Submission - Summary

MEDICAID | Medicaid State Plan | Administration | MS2020MS0001O | MS-20-0026

Package Header

Package ID MS2020MS0001O

Submission Type Official

Approval Date 3/4/2021

Superseded SPA ID N/A

SPA ID MS-20-0026

Initial Submission Date 12/15/2020

Effective Date N/A

Executive Summary

Summary Description Including Goals and Objectives State Plan Amendment (SPA) 20-0026 is being submitted to allow the Mississippi Division of Medicaid (DOM) to replace the Attorney General Certification signature with the signature of the current Attorney General, Lynn Fitch.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2021	$0
Second	2022	$0

Federal Statute / Regulation Citation

42 C.F.R. §§ 431.10, 431.11, 431.50, 430.12(b)

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Medicaid State Plan Administration

Organization

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | MS2020MS0001O | MS-20-0026

Package Header

Package ID MS2020MS0001O

Submission Type Official

Approval Date 3/4/2021

Superseded SPA ID MS-18-0003

System-Derived

SPA ID MS-20-0026

Initial Submission Date 12/15/2020

Effective Date 10/1/2020

A. Single State Agency

1. State Name: Mississippi

☑ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).

3. Name of single state agency:

Office of the Governor

4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name	Date Created	
MS SPA 20-0026 Attorney General_s Certification Signature AG Memo	11/18/2020 9:02 AM EST	

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

○ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.

◉ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

- ☐ a. The single state agency supervises the administration through counties or local government entities.
- ☐ b. The single state agency supervises the administration through other state agencies. The other state agency implements the state plan through counties and local government entities.
- ☑ c. Another state agency administers a portion of the state plan through a waiver under the Intergovernmental Cooperation Act of 1968.

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Submission Type	Official	**Initial Submission Date**	12/15/2020
Approval Date	3/4/2021	**Effective Date**	10/1/2020
Superseded SPA ID	MS-18-0003		
	System-Derived		

D. Additional information (optional)

Pursuant to Miss. Code Ann. § 43-13-107, the Division of Medicaid in the Office of the Governor administers the Medicaid program as prescribed by law.

State of Mississippi

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

Office of the Governor is the Single State Agency responsible for:

☒ administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is Sections 43-13-101 through 43-13-149, Mississippi Code of 1972, Annotated.
(Statutory Citation)

☐ supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

_____
(Statutory Citation)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

_____
(Statutory Citation)

10-22-20
DATE

Lynn Fitch
Signature

Attorney General
Title

Medicaid State Plan Administration

Organization

Intergovernmental Cooperation Act Waivers

MEDICAID | Medicaid State Plan | Administration, Eligibility | MS2018MS0004O | MS-18-0003

Package Header

Package ID	MS2018MS0004O	**SPA ID**	MS-18-0003
Submission Type	Official	**Initial Submission Date**	3/30/2018
Approval Date	N/A	**Effective Date**	5/31/2018
Superseded SPA ID	76-16		
	User-Entered		

A. Intergovernmental Cooperation Act Waivers

The state has the following Intergovernmental Cooperation Act Waivers:

View Waiver - Mississippi Department of Human Services

1. Name of state agency to which responsibility is delegated:

Mississippi Department of Human Services

2. Date waiver granted:

6/21/2018

3. The type of responsibility delegated is (check all that apply):

☑ a. Conducting fair hearings

☐ b. Other

4. The scope of the delegation (i.e. all fair hearings) includes:

The Mississippi Division of Medicaid delegates all fair hearings for eligibility determinations and services/benefits for IV-E and non IV-E foster care and adoption assistance-related children to the MS Department of Child Protective Services (MDCPS) which is a sub-agency of the Mississippi Department of Human Services (MDHS) the IV-A/TANF agency. MDCPS issues the final hearing decisions for this sub-population for IV-e and non-IV-e foster care and adoption assistance Medicaid categories. The Division will enter into a Memorandum of Understanding with MDCPS detailing the scope and responsibilities of the Division and MDCPS as well as quality control and oversight.

5. Methods for coordinating responsibilities between the agencies include:

☑ a. The Medicaid agency retains oversight of the state plan, as well as the development and issuance of all policies, rules and regulations on all program matters.

☑ b. The Medicaid agency has established a process to monitor the entire appeals process, including the quality and accuracy of the hearing decisions made by the delegated entity.

☑ c. The Medicaid agency informs every applicant and beneficiary in writing of the fair hearing process and how to directly contact and obtain information from the Medicaid agency.

☑ d. The Medicaid agency ensures that the delegated entity complies with all applicable federal and state laws, rules, regulations, policies and guidance governing the Medicaid program.

☑ e.The Medicaid agency has written authorization specifying the scope of the delegated authority and description of roles and responsibilities between itself and the delegated entity through:

- ☑ i. A written agreement between the agencies.
- ☐ ii. State statutory and/or regulatory provisions.

6. The single state agency has established a review process whereby the agency reviews fair hearing decisions made by the delegated entity.

○ Yes

◉ No

7. Additional methods for coordinating responsibilities among the agencies (optional):

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	User-Entered		

B. Additional information (optional)

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration, Eligibility | MS2018MS0004O | MS-18-0003

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Package ID	MS2018MS0004O	**SPA ID**	MS-18-0003
Submission Type	Official	**Initial Submission Date**	3/30/2018
Approval Date	N/A	**Effective Date**	1/1/2018
Superseded SPA ID	76-16		
	User-Entered		

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- [x] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [x] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [ ] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [ ] iii. Other

2. The entity or entities that conduct determinations of eligibility based on age, blindness, and disability are:

- [x] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [ ] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [ ] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [x] iii. The Social Security Administration determines Medicaid eligibility for SSI beneficiaries
  - [ ] iv. Other

3. Assurances:

- [x] a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- [x] b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- [x] c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- [x] d. The delegated entity is capable of performing the delegated functions.

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Superseded SPA ID	76-16		
	User-Entered		

B. Fair Hearings (including any delegations)

☑ The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.

☑ The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

☑ a. Medicaid agency

☐ b. State agency to which fair hearing authority is delegated under an Intergovernmental Cooperation Act waiver.

☐ c. Local governmental entities

☐ d. Delegated governmental agency

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

☑ All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

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Superseded SPA ID	76-16		
	User-Entered		

C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ○ Yes
- ◉ No

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Organization and Administration

MEDICAID | Medicaid State Plan | Administration, Eligibility | MS2018MS0004O | MS-18-0003

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Superseded SPA ID	84-35; 92-09		
	User-Entered		

A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- (●) a. A stand-alone agency, separate from every other state agency
- ( ) b. Also the Title IV-A (TANF) agency
- ( ) c. Also the state health department
- ( ) d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

The Office of Eligibility, consisting of thirty (30) Regional Offices (ROs), is responsible for determining all Medicaid eligibility for all applicants and beneficiaries except for (1) IV-E and non IV-E foster care and adoption assistance-related children, and (2) individuals eligible for SSI. The Office of Eligibility includes:
-Office of State Operations is responsible for overseeing eligibility systems and policy and training for Medicaid and CHIP.
-Office of Provider Enrollment is responsible for enrolling and credentialing health service providers.
-Office of RO Administration is responsible for overseeing the thirty (30) ROs as well as supervising all of the Outstation Sites.

b. Fair Hearings (including expedited fair hearings)

The Office of Appeals in the Division of Medicaid conducts all Medicaid fair hearings for all applicants and beneficiaries except for IV-E and non IV-E foster care and adoption assistance-related children.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

The Office of Executive Administrator is responsible for the core administrative functions of Procurement, Contract Compliance, Policy, Appeals and managing the coordinated care program, MississippiCAN.

