

State of Mississippi

Title XIX Inpatient Hospital Reimbursement Plan

R. Long-term Ventilator-dependent Patients Admitted Prior to October 1, 2012

Payment for ventilator-dependent patients admitted to the hospital prior to October 1, 2012 will continue to be reimbursed on a per diem basis until they are discharged from the hospital, the per diem in effect in the preceding year will be increased by the percentage increase. For hospitals with these patients, for rate years beginning October 1, 2012, and thereafter of the most recent Medicare Inpatient Hospital PPS Market Basket Update as of October 1 of each year as published in the Federal Register. All patients admitted to a hospital on or after October 1, 2012 will be reimbursed under the APR-DRG methodology.

S. Post-Payment Review

All claims paid under the APR-DRG payment methodology are subject to post-payment review.

T. Payments Outside of the DRG Base Payment

The following payments are made outside of, and in addition to, the DRG base payment:

1. Long Acting Reversible Contraceptives (LARCs) and their insertion at the time of delivery will be reimbursed separately from the APR-DRG payment. A separate outpatient claim will be submitted by the hospital for reimbursement for LARCs and their insertion at the time of delivery. Reimbursement for the insertion of LARCs at the time of delivery will be based on the Physician Fee Schedule effective July 1, 2023, and updated annually as described in Attachment 4.19-B. The LARC will be reimbursed at the lesser of the provider's usual and customary charge or the fee listed on the Physician Administered Drugs and Implantable Drug System Devices Fee Schedule effective July 1, 2023, and updated quarterly as described in Attachment 4.19-B. All fees are published on the Division of Medicaid's website at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/>.
2. Effective January 1, 2025, select drugs provided in an inpatient hospital setting will be reimbursed separately from the APR-DRG payment. A separate claim will be submitted to receive reimbursement for select drugs during the time of inpatient services. These drugs will be reimbursed using the provider's invoice price. Invoice price must be the actual net price paid for the drug. The list of select drugs is maintained on the Division of Medicaid's website at <https://medicaid.ms.gov/pharmacy/>.

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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 rate 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 rate 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 rate, Medicare payment rate, or MS Medicaid fee for a procedure or service, or a device, drug, biological or imaging agent, or (2) when it is determined, based on documentation, that a procedure or service, or device, drug, biological or imaging agent reimbursement is insufficient for the Mississippi Medicaid

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

- e. Effective January 1, 2025, select drugs provided in an outpatient hospital setting will be reimbursed using the provider's invoice price. Invoice price must be the actual net price paid for the drug. The select drug list is maintained by the Division of Medicaid's Office of Pharmacy.
 - f. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services.
- 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 of each year 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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2. For a non-340B covered entity reimbursement for prescribed drugs is the lesser of the provider's total usual and customary charge or an ingredient cost as defined in the hierarchy below:
 - a. WAC minus ten percent (10%) plus a professional dispensing fee of \$0.02 per Unit. If there is no WAC available, then
 - b. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of \$0.02.

- 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 - F above, or
 2. As described in Attachment 4.19-B, pages 12a.3-12a.4.
- J. Prescribed drugs dispensed by Indian Health Services are reimbursed the current Federal Register encounter rate for outpatient hospital. Refer to Attachment 4.19-B, Supplement 3, Page 1.
- K. Effective January 1, 2025, select drugs provided in an inpatient hospital setting will be reimbursed separately from the APR-DRG payment. A separate claim will be submitted to receive reimbursement for select drugs during a time of inpatient services. These drugs will be reimbursed using the provider's invoice price. The invoice price must be the actual net price paid for the drug. The list of select drugs is maintained on the Division of Medicaid's website at <https://medicaid.ms.gov/pharmacy/>.

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.

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[Reserved]