

Division of Medicaid State of Mississippi Provider Policy Manual	New: <input checked="" type="checkbox"/> Revised: <input checked="" type="checkbox"/> Current:	Date: 04/01/08 Date: 08/06/08
Section: Benefits	Section: 2.05 Pages: 1	Cross Reference:
Subject: Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles		

Under provisions of the Balanced Budget Act of 1997, a state is not required to pay for any expenses related to payment for deductibles, coinsurance, or co-payments for Medicare cost sharing for dually eligibles that exceed what the state's Medicaid program would have paid for such service for a beneficiary who is not a dually eligible. When a state's payment for Medicare cost-sharing for a dually eligible is reduced or eliminated, the Medicare payment plus the state's Medicaid payment is considered payment in full, and the dually eligible cannot be billed the difference between the provider's charge and the Medicare and Medicaid payment.

The Medicaid reimbursement for Medicare ~~Part A~~ crossover claims for dually eligible beneficiaries is restructured as follows:

- (1) The Medicaid reimbursement combined with the Medicare reimbursement will not exceed what the Mississippi Medicaid program would have paid for such service for a beneficiary who is not dually eligible;
- (2) All service limits will be applied to beneficiaries who are dually eligible when reimbursement is made toward covered services with service limits. Once the service limits are reached each state fiscal year, no additional payments will be made for these services.
- (3) All providers must accept the Medicare and Medicaid payment as payment in full. The provider is prohibited from billing the beneficiary the balance between the provider's charge and Medicare and Medicaid payments.

This reimbursement methodology became effective for Medicare part A crossover claims on April 1, 2008. The effective date for Medicare Part B crossover claims is August 6, 2008.

Laboratory and Radiology Services

All outpatient laboratory services shall be reimbursed on a fee-for-service basis.
All outpatient radiology services shall be reimbursed on a fee-for-service basis.

Hospital-Based Clinics

Hospital-based clinics may not bill facility fees on the UB-92 unless they are a teaching hospital with a resident-to-bed ratio of .25 or greater.

Medicaid Upper Payment Limit

In addition to the reimbursement methodology described above, hospitals located within Mississippi may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each specified class of hospital (State government-owned or operated facilities, non-State government-owned or operated facilities, and privately owned and operated facilities), the amount that Medicare would have paid for the previous year will be calculated and compared to the payments actually made by Medicaid during that same time period. This calculation may then be used to make payments for the current year to hospitals eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. Up to 100 percent of the difference between Medicaid payments and what Medicare would have paid may be paid to State government-owned or operated facilities, non-State government-owned or operated facilities, and privately owned and operated facilities, in accordance with applicable State and Federal laws and regulations, including any provision specified in appropriations by the Mississippi Legislature. This provision will sunset as of December 31, 2007. ~~Any payment made under this provision will be made bi-monthly.~~

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. Effective August 6, 2008, the Division of Medicaid shall reduce the rate of reimbursement to all hospital providers, with the exception of state owned and operated and Medicare designated critical access hospitals, for any service by an additional thirty-three and one-half percent (33.5%) of the allowed amount for that service. Hospitals that are owned and operated by the State of Mississippi (State hospitals) and hospitals designated as critical access hospitals (CAHs) by Medicare will not be subject to the reimbursement reductions described above. These facilities will be paid based on 100% of allowable costs. State hospitals and CAHs may request that the outpatient rate be adjusted during the year based on changes in their costs. After the State hospital and CAH files their cost report during the rate year, total outpatient payments for each cost report period will be adjusted to the actual allowable cost for that period.