The Office of Health Services is responsible for the overall development, implementation and operation of all Medicaid health-care services and benefits and includes the following:
-Office of Medical Services is responsible for overseeing the delivery of healthcare in over thirty (30) medical program areas and includes: medical and operational services; expanded EPSDT, professional/ancillary services, and preventative services.
-Office of Pharmacy is responsible for the development and administration of evidence-based medication use strategies that enhance eligible beneficiary and population health outcomes while optimizing health care resources. The Medicaid prescription drug programs include application of systems and data collection necessary to manage, analyze, and review of drug adherence, management of quality and cost-effective pharmacy benefits, and the Medicaid Drug Rebate Program including supplemental rebates. The P&T Committee and the DUR Board are directed by the Office of Pharmacy. Other responsibilities include the management and oversight of contracted vendors including: pharmacy point of sale claims processing, rate setting and reimbursement, DUR related projects, pharmacoeconomic modeling and analysis for the Universal Preferred Drug List, in addition to both the Prior Authorization and the Complex Pharmaceutical Care Programs.
-Office of Community-Based Services is responsible for administering the Bridge to Independence (B2I) program, the Housing Locator, and administering the State's e-LTSS system.
-Office of Hospital Programs and Services is responsible for managing the policies governing prior authorization, the rendering of prior authorized services, and validating the adjudication or coordination of the federally mandated auditing programs associated with these claim types. This Office is also responsible for analyzing trends in claim processing to assist in identifying and quantifying issues, conducting ongoing assessments and investigations of claim payments and operations, and monitoring managed care plans to assure contracting and regulatory obligations are met.
-Office of Clinical Support Services is responsible for overseeing the Division of Medicaid's fee schedules and rates, ensuring compliance with coding and billing regulations, monitoring contractor compliance with the Division of Medicaid coding coverage and adjudication, responding to requests for coverage information, and overseeing MississippiCAN quality activities.
-Office of Long-Term Care is responsible for overseeing the following programs: institutional settings for nursing homes, the hospice program and the following HCBS waivers: E&D, IL, AL, and TBI/SCI.
-Office of Mental Health is composed of two divisions. The Division of Mental Health Services is responsible for overseeing PASRR, acute freestanding psychiatric facilities, community/private mental health centers, therapeutic and evaluative mental health services for children, outpatient mental health hospital services, PRTFs, and psychiatric units at hospital's inpatient detox for chemical dependency. The Division of Special Mental Health Initiatives is responsible for overseeing autism services, mental health services provided by FQHCs and RHCs, ICF/IIDs, MYPAC, psychiatric services by a physician, and 1915(i) community support programs.
-Office of Program Integrity is responsible for investigating potential provider and beneficiary fraud, waste, and abuse of Medicaid programs and services as well as identifying vulnerabilities in policies and systems and making recommendations for improvements.
-Medical Director is responsible for serving as a resource in the review of policy, interpreting clinical best practices, and communicating with the medical provider community.

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

The Office of Policy is responsible for developing and maintaining policies for Mississippi Medicaid programs, submissions of State Plan Amendments (SPA), Waivers, and Administrative Code filings.

e. Administration, including budget, legal counsel

Executive Leadership- the Executive Director, appointed by the Governor, serves as full-time director of the Mississippi Division of Medicaid to administer the Medicaid program, subject to federal and state laws and regulations and duties as approved by the Governor.

The Office of Legal, staffed by attorneys from the Office of the Attorney General, is responsible for providing legal consultation and representing the Division of Medicaid in a variety of areas including personnel matters, statutory and regulatory issues, procurement and contracting, recovery efforts, garnishments, levies, bankruptcies and tax liens. The attorneys are responsible for drafting all Division of Medicaid contracts, representing the agency at various administrative hearings, providing guidance on policy drafting and filing, assisting the RFI Officer with public records requests, and serving as liaisons to the Medicaid Fraud Control Unit (MFCU). In addition to administrative hearings, the attorneys are also responsible for representing the Division of Medicaid before the Employee Appeals Board, United States Equal Employment Opportunity Commission (EEOC) and state and federal courts.

The Office of Government Relations is responsible for serving as the primary point of contact for legislative inquiries, handling requests, and leading the government relations team.
-Requests for Information is responsible for processing information in accordance with the Mississippi Public Records Act and the Division of Medicaid's policy.

f. Financial management, including processing of provider claims and other health care financing

The Office of Finance is responsible for effective fiscal management of the agency. This office provides fiscal oversight for the managed care contracts.

-Office of Financial and Performance Review is responsible for conducting financial and performance reviews and is composed of three units: the Provider Review Unit, the Contracts Monitoring Unit, and the Certified Electronic Health Records Unit.
-Office of Reimbursement is responsible for payment policy and rate setting for long-term care facilities, home health agencies, hospitals, rural health clinics, federally qualified health centers, end-stage renal disease centers, hospices, and Mississippi State Department of Health clinics.
-Chief Financial Office is responsible for overseeing the Office of Financial Reporting, the Office of Accounting and the Office of Third Party Recovery.
-Office of Financial Reporting is responsible for state and federal financial reporting.
-Office of Accounting is composed of three units: Purchasing, Accounts Payable and Cash Receipts.
-Office of Third Party Recovery is responsible for ensuring Medicaid is the payer of last resort on medical claims, recovering any monies reimbursed prior to the knowledge of a liable third party, and verifying accurate and complete third party records and files in accordance with state and federal requirements.

g. Systems administration, including MMIS, eligibility systems

The Office of Information Technology Management (iTECH) is responsible for overseeing the Medicaid Eligibility Determination System (MEDS), the Medicaid Management Information System (MMIS), the Data Warehouse/Decision Support System (DW/DSS), and is comprised of the following areas:

-Legacy Enterprise Systems is responsible for managing the Fiscal Agent who operates and maintains the MEDS for Medicaid's eligibility determinations and the MMIS for claims processing and payment, the Pharmacy Benefits Management (PBM) system, analyzing data to support state health policy changes and healthcare reform, and providing reporting capabilities through the DW/DSS.
-Eligibility Systems is responsible for enhancing and maintaining the electronic MEDS as well as the coordination of cross agency collaboration on the eligibility and fraud and abuse initiatives set forth in the HOPE bill.
-Medicaid Enterprise Systems is responsible for managing the implementation of the new Medicaid Enterprise System (MES) which includes Fiscal Agent services, claims processing and payment systems, and the PBM system; managing and coordinating associated vendor contracts (PMO, IV&V, SI, etc.); and providing maintenance and operational support of the MES.
-Health Information Technology is responsible for the design, development, implementation, and maintenance of the Medicaid Clinical Information (MCI) architecture. The MCI houses transformed claims and clinical information on Medicaid beneficiaries for use in analytics, reporting, and point of care by providers.
-Project Administration, Systems and Structure is responsible for establishing and ensuring compliance with industry standard project management guidelines, structure and process for all projects that fall within iTECH that are internally or externally initiated. This office also is responsible for coordination of business and technical process improvements.
-Infrastructure Support is responsible for monitoring and maintaining the performance of the network infrastructure comprised of the hardware, software, and tools that connect the central office and 30 regional offices located throughout the state. This area manages the Division of Medicaid's data and telephonic network through coordination with the state information technology systems infrastructure team.
-Administrative Oversight is responsible for strategic planning, budgeting, developing and updating funds for Advanced Planning Documents (APDs) for all IT-related projects. This office is also responsible for developing and implementing iTECH's internal policies and IT planning and acquisition management.
-Cyber-Security is responsible for protecting and maintaining the Division of Medicaid's electronic and physical security as well as gatekeeping of electronic Personal Health Information (PHI) and Personally Identifiable Information (PII) of beneficiaries. This office is also responsible for ensuring compliance with the regulatory oversight agencies, responding to external audit requests, and developing and enforcing cyber security policies.
-Special Projects is responsible for overseeing the Medicaid Information Technology Architecture (MITA) initiative, change management, provider incentive payments, site build-out and property tracking.
-Technical Support & User Assistance is responsible for supporting access control management and providing help desk assistance related to hardware and software issues for the Division of Medicaid's employees both in the central office and ROs.

h. Other functions, e.g., TPL, utilization management (optional)

Office of Third Party Recovery is responsible for ensuring Medicaid is the payer of last resort on medical claims, recovering any monies reimbursed prior to the knowledge of a liable third party, and verifying accurate and complete third party records and files in accordance with state and federal requirements.

