

PUBLIC NOTICE

February 26, 2019

Pursuant to 42 C.F.R. Section 447.205, public notice is hereby given to the submission of a Medicaid State Plan Amendment (SPA) 19-0010 Dental and Orthodontic Reimbursement. The Division of Medicaid, in the Office of the Governor, is submitting the proposed SPA to the Centers for Medicare and Medicaid Services (CMS) effective March 1, 2019, contingent upon approval from CMS, our Transmittal #19-0010.

1. Mississippi Medicaid SPA#19-0010 Dental and Orthodontic Reimbursement proposes:
 - a) To revise the reimbursement methodology for dental and orthodontic services as the lesser of:
 - a. The provider's usual and customary charge,
 - b. A fee from the Mississippi Medicaid statewide uniform dental fee schedule in effect July 1, 2018, or
 - c. The fiftieth (50th) percentile fee reflected in the 2019 National Dental Advisory Service (NDAS) Fee Report.
 - b) To remove language excluding dental services for:
 - a. Pregnant women as required by the Affordable Care Act (ACA), and
 - b. Beneficiaries enrolled in the Healthier Mississippi Waiver (HMW) as required by the 2014 waiver renewal.
2. The proposed SPA is estimated to be budget neutral and was calculated by multiplying the CY18 units of service for the codes affected by this payment methodology by the revised fee. This estimate results in a savings of approximately \$9,987 in federal dollars for federal fiscal year (FFY)19 and \$17,120 for FFY20. The estimated savings in state dollars is \$1,764 for state fiscal year (SFY)19 and \$5,291 for SFY20.
3. 42 C.F.R. § 430.12 requires that if the Division of Medicaid amends the state plan a SPA must be submitted.
4. A copy of the proposed SPA will be available in each county health department office and in the Department of Human Services office in Issaquena County for review. A hard copy can be downloaded and printed from www.medicaid.ms.gov or requested at 601-359-2081 or by e-mailing Margaret.Wilson@medicaid.ms.gov.
5. Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or Margaret.Wilson@medicaid.ms.gov for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.
6. A public hearing on this SPA will not be held.

State of Mississippi
DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE
AND SERVICES PROVIDED

10. Dental Services

The Division of Medicaid covers medically necessary dental services for non-Early and Period Screening, Diagnostic and Treatment (EPSDT)-eligible beneficiaries that:

- a) Are an adjunct to treatment of an acute medical or surgical condition,
- b) Include services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone, and
- c) Include emergency dental extractions and treatment.

The Division of Medicaid requires prior authorization, except for emergencies, for certain medically necessary dental services by the Division of Medicaid or designee for non-EPSDT-eligible beneficiaries.

The Division of Medicaid covers medically necessary dental services for EPSDT-eligible beneficiaries including:

- a) Diagnostic,
- b) Preventive,
- c) Therapeutic,
- d) Emergency, and
- e) Orthodontic.

Dental Benefit Limits:

For dates of service beginning July 1, 2007, dental services (except orthodontia) are limited to \$2,500 per beneficiary per fiscal year. Additional dental services in excess of the \$2,500 annual limit may be provided with prior approval from the Division of Medicaid or designee.

The Division of Medicaid requires prior authorization, except for emergencies, for certain medically necessary dental services by the Division of Medicaid or designee for EPSDT-eligible beneficiaries.

Orthodontic Services:

Orthodontic services are covered when medically necessary and prior authorized by the Division of Medicaid or designated entity for EPSDT-eligible beneficiaries. Orthodontia-related services are limited to \$4,200 per beneficiary per lifetime. Additional dental services in excess of the \$4,200 lifetime limit may be provided with prior approval from the Division of Medicaid or designee.

Dentures:

Dentures are covered when medically necessary and prior authorized by the Division of Medicaid or designated entity for EPSDT-eligible beneficiaries.

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

Dental and Orthodontic Services - Payment for dental services is the lesser of:

1. The provider's usual and customary charge,
2. A fee from the Mississippi Medicaid statewide uniform dental fee schedule in effect July 1, 2018, or
3. The fiftieth (50th) percentile fee reflected in the 2019 National Dental Advisory Service (NDAS) Fee Report.

All fees are published on the Division of Medicaid's website at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/>.

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.

Medically necessary dental services for EPSDT-eligible beneficiaries which exceed the scope for Medicaid beneficiaries as covered in this Plan are reimbursed according to the methodology in the above paragraphs.

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. The published fees do not include the five percent (5%) reduction.

State of Mississippi
DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE
AND SERVICES PROVIDED

10. Dental Services:

The Division of Medicaid covers medically necessary dental services for Adults (non-Early and Period Screening, Diagnostic and Treatment (EPSDT)-eligible beneficiaries age twenty-one (21) and over care that:

- a) is Are an adjunct to treatment of an acute medical or surgical condition;
- b) Include services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and
- c) Include emergency dental extractions and treatment, related thereto are covered services.

The Division of Medicaid requires prior authorization, except for emergencies, for certain medically necessary dental services by the Division of Medicaid or designee for non-EPSDT-eligible beneficiaries.

Children (beneficiaries under age twenty-one (21): The Division of Medicaid covers medically necessary dental services for are a necessary component of overall health services provided to children EPSDT-eligible beneficiaries who are eligible for services. Beneficiaries under age twenty-one (21) are eligible for medically necessary dental services, including:

- a) dDiagnostic,
- b) pPreventive,
- c) tTherapeutic,
- d) eEmergency, and
- e) oOrthodontic services.

Dental Benefit Limits:

For dates of service beginning July 1, 2007, dental services (except orthodontia) are limited to \$2,500 per beneficiary per fiscal year. Additional dental services in excess of the \$2,500 annual limit may be provided with prior approval from the Division of Medicaid or designee.

The Division of Medicaid requires prior authorization, except for emergencies, for certain medically necessary dental services by the Division of Medicaid or designee for EPSDT-eligible beneficiaries

Orthodontiac Services:

Orthodontiac services are covered with when prior approval medically necessary and prior authorized by the Division of Medicaid or designated entity for EPSDT-eligible beneficiaries, under age twenty-one (21) only. Orthodontia-related services are limited to \$4,200 per beneficiary per lifetime. Additional dental services in excess of the \$4,200 lifetime limit may be provided with prior approval from the Division of Medicaid or designee.

Dentures:

Dentures may be are covered for beneficiaries under age twenty-one (21) with when prior medically necessary and prior authorized by the Division of Medicaid, or designated entity approval for EPSDT-eligible beneficiaries.

Medicaid Eligibles Not Covered for Dental Benefits: The following Medicaid eligibles are not covered for dental benefits:

- Women who are eligible for Medicaid only because of pregnancy (pregnancy related eligibles) and who are age twenty one (21) or older;
- Beneficiaries in the Healthier Mississippi Waiver who are age twenty one (21) or older;

State of Mississippi
DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE
AND SERVICES PROVIDED

The Division of Medicaid does not cover Medicare beneficiaries who are not eligible for full Medicaid benefits.

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

Dental and Orthodontic Services - Payment for dental services is the lesser of:

1. The provider's usual and customary charge.
2. A fee from the Mississippi Medicaid statewide uniform dental fee schedule in effect July 1, 2018, or
3. The fiftieth (50th) percentile fee reflected in the 2019 National Dental Advisory Service (NDAS) Fee Report.

All fees are published on the Division of Medicaid's website at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/>.

~~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 per 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;~~

State of Mississippi

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

- ~~• 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;~~
- ~~• 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.

Medically necessary dental services for EPSDT-eligible 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. The published fees do not include the five percent (5%) reduction.