET program, entitled “the Mississippi Medicaid Non-emergency Transportation (NET) Waiver.”

The state is divided into NET service regions. Each region is served by a primary group provider. Group providers are for-profit and not-for-profit, public or private entities that are selected through a competitive bid process. The Division of Medicaid issues a Request for Bids (RFB) through which qualified bidders submit bids to provide NET assistance in the NET service regions. The successful bidder (primary provider) is selected for each region by the Division of Medicaid through a bid evaluation process that is published as part of the RFB. Bidders include in their price components a flat rate per one-way transport. The Division of Medicaid pays the successful bidder in each region the rate included in the winning bid for that region. This rate is paid per one-way transport, regardless of the length of the transport or the type of vehicle required (ambulatory or lift), and regardless of the number of transports. The Division of Medicaid may utilize an alternate group provider on a temporary basis when the primary provider cannot provide a requested service (for example, when a beneficiary requires a lift vehicle and the primary provider is operating all life vehicles at capacity).

When the Division of Medicaid utilizes individual providers, these providers are paid by the mile. The rate paid is equal to the rate paid to state employees who travel on official business; however, the Division reserves the right to change the rate at any time upon notification to the provider. The Division will review the individual provider rate on an annual basis. The review will ensure that current rates cover at least the average operating costs as determined by an analysis of cost data, not to exceed the rate paid to state employees. Upon changes to the rate, providers will be notified.

State of Mississippi

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

24a. Transportation – The State Agency will assure necessary transportation of recipients to and from providers of services through the following methods:

Ambulance Services – The reimbursement methodology for ambulance services is a statewide fee schedule. Payment is made from a statewide uniform fee schedule based on 70 percent of the rate established under Medicare (Title XVIII of the Social Security act), as amended.

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

Notwithstanding any other provision of the ambulance 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Mississippi

Attachment 4.19-B
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Care and services provided in Christian Science sanatoria - Reimbursement is a prospective per diem based on cost report data.

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

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Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Home Health Aide
<input type="checkbox"/>	HCBS Personal Care
<input type="checkbox"/>	HCBS Adult Day Health
<input checked="" type="checkbox"/>	HCBS Habilitation Day Habilitation Services \$10.80 per hour Prevocational Services \$12.52 per hour Supported Employment Services \$25.00 per hour
<input type="checkbox"/>	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)
<input type="checkbox"/>	Other Services (specify below)

Except as otherwise noted in the plan, state-developed uniform fixed fee schedule rates are the same for both governmental and private providers of habilitation services as described in Attachment 3.1-i.

State of Mississippi

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

Telehealth Services

Payment for telehealth services is made as follows:

The originating or spoke site provider is paid a Mississippi Medicaid telehealth originating site facility fee per completed transmission. The originating site provider may not bill for an encounter or Evaluation and Management (E&M) visit unless a separately identifiable service is performed.

The distant or hub site provider is paid the current applicable Mississippi Medicaid fee for the telehealth service provided.

The Mississippi Medicaid telehealth originating site facility fee was calculated by an actuarial firm using the May 2013 Bureau of Labor Statistics (BLS) mean wage for Nurse Practitioners in MS adjusted by 35% for benefits and 2% for wage growth at half of the rate for 30 minute increments and is effective for services provided on or after January 1, 2015. The Mississippi Medicaid telehealth originating site facility fee is updated July 1 of each year based on the annual percentage change in the Medicare physician fee schedule for Level III Established Patient E&M code effective on January 1 of each year.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of telehealth services. All rates are published on the Division of Medicaid's website at <http://www.medicaid.ms.gov/providers/fee-schedules-and-rates/>.

