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

Hospital Outpatient Services

A. Outpatient hospital services for all hospitals except Indian Health Services and Rural hospitals that have fifty (50) or fewer licensed beds who opt to not be reimbursed using the prospective payment methodology will be reimbursed using the Medicaid Outpatient Prospective Payment System (OPPS), Ambulatory Payment Classification (APC) Groups effective as of July 1, 2021:

1. 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 effective July 1, 2021.

   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, 2021, 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, 2021, multiplied by the units (when applicable). No retroactive adjustments will be made. The MS Medicaid OPPS fee schedule is set as of July 1,2021 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 as of July 1, 2021 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 as of July 1, 2021 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, 2021 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, 2021 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.

3. Indian Health Services are reimbursed 100% of the annually published Federal Register Outpatient Hospital rate.

4. Rural Hospitals that have fifty (50) or fewer licensed beds who opt to not be reimbursed using the OPPS payment methodology will be reimbursed based on 101% of the rate established under Medicare effective as of July 1, 2021 for a two (2) year period.

B. Miscellaneous

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

1. Principles and Procedures

2. Availability of Hospital Records

3. Records of Related Organizations

4. Appeals and Sanctions.

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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~~ effective July 1, 2021 ~~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, 2021, ~~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, 2021 ~~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, 2021 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, 2021 and is effective for services provided on or after that date.

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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

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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, 2021 ~~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, 2021 ~~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.

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