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.

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.

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.)

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-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.

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

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State of Mississippi
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.

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

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.

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.

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 (4^{th}) 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 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 (4^{th}) 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

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

1. 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/#.

2. The Division of Medicaid reimburses an RHC the encounter rate for the administration of certain categories of physician administered drugs (PADs), referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs), reimbursed under the pharmacy benefit to the extent the CADDs were not included in the calculation of the RHC's encounter rate.

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.

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).

I. Out of State Providers

The Division of Medicaid does not enroll out-of-state providers to provide RHC services, except in those circumstances specified at 42 CFR 431.52.

State of Mississippi
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 (4^{th}) 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

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 (4^{th}) 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

1. 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/#.

2. The Division of Medicaid reimburses an FQHC the encounter rate for the administration of certain categories of physician administered drugs (PADs), referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs), reimbursed under the pharmacy benefit to the extent the CADDs were not included in the calculation of the FQHC's encounter rate.

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 occurs if: (1) the FQHC has added or has dropped any services that meets the definition of an FQHC 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 FQHC 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.

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 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).

G. Out-Of-State Providers

The Division of Medicaid does not enroll out-of-state providers to provide FQHC services, except in those circumstances specified at 42 CFR 431.52.

State of Mississippi

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.

Not withstanding 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

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) EPSDT screening fee(s) will be reimbursed using the Current Procedural Terminology (CPT) codes based on Centers for Medicare and Medicaid Services (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. Fees are updated July 1 of each year and reimbursed at ninety percent (90%) of the Medicare Physician Fee Schedule in effect on January 1of each year. 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 visits are 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 updated July 1 of each year and are reimbursed at ninety percent (90%) of the Medicare Physician Fee Schedule in effect on January 1 of each year.

(3) [Reserved]

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.

Not withstanding 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

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

Reimbursement for non-Autism Spectrum Disorder services to Psychologists, Licensed Clinical Social Workers (LCSW), and Licensed Professional Counselors (LPC) for EPSDT-eligible beneficiaries is the lesser of the usual and customary charge or 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.

The Division of Medicaid reimburses Autism Spectrum Disorder (ASD) services in accordance with the most recent publication of the Current Procedural Terminology (CPT) ©American Medical Association. Reimbursement for ASD service codes is the lesser of the usual and customary charge or a rate calculated by an actuarial firm based on Division of Medicaid anticipated mix of providers delivering each service, Bureau of Labor Statistics (BLS) wage and benefit information, provider overhead cost estimates, and annual hours at work and percentage of work time that is billable. The rates effective for July 1st for 2017, 2018 and 2019 were updated annually based on changes in the seasonally adjusted health care and social assistance compensation for civilian workers as reported by BLS on July 1. Effective July 1, 2020, the rates will remain the same as those effective July 1, 2019.

Rates for ASD services are the same for private and governmental providers and are published on the Division of Medicaid'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

The Division of Medicaid reimburses Prescribed Pediatric Extended Care (PPEC) providers the lesser of the provider's usual and customary charge or at an hourly rate for each completed hour up to six (6) completed hours of services or at a daily rate for over six (6) hours of services from a statewide uniform fee schedule that was calculated utilizing the costs used to set the 2018 average small nursing facility rates, adjusting the staff costs to reflect the minimum requirements for a PPEC and removing food costs, dietary salaries and benefits, and other expenses not related to costs incurred by a PPEC.

Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers of PPEC services. The Division of Medicaid's fee schedule rate was set as of January 1, 2020, and is effective for services provided on or after that date. All fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

The Division of Medicaid reimburses for transportation provided by PPECs as described in Attachment 3.1-D.

The Division of Medicaid, as required by state law, will reduce the rate of reimbursement to providers for PPEC services 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

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Private Duty Nursing

The Division of Medicaid reimburses private duty nursing (PDN) services for a registered nurse (RN) by adding the Federal Insurance Contributions Act (FICA) percentage of 7.65% and an administrative allowance of 0.53% to the May 2018 National Bureau of Labor Statistics (BLS) Highest Median Hourly rate for an RN in the Memphis, TN-MS-AR area . An additional $17.00 per hour is added to the rate calculation for RN PDN ventilator services.