MISSISSIPPI TITLE XIX HOME HEALTH
AGENCIES REIMBURSEMENT PLAN

I. Cost Finding and Cost Reporting

- A. Each home health agency participating in the Mississippi Medicaid Program will submit a uniform cost report using the appropriate Medicare/Medicaid forms postmarked no later than five (5) calendar months after the close of its cost reporting year. There will be no extensions granted. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII, if applicable. One (1) completed copy of the cost report, with original signature, must be submitted to the Division of Medicaid (DOM).
- B. Cost reports must be postmarked by the specified due date, unless a waiver is granted by the Executive Director of the Division of Medicaid, in order to avoid a penalty in the amount of \$50.00 per day for each day the cost report is delinquent. Cost reports with a due date that falls on a weekend, a State of Mississippi holiday or a federal holiday will be due the following business day.

A home health agency which does not file a cost report within six (6) calendar months after the close of its cost reporting year may be subject to cancellation of its provider agreement at the discretion of the Division of Medicaid, Office of the Governor.

In order for cost reports to be considered complete, the following information must be filed:

1. Cost report with original signature (1 copy)
2. Working Trial Balance including assets and liabilities (1 copy)
3. Depreciation Schedule (1 copy)
4. Home office cost report and other Related Party support, i.e., a detailed statement of total costs with adjustments for non-allowable costs and a description of the basis used to allocate the costs, along with a narrative description or a copy of contracts of management services provided by the related party or home office (1 copy)
5. Medicaid Cost Reporting Schedules, i.e., Medicaid costs and visits by discipline and a schedule to reflect the lower of reasonable costs or customary charges as applicable to Medicaid (1 copy)
6. Medicare provider questionnaire and related Exhibits (1 copy)
7. Supporting workpapers for the Medicare cost report Worksheets for reclassifications, adjustments, and related party expenses (1 copy)

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TN NO <u>96-05</u>	DATE EFFECTIVE <u>OCT 01 2003</u>

8. A narrative description of purchased management services or a copy of contracts for managed services (1 copy); and
9. Verification of the Medicare and Medicaid surety bond premiums included in the cost report (1 copy).

If all required information is not submitted with the original cost report on the due date, the provider will be notified via a faxed letter to the Administrator of the facility of the specific items missing and will be given 10 working days to submit the missing information. If the information has not been received by the 10th day, a second request letter will be faxed to the Administrator. The provider will have 5 working days to submit the information. Failure to submit the information postmarked no later than the due date of the second request, will result in the related costs being disallowed. The provider will not be allowed to submit the information at a later date, amend the cost report in order to submit the requested information, or appeal the desk review and/or audit as a result of the omission of the requested information.

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- C. All home health agencies are required to maintain financial and statistical records. For purposes of this plan, statistical records shall include beneficiaries' medical records. All records must be available upon demand to representatives, employees or contractors of the Division of Medicaid (DOM), Mississippi State Department of Audit, General Accounting Office (GAO) or the United States Department of Health & Human Services (HHS).
- D. Records of related organizations as defined by 42 CFR 413.17 must be available upon demand to representatives, employees or contractors of the DOM, Auditor General, GAO, or HHS.
- E. DOM shall retain all uniform cost reports submitted for a period of at least five (5) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 45 CFR 205.60 and Mississippi State Law. Access to submitted cost reports will be in conformity with Mississippi Statutes. Upon request for a copy of any cost report, the home health agency involved will be notified as to why and what is being requested. Unless otherwise advised, the cost report will be released to the requestor 10 days from receipt of the request by the DOM or fiscal agent.

II. Audits

A. Background

Medicaid (Title XIX) requires that home health agencies be reimbursed on a reasonable cost related basis. Medicare (Title XVIII) is reimbursed based on a prospective payment system. To assure that payment of reasonable cost is being achieved, a comprehensive audit program has been established.

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SUPERSEDES
TN NO 79-09

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DATE EFFECTIVE OCT 01 2003

The common audit program has been established to reduce the cost of auditing submitted cost reports under the above programs and to avoid duplicate auditing efforts. The purpose then is to have one audit which will serve the needs of participating programs reimbursing home health agencies for services rendered.