 TN NO 2005-013

Supersedes

TN NO 2002-22

Date Received _____

Date Approved _____

Date Effective August 6, 2008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPIMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CAREOutpatient Hospital Services –Prior to October 1, 2008

~~Outpatient hospital services shall be reimbursed at a percentage of billed charges unless specified differently elsewhere in this Plan. The percentage paid is the lower of 75% of charges or the cost to charge ratio, as computed by Medicaid using the hospital's cost report. The cost to charge ratio shall be computed each year for use in the following rate year's payments. Adjustments to outpatient services claims may be made if the cost to charge ratio is adjusted as a result of an amended cost report, audit, or Medicare settlement. The cost to charge ratio for outpatient services will be computed under Title XVIII (Medicare) methodology, excluding bad debts and other services paid by Medicaid under a different rate methodology (i.e., Rural Health Clinic services and Federally Qualified Health Center services). Out of state hospitals shall be reimbursed at the lower of 75% of charges or the average cost to charge ratio of hospitals located in Mississippi for their classification, as computed by Medicaid.~~

Outpatient Hospital Services –Effective Beginning October 1, 2008

Outpatient hospital services shall be reimbursed on a prospective basis at a percentage of billed charges unless specified differently elsewhere in this Plan. The percentage paid is equal to the Medicaid cost to charge ratio, as computed by Medicaid, based on the hospital's Medicare cost report, using the attached protocol. The percentage paid will be computed annually, unless this plan requires a rate being calculated at another time, for the period October 1 through September 30. Cost reports used to calculate the percentage will be the cost report filed by the provider for a cost reporting period ending in the preceding calendar year. For example, the percentage effective October 1, 2008, will be based on the most recent cost report filed with a reporting year end as of or prior to December 31, 2007, unless a short period cost report is required for a new provider.

Percentages for new providers, including changes of ownership, will be set at the average outpatient percentage of hospitals located in Mississippi, as determined by the Division. The outpatient percentage computed based on the hospital's initial Medicare cost report, using the attached protocol, will be effective retroactive to the effective date of enrollment.

Out-of-state hospitals shall be reimbursed at the average outpatient reimbursement rate of hospitals located in Mississippi, as determined by the Division.

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II. Cost Findings and Cost Reporting – For Rate Years Prior to October 1, 2005

A. Each Mississippi hospital participating in the Mississippi Medicaid Hospital program will submit a Uniform Cost Report using the appropriate Medicare/Medicaid forms postmarked no later than five (5) calendar months after the close of its cost reporting year. No routine extensions will be granted. All other filing requirements shall be the same as those for Title XVIII. Extraordinary circumstances will be considered on a case-by-case basis. One (1) complete copy of the cost report shall be submitted to the Division of Medicaid (DOM). The cost reports for periods ending in the prior calendar year will be used to calculate the per diem rates for the following October 1 – September 30 fiscal year. For example, the cost report of a hospital with a June 30, 1996 year end would be used to set the rate effective October 1, 1997 through September 30, 1998.

B. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII.

C. Cost reports used to initiate this plan will be for reporting periods beginning April 1, 1980, or earlier.

D. All hospitals are required to detail their cost reports for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals must adhere to all requirements of Section 25, Provider Policy Manual.

TN NO 2008-008

Supersedes

TN NO 2005-012

Date Received _____

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Date Effective 8/6/08

~~For rate years beginning October 1, 2006, and thereafter, the prospective rate for the immediately preceding rate year will be increased by the percentage increase of the then most recently published Inpatient Hospital PPS Market Basket Update. Facility per diem shall be trended forward in this manner annually until such time as a new methodology is adopted by the Division or for five rate years beginning October 1, 2005, whichever comes first. If no new methodology has been adopted by the end of the fifth rate year of trending, hospital inpatient reimbursement rates will be rebased using the cost reporting methodology employed prior to October 1, 2005, and every five years thereafter.~~

B. ~~Subsequent Adjustment~~

~~The base year payments effective October 1, 2005 will not be adjusted when fiscal year 2004 and fiscal year 2005 rates are amended due to final settlement cost reports. Rates determined under this methodology will be subject to subsequent adjustment only in cases of error or omission, as determined by the Division, affecting the base year(s) or for adjustments made to include or exclude the low DSH component, as appropriate, based on changes in low DSH eligibility.~~

C. ~~Class of Facilities~~

~~The statewide classes of facilities shall be the same as specified in Section VII, Paragraph C of this Attachment 4.19 A.~~