The Division of Medicaid reimburses private duty nursing (PDN) services for a licensed practical nurse (LPN) by adding the Federal Insurance Contributions Act (FICA) percentage of 7.65% and an administrative allowance of 16.51% to the May 2018 National Bureau of Labor Statistics (BLS) Highest Median Hourly rate for an LPN in the Memphis, TN-MS-AR area.

Personal Care Services

The Division of Medicaid reimburses personal care services (PCS) for a certified nursing assistant (CNA) by adding the Federal Insurance Contributions Act (FICA) percentage of 7.65% and an administrative allowance of 21.35% to the May 2018 National Bureau of Labor Statistics (BLS) Mean Hourly rate for a CNA in the Memphis, TN-MS-AR.

Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers of PDN services and PCS. The Division of Medicaid's fee schedule rate was set as of July 1, 2020, and is effective for services provided on or after that date. All fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

The Division of Medicaid reimburses one hundred percent (100%) of the maximum allowable rate for the first beneficiary and fifty percent (50%) of the maximum allowable rate for the second beneficiary when a private duty nurse is caring for two (2) beneficiaries simultaneously in the same home.

The Division of Medicaid will reduce the rate of reimbursement to PDN and PCS providers for EPSDT services by five percent (5%) of the allowed amount for that service. The five percent (5%) reduction has been in place since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction. The federal match will be paid based on the reduced amount.

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.

State of Mississippi
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 certain Evaluation and Management (E&M) and Vaccine Administration Codes. 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.

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

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.

State of Mississippi

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

Supplemental Payments for Physician and Professional Services Practioners at Qualifying Hospitals

Effective for dates of payment on or after January 1, 2021, 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.

State of Mississippi

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 commerical rate level. The average commerical 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 the current procedural terminology (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 national non-facility fees that were effective at the time the Medicaid claims were paid.

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 158.63% 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 particpating physicians have assigned the Mississippi Medicaid payment.

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

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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.

Not withstanding 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 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.

Not withstanding 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.

State of Mississippi

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

6d. Other Licensed 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.

Reimbursement to a pharmacy provider, for vaccine administration by a pharmacist, is the same fee as a primary care physician outlined in Attachment 4.19-B page 5a.

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.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private other licensed practitioner providers. The Division of Medicaid's fee schedule rate was set as of September 1, 2020, and is effective for services provided on or after that date. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#. The Division of Medicaid will reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The 5% reduction has been in effect since July 1, 2002, and the fee schedule already incorporates the 5% adjustment. The federal match will be paid based on the reduced amount. Prescription drugs and other covered drugs and services as may be determined by the division are exempt from the 5% exemption.

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.

Not withstanding 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.

Home Health Care Services - Payment for home health service's 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 thc Mississippi Title XIX Home Health Agency Reimbursement Plan (see Exhibit "A", pages 1-9); 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.

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.

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 (4^{th}) 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.

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,
3. The fiftieth (50th) percentile fee reflected in the 2019 National Dental Advisory Service (NDAS) Fee Report, or
4. The fiftieth (50^{th}) percentile fee reflected in the most current NDAS Fee Report for any new dental or orthodontic services not previously priced.

   Once a dental or orthodontic service has been assigned a fee using the methodology above, that dental or orthodontic service will not be repriced. When a dental or orthodontic services Current Dental Terminology (CDT) code is discontinued and replaced with a new CDT code, the new CDT code will not be repriced. 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.

The Division of Medicaid will 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 five percent (5%) reduction has been in place since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction. The federal match will be paid based on the reduced amount.

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

The Division of Medicaid reimburses for certain legend and non-legend drugs, as authorized under the State Plan, prescribed by a Mississippi enrolled Medicaid prescribing provider licensed to prescribe drugs and dispensed by a Mississippi enrolled Medicaid pharmacy in accordance with Federal and State laws.

The Division of 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) and complies with the Centers for Medicare and Medicaid (CMS) Covered Outpatient Drug Final Rule in accordance with 42 C.F.R. Part 447.

I. The Division of Medicaid reimburses the following drugs as described below:

A. Brand Name drugs – Ingredient cost based on actual acquisition cost (AAC) which is defined as the lesser of:
   1. National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee of $11.29, or
   2. Wholesale Acquisition Cost (WAC) plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
   3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
   4. The provider's usual and customary charge.