B. Common Audit Program

The Division of Medicaid has entered into agreements with Medicare intermediaries for participation in a common audit program of Titles XVIII and XIX. Under this agreement, the intermediaries shall provide the Division of Medicaid the results of desk reviews and field audits of those agencies, located in Mississippi.

C. Other Audits

For those home health agencies not covered by the common audits agreement with Medicare intermediaries, the Bureau of Compliance and Financial Review of the Division of Medicaid shall be responsible for performance of field reviews and field audits. The Bureau of Reimbursement of the Division of Medicaid will be responsible for performance of desk reviews.

D. Retention

All audit reports received from Medicare intermediaries or issued by the Division of Medicaid will be retained for a period of at least five (5) years.

E. Overpayment

Overpayments as determined by desk review or audit will be reimbursable to the Division of Medicaid. All overpayments shall be reported to HHS as required.

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TN NO 79-09

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F. Desk Review Appeals

A provider may appeal the results of their original desk review. The appeal must be made in writing to the Division of Medicaid within thirty (30) calendar days of the date of the original desk review. The written request for appeal should include the provider's name, provider number, cost reporting period, and a detailed description of the adjustment(s) being appealed. Workpapers and CFR references supporting the basis of the appeal should also be submitted.

If the appeal is submitted on a timely basis and includes all required information, the Division of Medicaid will review the appeal request and respond to the provider within sixty (60) calendar days of the date of receipt of all the required information. If the provider is not satisfied with the results of the appeal, within thirty (30) calendar days of the date of the Division of Medicaid's original response to the appeal, the provider may request a formal hearing. Such request must be in writing and must contain a statement and be accompanied by supporting documents setting forth with particularity the facts which the provider contends places him in compliance with the Division of Medicaid's regulations or his defenses thereto.

Unless a timely and proper request for a hearing is received by the Division of Medicaid from the provider, the findings of the Division of Medicaid shall be considered a final and binding administrative determination. The hearing will be conducted in accordance with the Procedures for Administrative and Fair Hearings as adopted by the Division of Medicaid.

G. Final Cost Reports

The final cost reports received from Medicare intermediaries will be used as received from the intermediary to adjust rates. Providers may not appeal to the Division of Medicaid for the results of final cost reports. Appeals should be made to the Medicare intermediary under the procedures established by the intermediary. Once appealed adjustments have been resolved by the Medicare intermediary, the provider's rates will be adjusted if necessary, based on the amended final cost report. (See Section III.1.7 and 8.)

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SUPERSEDES	DATE APPROVED <u>MAR 03 2004</u>
TN NO <u>New</u>	DATE EFFECTIVE <u>OCT 01 2003</u>

III. Allowable Costs

Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement and the guidelines in the Provider Reimbursement Manual (HIM-15) except as modified by Title XIX of the Act, this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Mississippi Medicaid Program.

- A. All items of expense may be included which home health agencies must incur in meeting:
1. The definition of a home health agency to meet the requirements of Section 1901(a)(13) of the Social Security Act.
 2. Requirements established by the State Agency responsible for establishing and maintaining health standards.
 3. Any other requirements for licensing under the State Law which are necessary for providing home health services.
- B. Implicit in any definition of allowable costs is that those costs should not exceed what a prudent and cost conscious buyer pays for a given service or item. If costs are determined to exceed the level that a prudent buyer would incur, then the excess costs would not be reimbursable under the plan.
- C. A proportion of costs incurred by a home health agency for services to an eligible Medicaid patient for whom payments are received from third parties are not reimbursable under this plan. Appropriate adjustments shall be made.