D. ~~Upper Payment Limit~~

~~In addition to the Medicaid prospective rate described above, hospitals located within Mississippi may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit, as described in Section VIII of this Attachment 4.19 A.~~

E. ~~Requests for Rate Change~~

~~A hospital may appeal its prospective reimbursement rate to the Division of Medicaid whenever there is a significant, documented change in the overall cost of providing services. Requests for changes in the prospective rates will be reviewed when a provider can demonstrate that allowable Medicaid expenses per patient day have increased by 5% or more as compared to allowable Medicaid expenses per patient day reported in the most recently filed cost report; however, requests which do not result in a rate change of at least 5% more than the current rate will not be granted. The request must be submitted in writing to the Division of Medicaid, clearly identifying the grounds of the appeal and the dollar amount in question. Copies of documenting support for the appeal must be included. Facilities should make every effort possible to ensure that requests which do not meet the criteria are not submitted.~~

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Mississippi Title XIX Inpatient Hospital
Reimbursement Plan

Payment Methodology for Rate Years Beginning August 6, 2008

- A. Notwithstanding any other provision of this section, the Division of Medicaid shall recalculate hospital inpatient per diem rates for all providers, except for state owned and operated and Medicare designated critical access hospitals. Existing hospital inpatient per diem base rates shall be multiplied by an adjustment factor specified in subsection B of this section.
- B. Effective August 1, 2008, the adjustment factor for all providers, except state owned and operated and Medicare designated critical access hospitals, shall be .665.
- C. Hospitals that are owned and operated by the State of Mississippi (State hospitals) and hospitals designated as critical access hospitals (CAHs) by Medicare will not be subject to the rebasing of inpatient per diem rates described above. These facilities will be paid based on 100% of allowable costs. State hospitals and CAHs may request that the per diem rate be adjusted during the year based on changes in their costs. After the State hospital and CAH files their cost report during the rate year, the per diem rate for each cost report period will be adjusted to the actual allowable cost for that period.

I. Payment Methodology for Rate Years Beginning ~~October 1, 2005~~

A. ~~Prospective Rate~~

~~The Division of Medicaid will set hospital inpatient reimbursement rates prospectively on an annual (October 1 – September 30) basis. For the rate year beginning October 1, 2005, the rate shall be based upon the greater of (1) the facility's most recent inpatient per diem rate for FFY 2005, or (2) the average of the facility's most recent inpatient per diem rates for FFY 2004 and 2005. The resulting base amount will then be increased by the percentage increase of the most recent Inpatient Hospital PPS Market Basket Update as published in the Federal Register. The base rate will not be recalculated for any subsequent changes that occur in the FFY 2004 or 2005 inpatient per diem rates, except for adjustments made to include or exclude the low DSH component, as appropriate, based on changes in low DSH eligibility.~~

~~A base rate will be established for hospitals that open or change ownership on or after October 1, 2005. The base rate will be set using the hospital's initial cost report and rate setting procedures in place prior to October 1, 2005. The fiscal year 2005 class ceilings will be trended using the percentage increase of the most recent Inpatient Hospital PPS Market Basket Update as published in the Federal Register to establish class ceilings for those rates.~~

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H. Total Base Rate

The annual base rate is the sum of the standard direct care per diem rate, the care related per diem rate, the administrative and operating per diem rate, the per diem property payment, the per diem hold harmless payment, and the per diem return on equity payment. The annual base rate for PNFSD's also includes the therapy per diem rate.

I. Calculation of the Rate for One Provider

In years when the rate is calculated for only one PNFSD, reimbursement will be based upon allowable reported costs of the facility. Reimbursement for direct care, therapies, care related, and administrative and operating costs will be calculated at cost plus the applicable trend factors. Reimbursement for administrative and operating costs will be subject to the ceiling for the facility as described in Section 3-4 E. The property payment and the return on equity payment will be calculated for the facility as described in Sections 3-4 F and G.