The Office of Human Resources is responsible for coordinating all personnel matters including: recruiting of personnel, classifying of positions, verifying fair and adequate compensation, ensuring all disciplinary actions are carried out in a fair and legal manner, validating that the agency complies with relevant federal and state laws and regulations, overseeing leave and benefit matters, facilitating training of current employees and maintaining personnel files. Human Resources is composed of recruitment and selection, benefits and leave, administration, workforce development, and human capital strategy.

The Office of Communications is responsible for disseminating information to internal and external audiences including the designing, writing, formatting, editing, and distributing process for the Division of Medicaid's external website, publications, collateral materials, and digital media. This area is responsible for public relations, issuing official statements and serving as the primary contact for news media requests.

The Office of Project Coordination is responsible is responsible for defining agency project expectations and goals, ensuring clear communication and creating efficient ways to work together and includes the following:
-Office of Operations is responsible for providing support to the Agency and ROs and is comprised of warehouse management, postal services unit, document imaging and records management.
-Office of Property Management, which includes fixed assets, is responsible for scheduling and conducting internal agency property audits, recording inventory of all new

property acquisition, facilitating selection, approval and execution of all real property leases, execution of janitorial and other related contractual agreements, facilities maintenance liaison, agency fleet management, ITECH warehouse management, garage/parking assignments, office renovations, and maintaining the vehicle policy manual. -Office of Provider Beneficiary Relations is responsible for all outreach to and conducting educational events for providers and beneficiaries about Medicaid programs, services and eligibility. This office is responsible for maintaining the Division of Medicaid's switchboard which is the primary contact for provider, beneficiary, and general inquirers.

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created	
MS SPA 18-0003 Medicaid Administration Organizational Chart	6/5/2018 2:58 PM EDT	

Package Header

Package ID	MS2018MS0004O	**SPA ID**	MS-18-0003
Submission Type	Official	**Initial Submission Date**	3/30/2018
Approval Date	N/A	**Effective Date**	1/1/2018
Superseded SPA ID	84-35; 92-09		
	User-Entered		

B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title

Single state agency under Title IV-A (TANF)

Description of the functions the delegated entity performs in carrying out its responsibilities:

The Division of Medicaid delegates the authority to conduct all eligibility determinations and redeterminations and all fair hearings for IV-E and non IV-E foster care and adoption assistance-related children to the Mississippi Department of Child Protective Services (MDCPS) a sub-agency of the Mississippi Department of Human Services (MDHS) which is the IV-A/TANF state agency. All fair hearing decisions made by MDCPS are final. The Division of Medicaid has a Memorandum of Understanding with MDCPS that describes the scope, the relationship between the Division and MDCPS and their respective responsibilities.

Title

The Social Security Administration

Description of the functions the delegated entity performs in carrying out its responsibilities:

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries.

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	User-Entered		

E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

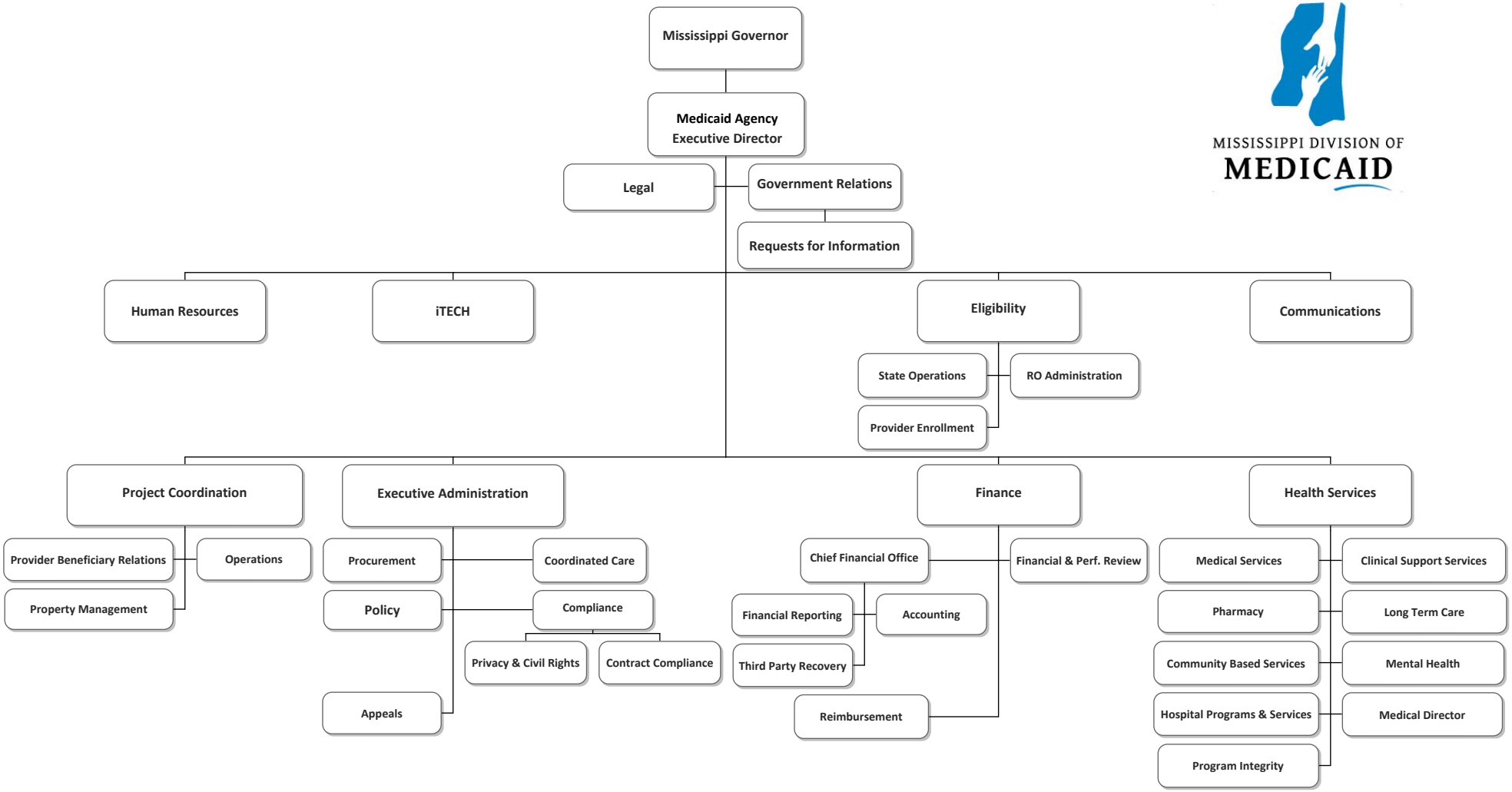
- ○ Yes
- ◉ No

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F. Additional information (optional)

State of Mississippi – Organizational Chart



Medicaid State Plan Administration

Organization

Single State Agency Assurances

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Supersedes Section 1.1: page 6
Section 1.3: page 8
Section 5.1: page 80
Section 5.3: page 82
Partially supersedes Section 1.4: page 9

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SPA ID MS-18-0003
Submission Type Official
Initial Submission Date 3/30/2018
Approval Date N/A
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Superseded SPA ID 74-7
User-Entered

A. Assurances

☑ 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ 2. All requirements of 42 CFR 431.10 are met.

☑ 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.

☑ 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

☑ 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with the standards described at 5 USC 2301, and regulations at 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☑ 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.

B. Additional information (optional)

*Page Partially Superseded by approved SPA # 18-0003-MM4

State of Mississippi

~~1.4~~ ~~**State of Mississippi Medical Care Advisory Committee**~~

~~There is an advisory committee to the Mississippi Division of Medicaid on health and medical care services established in accordance with and meeting all the requirements of 42 C.F.R § 431.12.~~

Tribal Consultation Requirements

The Mississippi Division of Medicaid complies with Section 1902(a)(73) and Section 2107(e)(I) of the Social Security Act by seeking advice on a regular, ongoing basis from a designee of the Indian health programs concerning Medicaid and Children's Health Insurance Program (CHIP) matters having a direct impact on Indian health programs and urban Indian organizations. Mississippi has only one federally recognized Tribe and that is the Mississippi Band of Choctaw Indians (MBCI).