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- D. Cost reports for years ended within a calendar year will be used to establish the class ceilings and home health agency rates beginning the following October 1. For example, cost reports ended during 1996 will be used to compute the rate effective October 1, 1997. The exception will be the cost reports for periods ended in 1995. These cost reports will be used to compute the class ceilings and home health agency rates for a fifteen (15) month period. The 1995 cost reports will be used to compute rates for the period July 1, 1996 through September 30, 1997. This will allow for a transition from a rate year of July 1 through June 30 to a rate year of October 1 through September 30. If a provider experiences a change of ownership and files two cost reports during the calendar year, the last filed cost report will be used. Providers will be notified of their respective rates by type of visit and rate ceilings by type of visit prior to implementation of the rates. Any provider of home health services under the Medicaid Program may appeal its prospective rates in accordance with Section VI of this Plan.
- E. The DOM shall maintain any responses received on the plan, subsequent changes to the plan, or rates for a period of five (5) years from the date of receipt. Such comments shall be available to the public upon request.
- F. A home health agency may at times offer to the public new or expanded services or may drop a service. Within sixty (60) days after such an event, the home health agency may submit a budget which shall take into consideration new and expanded services or dropped services. Such budgets will be subject to desk review and audit by the DOM. Upon completion of the desk review, new reimbursement rates will be established. Failure to submit budgets within sixty (60) days shall require disallowance of all expenses, direct and indirect, associated with the service. Overpayments as a result of the differences between budget and actual costs shall be refunded to the DOM. New reimbursement rates shall not exceed the established class ceilings.
- G. Type of visit ceilings and individual provider's reimbursement rates will not include amounts representing growth allowances.
- H. Payment by type of visit and type of visit ceilings will be established prospectively.

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- I. The prospectively determined individual home health agency's rate will be adjusted under certain circumstances which are:
1. Administrative errors on the part of the DOM or the agencies that result in erroneous payments. Overpayments or underpayments resulting from errors will be corrected when discovered. Overpayments will be recouped by the DOM and underpayments will be paid to the home health agency. In no case will payment adjustments be made for administrative error or audit findings prior to notifying the appropriate agency and affording an opportunity to present facts and evidence to dispute the exception.
 2. The amendment of a previously submitted cost report. Such amendments must be submitted within eighteen (18) months following the close of the cost report period that is being amended. If an increase or decrease in the rate is computed as a result of the amended cost report, claims history will be adjusted retroactive to the effective date of the original rate.
 3. The information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. At the discretion of the DOM, this shall be grounds to suspend the home health agency from the Mississippi Medicaid Program until such time as an administrative hearing is held, if requested by the home health agency.
 4. The home health agency experiences extraordinary circumstances which may include, but are not limited to riot, strike, civil insurrection, earthquakes or flood.
 5. The home health agency experiences a change of ownership (See Section V.1.)

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6. Under no circumstances shall such adjustment exceed the class ceiling established for the respective classes.
7. The receipt of the final or amended final cost report from the Medicare intermediary.
8. Resolution by the Medicare intermediary of a provider appealed adjustment on a previous year final cost report that was applied to an original desk review. The rates for all years affected by the appealed adjustment for which the final cost report has not been received will be recalculated and claims history adjusted retroactive to the effective date of the original rate.

J. Costs incurred for the acquisition of durable medical equipment and supplies are non-allowable costs since they are reimbursed outside of the home health agency visit rate.

IV. Rate Methodology

A. Prospective Rates. The DOM will utilize a prospective rate of reimbursement and will not make retroactive adjustments except as specified in these regulations. The prospective rates will be determined from cost reports and will be set on a yearly (October 1 - September 30) basis from the date established and will be applicable to all facilities with a valid provider agreement. An exception to this is that rates will be set for fifteen (15) months for the period July 1, 1996 through September 30, 1997. This will allow for a transition to the new rate year due to the change in the due dates of cost reports. Total payments per month for each home health patient may not exceed the average Medicaid nursing facility rate per month as determined based on the nursing facility rates computed at July 1 of each year.

Providers will be paid the lower of their prospective rate as computed in accordance with this plan or their usual and customary charge.

In order to compensate for new or expanded services not accounted for in the reporting year, the home health agency must identify such services no later than each June 30, prior to the start of the October 1 rate determination, and submit financial data in order for a determination to be made of the impact on the cost report.

