Table of Contents

State/Territory Name: Mississippi

State Plan Amendment (SPA) #:13-004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

November 7, 2013

Dr. David J. Dzielak
Executive Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, Mississippi 39201-1399

Attention: Kristi Plotner

RE: Title XIX State Plan Amendment, MS 13-004

Dear Dr. Dzielak:

We have reviewed the proposed State Plan Amendment, MS 13-004, which was submitted to the Atlanta Regional Office on March 19, 2013. This amendment proposes to change reimbursement under the APC methodology ensuring access to care for all Medicaid beneficiaries:

1. Revises the payment methodology of chemotherapy and chemotherapy related drugs in the outpatient hospital setting. Chemotherapy and chemotherapy associated drugs billed on the same claim as the chemotherapy treatment will be paid a Medicaid fee calculated using the Medicare Average Sales Price (ASP) plus six percent (6%).

2. Clarifies observation is paid using a Mississippi Medicaid calculated fee.

3. Includes a manual pricing procedure in the payment hierarchy.

4. Changes reimbursement from ninety percent (90%) of Medicare to one-hundred percent (100%) of Medicare.

Based on the information provided, the Medicaid State Plan Amendment MS 13-004 was approved on November 7, 2013. The effective date of this amendment is January 1, 2013. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact CaLetha J. Henry at (404) 562-7506 or Caletha.Henry@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **2013-004**

2. STATE: **MS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR § 440.230

7. FEDERAL BUDGET IMPACT:
a. FFY **2013** **$14,556,226**
b. FFY **2014** **$19,408,301**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4 19-B Page 2a.2, 2a.3, 2a.4, 2a.5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4 19-B Page 2a.2, 2a.3, 2a.4, 2a.5

10. SUBJECT OF AMENDMENT:
Change reimbursement under the APC methodology ensuring access to care for all Medicaid beneficiaries: 1) revises the payment methodology of chemotherapy and chemotherapy related drugs, 2) clarifies observation is paid using a Mississippi Medicaid calculated fee, 3) includes a manual pricing procedure in the payment hierarchy, and 4) changes reimbursement from ninety percent (90%) of Medicare to one-hundred percent (100%) of Medicare.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: David J. Dzielak

14. TITLE: Executive Director

15. DATE SUBMITTED: March 19, 2013

16. RETURN TO:
David J. Dzielak
Miss. Division of Medicaid
Attn: Kristi Plotner
550 High Street, Suite 1000
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
03/19/13

18. DATE APPROVED: 11/14/13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/13

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:

Approved with the following change to item 8 as authorized by State Agency letter dated 05/31/13:

Block # 8 changed to read: Attachment 4.19-B pages 2a.2, 2a.3, 2a.4, 2a.5 and 12a.2.

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, status indicators, APC group assignments and Medicare fees), will be used by the Division of Medicaid (DOM) in calculating these predetermined rates and will be updated July 1 of each year.

   a. The Medicaid OPPS fees, including Clinical Diagnostic Laboratory OPPS fees, are calculated using 100% of the applicable APC relative weight or the payment rate for codes listed in the most current final Medicare outpatient Addendum B or C effective as of April 1st of each year as published by the Centers for Medicare and Medicaid Services (CMS). Codes with no applicable relative weight or payment rate in Addendum B or C are paid via a DOM published fee schedule based on 90% of the Medicare physician fee schedule or the Medicare Clinical Laboratory fee schedule of the current year. No retroactive adjustments will be made. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1st and is effective for services provided on or after that date. All fees are published on the agency's website at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

   b. The Medicaid conversion factor used by DOM is the current Jackson, MS Medicare conversion factor. This conversion factor is used for all APC groups and for all hospitals. Each APC rate equals the Medicare Addendum B specific relative weight at 100% multiplied by the Medicaid conversion factor, with the exception of observation fee which is paid 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 average relative weights for APC 8002 and APC 8003 multiplied by the current Jackson, MS Medicare conversion factor divided by the sixteen (16) maximum payable hours. Documentation requirements for medical necessity regarding observation services can be found in the MS Administrative Code Title 23 Medicaid, Part 202 Hospital Services, Chapter 2 Outpatient Hospital, Rule 2.4: Outpatient (23-Hour) Observation Services as of April 1, 2012, located at www.medicaid.ms.gov/AdminCode.aspx. 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 http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

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

2. Outpatient Payment Methodology Paid Under Medicaid OPPS

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

reimbursed as follows:

a. For each outpatient service or procedure, the fee is 100% of the current Ambulatory Payment Classification (APC) rate multiplied by the units (when applicable).

b. Where no APC relative weight has been assigned, outpatient services will be paid at 100% of any applicable Medicare payment rate in the most current final Medicare outpatient Addendum B or C as of April 1st of each year as published by the CMS multiplied by the units (when applicable).

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

d. If there is no APC relative weight, Medicare payment rate, or MS Medicaid fee for a procedure, service, or device, 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 payment will be limited to the cost of a comparable service or the provider submitted invoice.

3. Five Percent (5%) Reduction

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 published fee does not include the five percent (5%) reduction. This provision is not applicable to Indian Health Services.

B. Miscellaneous

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

1. Principles and Procedures (except the reimbursement period for hospital outpatient services runs from July 1 through June 30).
2. Availability of Hospital Records
3. Records of Related Organizations
4. Appeals and Sanctions.

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

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 fee.

b. The APC and the Medicare fees on the MS Medicaid OPPS fee schedule will be calculated based on the most recent final Medicare outpatient Addendum B and C published by the Centers for Medicare and Medicaid Services (CMS) as of April 1 of each year. The MS Medicaid OPPS fee schedule is effective July 1 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 specific fee. The MS Medicaid specific fee will be calculated using the Medicare Average Sales Price (ASP) plus six percent (6%) based on the most recent final Medicare ASP Drug Pricing Files published by CMS as of April 1 of each year. The MS Medicaid specific fee is effective July 1 with no retroactive adjustments.

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

e. All fees are published on the agency's website at www.medicaid.ms.gov/FeeScheduleLists.aspx.