J. Total Rate for Nursing Facilities

Calculate the sum of the standard direct care per diem rate, as case mix adjusted by multiplying by each facility's average case mix for the second preceding quarter; the care related per diem rate; the administrative and operating rate; the per diem property payment; the per diem hold harmless payment; and the per diem return on equity payment. Reduce the sum by six and one-tenth percent (6.1%). The net per diem is the total rate used to reimburse each nursing facility.

3-5 Occupancy Allowance

The fixed per diem costs for administrative and operating costs and for property will be calculated using the greater of the facility's actual occupancy level or eighty percent (80%). This level is considered to be the minimum occupancy level for economic and efficient operation.

For facilities having less than eighty percent (80%) occupancy, the number of total patient days will be computed on an eighty percent (80%) factor instead of a lower actual percentage of occupancy. This will not apply to the computation of patient days used in computing the direct care and therapy rates. For example: a facility with an occupancy level of seventy percent (70%) representing 20,000 actual patient days in a reporting period will have to adjust this figure to 22,857 patient days ((22,000 / 70%)

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Chapter or
Section
Number

	<u>Subject</u>	<u>Page</u>
	A. Submission of MDS Forms	83
	B. Assessments Used to Compute a Facility's Average Case Mix Score	84
	C. Audits of the MDS	85
	D. Roster Reports and Bed Hold Reports	86
	E. MDS+ Forms Which Can Not Be Classified	88
	F. Failure to Submit MDS Forms	88
3-3	Resident Classification System	89
3-4	Computation of Per Diem Rate for Nursing Facilities	98
	A. Direct Care Base Rate and Care Related Rate Determination	99
	B. Direct Care Access and Quality Incentives	107
	C. Case Mix Adjusted Per Diem Rate	108
	D. Therapy Rate for PNFSD	109
	E. Administrative and Operating Rate	110
	F. Property Payment	112
	G. Return on Equity Payment	129
	H. Total Base Rate	132
	I. Calculation of the Rate for One Provider	132
	J. Total Rate for Nursing Facilities	132
3-5	Occupancy Allowance	132
3-6	State Owned NF's	133
3-7	Adjustments to the Rate for Changes in Law	133
3-8	Upper Payment Limit	133

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

Independent Laboratory and X-Ray Services

Payment is made from a statewide uniform fee schedule based on 70 percent of the Medicare fee schedule with adjustments as authorized by the state Legislature.

Independent laboratory and x-ray services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

~~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.~~

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

A home health agency which undergoes a change of ownership must notify the DOM in writing of the effective date of the sale. The seller's provider number will be closed and a new provider number assigned to the new owner after the new owner submits the provider enrollment information required under DOM policy. The new owner is not allowed to use the provider number of the old owner to file claims for reimbursement.

The new owner will be reimbursed at the previous owner's rate until the rate is adjusted based on the new owner's initial cost report. This adjusted rate will be effective retroactive to the date of the change of ownership. A prospective rate will also be determined based on this cost report.

The new owner, upon consummation of the transaction effecting the change of ownership, shall as a condition of participation, assume liability, jointly and severally, with the prior owner for any and all amounts that may be due or become due to the Medicaid program, and such amounts may be withheld from the payment of claims submitted when determined. However, the new owner shall not be construed as relieving the prior owner of his liability to the Division.

2. New Home Health Agencies

When new providers are established that are not changes of ownership, the provider shall be reimbursed at the maximum rate for each type of home health visit pending the receipt of the initial cost report. After receipt of the initial cost report, a rate will be determined that is retroactive to the date of the establishment of the provider.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

VI. Provider Participation

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of home health agencies in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public. Providers must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and meet all applicable state laws and requirements.

VII. Payment in Full

Participation in the program shall be limited to home health agencies who accept, as payment in full, the amount paid in accordance with the State Plan.

~~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.~~

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

Transportation- Ambulance Services – The reimbursement methodology for ambulance services is a statewide fee schedule. Payment is made from a statewide uniform fee schedule based on 70 percent of the rate established under Medicare (Title SVIII of the Social Security Act), as amended.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

~~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.~~

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State of Mississippi

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

24a. Transportation – The State Agency will assure necessary transportation of recipients to and from providers of services through the following methods:

Ambulance Services – The reimbursement methodology for ambulance services is a statewide fee schedule. Payment is made from a statewide uniform fee schedule based on 70 percent of the rate established under Medicare (Title XVIII of the Social Security act), as amended.

