

**State of 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.

**Payment Adjustment for Provider Preventable Conditions**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, with respect to non-payment for provider-preventable conditions.

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19-B:

  X   Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

       Additional Other Provider-Preventable Conditions identified below:

Not applicable.

---

TN No. <u>  2011-006  </u>	Date Received <u>          </u>
<u>  Supercedes  </u>	Date Approved <u>          </u>
TN No. <u>  2002-22  </u>	Date Effective <u>  07/01/11  </u>

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

---

Section 2702 of the Patient Protection and Affordable Care Act of 2010 prohibits Federal payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for certain provider-preventable conditions (PPC) and health care-acquired conditions (HCAC) for dates of service effective July 1, 2011. This policy applies to all for individuals for which Medicaid is primary and those dually eligible for both the Medicare and Medicaid programs, and Mississippi Medicaid enrolled hospitals except for acute psychiatric hospitals and Indian Health Services. Reduced payment to providers is limited to the amounts directly identifiable as related to the PPC and the resulting treatment.

The following method will be used to determine the related reduction in payments:

A. Dates of service beginning on or after July 1, 2011:

1. The claims identified with Present on Admission (POA) values and provider-preventable conditions through the claims payment system will be reviewed.
2. When the review of claims indicates an increase of payment to the provider for an identified provider-preventable condition, the amount for the provider-preventable condition will be excluded from the providers' payment.

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.

---

TN No. 2011-006  
Supercedes  
TN No. NEW

---

Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective 07/01/11

**State of 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.

**Payment Adjustment for Provider Preventable Conditions**

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, with respect to non-payment for provider-preventable conditions.

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19-B:

  X  Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

      Additional Other Provider-Preventable Conditions identified below:

      Not applicable.

---

TN No. 2011-006  
      Supersedes  
TN No. 2002-22

---

Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective 07/01/11

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

---

Section 2702 of the Patient Protection and Affordable Care Act of 2010 prohibits Federal payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for certain provider-preventable conditions (PPC) and health care-acquired conditions (HCAC) for dates of service effective July 1, 2011. This policy applies to all for individuals for which Medicaid is primary and those dually eligible for both the Medicare and Medicaid programs, and Mississippi Medicaid enrolled hospitals except for acute psychiatric hospitals and Indian Health Services. Reduced payment to providers is limited to the amounts directly identifiable as related to the PPC and the resulting treatment.

The following method will be used to determine the related reduction in payments:

A. Dates of service beginning on or after July 1, 2011:

1. The claims identified with Present on Admission (POA) values and provider-preventable conditions through the claims payment system will be reviewed.
2. When the review of claims indicates an increase of payment to the provider for an identified provider-preventable condition, the amount for the provider-preventable condition will be excluded from the providers' payment.

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.

---

TN No. 2011-006  
Supercedes  
TN No. NEW

---

Date Received \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Date Effective 07/01/11