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State/Territory Name: Mississippi

State Plan Amendment (SPA) #:15-0011

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

May 12, 2016

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

RE: Title XIX State Plan Amendment, MS 15-0011

Dear Dr. Dzielak:

We have reviewed the proposed Mississippi State Plan Amendment 15-0011, which was submitted to the Atlanta Regional Office on September 30, 2015. The SPA was submitted to allow the Mississippi Division of Medicaid to implement discounts of claims with more than (1) one significant procedure and compute a Mississippi Medicaid fee when a procedure's Ambulatory Payment Classification (APC) rate, including all of its bundled services, is determined to be insufficient for the Mississippi Medicaid population, effective July 1, 2015.

Based on the information provided, the Medicaid State Plan Amendment MS 15-0011 was approved on May 12, 2016. The effective date of this amendment is July 1, 2015. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact at Shelia Brady at (601) 965-4056 or by email at Sheila.Brady@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: **15-011**

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
7/1/2015

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 C.F.R. § 447.201, 447.203.

7. FEDERAL BUDGET IMPACT:
FY 2015: $312,024.00

FY 2016: $1,248,096.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Pages 2a.2, 2a.3, 2a.4, 2a.5, 2a.6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Pages 2a.2, 2a.3, 2a.4, 2a.5, 2a.6

10. SUBJECT OF AMENDMENT:
State Plan Amendment (SPA) 15-011 Outpatient Prospective Payment System (OPPS) Phase II is being submitted to allow the Division of Medicaid to implement discounts of claims with more than one (1) significant procedure and compute a Mississippi Medicaid fee when a procedure's Ambulatory Payment Classification (APC) rate, including all of its bundled services, is determined to be insufficient for the Mississippi Medicaid population, effective July 1, 2015.

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/

13. TYPED NAME: **David J. Dzielak**

14. TITLE: **Executive Director**

15. DATE SUBMITTED: 9/30/2015

16. RETURN TO:

David J. Dzielak
Miss. Division of Medicaid
Attn: Margaret Wilson
550 High Street, Suite 1000
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
09/30/15

18. DATE APPROVED: 05/12/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/15

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

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

23. REMARKS:

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 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 relative weight for APC 8009 multiplied by the current Jackson, MS Medicare conversion factor divided by the twenty-three (23) 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. A MS Medicaid OPPS status indicator is assigned to each procedure code determining payment under Medicaid OPPS. The full list of MS Medicaid OPPS status indicators and definitions is found on Attachment 4.19-B, page 2a.6.

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 paid at one hundred percent (100%). 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 paid at fifty percent (50%).

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 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 (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. 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
2. Availability of Hospital Records
3. Records of Related Organizations
4. Appeals and Sanctions.

MS MEDICAID OPPS STATUS INDICATORS

Status Indicator	MS Medicaid Definition
A, B, M	Miscellaneous codes priced by a Medicaid fee
C	Inpatient only services
D	Discontinued code
E	Non-covered code
G, K	Drugs & biologicals priced by a Medicare fee
M1	Mississippi Medicaid Specific Fee
N	Service is bundled into an APC (If all codes are N on a claim, the claim pays zero)
R	Blood products priced by a Medicare fee
S	Significant procedure priced by APC that the multiple procedure discount DOES NOT apply
T	Significant procedure priced by APC that the multiple procedure discount DOES apply
MT	MS Medicaid discounted services not covered under Medicare OPPS
U	Brachytherapy
V	Medical visits in the clinic, critical care or emergency department (includes codes for direct admits)
X	Ancillary services paid by APC