The Mississippi Division of Medicaid consults with the MBCI by notifying the MBCI's designee in writing with a description of the proposed change and direct impact, at least thirty (30) days prior to each submission by the State of any Medicaid State Plan Amendment (SPA), and at least sixty (60) days prior to each submission of any waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects likely to have a direct impact on Indian health programs, Tribal organizations, or urban Indian organizations (I/T/U) by email. Direct impact is defined as any Medicaid or CHIP program changes that are more restrictive for eligibility determinations, changes that reduce payment rates or payment methodologies to I/T/U providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact I/T/U providers. If no response is received from the MBCI within the notification time-frames listed above, the Division of Medicaid will proceed with the submission to the Centers for Medicare and Medicaid Services (CMS).

MBCI designees are the Choctaw Health Center's Deputy Health Director and Director of Financial Services.

If the Mississippi Division of Medicaid is not able to consult with the Tribe within the notification time-frames prior to a submission the Division of Medicaid must e-mail a copy of the proposed submission along with the reason for the urgency to the MBCI designee. The Tribe may waive this notification time-frame requirement in writing via e-mail. If requested, a conference call with the MBCI designee and/or other Tribal representatives will be held to review the submission and its impact on the Tribe. In the event of a conference call, the Division of Medicaid will then confirm the discussion via email and request a response from the designee to ensure agreement on the submission. This documentation will be provided as part of the submission information to CMS.

If the tribe does not respond to the request or responds that they do not agree to the expedited process, the Division of Medicaid will follow the normal consultation timeframes articulated in the preceding paragraph.

Medicaid State Plan Eligibility

Financial Eligibility Requirements for Non-MAGI Groups

MEDICAID | Medicaid State Plan | Administration, Eligibility | MS2018MS0004O | MS-18-0003

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The state applies the following financial methodologies for all eligibility groups whose eligibility is not based on modified adjusted gross income (MAGI) rules (described in 42 C.F.R. §435.603):

A. Financial Eligibility Methodologies

☑ The state determines financial eligibility consistent with the methodologies described in 42 C.F.R. §435.601.

B. Eligibility Determinations of Aged, Blind and Disabled Individuals

Eligibility is determined for aged, blind and disabled individuals based on one of the following:

◉ SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

○ State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

○ State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being aged, blind or disabled, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

C. Financial Responsibility of Relatives

☑ The state determines the financial responsibility of relatives consistent with the requirements and methodologies described in 42 C.F.R. §435.602.

D. Additional Information (optional)

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: Mississippi

Citation — 1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: Mississippi

Citation
1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

___ State Medicaid Agency

_X_ State Public Health Agency

Section 1932 A(1) State Option to Use Managed Care - Population Health Management Program

Citation
Section 1932 of
the Social Security Act

Maternity care provided to Medicaid beneficiaries is provided through the provisions of Section 1932(a) of the Social Security Act enacted through provisions of the Balanced Budget Act of 1997. Population Health Management Program will provide services for pregnant women and infants under one year of age. This program is primarily for inpatient and outpatient obstetrical care associated with low birth-weight and pre-term babies. The Population Health Management Program will operate on a statewide basis, through the state's public health districts that are currently recognized by the State Public Health Department. The state contracts with entities who have arrangements with health care professionals to provide case management related services to pregnant women and infants one year and under who are in the program.

I. Assurances

A. All requirements will be met for 1932 and 1905(t) of the Social Security act. There will be public involvement in the design and implementation of the program. Public comments and involvement will be solicited on an on-going basis through surveys, focus groups and other means.

B. The following categories of Beneficiaries are not eligible to enroll in the Plan:

(1) Beneficiaries who are, at the time of application for enrollment or at the time of enrollment, domiciled or residing in an institution, including nursing facilities, hospital swing bed units, intermediate care facilities for the mentally retarded, mental institutions, psychiatric residential treatment facilities, or correctional institutions;

(2) Beneficiaries enrolled in Home and Community-Based (HCBS) Waiver programs. HCBS beneficiaries can dis-enroll from the HCBS program and can choose to enroll.

(3) Disabled workers at 200% poverty level;
(4) Individuals who meet the eligibility requirements for receipt of both Medicaid and Medicare benefits.
(5) Indians who are members of Federally-recognized tribes;
(6) Children under 19 years of age who are:
    (1) eligible for SSI under Title XVI except children under one of low birthweight (< 2500 grams).
    (2) described in Section 1902(e)(3) of the Social Security Act;
    (3) in foster care or other out-of-home placement;
    (4) receiving foster care or adoption assistance; or
    (5) receiving services through a family-centered, community-based, coordinated care system receiving grant funds under Section 501(a)(1)(D) of Title V.

C. Each Public Health Region will have one entity known as the Population Health Management Contractor responsible for the Population Health Management Program in that region. These public health regions will be comprised of public health districts as follows:

Region I - Districts 1, 2 and 3
Region II - Districts 4, 5 and 6
Region III - Districts 7, 8 and 9

Each pregnant beneficiary will be enrolled in the PHM in the county of her residence. Individuals will have a choice of at least two (2) delivering health care professionals from within the system. Population Health Management Contractor (PHMC) must ensure that each beneficiary has the ability to choose among delivering health care professionals enrolled in the entity.

4. Beneficiaries will be permitted to change delivering health care professionals at any time for cause and without cause once in the first 90 days beginning on the date the beneficiary receives official notification of enrollment and at least 12 months after enrollment with the entity. Beneficiaries may elect to change providers within the system but may not elect to dis-enroll from the Population Health Management Program (PHM). Beneficiaries who refuse to enroll or follow program guidelines will be responsible for payment of services provided.

E. **Default Enrollment Process**
Default enrollment by the PHMC in a PHM Program area will be through equivalent distribution among delivering health care professionals who are enrolled in the Maternity Program and have the capacity to serve additional beneficiaries. At program implementation and 30 days post implementation, PHM Contractors are required to offer participation to qualified delivering Health Care Professionals who agree to participation requirements. Afterwards the PHMC will offer open enrollment annually. The state has established a policy that each provider meets required qualifications to participate as a program provider. Beneficiaries will be required to select a provider or be assigned to one within two weeks after contractor's notification.

F. Information will be provided to beneficiaries on the PHMC, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered through the Population Health Management Program, cost sharing, service areas and quality performance to the extent available. This information will be provided to all Medicaid eligible women of childbearing age and infants under one year of age upon implementation of the program. Additionally, this information will be updated if PHMC(s) change. This information will be available on an ongoing basis in key places within the state such as physician's offices, clinics, and local Department of Human Services. Medicaid will retain approval authority for all marketing materials.

II The number of Population Health Management Contractors will be restricted to one in each of the public health regions within the state. The State will assure that the contractor provider network is adequate and available during procurement of Population Health Management Contractors for each region. Assurance of access to care is accomplished through review of the number of beneficiaries and delivering health care professionals within each district and county. Consideration will be given to the number of providers that practice in the county, travel times, national standards such as published by the American College of Obstetrics and Gynecology and other factors that may be present in the health care infrastructure in the area. The PHMC will be required to continuously monitor access to care to ensure that standards are met on an ongoing basis. Monitoring is

also accomplished through the grievance process. Medicaid will monitor the PHMC annually through the administrative review process to ensure access to care is available. Public Health districts are based on county designation and consist of one or more counties per district.

III. Population Health Management Contractors will be selected through evaluation of the contractor's ability to provide required components of the Population Health Management Program. These include, but are not limited to, private entities, non-profit corporations, Provider Service Organizations, Health Departments, or similar entities that meet Population Health Management Contractor Qualifications. Assurance is provided that Population Health Management Contractor contracts will contain, at a minimum, terms required under Sections 1932 and 1905 (t) (3) of the Social Security Act.