B. Payment for Home Health Services. Home health services include skilled nursing services, physical therapy services, speech therapy services, home health aide services and medical supplies. Payments of medical supplies which are directly identifiable supplies furnished to individual patients and for which a separate charge is made will be reimbursed as described in Section IV. D. 5., of this plan. Payments of durable medical equipment and supplies are reimbursed as described in Section VIII, of this plan.

Prospective rates and ceilings will be established for the home health visits. Services must be provided at the recipient's place of residence on his physician's orders as part of a written plan of care that the physician reviews every sixty (60) days. A recipient's place of residence, for home health services, does not include a hospital, skilled nursing facility, nursing facility, or intermediate care facility except for home health services in an intermediate care facility that are not required to be provided by the facility under federal regulations.

Home health visits reimbursed by this plan include:

1. Skilled Nursing Visit - Nursing services provided by or under the supervision of registered nurses currently licensed in the State of Mississippi. These services must be provided directly by agency staff in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

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2. Physical Therapy Visit - These services shall be given in accordance with the responsible physician's written order by a physical therapist or physical therapy assistant currently licensed in the State of Mississippi to practice as a physical therapist or physical therapist assistant. The physician's order shall be specific as to modalities to be utilized and frequency of therapy. Each visit should be for a period of not less than thirty (30) minutes.

These services must be provided by agency staff directly or provided under arrangement through a contractual purchase of services in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

3. Speech Therapy Visit - The speech pathologist shall be currently licensed by the Mississippi State Department of Health at the time the services are provided. The audiologist shall be currently licensed by the Mississippi State Department of Health. Speech pathology and audiology services shall be given in accordance with the responsible physician's written order by a licensed speech pathologist or a licensed audiologist. The frequency of service shall be specified in the physician's order. Each visit should be for a period of not less than thirty (30) minutes.

These services must be provided by agency staff directly or provided under arrangement through a contractual purchase of services in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

4. Home Health Aide Visit - These services shall be given under a physician's order and shall be supervised by a Registered Nurse. When appropriate, supervision may be given by a physical therapist, a speech therapist, or an occupational therapist. These services must be provided by agency staff directly or provided under arrangement through a contractual purchase of services in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.

C. Trend Factor

A trend factor will be computed in order to adjust costs for anticipated increases or decreases due to changes in the economy. This will be done by using the Global Insight Health Care Cost Review - National Forecasts CMS Home Health Agency Market Basket, or its successor. The moving averages from the fourth quarter of the previous calendar year, prior to the start of the rate period, used are Wages and Salaries, Employee Benefits, Fixed Capital, Medical Equipment, Utilities, Telephone, Paper Products, Postage, Administrative Costs, Transportation, Insurance, and Miscellaneous. Relative weights are obtained from the same period National Market Basket Price Proxies - Home Health Agency Operating Costs.

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An example of the computation of the trend factor is described below.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
EXPENSE CATEGORY	RELATIVE WEIGHT	ADJUSTED RELATIVE WEIGHT COL 2/COL 1 TOTAL LINE	PERCENT GROWTH QUARTER 96:4	TREND FACTOR COL 3 * COL 4
Wages & Salaries	64.23%	0.6423	0.029	0.0186
Employee Benefits	13.44%	0.1344	0.018	0.0024
Fixed Capital	1.76%	0.0176	0.032	0.0006
Transportation	3.41%	0.0341	0.027	0.0009
Utilities	0.83%	0.0083	0.031	0.0003
Telephone	0.73%	0.0073	0.014	0.0001
Paper Products	0.53%	0.0053	0.053	0.0003
Postage	0.72%	0.0072	0.000	0.0000
Administrative Costs	7.59%	0.0759	0.033	0.0025
Medical Equipment	0.88%	0.0088	0.000	0.0000
Insurance	0.56%	0.0056	0.022	0.0001
Miscellaneous	5.32%	0.0532	0.028	0.0015
Total	100.00%	1.0000		0.0273

The trend factor of 2.73%, as determined above for a one year period, will be adjusted based on the cost report period in order to trend costs from the mid-point of the cost report period to the mid-point of the rate period.