B. Generic drugs – Ingredient cost based on AAC which is defined as the lesser of:
   1. NADAC plus a professional dispensing fee of $11.29, or
   2. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
   3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
   4. The provider's usual and customary charge.

C. Reimbursement for 340B covered entities as described in section 1927(a)(5)(B) of the Act, including an Indian Health Service, tribal and urban Indian pharmacy as follows:
   1. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the covered outpatient drug plus a professional dispensing fee of $11.29.
   2. Drugs purchased outside of the 340B program by covered entities – Ingredient cost based on AAC which is defined as the lesser of:
      a. NADAC plus a professional dispensing fee of $11.29, or
      b. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
      c. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no WAC is available, or
      d. The provider's usual and customary charge.
   3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

D. Drugs acquired via the Federal Supply Schedule (FSS) – Ingredient cost based on AAC plus a professional dispensing fee of $11.29.

E. Drugs acquired at Nominal Price (outside of 340B or FSS) – Ingredient cost based on AAC plus a professional dispensing fee of $11.29.

F. Specialty drugs are defined by the Division of Medicaid, updated no less than monthly, and listed at https://medicaid.ms.gov/providers/pharmacy/pharmacy-reimbursement/. Ingredient cost is defined as the lesser of:
   1. For a 340B covered entity:
      a. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the outpatient drug plus a professional dispensing fee of $61.14.
      b. Drugs purchased outside of the 340B program by covered entities – Ingredient cost is defined as the lesser of:
         1) WAC plus zero percent (0%) plus a professional dispensing fee of $61.14, or
         2) A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $61.14 when no WAC is available, or
         3) The provider's usual and customary charge.
   2. For a non-340B covered entity:
      a. WAC plus zero percent (0%) plus a professional dispensing fee of $61.14, or
      b. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $61.14 when no WAC is available, or
      c. The provider's usual and customary charge.

G. Drugs not dispensed by a retail community pharmacy (e.g., institutional or long-term care pharmacy when not included as part of an inpatient stay) – Ingredient cost based on AAC which is defined as the lesser of:
   1. NADAC plus a professional dispensing fee of $11.29, or
   2. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
   3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
   4. The provider's usual and customary charge.

H. Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers (HTCs), or Centers of Excellence – Ingredient cost defined as:
   1. For a 340B covered entity:
      a. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the clotting factor product plus a professional dispensing fee of $0.02 per Unit.
      b. Drugs purchased outside of the 340B program by covered entities – Ingredient cost which is defined as the lesser of:
         1) WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit, or
         2) A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02 when no WAC is available, or
         3) The provider's usual and customary charge.

2. For a non-340B covered entity – Ingredient cost is defined as the lesser of:
   a. WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit, or
   b. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02 when
   c. The provider's usual and customary charge.

I. Physician Administered Drugs and Implantable Drug System Devices as defined in Attachment 3.1-A, Exhibit 12a, Page 5 and reimbursed:
   1. Using the lesser of methodology under the pharmacy benefit as described in A - H above, or
   2. As described in Attachment 4.19-B, pages 12a.3-12a.4.

II. The Division of Medicaid does not reimburse for Investigational Drugs.

III. Usual and Customary Charges

The Division of Medicaid defines usual and customary charge as the lowest price the pharmacy would charge to a particular customer if such customer were paying cash for the identical prescription drug services on the date dispensed. This includes any applicable discounts including, but not limited to, senior discounts, frequent shopper discounts, and other special discounts offered to attract customers such as four dollar ($4.00) flat rate generic price lists. A pharmacy cannot have a usual and customary charge for prescription drug programs that differs from either cash customers or other third-party programs. The pharmacy must submit the accurate usual and customary charge with respect to all claims for prescription drug services.

IV. Overall, the Division of Medicaid's payment will not exceed the federal upper limit (FUL) based on the NADAC for ingredient reimbursement in the aggregate for multiple source drugs.

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/#.

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 July 1 of each year and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using the April 1 Medicare Part B Drug Fee Schedule of each year.

1) If there is no Medicare Part B Drug Fee Schedule a fee will be calculated at one hundred percent (100%) of the current April 1 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 Medicare Part B Drug Fee Schedule or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using Wholesale Acquisition Cost (WAC) + 0% in effect on April 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 Part B Drug Fee Schedule, Medicare Addendum B OPPS Fee or WAC + 0% 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 July 1 of each year and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using the April 1 Medicare Part B Drug Fee Schedule of each year.