Transportation for EPSDT beneficiaries, if medically necessary, which exceed the limitations and scope for Medicaid beneficiaries, as covered in the Plan, are reimbursed according to the methodology in the above paragraph.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

~~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.~~

~~Non-emergency Transportation Services—Costs for non-emergency transportation services are reimbursed per the 1915(b)(4) Initial Selective Contracting Waiver for the NET program, entitled "the Mississippi Medicaid Non-emergency Transportation (NET) Waiver."~~

~~The state is divided into NET service regions. Each region is served by a primary group provider. Group providers are for-profit and not-for-profit, public or private entities that are selected through a competitive bid process. The Division of Medicaid issues a Request for Bids (RFB) through which qualified bidders submit bids to provide NET assistance in the NET service regions. The successful bidder (primary provider) is selected for each region by the Division of Medicaid through a bid evaluation process that is published as part of the RFB. Bidders include in their price components a flat rate per one-way transport. The Division of Medicaid pays the successful bidder in each region the rate included in the winning bid for that region. This rate is paid per one-way transport, regardless of the length of the transport or the type of vehicle required (ambulatory or lift), and regardless of the number of transports. The Division of Medicaid may utilize an alternate group provider on a temporary basis when the primary provider cannot provide a requested service (for example, when a beneficiary requires a lift vehicle and the primary provider is operating lift vehicles at capacity).~~

~~When the Division of Medicaid utilizes individual providers, these providers are paid by the mile. The rate paid is equal to the rate paid to state employees who travel on official business; however, the Division reserves the right to change the rate at any time upon notification to the provider. The Division will review the individual provider rate on an annual basis. The review will ensure that current rates cover at least the average operating costs as determined by an analysis of cost data, not to exceed the rate paid to state employees. Upon changes to the rate, providers will be notified.~~

~~When the Division of Medicaid utilizes public transit providers, these providers are paid at the usual and customary rate charged to the general public for similar services. Billing units may include one-way rates, daily transit or monthly transit passes.~~

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MEDICAL ASSISTANCE PROGRAM
State of Mississippi

- The percentile and percentage reduction will be determined by adjusting the allowed fee for each dental procedure code so that expected expenditures will equal approximately the total expenditures plus a ten percent increase over the state's share for the previous fiscal year.

The state will publish the annual percentile and annual percentage amount of the reduction for dental fees on the DOM web site at www.dom.state.ms.us. The dental fee schedule will be posted on the DOM web site and the fiscal agent web portal for providers.

Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services.

Dental services for EPSDT beneficiaries (beneficiaries under age twenty-one (21)) which exceed the limitations and scope for Medicaid beneficiaries as covered in this Plan are reimbursed according to the methodology in the above paragraphs, if medically necessary.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

~~Dental Services -Payment is from a statewide fixed fee schedule. Effective July 1, 1999, all fees will be increased to 160% of the amount of the reimbursement rate that was in effect on June 30, 1999.~~

~~Dental services for EPSDT beneficiaries, if medically necessary, which exceed the limitations and scope for Medicaid beneficiaries, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.~~

~~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.~~

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MEDICAL ASSISTANCE PROGRAM

State of Mississippi

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

Dental Services –Effective for dates of service beginning July 1, 2007, the fee schedule shall provide for a fee for each dental service that is equal to a percentile of normal and customary private provider fees, as defined by the Ingenix[®] Customized Fee Analyzer Report, which percentile shall be determined by the Division. The fee schedule shall be reviewed annually by the Division, and dental fees shall be adjusted each July based on service utilization data for the previous fiscal year, an updated Ingenix[®] Customized Fee Analyzer Report, and state budgeted amounts in order to meet requirements for a balanced budget. Dental providers will be reimbursed the provider's charge or the allowed fee for the procedure, whichever is less.