D. Setting of Type of Visit Ceilings and Rates

1. Skilled Nursing Visit rates are determined in accordance with the following rate methodology. Home Health Agencies are reimbursed for skilled nursing visits at the lower of the following:
 - (a) trended cost, plus a profit incentive, but not greater than 105% of the median, which is computed as follows:

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- (1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;
 - (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;
 - (3) array the trended costs from the lowest to the highest with the total number of skilled nursing visits and determine the cost associated with the median visit (interpolate, if necessary);
 - (4) multiply the median visit trended cost by 105% to determine the ceiling;
 - (5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;
 - (6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above; or,
- (b) the sum of the following:
- (1) the ceiling for direct care and care related costs for nursing facilities at a case mix score of 1.000 as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period; and
 - (2) the ceiling for administrative and operating costs for Large Nursing Facilities as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period.
- (c) plus the medical supply add-on as computed in Section IV. D. 5.
2. Physical Therapy Visits are reimbursed on a fee-for-service basis at an all inclusive, per visit rate of \$65.00 plus the medical supply add-on as computed in Section IV. D. 5.
 3. Speech Therapy Visits are reimbursed on a fee-for-service basis at an all inclusive, per visit rate of \$65.00 plus the medical supply add-on as computed in Section IV. D. 5.
 4. Home Health Agencies are reimbursed for home health aide visits based on the following methodology:
 - (a) trended cost, plus a profit incentive, but not greater than 105% of the median, plus the medical supply add-on, which is computed as follows:

- (1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;
- (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;
- (3) array the trended costs from the lowest to the highest with the total number of home health aide visits and determine the cost associated with the median visit (interpolate, if necessary);
- (4) multiply the median visit trended cost by 105% to determine the ceiling;
- (5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;
- (6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above, plus the medical supply add-on as computed in Section IV. D. 5.

5. The Medical Supply payment amount that will be added on to each discipline will be reimbursed at the lower of the following:

- (a) trended medical supply cost per visit computed as follows:
 - (1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk review; divide this number by total Medicaid visits);
 - (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period; or
- (b) 105% of the median medical supply trended cost, which is computed as follows:
 - (1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk review; divide this number by total Medicaid visits);
 - (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;
 - (3) array the trended costs from the lowest to the highest with the total number of Medicaid visits per the desk review and determine the cost associated with the median visit (interpolate, if necessary);
 - (4) multiply the median visit trended cost by 105% to determine the ceiling.

V. New Providers

1. Changes of Ownership

For purposes of this plan, a change of ownership of a home health agency includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer - seller relationship.

Prior to the DOM's concurrence of a change of ownership transaction, the following information is required in order for the DOM to determine the appropriate allowance for depreciation and interest on capital indebtedness:

- a. the prior owner's basis in the assets sold;
- b. the purchase amount of these assets by the new owner;
- c. the amount of annual depreciation and interest expense for the buyer; and
- d. a description of the assets being purchased.

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A home health agency which undergoes a change of ownership must notify the DOM in writing of the effective date of the sale. The seller's provider number will be closed and a new provider number assigned to the new owner after the new owner submits the provider enrollment information required under DOM policy. The new owner is not allowed to use the provider number of the old owner to file claims for reimbursement.

The new owner will be reimbursed at the previous owner's rate until the rate is adjusted based on the new owner's initial cost report. This adjusted rate will be effective retroactive to the date of the change of ownership. A prospective rate will also be determined based on this initial cost report.

The new owner, upon consummation of the transaction effecting the change of ownership, shall as a condition of participation, assume liability, jointly and severally, with the prior owner for any and all amounts that may be due or become due to the Medicaid Program, and such amounts may be withheld from the payment of claims submitted when determined. However, the new owner shall not be construed as relieving the prior owner of his liability to the Division.