1) If there is no Medicare Part B Drug Fee Schedule a fee will be calculated at one hundred percent (100%) of the current April 1 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 Part B Drug Fee Schedule or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using WAC + 0% in effect on April 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 Part B Drug Fee Schedule, Medicare Addendum B OPPS Fee Schedule or WAC + 0% 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 April 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 1 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 WAC + 0% in effect on April 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 WAC + 0% 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/#. The Division of Medicaid will reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service when applicable. The five percent (5%) reduction has been in place since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction. The federal match will be paid based on the reduced amount.

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.

Not withstanding 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.

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.

Not withstanding 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.

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

Eyeglasses - Payment is made from a statewide uniform fixed fee schedule for the professional services of the eye doctor plus actual acquistion 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 paragarph.

Not withstanding 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.

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.

State of Mississippi

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

13c. Preventive Services:

The Division of Medicaid reimburses for vaccines and vaccine administration the lower of the provider's usual and customary charge or the below:

Vaccine Ingredient Cost:

The federal Vaccine for Children (VFC) program provides vaccines free of charge to VFC enrolled providers. The Division of Medicaid does not reimburse for the cost of vaccines supplied through the VFC program.

Vaccines not covered through the VFC program are reimbursed:

1. In the pharmacy setting, at the actual acquisition cost (AAC) of the vaccine and are listed on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#. The AAC is defined as the wholesale acquisition cost (WAC) plus 0% for any claim type.

2. In the office setting, according to Attachment 4.19B, page 12a.3.

Vaccine administration for VFC vaccines is outlined in Attachment 4.19-B, page 5a.

Vaccine administration for non-VFC vaccines:

1. For a pharmacist is located in Attachment 4.19-B, page 6d.

2. For practitioners is located on the physician fee schedule at https://medicaid.ms.gov/ providers/fee-schedules-and-rates/.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Division of Medicaid's fee schedule rate was set as of ~~July~~ September 1, 2020, and is effective for services provided on or after that date. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#. The Division of Medicaid will reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The 5% reduction has been in effect since July 1, 2002, and the fee schedule already incorporates the 5% adjustment. The federal match will be paid based on the reduced amount.

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

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.

Not withstanding 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 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.

State of Mississippi

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

Targeted Case Management:

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of TCM as described in Supplement 1C to Attachment 3.1-A. The agency's fee schedule rate was set as of January 1, 2019, 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.

TCM 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 the TCM fee based on a comparable service for the target population in other Mississippi Medicaid programs. 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 TCM services. The agency's state developed fee schedule rate is set as of January 1, 2019, and is effective for services provided on or after that date.

The Division of Medicaid, as required by state law, will reduce the rate of reimbursement to providers for TCM services 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 to providers who are paid the fee schedule rate.

Payments for TCM 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.

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.

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.

3. Reimbursement for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services - The Division of Medicaid reimburses for SBIRT services according to Healthcare Common Procedure Coding System (HCPCS) guidelines and in accordance with provider reimbursement methodologies applicable in the 4.19B pages.

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 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	___ limited to State Plan rates _X_ full amount	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount
Part A Coinsurance Inpatient Hospital	___ limited to State plan rates _X_ full amount	___limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount
Part A Deductible Nursing Facility Hospice Home Health	_X_ limited to State plan rates* ___ full amount	_X_ limited to State plan rates ___ full amount	_X_ limited to State plan rates ___ full amount
Part A Coinsurance Nursing Facility Hospice Home Health	_X_ limited to State plan rates* __ full amount	_X_ limited to State plan rates ___ full amount	_X_ limited to State plan rates ___ full amount
Part B Deductible	__ limited to State plan rates _X_ full amount	__ limited to State plan rates _X_ full amount	__ limited to State plan rates _X_ full amount
Part B Coinsurance	__ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount

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

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.

Not withstanding 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.

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.

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.

Not withstanding 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

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

24a. Transportation

Emergency Ground Ambulance

The Division of Medicaid reimburses emergency ground ambulance services, including mileage beginning with the twenty-sixth (26th) mile, the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule set as of July 1, 2020 and effective for the services provided on or after July 1, 2020. The fees are calculated at one hundred percent (100%) of the Medicare ambulance urban fee schedule in effect as of January 1, 2020. If a Medicare fee is not established, then the fee is set at one hundred percent (100%) of the Medicare fee for a comparable service.

