PUBLIC NOTICE
June 10, 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 19-0013) Outpatient Prospective Payment System (OPPS) 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 July 1, 2019, contingent upon approval from CMS, our Transmittal #19-0013.

1. Mississippi Medicaid SPA #19-0013 proposes to:
   a) Remove specific diagnosis codes related to Never Events and refer to the diagnosis code descriptions,
   b) Use the Medicare outpatient Addendum B as of January 1 of each year as published by CMS to calculate the Medicaid OPPS fee,
   c) Apply the multiple discounting policy to dental procedures billed on the hospital outpatient claim to price the highest allowed dental procedure at one hundred percent (100%) of the allowed amount or published fee and price all subsequent dental procedures at twenty-five percent (25%) of the allowed amount or published fee, and
   d) Require prior authorization on all dental procedures performed in the outpatient hospital setting.

2. The estimated annual aggregate expenditure is anticipated to be a total annual savings of $2,214,139 with savings in state funds $174,253 in FFY19 and $509,695 in FFY20 and a savings in federal funds of $563,794 in FFY19 and $1,704,444 in FFY20.
   a) There is no anticipated financial impact for removing specific diagnosis codes related to Never Events and referring to the diagnosis code descriptions.
   b) There is an anticipated increase in expenditures of $8,686 in state funds and $28,103 in federal funds for federal fiscal year (FFY)19 and an increase of $25,406 in state funds and $84,961 in federal funds for FFY20 using Medicare outpatient Addendum B as of January 1 of each year as published by CMS.
   c) There is an anticipated decrease in expenditures of $182,939 in state funds and $591,897 in federal funds for federal fiscal year FFY19 and a decrease of $535,101 in state funds and $1,789,405 in federal funds for FFY20 by applying the multiple discounting policy to dental procedures billed on the hospital outpatient claim.
   d) There is no anticipated economic impact on requiring prior authorization on all dental procedures in the outpatient hospital setting.

3. 42 C.F.R. § 430.12 requires that if the Division of Medicaid amends the state plan a SPA must be submitted and the reasons for the changes are:
   a) Using the Medicare outpatient Addendum B as of January 1 of each year as published by CMS rates will reduce the number of mass adjustments of outpatient hospital claims.
   b) Applying the multiple discounting policy to dental procedures will reduce the allowed amount or published fee for the second and subsequent dental procedures performed during the same dental session in the outpatient hospital setting.
   c) Requiring prior authorization for all dental procedures in the outpatient hospital setting will ensure that dental procedures are performed in the appropriate setting.

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 emailing at 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 will be held on Friday, June 21, 2019, at 11:00 a.m. at the Woolfolk State Office Building, Room 145, 501 N. West St. Jackson, MS 39201.

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 requires prior authorization for certain medically necessary dental services in an office setting and all dental services provided in an outpatient hospital setting by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO for all beneficiaries except for emergencies.

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 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 l, 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 authorization from the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO.

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 authorization from the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO.

Dentures:
Dentures are covered when medically necessary and prior authorized by the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO for EPSDT-eligible beneficiaries.

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

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 appropriate ICD-9 or ICD-10 diagnosis codes for:

- Performance of wrong operation (procedure) on correct patient
- Performance of operation (procedure) on patient not scheduled for surgery
- 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 for dates of services beginning on or after June 1, 2012:

Once quarterly, paid claims identified 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.

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 Medicare outpatient Addendum B effective as of January 1 of each year as published by the Centers for Medicare and Medicaid Services (CMS). Codes with no applicable APC relative weight or Medicare payment rate established in Addendum B are reimbursed using the applicable MS Medicaid fee effective July 1 of each year, multiplied by the units (when applicable). No retroactive adjustments will be made. 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 medicaid.ms.gov/providers/fee-schedules-and-rates/.

   b. The Medicaid conversion factor used by DOM is the SFY18 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 reimbursed using a MS Medicaid fee. Except as otherwise noted in the plan, MS

Medicaid 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).