Contracts with such entities require:

A. PHM Contractors will provide reasonable and adequate hours of operation, including 24 hour 7 day availability of information referral and treatment with respect to medical emergencies;

B. The PHM Contractors will enroll only those individuals residing sufficiently near a service delivery site to be able to reach that site within a reasonable time using available and affordable means of transportation;

C. The PHM Contractors will provide for arrangements with or referrals to a sufficient number of physicians and other appropriate health care professionals to ensure that services under the contract will be delivered promptly and without compromising quality of care;

D. The PHM Contractors will not discriminate on the basis of health status or requirements for health care services in enrolling, disenrolling or re-enrolling Medicaid beneficiaries;

E. The PHM Contractors will permit individuals to change delivering health care professionals in accordance with the provisions in Section 1932 (a) (4); and

F. The PHM Contractors will comply with other applicable provisions of Section 1932, including requirements and provisions of marketing.

G. The state assures that the contract with Population Health Management Contractors meets all the terms required under Section 1905(t)(3). Reimbursement for the contractors will be based on a global rate determined by the cost reports.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State: Mississippi

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Revision: HCFA-PM-93-2 (MB)
March 1993

State: Mississippi

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1 (b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and 1920 of the Act	___	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
42 CFR 434.20	(c)	The Medicaid agency elects to enter into a risk contract with an HMO that is--	
		_X_	Qualified under title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to section 1903(m)(3) of the Social Security Act.
		_X_	Not Federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in ATTACHMENT 2.1-A.
		___	Not applicable.

1902(a)(55) 2.1(d) The Medicaid agency has procedures to take applications, assist applicants and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i) (IV), (a)(10)(A)(i) (VI), (a)(10)(A)(i)(VIII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

Mississippi has implemented Section 1902(a) (55) of the Act by operating regional district offices and outstationing workers or developing procedures to assure that applications are taken and clients are assisted in completion of same at sites other than the single state agency's primary place of business:

- The agency maintains thirty (30) full service regional offices throughout the state which are open from 7:30 a.m. to 5:30 p.m. (excluding holidays) during the normal business week. These offices are staffed by employees of the agency who assist clients and applicants with the processing, review and determination of applications.

- In addition to the regional offices, the agency operates a network of outstationed locations within facilities not owned, leased or operated by the agency. Such locations include county departments of health (WIC locations), FQHCs, disproportionate share hospitals and rural health clinics.

- The agency has either an outstationed location or a regional office in 81 of the state's 82 counties. The one county without an office shares many government services (including a combined school district, health department office, and human services office) with a neighboring county because both counties are so small in population. In addition, the agency has three regional offices within a thirty (30) minute drive of that county. Approximately sixty-four (64) out of eighty two (82) counties have more than one location.

- Posters and pamphlets will be placed in prominent places in all admission offices and emergency rooms of disproportionate share hospitals, as well as in all FQHCs and rural health clinics. Information describes the closest location of the full service regional offices and outstation locations and provides telephone numbers for additional assistance.

Hours of operation are posted at each outstationed location and on the agency's website and are available at each regional office. Applicants are directed to the closest outstation site or regional office to file an application. Applicants may apply or be seen or assisted in any location, regardless of regional office boundary lines. Health facilities that do not participate in the outstationing of workers have access to the outstation schedules of each regional office.

Revision: HCFA-PM-91-8 (MB) OMB No.:
October 1991

State/Territory: Mississippi

Citation		
1902(a)(55) of the Act	2.1(e)	The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the AFDC form except as permitted by HCFA instructions.

Citation
42 CFR
435.10

2.2 **Coverage and Conditions of Eligibility**

Medicaid is available to the groups specified in **ATTACHMENT 2.2-A**.

☐ Mandatory categorically needy and other required special groups only.

☐ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

P&I → HCFA 3-16-92 ☒ Mandatory categorically needy, other required special groups, and specified optional groups.

☐ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in **ATTACHMENT 2.6-A**.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: Mississippi

Citation
435.10 and
435.403, and
1902(b) of the
Act, P.L. 99-272
(Section 9529)
and P.L. 99-509
(Section 9405)

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

Page superseded by SPA 13-0022 S88
effective 01-01-14

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: Mississippi

Citation
42 CFR 435.530(b)
42 CFR 435.531
AT-78-90
AT-79-29

2.4 Blindness

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

State: Mississippi

Citation		
42 CFR 435.121, 435.540(b) 435.541	2.5	Disability

All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of **ATTACHMENT 2.2-A** of this plan.

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: Mississippi

Citation(s)

42 CFR
435.10 and
Subparts G & H
1902(a)(10)(A)(i)
(III), (IV), (V),
(VI), and (VII),
1902(a)(10)(A)(ii)
(IX), 1902(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(l)
and (m),
1905(p) and (s),
1902(r)(2),
and 1920

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: Mississipoi

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

State/Territory: Mississippi

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

___ Not applicable. Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation	3.1(a)(1)	Amount, Duration, and Scope of Services: Categorically Needy (Continued)
1902 (e)(5) of the Act	(iii)	Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.
	/x/ (iv)	Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.
1902(a)(10)(A) ~~clause~~ (VII) of the matter following (E) of the Act	(F) HCFA Prog. Mem. Pot 92-4, 8/92 (v)	Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

TN No. 92-02
Supersedes TN No. 90-12

Effective Date January 1, 1992
Approval Date March 16, 1992
Date Received January 30, 1992

HCFA ID: 7982E

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: **Mississippi**

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act		(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	____	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act		(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	____	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation 3.1 Amount, Duration, and Scope of Services (Continued)

42 CFR Part 440, Subpart B

(a)(2) Medically needy

☐ This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act
42 CFR 440.220

(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

☐ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act

(ii) Prenatal care and delivery services for pregnant women.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☐ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B for recipients under age 18 and recipients entitled to institutional services.

☐ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, 440.160, Subpart B, 442.441. Subpart C (10) (C) 1902(a) ~~(20) and (21)~~ of the Act

☐ (vii) Services in an institution for mental diseases for individuals over age 65.

☐ (viii) Services in an intermediate care facility for the mentally retarded.

HCFA Plcy. Memo TP #92-4, 2/92 ☐ (ix) Inpatient psychiatric services for individuals under age 21.

TN No. 92-02
Supersedes TN No. 87-9

Effective Date January 1, 1992
Approval Date March 16, 1992
Date Received Janaury 30, 1992

HCFA ID: 7982E

Revision: HCFA-PM-93-5 (MB)
May 1993

State: Mississippi

Citation

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of the Act

___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23) and 1929 of the Act

___ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Citation	3.1	Amount, Duration, and Scope of Services (continued)
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)1905(p)(3)(A)(ii), and 1933 of the Act	(iii)	Other Required Special Groups: Qualifying Individuals – 1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.
1925 of the Act	(a)(5)	Other Required Special Groups: Families Receiving Extended Medicaid Benefits Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Revision: HCFA-PM- (CMSO)

State: Mississippi

Citation

Sec. 245A(h) of the Immigration and

(a)(6) Limited Coverage for Certain Aliens

An alien who is not a qualified alien or who is a qualified alien as defined in section 431(b) of P.L. 104-193, but is not eligible for Medicaid based on alienage status, and who would otherwise qualify for Medicaid are provided Medicaid only for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation

3.1 Amount, Duration, and Scope of Services (continued

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(1) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation		
	3.1(a)(6)	Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902(a) and 1903(v) of the Act		(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	/_/ (a)(8)	Presumptively Eligible Pregnant Women Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

Revision: HCFA-PM-91-4 August 1991 (BPD) OMB No.: 0938-

State/Territory: Mississippi

Citation		Amount, Duration, and Scope of Services: EPSDT Services (continued)
42 CFR 441.60		The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.*
42 CFR 440.240 and 440.50	(a)(10)	Comparability of Services
1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), and 1925(b)(4) of the Act		Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:
		(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
		(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
		(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
	☐	(iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medially needy.