Emergency Air Ambulance

The Division of Medicaid reimburses 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 the services listed below provided on or after July 1 of each year and is calculated as seventy percent (70%) of the Medicare ambulance fee schedule in effect as of January 1 of each year. If a Medicare fee is not established, then the fee is set at seventy percent (70%) of the Medicare fee for a comparable service.

1) Emergency Air Ambulance Services provided in a rotary-wing aircraft, including mileage, and
2) Emergency and Urgent Air Ambulance Services provided in a fixed-wing aircraft, including mileage.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of emergency ambulance transportation services. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

The Division of Medicaid will reduce the rate of reimbursement to providers for emergency ambulance transportation services by five percent (5%) of the allowed amount for that service. The five percent (5%) reduction has been in place since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction. The federal match will be paid based on the reduced amount.

Non-Emergency Transportation

The Division of Medicaid reimburses for Non-Emergency Transportation (NET) services through a Broker Program or Broker as described in Attachment 3.1-D.

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.

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

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

Not withstanding 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

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*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation
	Based on statistical analysis conducted as part of the national norming of the ICAP, the instrument produces a Service Score to reflect the level of care, supervision, and training that a person needs. The Service Scores range from 0 to 100, with lower scores indicating more significant needs. The Service Scores are then combined into nine service levels. The State, in turn, has further collapsed the ICAP service levels into five levels of support, with Level 1 including people with the relatively fewest support needs (ICAP Service Scores of 90 or greater), and Level 5 including people with the greatest support needs (ICAP Service Scores below 30). Day Services - Adult - Low Support (Level 1 & 2) $3.78 per 15 min. unit Day Services - Adult - Medium Support (Level 3) $4.10 per 15 min. unit Day Services - Adult - High Support (Level 4 & 5) $4.66 per 15 min. unit Prevocational Services Low Support (Level 1 & 2) $12.48 per hour Prevocational Services Medium Support (Level 3) $13.28 per hour Prevocational Services High Support (Level 4 & 5) $14.64 per hour Supported Employment – Job Development, $8.80 per 15 minute Supported Employment – Job Maintenance (1 person) $8.35 per 15 minute Supported Employment – Job Maintenance (2 person) $5.22 per 15 minute Supported Employment – Job Maintenance (3 person) $4.17 per 15 minute Supported Living (1 person) $6.34 per 15 minute Supported Living (2 person) $3.97 per 15 minute Supported Living (3 person) $3.17 per 15 minute
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	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/.

State of Mississippi

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

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, CMS-1728-94 or CMS-2552-10, postmarked no later than five (5) calendar months after the close of its cost reporting year. Extensions will be granted only if the provider submits documentation of an extension granted by CMS or a waiver granted by the Executive Director of the Division of Medicaid (DOM). 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.

B. Cost reports must be submitted 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 fifty dollars ($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 five (5) 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.

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

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 (1copy),
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 (1copy),
6. Medicare provider questionnaire and related exhibits (1copy),
7. Supporting work papers for the Medicare cost report worksheets for reclassifications, adjustments, and related party expenses (1 copy),
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 by the due date, the provider will be notified via fax or email to the provider's designee on file with the Division of Medicaid. The notification will contain the specific items missing. The provider will have ten (10) business days from the date of the notification to submit the requested information. If the information has not been received by the tenth (10th) business day, a second request will be faxed or emailed to the provider's designee on file with the Division of Medicaid. The provider will have five (5) business days from the date of the second notification to submit the requested information. Failure to submit the requested information by the fifth (5th) business day after the second notification 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.

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, Mississippi Office of the State Auditor, General Accounting Office (GAO) or the United States Department of Health & Human Services (HHS).

D. Records of related organizations as defined by 42 C.F.R. § 413.17 must be available upon demand to representatives, employees or contractors of the Division of Medicaid, Mississippi Office of the State Auditor, GAO, or HHS.

E. The Division of Medicaid 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 C.F.R. § 205.60 and Mississippi state law. Access to submitted cost reports will be in conformity with the Mississippi Public Records Act.

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.