   The hourly fee for observation is calculated based on the relative weight for the Medicare APC which corresponds with comprehensive observation services multiplied by the SFY18 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 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 reimbursement under Medicaid OPPS. A complete list of MS Medicaid OPPS status indicators and definitions is located within the OPPS Fee Schedule that is published on the agency's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

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

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

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

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

2. Outpatient Payment Methodology Paid Under Medicaid OPPS

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

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

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

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

d. If there is (1) no APC 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

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 Medicare outpatient Addendum B published by the Centers for Medicare and Medicaid Services (CMS) as of January 1 of each year. The MS Medicaid OPPS fee schedule is updated and effective July 1 of each year with no retroactive adjustments.

c. Chemotherapy drugs and concomitant non-chemotherapy drugs administered during the chemotherapy treatment billed on the same claim as the chemotherapy treatment will be paid a MS Medicaid OPPS Chemotherapy fee. The MS Medicaid OPPS Chemotherapy fee will be the amount listed on the Medicare Average Sales Price (ASP) Drug Pricing File, titled Payment Allowance Limits for Medicare Part B, published by CMS as of January 1 of each year. The ASP files are one-hundred six percent (106%) of the ASP calculated from data submitted by drug manufacturers. The MS Medicaid OPPS Chemotherapy fee is updated and effective July 1 of each year with no retroactive adjustments.

d. If there is no APC relative weight, Medicare payment rate, MS Medicaid OPPS Chemotherapy fee or ASP for a drug, reimbursement is made at no more than one-hundred percent (100%) of the provider's acquisition cost.

e. All fees are published on the agency's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

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

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State of Mississippi
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Never Events will be identified with the appropriate ~~following~~ ICD-9 or ~~diagnosis codes or~~ ICD-10 ~~replacement~~ diagnosis codes for:

- ~~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

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   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 effective as of ~~April~~January 1st of each year as published by the Centers for Medicare and Medicaid Services (CMS). Codes with no applicable APC relative weight or Medicare payment rate established in Addendum B are ~~paid~~reimbursed using the ~~current~~ applicable MS Medicaid fee effective July 1 of each year, multiplied by the units (when applicable). 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 medicaid.ms.gov/providers/fee-schedules-and-rates/.

   b. The Medicaid conversion factor used by DOM is the SFY18 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~~reimbursed using a MS Medicaid fee. Except as otherwise noted in the plan, MS Medicaid

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 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 comprehensive observation services multiplied by the SFY18 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 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 reimbursement ~~payment~~ under Medicaid OPPS. ~~The~~ A complete ~~full~~ list of MS Medicaid OPPS status indicators and definitions is ~~found on Attachment 4.19-B, page 2a.6~~ located within the OPPS Fee Schedule that is published on the agency's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

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

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

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

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

2. Outpatient Payment Methodology Paid Under Medicaid OPPS

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

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

b. Where no APC relative weight has been assigned, the outpatient services fee will be ~~paid at~~ no more than 100% of any applicable Medicare payment rate in the ~~most current final~~ Medicare outpatient Addendum B as of January ~~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 as of January~~April~~ 1~~st~~ 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

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

~~MS MEDICAID OPPS 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 OPPS~~
~~U~~	~~Brachytherapy~~
~~V~~	~~Medical visits in the clinic, critical care or emergency department (includes codes for direct admits)~~
~~X~~	~~Ancillary services paid by APC~~

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 January ~~April~~ 1 of each year. The MS Medicaid OPPS fee schedule is updated and effective July 1 of each year with no retroactive adjustments.

c. Chemotherapy drugs and concomitant non-chemotherapy drugs administered during the chemotherapy treatment billed on the same claim as the chemotherapy treatment will be paid a MS Medicaid OPPS Chemotherapy fee. The MS Medicaid OPPS Chemotherapy fee will be the amount listed on the ~~most recent final~~ Medicare Average Sales Price (ASP) Drug Pricing File, titled Payment Allowance Limits for Medicare Part B, published by CMS as of January ~~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 updated and effective July 1 of each year with no retroactive adjustments.

d. If there is no APC relative weight, Medicare payment rate, MS Medicaid OPPS Chemotherapy fee or ASP for a drug, reimbursement is made at no more than one-hundred percent (100%) of the provider's acquisition cost.

e. All fees are published on the agency's website at https://medicaid.ms.gov/providers/fee -schedules -and-rates/#.

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