*Described on Page 22a

TN No. 92-02
Supersedes TN No. 90-13

Effective Date January 1, 1992
Approval Date March 16, 1992
Date Received January 30, 1992

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BERC) OMB No. : 0938-0193
March 1987

State/Territory: Mississippi

A continuing care provider is one who formally agrees: to provide to individuals formally enrolled, screening, diagnosis and treatment for conditions identified during screening (within the provider's capacity) or referral to a provider capable of providing the appropriate services; maintain a complete health history, including information received from other providers; is responsible for providing needed physician services for acute, episodic and/or chronic illnesses and conditions.

A continuing care provider will function as a health care manager, performing the entire set of EPSDT functions. Providing screening, information, and referral services is part of but does not constitute a complete continuing care set.

Continuing care providers may have to arrange for certain specialty services that are beyond the scope of their practice and may agree, at their option, to provide dental services or to make direct dental referrals.

The continuing care provider may provide assistance with transportation or refer recipients to the agency responsible for this service.

The agency will maintain a description of the services provided and ensure adequate tracking of these services. The agency will also have performance standards that will be monitored by on site reviews.

Revision: HCFA - Region VI
November 1990

State Mississippi

Citation
42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

Section 1905(a)(4)(A) of Act (Sec. 4211(f) of P.L. 100-203).

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes

☐ Not applicable. The State plan does not provide for nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

☐ Yes, to all

☐ Yes, to individuals age 21 or over; nursing facility services are provided.

☒ Yes, to individuals under age 21; nursing facility services are provic

☐ No; nursing facility services are not provided.

☒ Not applicable; the medically needy are not included under this plan

TN # 91-23
Supersedes
TN # 79-28

Approval Date 5-4-93
Date Received 9-12-91

Effective Date 7-1-91

Revision: HCFA-PM-93-4 (BPD)
December 1993

State/Territory: Mississippi

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53 (c) (1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in Attachments 3.1-D and 3.1-A, Exhibit 24a

42 CFR 483.10 (c) (2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation	3.1(d)	Methods and Standards to Assure Quality of Services
42 CFR 440.260 AT-78-90		The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State Mississippi

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	Family Planning Services The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN # 76-15
Supersedes
TN #

Approval Date 2/16/77 Effective Date 11/23/76

State/ Territory: Mississippi

Revision: HCFA-PM-87-5 (BERC) OMB No.: 0938-0193
April 1987

State: Mississippi

Citation 42 CFR 441.30 AT-78-90	3.1 (f)	(1) Optometric Services Optometric services (other than those provided under §435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist. ☒ Yes. ☐ No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform. ☐ Not applicable. The conditions in the first sentence do not apply.
1903 (i) (1) of the Act, P.L. 99-272 (Section 9507)		(2) Organ Transplant Procedures Organ transplant procedures are provided. ☐ No. ☒ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at Attachment 3.1-E.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Mississippi

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act,
P.L. 99-509
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

/ / 30 consecutive days;

/ / ___ days (the maximum number of inpatient days allowed under the State plan).

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/ / Yes. The requirements of section 1902(e)(9) of the Act are met.

/X/ Not applicable. These services are not included in the plan.

Revision: HCFA-PM-93-5 (MB)
May 1993

State: Mississippi

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

X Part A X Part B

___ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Citation

1902(a)(10)(E)(ii) and 1905(s) of the Act

(ii) Qualified Disabled and Working Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E. for individuals in the QDWI group defined in item A.26 ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(II) of the Act

(iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv) 1905(p)(3)(A)(ii), and 1933 of the Act

(iv) Qualifying Individual -1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv) and subject to 1933 of the Act.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: Mississippi

Citation

1843(b) and 1905(a) of the Act and 42 CFR 431.625 (vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

x All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); (b) receiving State supplements under title XVI; or (c) within a group listed at 42 CFR 431.625(d)(2).

___ Individuals receiving title II or Railroad benefits.

___ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act (2) Other Health Insurance

___ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A, but not enrolled in Medicare Part B).

Revision: HCFA-PM-93-2TC (MB)
June 1998

State: Mississippi

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1905(a)
1902(a)(30), 1902(n),
1905(a), and 1916 of
the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902
(a)(10)(E)(i) and
1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBs)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) only for the amount, duration and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30),
and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

— For the entire range of services available under Medicare Part B.

X Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30),
1905(a), and 1905(p)
of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for services available under Medicare only for the amount, duration and scope of services otherwise available under this plan and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

TN No. 98-15
Supersedes
TN No. 98-08

Date Received 12/23/98
Approval Date FEB 00 1999
Effective Date JUL 01 1998

Revision: HCFA-PM-91-8 (MB) OMB No.:
October 1991

State/Territory: Mississippi

Citation		Condition or Requirement
1906 of the Act	(c)	Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).
1902(a)(10)(F) of the Act	(d)	/__/ The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☐ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☒ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation		
42 CFR 441.252 AT-78-99	3.4	Special Requirements Applicable to Sterilization Procedures All requirements of 42 CFR Part 441, Subpart F are met.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State: Mississippi

Citation

1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

/x/ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

/ / Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

/ / Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/ / Medical or remedial care provided by licensed practitioners.

/ / Home health services.

Revision: HCFA-PM-91-4
August 1991 (BPD) OMB No.: 0938-

State: Mississippi

Citation 3.5 Families Receiving Extended Medicaid Benefits (continued)

☐ Private duty nursing services.

☐ Physical therapy and related services.

☐ Other diagnostic, screening, preventive, and rehabilitation services.

☐ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.

☐ Intermediate care facility services for the mentally retarded.

☐ Inpatient psychiatric services for individuals under age 21.

☐ Hospice services.

☐ Respiratory care services.

☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

Revision: HCFA-PM-91-4
August 1991

(BPD)

OMB No.: 0938-

State: Mississippi

Citation 3.5 Families Receiving Extended Medicaid Benefits (continued)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

☐ 1st 6 months ☐ 2nd 6 months

☐ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

☐ 1st 6 months ☐ 2nd 6 months

(d) ☐ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a State employee health plan.

☐ Enrollment in the State health plan for the uninsured.

☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State: Mississippi

Citation 3.5 Families Receiving Extended Medicaid Benefits (continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/_/ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Mississippi

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State Mississippi

Citation	4.2 Hearings for Applicants and Recipients
42 CFR 431.202 AT-79-29 AT-80-34	The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

Revision: HCFA-AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: Mississippi

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Mississippi

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of the Act.
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

/ / Yes.

/X/ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Mississippi **OMB Control Memo Number: 0938-1151**

4.46 Provider Screening and Enrollment

Citation	
1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152	The State Medicaid agency gives the following assurances:
42 CFR 455 Subpart E	PROVIDER SCREENING __X__ Assures that the Mississippi Division of Medicaid complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X__ Assures that the Mississippi Division of Medicaid requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__ Assures that the Mississippi Division of Medicaid has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__ Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X__ Assures that the Mississippi Division of Medicaid will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420 REACTIVATION OF PROVIDER ENROLLMENT

__X__ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422 APPEAL RIGHTS

__X__ Assures that all terminated providers and providers denied Enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432 SITE VISITS

__X__ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will Occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS

__X__ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS

__X__ Assures that the Mississippi Division of Medicaid will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER

__X__ Assures that the Mississippi Division of Medicaid requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS

__X__ Assures that the Mississippi Division of Medicaid complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460

APPLICATION FEE

__X__ Assures that the Mississippi Division of Medicaid complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

__X__ Assures that the Mississippi Division of Medicaid complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Mississippi

Citation	4.5 Medicaid Agency Fraud Detection and Investigation Program
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: Mississippi

Citation
Section 1902(a)(64) of the Social Security Act
P.L. 105-33

4.5a Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

State of Mississippi

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act	_X_ Effective April 1, 2017, the State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid Claims under the State plan and under any waiver of the State Plan. ___ The State is seeking an exception to establishing such program for the following reasons: _X_ The State/Medicaid agency has contracts of the type(s) listed in section 1902(a) (42) (B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following: _X_ The State will make payments to RAC(s) only from amounts recovered.
Section 1902 (a)(42)(B)(ii)(I) of the Act	_X_ The State will make payments to the RAC(s) on a contingent basis for collecting over payments. The following payment methodology shall be used to determine State Payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee): _X_ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.
Section 1902(a)(42)(B)(ii)(II)(aa) of the Act	____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate. ____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The state will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.