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

State of Mississippi

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

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

F. Appeal Procedures – Desk Reviews

A provider who disagrees with the results of their original desk review may request a reconsideration. The request for reconsideration must be made in writing to the Division of Medicaid and must include the reason for the request and any supporting documentation, and must be made within thirty (30) calendar days after receipt of the notification of the desk review results. Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received, if by certified mail or overnight mail, on the day the delivery receipt is signed, or if by hand delivery, on the date delivered. The written request for reconsideration should include the provider's name, provider number, cost reporting period, and a detailed description of the adjustment(s) or issues to be reconsidered. If the provider does not request a reconsideration, the Division of Medicaid will consider the provider’s nonresponse as acceptance of the final desk review results. Therefore, no administrative hearing request will be considered.

If the reconsideration is submitted on a timely basis and includes all required information, the Division of Medicaid will review the reconsideration request and respond to the provider within thirty (30) calendar days of the date of receipt of all the required information.

If the provider disagrees with the results of the reconsideration, the provider may request an administrative hearing by the Division of Medicaid as described in Miss. Admin. Code Part 300, within thirty (30) calendar days of the receipt date of the final reconsideration letter.

Unless a timely and proper request for an administrative 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. Any administrative hearing will be conducted in accordance with the procedures for administrative 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 regarding 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.

III. Allowable Costs

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

A. Allowable costs include all expense items that home health agencies incur in meeting:

1. The definition of a home health agency as described in 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 State Plan.

C. A proportion of costs incurred by a home health agency for services to an eligible Medicaid beneficiary for whom payments are received from third parties are not reimbursable under the State Plan. Appropriate adjustments shall be made.

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. 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 Attachment 4.19-B, Exhibit A, Section VI of the State Plan.

E. The Division of Medicaid shall maintain any responses received on the State Plan, subsequent changes to the State 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 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 Division of Medicaid. 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 Division of Medicaid. 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.

I. The prospectively determined individual home health agency's rate will be adjusted under the following circumstances:

1. Administrative errors on the part of the Division of Medicaid or the home health agencies that result in erroneous payments. Overpayments or underpayments resulting from errors will be corrected when discovered. Overpayments will be recouped by the Division of Medicaid 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 an adjustment shall be made retroactive to the date of the original rate. At the discretion of the Division of Medicaid, 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. Under no circumstances shall such adjustment exceed the class ceiling established for the respective classes.

6. The receipt of the final or amended final cost report from the Medicare intermediary.

7. 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, appliances and supplies related to the use of durable medical equipment are non-allowable costs since they are reimbursed outside of the home health agency visit rate.

IV. Rate Methodology

State of Mississippi

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

A. The Division of Medicaid will utilize a prospective rate of reimbursement and will not make retroactive adjustments except as specified in the State Plan. The prospective rates will be determined from cost reports and will be set on a yearly (October 1 -September 30) basis and will be applicable to all facilities with a valid provider agreement. Total payments per month for each home health beneficiary may not exceed the average Medicaid nursing facility rate per month as determined based on the nursing facility rates computed July 1 of each year. The average Medicaid Nursing Facility rates are posted on the Mississippi Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

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

B. Payments of medical supplies which are directly identifiable supplies furnished to individual beneficiaries 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, appliances and supplies are reimbursed as described In Section VIII, of the State Plan.

Prospective rates and ceilings will be established for the home health visits.

C. Trend Factor

In order to adjust costs for anticipated increases or decreases due to changes in the economy, a trend factor is computed using the Centers for Medicare and Medicaid Services (CMS) Home Health Market Baskets that are published in the Integrated Healthcare Strategies (IHS) Economic Healthcare Cost Review, or its successor, in the fourth (4^{th}) quarter of the previous calendar year, prior to the start of the rate period. The moving averages for the following market basket components are used: Wages and Salaries, Benefits, Utilities, Malpractice Insurance, Administrative Support, Financial Services, Medical Supplies, Rubber Products, Telephone, Postage, Other Services, Other Products, Transportation, Fixed Capital, and Movable Capital. Relative weights are obtained from the same period National Market Basket Price Proxies-Home Health Agency Operating Costs.

D. Rate Setting

1. 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:

(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;

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

(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 for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries 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 for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries 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 1through September30 (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

State of Mississippi

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

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, transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the agency. 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.

