EPARTMENT OF HEALTH AND HUMAN SERVICES
EALTH CARE FINANCING ADMINISTRATION

Revised

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **2002-22**

2. STATE **MS**

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE **July 1, 2002**

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**

7. FEDERAL BUDGET IMPACT:
a. FFY **2002** **$ -0-**
b. FFY **2003** **$ -0-**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 2a

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT: This State Plan Amendment contains technical corrections to two previous SPAs. SPA 2002-26 contained the UPL provisions which were approved by CMS. SPA 2002-06, which was also approved by CMS and contained the 5% reduction in reimbursement for out-patient hospital services required in House Bill 1200, inadvertently overwrote the UPL provisions of SPA 2002-26. This SPA, 2002-22, incorporates the provisions of both SPA 2002-06 and SPA 2002-26.

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: **Rica Lewis-Payton**

14. TITLE: **Executive Director**

15. DATE SUBMITTED: **September 18, 2002**

16. RETURN TO:
Rica Lewis-Payton, Executive Director
Miss. Division of Medicaid
Attn: Rose Compere
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 19, 2002

18. DATE APPROVED: November 18, 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: May 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL: Rhonda R. Cottrell

21. TYPED NAME: Rhonda R. Cottrell

22. TITLE: Associate Regional Administrator
Division of Medicaid

23. REMARKS:

ORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: MISSISSIPPI

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

Outpatient Hospital Services

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.

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 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.

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 provisions specified in appropriations by the Mississippi Legislature. Any payment made under this provision will be made bi-monthly.

Not withstanding 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 PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: MISSISSIPPI

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