Section 1902(a)(42)(B)(ii)(II)(bb) of the Act	_X_ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee): Percentage of recovery established through procurement process.
Section 1902(a)(42)(B)(ii)(III) of the Act	_X_ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902(a)(42)(B)(ii)(IV)(aa) of the Act	_X_ The state assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State Plan or waiver of the plan.
Section 1902(a)(42)(B)(ii)(IV)(bb) of the Act	_X_ The state assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902(a)(42)(B)(ii)(N)(cc) of the Act	_X_ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 431.18 (b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: Mississippi

Citation

4.10 Free Choice of Providers

42 CFR431.51
AT-78-90
46 FR 48524
48 FR23212
1902 (a) (23)
of the Act
P.L. 100-93
(section 8(f))
P.L. 100-203
(Section 4113)

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual--

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or

Section 1902(a)(23)
of the Social Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is Mississippi State Department of Health

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): Social Services Division (Child Welfare), Department of Public Welfare, sets standards for Foster Care.

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The Mississippi State Department of Health (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

☐ Yes, as listed below:

☒ Not applicable. Similar services are not provided to other types of medical facilities.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subpart A and B (if applicable) are met.

42 CFR part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

/x/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: Mississippi

Citation		
1902(a)(58) 1902(w)	4.13	(e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met: (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following: (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. (b) Provide written information to all adult individuals on their policies concerning implementation of such rights; (c) Document in the individual's medical records whether or not the individual has executed an advance directive; (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; (e) Ensure compliance with requirements of State Law (whether

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: Mississippi

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law or court decision exist regarding advance directives.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: Mississippi

Citation

42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
Section 9431)

4.14 Utilization/Quality Control

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

___ Directly

_X_ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO--

(1) Meets the requirements of §434.6(a);

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

_X_ Quality review requirements described in section 1902(a)(30)(C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designed under 42 CFR Part 462.

1902(a)(30)(C)
and 1902(d) of the
Act, P.L. 99-509
(section 9431)

___ By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Mississippi

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

/X/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/ / All hospitals (other than mental hospitals).

/ / Those specified in the waiver.

/ / No waivers have been granted.

Revision: HCFA-PM-85-7 (BERC) OMB NO.: 0938-0193
JULY 1985

State/~~Territory~~: Mississippi

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/ / All mental hospitals.

/ / Those specified in the waiver.

/ / No waivers have been granted.

/X/ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Mississippi

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/X/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/X/ All skilled nursing facilities.

/ / Those specified in the waiver.

/ / No waivers have been granted.

Revision: HCFA-Pm-85-3 (BERC)
MAY 1985

State: Mississippi

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /X/ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/ / Facility-based review.

/ / Direct review by personnel of the medical assistance unit of the State agency.

/X/ Personnel under contract to the medical assistance unit of the State agency.

/ / Utilization and Quality Control Peer Review Organizations.

/ / Another method as described in ATTACHMENT 4.14-A.

/ / Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/ / Not applicable. Intermediate care facility services are not provided under this plan.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: Mississippi

Citation

4.14 Utilization/Quality Control (Continued)

1902(a)(30) and 1902(d) of the Act, P.L. 99-509 (Section 9431) P.L. 99-203 (section 4113)

(f) The Medicaid agency meets the requirements of section 1902(a)(30) of section 1902(a)(30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

X A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

___ A private accreditation body.

___ An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.

Revision: HCFA-PM-92-2 (HSQB)
March 1992

State/Territory: Mississippi

Citation

4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act

___ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

___ ICFs/MR;

___ Inpatient psychiatric facilities for recipients under age 21; and

___ Mental Hospitals.

42 CFR Part 456 Subpart A and 1902(a)(30) of the Act

___ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

___ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

_X_ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

___ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

_X_ Not applicable with respect to ICF/MR services.

_X_ All applicable requirements of 42 CFR part 456, Subpart I, are met with respect to periodic inspections of care and services to facilities providing inpatient psychiatric services for individuals under the age of 21.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Citation
42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

____ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

____ The State imposes liens on real property on account of benefits incorrectly paid.

____ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

____ The State imposes liens on both real and personal property of an individual after the individual's death.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

(b) Adjustments or Recoveries

The State Division of Medicaid complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

____ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) ____ The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

____ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1,2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

(4)____ The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

__X__ The State Division of Medicaid adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

____ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

____ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

(c) Adjustments or Recoveries: Limitations

The State Division of Medicaid complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation

4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51 through 447.58

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation 4.18(b) (Continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☐ 21 or older

☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Revision: HCFA-PM-91-4 August 1991 (BPD) OMB No.: 0938-

State/Territory: Mississippi

Citation 4.18(b)(3) (Continued)

42 CFR 447.51 through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

X Not applicable. There is no maximum.

PET HCFA 3-16-92

TN No. 92-02
Supersedes TN No. 90-12

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HCFA ID: 7982E

Revision: HCFA-PM-91-4
August 1991

(BPD)

OMB No.: 0938-

State/Territory: Mississippi

Citation		
1916(c) of the Act	4.18(b)(4) ☐/	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5) ☐/	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6) ☐/	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation			
	4.18(c)	☐	Individuals are covered as medically needy under the plan.
42 CFR 447.51 though 447.58	(1)	☐	An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.
447.51 through 447.58	(2)		No deductible, coinsurance, copayment or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

Citation

4.18(c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

___ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

_X_ Not applicable. No such charges are imposed.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation 4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☐ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-91-4 August 1991 (BPD) OMB No.: 0938-

State/Territory: Mississippi

Citation 4.18(c)(3) (continued)

447.51 through 447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

☐ Not applicable. There is no maximum.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13), ~~1902(e)(7)~~
and 1923 of
the Act

HCFA Program Memorandum
TN# 93-5, 5/93

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

[ ] Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v) (1)(G) of the Act.

[x] Inappropriate level of care days are not covered.

Revision: HCFA-PM-91-4 August 1991 (BPD) OMB No.: 0938-

State/Territory: Mississippi

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920 and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(c) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State Mississippi

Citation		
42 CFR 447.40 AT-78-90	4.19(c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

Revision: HCFA - Region VI
November 1990

State/Territory: Mississippi

Citation
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141
Section 1902(a)(13)(A) of Act (Section 4211 (h)(2)(A) of P.L. 100-203).

4.19 (d)

(1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for nursing facility services and intermediate care facility services for the mentally retarded.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for nursing facility services and intermediate care facility services for the mentally retarded.

(2) The Medicaid agency provides payment for routine nursing facility services furnished by a swing-bed hospital.

[X] At the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.

[ ] At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

[ ] Not applicable. The agency does not provide payment for NF services to a swing-bed hospital.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation		
42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

TN # 79-19
Supersedes
TN #

Approval Date 10/1/79 Effective Date 8/23/79

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: Mississippi

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State Mississippi

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirement of 42 CFR 447.203 for documentation and availability of payment rates.

TN # 79-17
Supersedes
TN #

Approval Date 9/27/79

Effective Date 9/6/79

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Revision: HCFA-PM-91-4 August 1991 (BPD) OMB No.: 0938-

State: Mississippi

Citation

42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act

Revision: HCFA-AT-81-34 (BPP) 10-81

State Mississippi

Citation
42 CFR 447.342
46 FR 42669

4.19(k) Payments to Physicians for Clinical Laboratory Services

For services performed by an outside laboratory for a physician who bills for the service, payment does not exceed the amount that would be authorized under Medicare in accordance with 42 CFR 405.515(b), (c) and (d).

☐ Yes

☒ Not applicable. The Medicaid agency does not allow payment under the plan to physicians for outside laboratory services.

Revision: HCFA-PM-92-7 MB)
October 1992

State/Territory: Mississippi

Citation

1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physican to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: Mississippi

Citation 4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

___ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

_X_ sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine: $10.00

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

(1) adequate reimbursement for administration.