A home health agency which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the change of ownership. The new owner will be assigned the previous owner's rate. The Division of Medicaid will update the provider's information in the Medicaid Management Information System (MMIS).

The new owner, upon consummation of the transaction affecting 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 of Medicaid.

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 beneficiaries 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.

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 rural rate, if available, or the non-rural rate if there is no rural rate, on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year.

1. When it is determined by DOM, based on documentation, that the DMEPOS fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, then a fee will be calculated using market research from the area.

B. If there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid based on the lower of the Division of Medicaid's average/established fee or the average of the fees from other states, when available, or determine the fee from cost information from providers and/or manufacturers, survey information from national fee analyzers, or other relevant fee-related information. The fees will be updated every three (3) years effective July 1 of that third (3rd) year.

C. If there is no DMEPOS fee or a fee determined by the Division of Medicaid, the provider will be reimbursed a fee calculated through the following manual pricing:

1. Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%), or

2. If there is no MSRP, then the provider's invoice received from a wholesaler or manufacturer plus twenty percent (20%).

D. 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 or Medicaid established fee as described in letter A or B 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.

E. The payment for purchase of used DME is made from a statewide uniform fee schedule based on fifty percent (50%) of eighty percent (80%) of the Medicare DMEPOS or Medicaid established fee as described in letter A or B.

F. 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 or Medicaid established fee as described in letter A or B.

G. Any durable medical equipment not listed on the fee schedule may be requested for coverage by submitting documentation to the Division of Medicaid's UM/QIO who will determine medical necessity on a case-by-case basis.

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

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. The Division of Medicaid's fee schedule rate was set as of July 1, 2020, and is effective for services provided on or after that date. 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 shall reduce the rate of reimbursement to DME providers for any service by five percent (5%) of the allowed amount for that service. The 5% reduction has been in effect since July 1, 2002. The federal match will be paid based on the reduced amount.

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

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 rural rate, if available, or the non-rural rate if there is no rural rate, on the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year.

1. When it is determined by DOM, based on documentation, that the DMEPOS fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, then a fee will be calculated using market research from the area.

B. If there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid based on the lower of the Division of Medicaid's average/established fee or the average of the fees from other states, when available, or determine the fee from cost information from providers and/or manufacturers, survey information from national fee analyzers, or other relevant fee-related information. The fees will be updated every three (3) years effective July 1 of that third (3rd) year.

C. If there is no DMEPOS fee or a fee determined by the Division of Medicaid, the provider will be reimbursed a fee calculated through the following manual pricing:

1. Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%), or

2. If there is no MSRP, then the provider's invoice received from a wholesaler or manufacturer plus twenty percent (20%).

D. Any medical supplies not listed on the fee schedule may be requested for coverage by submitting documentation to the Division of Medicaid's UM/QIO who will determine medical necessity on a case-by-case basis.

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 medical supplies. The Division of Medicaid's fee schedule rate was set as of July 1, 2020, and is effective for services provided on or after that date. 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 shall reduce the rate of reimbursement to medical supply providers for any service by five percent (5%) of the allowed amount for that service. The 5% reduction has been in effect since July 1, 2002. The federal match will be paid based on the reduced amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 4.19-B
Supplement 1

State Mississippi

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.

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-
SUPERSEDES DATE/APPROVED 1-15-
TN No. New DATE/EFFECTIVE 10-1-

State of Mississippi

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

REIMBURSEMENT FOR INDIAN HEALTH SERVICES

AND TRIBAL 638 HEALTH FACILITIES

Services provided by or through facilities of the Indian Health Services (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act, also known as Tribal 638 facilities, are paid at the most current rates published in the Federal Register.

The most current published outpatient per visit rate, also known as the outpatient all-inclusive rate, is paid for up to five (5) outpatient visits per beneficiary per calendar day for professional services.

An outpatient visit is defined as a face-to-face or telemedicine contact between any health care professional, at or through the IHS facility as described above, authorized to provide services under the State Plan and a beneficiary for the provision of Title XIX defined services, as documented in the beneficiary's medical record.

To be included in the outpatient per visit rate are certain pharmaceutical/drugs, dental services, rehabilitative services, behavioral health services, any and all ancillary services, and emergency room services provided on-site and medical supplies incidental to the services provided to the beneficiary.