The Ingenix[®] Customized Fee Analyzer Report is a commercially available product produced by Ingenix[®], a health care industry information company located at 2525 Lake Park Boulevard, West Valley City, Utah 84120. The Ingenix[®] Dental Customized Fee Analyzer Report is compiled by the company through collecting charge data from insurance payer clients across the country. The Report then organizes the data into percentiles – 50th, 60th, 75th, 80th, and 95th. A fee at the 50th percentile indicates that 50 percent of submitted charges for that service in the database are equal to or higher than the fee listed. The Report is also customized by arraying the data by geozips. Comparing a fee or charge in the Report indicates how that amount stands in relation to fees from other providers in the geozip area.

Use of the Ingenix[®] Customized Fee Analyzer Report is intended to provide a benchmark for dental charges in Mississippi in order to set fair and reasonable fees for dental services. Mississippi Medicaid purchased the Report for geozip 392xx, which includes the Hinds and Rankin County areas that constitute the largest metropolitan area in the state and the largest number of dental providers. All dental fees will be set based on this Report and dentists statewide would be reimbursed using the same fee methodology.

The state will use the following process to determine the percentile and percentage reduction on an annual basis:

- The annual fee determination will be done each July, consistent with the state's fiscal year;
- The state will determine the total expenditures for dental services from the previous fiscal year;
- The portion of state funds from the total expenditures will be calculated based on the FFP rate for the previous fiscal year;
- The amount of state funds will be increased by ten percent (10%) and this amount will be added to the previous fiscal year dental expenditure total to give the expenditure total expected to be paid for the upcoming fiscal year;

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

Dentures for EPSDT recipients, if medically necessary are reimbursed according to the fee schedule for dental services.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

~~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.~~

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

VIII. Durable Medical Equipment

- A. The payment for purchase of Durable Medical Equipment (DME) is made from a statewide uniform fee schedule not to exceed 80 percent of the rate established annually under Medicare (Title XVIII of the Social Security Act), as amended.
- B. The payment for rental of DME is made from a statewide uniform fee schedule based on 10 percent of the above purchase allowance not to exceed ten (10) months. After rental benefits are paid for (10) months, the DME becomes the property of the Mississippi Medicaid recipient unless otherwise authorized by the Division of Medicaid through specific coverage criteria.
- C. The payment for purchase of used DME is made from a statewide uniform fee schedule based not to exceed 50 percent of the above purchase allowance.
- D. The payment for repair of DME is the cost, not to exceed 50 percent of the above purchase allowance.
- E. The payment for other individual consideration items must receive prior approval of the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Durable Medical Equipment Reimbursement and Coverage Criteria are applicable.

Durable Medical Equipment (DME) for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraphs.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

~~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.~~

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

Medical Supplies

- A. The payment for purchase of Medical Supplies is made from a statewide uniform fee schedule not to exceed 80 percent of the rate established annually under Medicare (Title XVIII of the Social Security Act), as amended.
- B. The payment for other individual consideration items must receive prior approval of the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Medical Supplies Reimbursement and Coverage Criteria are applicable.

Medical Supplies for EPSDT recipients, if medically necessary which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraphs.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

~~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 Federal match will be paid based on the reduced amount.~~

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

Orthotics and Prosthetics for children under age 21, if medically necessary, are reimbursed as follows:

- A. The payment for purchase of Orthotics and Prosthetics is made from a statewide uniform fee schedule not to exceed 80 percent of the rate established annually under Medicare (Title XVIII of the Social Security Act), as amended.
- B. The payment for repair of Orthotics and Prosthetics is the cost, not to exceed 50 percent of the purchase amount.
- C. The payment for other individual consideration items must receive prior approval from the Division and shall be limited to the amount authorized in that approval.

All terms of the Division's Orthotics and Prosthetics Reimbursement and Coverage Criteria are applicable.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by ten percent (10%) of the allowed amount for that service.

~~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 Federal match will be paid based on the reduced amount.~~

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