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State/Territory Name: Mississippi

State Plan Amendment (SPA) #: 19-0013

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Atlanta Regional Operations Group

August 14, 2019

Mr. Drew Snyder, Executive Director
Mississippi Division of Medicaid
Attention: Margaret Wilson
550 High Street, Suite 1000
Jackson, MS 39201-1399

Re: Mississippi State Plan Amendment, Transmittal # 19-0013

Dear Mr. Snyder:

We have reviewed the proposed Mississippi State Plan Amendment 19-0013, which was submitted to the Atlanta Regional Office on July 11, 2019. The SPA was submitted to update hospital outpatient reimbursement.

Based on the information provided, the Medicaid State Plan Amendment MS-19-0013 was approved on August 14, 2019. The effective date of this amendment is July 1, 2019. We are enclosing the approved CMS-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Tandra Hodges at 404-562-7409 or by email at Tandra.Hodges@cms.hhs.gov or Shelia Brady at 601-212-4659 or by email at Sheila.Brady@cms.hhs.gov.

Sincerely,

/s/

Shantrina D. Roberts, MSN
Deputy Director
Division of Medicaid Field Operations South

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: **19-0013**	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 **07/01/2019**	

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 §§ 447.201, 447.203.**	7. FEDERAL BUDGET IMPACT: FFY 2019: **$(563,794)** FFY 2020: **$(1,701,444)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 3.1-A Exhibit 10, Page 1** **Attachment 4.19-B Pages 1a.1, 2a.2, 2a.3, 2a.4, 12a.2**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 3.1-A Exhibit 10, Page 1** **Attachment 4.19-B Pages 1a.1, 2a.2, 2a.3, 2a.4,12a.2** **Attachment 4.19-B Page 2a.6 (delete)**

10. SUBJECT OF AMENDMENT:

State Plan Amendment (SPA) 19-0013 Outpatient Prospective Payment System (OPPS) Reimbursement is being submitted to update hospital outpatient reimbursement as follows, effective July 1, 2019: 1) Remove specific diagnosis codes related to Never Events and refer to the diagnosis code descriptions, 2) Use the Medicare outpatient Addendum B as of January 1 of each year as published by CMS to calculate the Medicaid OPPS fee, 3) Apply the multiple discounting policy to dental procedures billed on the hospital outpatient claim to price the highest allowed dental procedure at one hundred percent (100%) of the allowed amount or published fee and price all subsequent dental procedures at twenty-five percent (25%) of the allowed amount or published fee, and 4) Require prior authorization on all dental procedures performed in the outpatient hospital setting.

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: /s/	16. RETURN TO: **Drew L. Snyder** **Miss. Division of Medicaid** **Attn: Margaret Wilson** **550 High Street, Suite 1000** **Jackson, MS 39201-1399**
13. TYPED NAME: **Drew L. Snyder**	
14. TITLE: **Executive Director**	
15. DATE SUBMITTED: 7/11/2019	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 07/11/19	18. DATE APPROVED:08/14/19
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/19	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Shantrina D. Roberts	22. TITLE: Deputy Director Division of Medicaid Field Operation South

23. REMARKS:

10. Dental Services

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

The Division of Medicaid covers medically necessary dental services for non-Early and Period Screening, Diagnostic and Treatment (EPSDT)-eligible beneficiaries that:

a) Are an adjunct to treatment of an acute medical or surgical condition,

b) Include services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone, and

c) Include emergency dental extractions and treatment.

The Division of Medicaid covers medically necessary dental services for EPSDT-eligible beneficiaries including:

a) Diagnostic,

b) Preventive,

c) Therapeutic,

d) Emergency, and

e) Orthodontic.

Dental Benefit Limits:
For dates of service beginning July l, 2007, dental services (except orthodontia) are limited to $2,500 per beneficiary per fiscal year. Additional dental services in excess of the $2,500 annual limit may be provided with prior authorization from the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO.

Orthodontic Services:
Orthodontic services are covered when medically necessary and prior authorized by the Division of Medicaid or designated entity for EPSDT-eligible beneficiaries. Orthodontia-related services are limited to $4,200 per beneficiary per lifetime. Additional dental services in excess of the $4,200 lifetime limit may be provided with prior authorization from the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO.

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

Hospital Outpatient Drugs

a. Drugs paid outside the Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC) rate will be reimbursed by a Medicare fee. If there is no Medicare fee the drug will be reimbursed using a MS Medicaid OPPS Chemotherapy fee.

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

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

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

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

State of Mississippi
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.

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