2. New Home Health Agencies

When new providers are established that are not changes of ownership, the provider shall be reimbursed at the maximum rate for each type of home health visit pending the receipt of the initial cost report. After receipt of the initial cost report, a rate will be determined that is retroactive to the date of the establishment of the provider.

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.

VI. Provider Participation

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of home health agencies in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public. Providers must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and meet all applicable state laws and requirements.

VII. Payment in Full

Participation in the program shall be limited to home health agencies who accept, as payment in full, the amount paid in accordance with the State Plan.

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State of Mississippi

VIII. Durable Medical Equipment

- A. The payment for the purchase of new Durable Medical Equipment (DME) is the lesser of the provider's usual and customary charge or a fee from statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after July 1. The statewide uniform fee schedule will be calculated using eighty percent (80%) of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year.
1. If there is no DMEPOS fee the item will be priced at the Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%).
 2. If there is no MSRP the item will be priced at the provider's invoice plus twenty percent (20%).
 3. If one (1) and two (2) do not apply, then a fee will be calculated using market research from the area.
- B. The payment for rental of DME is made from a statewide uniform fee schedule based on ten percent (10%) of eighty percent (80%) of the Medicare DMEPOS fee schedule as described in letter A not to exceed ten (10) months. After rental benefits are paid for ten (10) months, the DME becomes the property of the Mississippi Medicaid beneficiary unless otherwise authorized by the Division of Medicaid through specific coverage criteria.
- C. The payment for purchase of used DME is made from a statewide uniform fee schedule not to exceed fifty percent (50%) of eighty percent (80%) of the Medicare DMEPOS fee schedule as described in letter A.
- D. The payment for repair of DME is the cost of the repair, not to exceed fifty percent (50%) of eighty percent (80%) of the Medicare DMEPOS fee schedule as described in letter A.
- E. The payment for other individual consideration items must receive prior approval of the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Durable Medical Equipment Reimbursement and Coverage Criteria are applicable.

DME for Early and Periodic Screening, Diagnosis, and Treatment (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 above paragraphs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of DME. 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.

State of Mississippi

Medical Supplies

- A. The payment for the purchase of Medical Supplies is 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 July 1. The statewide uniform fee schedule will be calculated using eighty percent (80%) of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year.
1. If there is no DMEPOS fee the item will be priced at the Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%).
 2. If there is no MSRP the item will be priced at the provider's invoice plus twenty percent (20%).
 3. If one (1) and two (2) do not apply, then a fee will be calculated using market research from the area.
- B. The payment for other individual consideration items must receive prior approval of the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Medical Supplies Reimbursement and Coverage Criteria are applicable.

Medical Supplies 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 above paragraphs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of DME. 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.

State Mississippi

Supplement 1

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Pursuant to the provisions of Section 25-14-1, et seq., Mississippi Code of 1972, as Amended, individual providers of medical care under Title XIX are eligible to participate in the Deferred Compensation Plan administered by the Mississippi Public Employees Retirement System Board. The Medicaid fiscal agent defers compensation of individual providers in accordance with the agreement between the provider and the Public Employees Retirement Board. All such deferred payments are made in accordance with State and Federal legal requirements pertaining to deferred compensation plans.

Transmittal #87-22

TN No. 87-22 DEPT. OF HEALTH 10-20-81
SUPERSEDES 6-15-78
TN No. New DEPT. OF HEALTH 10-1-81

State Mississippi

Supplement 2

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Coverage for Aliens — Payment to a provider who renders a covered service to an alien due to an emergency medical condition shall be at the same rate that is payable for that same service when rendered to any other Medicaid recipient who is not an alien.

TN NO. 87-22 DATE/RECEIPT 10-30-71
SUPERSEDES DATE/RECEIPT 7-15-71
TN NO. New DATE/EFFECTIVE 1-7-72

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Effective January 1, 2000, Mississippi will reimburse for Indian Health Service and Tribal 638 Health Facilities in accordance with the most recent Federal Register notice.

TN No. 2000-05

Effective Date January 1, 2000

Supersedes TN New

Approval Date JUN 16 2000