Clinical Services:

A. Ambulatory Surgical Center Facility Services – Reimbursement for facility services in ambulatory surgical centers (ASC) is based on the principles described in Subpart C, 42 CFR Part 416, further modified by the Mississippi Medical Commission to be statewide rates at 80% of the group rates set by HCFA by publication in the Federal Register.

   In no instance will payments for services exceed the upper limits of the reasonable cost as determined under Title XVIII. All requirement of 42 CFR 447 will be met in making payments.

B. Birthing Center Services – Reimbursement for birthing center providers is based on a fee-for-service basis. To establish a fee for birthing centers services, the per diem of hospitals providing delivery services was added for monitoring. The total per diem rate was divided by the number of hospitals providing delivery services for the average per diem. The reimbursement to birthing centers for monitoring services is 80% of the average hospital per diem. To establish a fee for birthing centers for monitoring services prior to transfer to a hospital, the fee for monitoring services was divided by 24 for an hourly rate. This rate was multiplied by three to arrive at a fee for monitoring services prior to transfer to a hospital.

C. Other Clinic Services – Reimbursement is for clinics as defined in Section 41-3-15 (5) of the Mississippi Code of 1972, as amended. Reimbursement is based on cost reports submitted by the provider. The rate will be determined by dividing total reasonable cost by total encounters but will not exceed the upper limits specified in 42 CFR 447.321 through 447.325. The established rate setting period is July1 to June 30. An interim rate is paid until the end of the reporting period when there is a retrospective cost settlement. Actual reasonable costs reported on the cost report are divided by actual encounters by clinic type to determine the actual cost per encounter. Overpayments will be recouped from the provider, and underpayments will be paid to the provider.

Clinic services for EPSDT recipients, is 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 five percent (5%) of the allowed amount for that service.

From April 1, 2010, through June 30, 2010, and/or in the event expenditure reductions or cost containment measures are implemented, the Division of Medicaid may reduce the rate of reimbursement to providers for any service up to an additional fifteen percent (15%) of the allowed amount for that service including Medicare crossover claims.