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State/Territory Name: Mississippi

State Plan Amendment (SPA) #:15-0018

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500Security Boulevard, Mail Stop 52-26-12
Baltimore, Maryland 21244-1850

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

Financial Management Group

MAR 08 2016

David J. Dzielak PH.D.
Executive Director
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201

Re: Mississippi State Plan Amendment 15-0018

Dear Dr. Dzielak:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-0018. Effective December 1, 2015 this amendment proposes to modify the state's reimbursement methodology. Specifically, this amendment proposes to remove language in the state plan that states the Medicaid agency is responsible for the payment of transplant services for beneficiaries enrolled in a Coordinated Care Organization. The state has transitioned inpatient services to the Mississippi Coordinated Access Network and as a result, the responsibility for payment would be under the managed care organizations.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of December 1, 2015. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Anna Dubois at (850) 878-0916.

Sincerely,

//s//

Kristin Fan
Director

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: **15-018**	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 **12/1/2015**	

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: SSA § 1932(a)(1); 42 CFR § 438.50(c).	7. FEDERAL BUDGET IMPACT: FY 2015: Included in the submittal of SPA 15-010 MSCAN. FY 2016: Included in the submittal of SPA 15-010 MSCAN.
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Page 31, 32, 33, and 72	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A, Page 31, 32, 33, and 72

10. SUBJECT OF AMENDMENT:

State Plan Amendment (SPA) 15-018 Transplants is being submitted to remove language that the Division of Medicaid is responsible for payment of inpatient transplant services for beneficiaries enrolled in a Coordinated Care Organization (CCO) effective December 1, 2015. The submittal of SPA 15-010 MSCAN removes inpatient hospital services from the excluded list of MSCAN services to comply with Miss. Code Ann. § 43-13-117(A)(18)(b)-(c), effective December 1, 2015. SPA 15-018 Transplants requires the CCOs to be responsible for reimbursement of transplant services received in the inpatient setting for those beneficiaries who are enrolled in a CCO.

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: **David J. Dzielak** **Miss. Division of Medicaid** **Attn: Margaret Wilson** **550 High Street, Suite 1000** **Jackson, MS 39201-1399**
13. TYPED NAME: **David J. Dzielak**	
14. TITLE: **Executive Director**	
15. DATE SUBMITTED: **12/29/2015**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/29/15	18. DATE APPROVED: 03/08/16
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 12/01/15	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS: Approved with following changes to block # 8 and 9 as authorized by state agency.

Block # 8 changed to read: Attachment 4.19-A, pages 31, 32, and 68.

Block # 9 changed to read: Attachment 4.19-A, pages 31, 32, and 68.

out-of-state hospital are set annually using the Federal Register that applies to the federal fiscal year beginning October 1 of each year, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

B. Payment for transplant services is made under the Mississippi APR-DRG payment methodology including a policy adjustor. (Refer to Appendix A.) If access to quality services is unavailable under the Mississippi APR-DRG payment methodology, a case rate may be set.

1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the most current *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion.*

2. The *Milliman* categories comprising the sum of billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) discharge. Outpatient immune-suppressants and other prescriptions are not included in the case rate. (Refer to Appendix B.)

State of Mississippi

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

3. If the transplant stay exceeds the hospital length of stay published by *Milliman*, an outlier per-diem payment will be made for each day that exceeds the hospital length of stay. The outlier per-diem payment is calculated by taking the difference between the sum of *Milliman's* total average billed charges including thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) discharge and the case rate, divided by the maximum outlier days. The outlier per-diem is added to the case rate for each day that exceeds the hospital length of stay. (Refer to Appendix B.)
4. Total reimbursement of transplant services cannot exceed one-hundred percent (100%) of the sum of average billed charges for the categories listed in B.2.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

5. Contracts for transplant services negotiated prior to October 1, 2012, are honored through the term of the contract.

6. For transplant services not available in Mississippi and not listed in the most current *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion*, the Division of Medicaid will make payment using the Mississippi APR-DRG payment methodology. If Mississippi APR-DRG payment impacts access to care, the Division will reimburse what the domicile state pays for the service.

C. For specialized services not available in Mississippi, the Division of Medicaid will make payment based on Mississippi APR-DRG payment methodology. If Mississippi APR-DRG payment affects access to care, the Division will reimburse what the domicile state pays for the service or a comparable payment other states reimburse under APR-DRG.

State of Mississippi
Title XIX Inpatient Hospital Reimbursement Plan

Appendix B

Out-of-State Hospital Transplant Services' Case Rates Effective October 1, 2012

Column	A	B	C	D	E	F	G	H	I	J	K
Transplant	30 Days Pre-Transplant Average Billed Charges	Procurement Average Billed Charges	Hospital Transplant Admission Average Billed Charges	Physician During Transplant Average Billed Charges	180 Days Post Transplant Discharge Average Billed Charges	Total Average Billed Charges* Sum of A through E	Case Rate F X 40%	Difference of F - G	Max Outlier Days	Hospital Length of Stay	Outlier Per-Diem H ÷ I
Single Organ/Tissue											
Bone Marrow Allogeneic	$41,400	$38,900	$419,600	$22,400	$259,800	$782,100	$312,840	$469,260	60	33	$7,821
Bone Marrow Autologous	44,600	18,200	198,200	10,800	84,900	356,700	142,680	214,020	60	20	3,567
Cornea	0	0	16,500	7,900	0	24,400	9,760	14,640	60		244
Heart	47,200	80,400	634,300	67,700	137,800	967,400	386,960	580,440	60	40	9,674
Intestine	55,100	78,500	787,900	104,100	146,600	1,172,200	468,880	703,320	120	70	5,861
Kidney	17,000	67,200	91,200	18,500	50,800	244,700	97,880	146,820	30	7	4,894
Liver	25,400	71,000	316,900	46,600	93,900	553,800	221,520	332,280	60	21	5,538
Lung - Single	10,300	73,100	302,900	33,500	117,700	537,500	215,000	322,500	60	19	5,375
Lung - Double	21,400	90,300	458,500	56,300	142,600	769,100	307,640	461,460	60	30	7,691
Multiple Organ											
Heart-Lung	56,800	130,500	777,700	81,000	169,100	1,215,100	486,040	729,060	120	45	6,076
Intestine with other Organs	57,900	172,700	795,900	116,300	160,900	1,303,700	521,480	782,220	120		6,518
Kidney- Heart	48,800	123,600	813,000	93,900	184,800	1,264,100	505,640	758,460	120	47	6,321
Kidney-Pancreas	20,800	102,500	194,900	34,700	100,400	453,300	181,320	271,980	60	12	4,533
Liver-Kidney	46,800	117,500	574,100	83,100	180,100	1,001,600	400,640	600,960	60	28	10,016
Other Multi-Organ	75,400	131,000	1,050,100	139,500	278,600	1,674,600	669,840	1,004,760	120		8,373

* Total reimbursement cannot exceed one-hundred percent (100%) of the sum of billed charges as published by Milliman in columns A-E.