(2) multiple provider/service sites.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 447.25 (b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

Revision: HCFA-AT-81-34 (BPP) 10-81

State Mississippi

Citation		
42 CFR 447.10(c) AT-78-90 46 FR 42699	4.21	Prohibition Against Reassignment of Provider Claims Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN # 81-25
Supersedes
TN # 78-1

Approval Date 11/30/81 Effective Date 7/1/81

State/Territory: Mississippi

Citation		
	4.22	Third Party Liability
42 CFR 433.137	(a)	The Medicaid agency meets all requirements of:
	(1)	42 CFR 433.138 and 433.139.
	(2)	42 CFR 433.145 through 433.148.
	(3)	42 CFR 433.151 through 433.154.
1902(a)(25)(H) and (I)	(4)	Sections 1902(a)(25)(H) and (I) of the Act.
42 CFR 433.138(f) 52 FR 5967	(b)	ATTACHMENT 4.22-A -- (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
42 CFF 433.138(g)(1)(ii)		(2) Describes the methods the agency uses for meeting the follow-up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
42 CFR 433.138(g)(3)(i)		(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources; and
42 CFR 433.138(g)(4)(i) through (iii)		(4) Describes the methods the agency uses for on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Mississippi

Citation

42 CFR 433.139(b)(3) ___ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(c)
55 FR 46652

(1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(c).

42 CFR 433.139(f)(2)

(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3)

(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20

(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Mississippi

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with at least one of the following (Check as appropriate.)

X State title IV-D agency. The requirements of 43 CFR 433.152(b) are met.

___ Other appropriate State agency(s)--

_____

_____

___ Other appropriate agency(s) of another State--

_____

_____

___ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of selecting one of the following.

___ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

X The State provides methods for determining cost effectiveness on Attachment 4.22-C.

State/Territory: Mississippi

Citation	4.23	Use of Contracts
42 CFR Part 434 448 FR 54013		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All Contracts meet the requirements of 42 CFR Part 434. ___ Not applicable. The State has no such contracts.
42 CFR Part 438		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply): ___ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2 ___ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2 ___ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2 ___ Not applicable.

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: Mississippi

Citation	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826		With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ___ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Revision: HCFA-PM-93-3 (MB)
April 1993

State/Territory: Mississippi

Citation

1927(g)
42 CFR 456.700

4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results.

1927(g)(1)(a)
42 CFR 456.705(b) and
456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patters of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs and well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

1927(g)(1)(B)
42 CFR 456.703
(d) and (f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia-Drug Information
- American Medical Association Drug Evaluations

Revision: HCFA-PM-93-3 (MB)
April 1993

State/Territory: Mississippi

Citation

1927(g)(1)(D)
42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 4893.60. The State has nevertheless chosen to include nursing home drugs in:

x Prospective DUR
x Retrospective DUR

1927(g)(2)(A)
42 CFR 456.705(b)

E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to he Medicaid recipient.

1927(g)(2)(A)(i)
42 CFR 456.705(b)
(1)-(7)

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927(g)(2)(A)(ii)
42 CFR 456.705(c) & (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
42 CFR 456.709(a)

F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Revision: HCFA-PM-93-3 (MB)
April 1993

State/Territory: Mississippi

Citation

1927(g)(2)(C)
42 CFR 456.709(b)

F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Clinical abuse/misuse

1927(g)(2)(D)
42 CFR 456.716(a)

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)
42 CFR 456.716(a)

G.1. The DUR program has established a State DUR Board either:

x Directly, or
___ Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) and (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs,
- Clinically appropriate dispensing and monitoring of covered outpatient drugs,
- Drug use review, evaluation and intervention,
- Medical quality assurance.

1927(g;)(3)(C)
42 CFR 456.716(d)

3. The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

Revision: HCFA-PM-93-3 (MB)
April 1993

State/Territory: Mississippi

Citation		
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)		G.4. The interventions include in appropriate instances: - Information dissemination - Written, oral, and electronic reminders - Face-to-face discussion - Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712		H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(1) 42 CFR 456.722	x	I.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims system to perform on-line: - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacists, etc. applying for and receiving payment
1927(g)(2)(A)(i) 42 CFR 456.705(b)	___	2. Prospective DUR is performed using and electronic point-of-sale drug claims processing.
1927(j)(2) 42 CFR 456.703(c)		J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

*U.S. G.P.O.: 1993-342-239:80043

State/Territory: Mississippi

1902(a)(85)

Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act for Patients and Communities

K.1. **Claims Review Limitations:**

a. The Division of Medicaid's opioid related prospective point-of-sale (POS) safety edits are as follows except for those beneficiaries with certain diagnoses as recommended by the DUR Board:

1) Duplicate fill and early fill alerts: In addition to duplicate fill and early fill alerts on all opioids, new opioid prescriptions for opiate-naïve patients must be for a short-acting (SA) opioid. SA opioid prescriptions for opiate-naïve patients are limited to both day supply allowed per prescription fill and number of times the prescription can be filled per month in accordance with current DUR Board recommendations.
2) Quantity limits: Monthly quantity limits for all opioids.
3) Dosage limits: Maximum daily dosage limits for all opioids in accordance within the FDA approved indications or compendia supported guidelines.
4) MME limitations: Daily opioid doses, whether individual and/or cumulative daily sum of all opioid prescriptions for the patient, in excess of the Morphine Milligram Equivalents (MME) as recommended by the DUR Board will require prior authorization (PA) with documentation that the benefits outweigh the risks and that the patient has been counseled about the risks of overdose and death.
5) Concomitant use of opioids and benzodiazepines will require PA

b. The Division of Medicaid's opioid related retrospective reviews are as follows:

1) Beneficiary claims are reviewed to identify prescriber(s) who order the concomitant use of opioids/benzodiazepines or opioids/antipsychotics.
2) Notification is made to those prescribers regarding the appropriate accepted clinical use of these drugs and suggested tapering guidelines.
3) Opioid prescriptions exceeding MME limitations on an ongoing basis.

2. **Program to Monitor Antipsychotic Medications by Children Including Foster Children:** The Division of Medicaid's opioid related retrospective reviews are as follows:

a. Beneficiary claims are reviewed to identify prescriber(s) who order the concomitant use of opioids/benzodiazepines or opioids/antipsychotics.
b. Notification is made to those prescribers regarding the appropriate accepted clinical use of these drugs and suggested tapering guidelines.
c. Antipsychotic agents are reviewed for appropriateness based on approved indications and clinical guidelines.

State/Territory: Mississippi

3. **Fraud and Abuse Identification:** The Division of Medicaid's Beneficiary Health Management (BHM) program is designed to:

   a. Closely monitor program usage to identify beneficiaries who may be potentially over-utilizing or misusing prescription drugs by screening against criteria designed to identify drug seeking behavior, inappropriate use of prescription drugs, and patterns of inappropriate, excessive or duplicative use of pharmacy services.
   b. Restrict beneficiaries whose utilization of prescription drugs is documented at a frequency or amount that is not according to DUR Board recommendations and utilization guidelines established by Division of Medicaid.
   c. "Lock-in" beneficiaries for a period of twelve (12) months to one (1) physician and/or one (1) pharmacy of their choice and up to three (3) physician specialists, if requested, for his/her medical and/or pharmacy services to prevent beneficiaries from obtaining opioids and benzodiazepines through multiple visits to different physicians and pharmacies with ongoing reviews to monitor patterns of care.
   d. Prevent beneficiaries from obtaining non-medically necessary prescribed drugs through multiple visits to different physicians and pharmacies, monitor services received and reduce inappropriate utilization.
   e. Identify and refer provider/prescribers with inappropriate over-prescribing patterns to the appropriate licensure or law enforcement entity.
   f. Identify potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation		
42 CFR 431.115(c) AT-78-90 AT-79-74	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

TN # 79-29
Supersedes
TN #

Approval Date 1/3/80 Effective Date 10/15/79

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Mississippi

Citation	4.28 Appeals Process
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)).	(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
	(b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: Mississippi

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29	Conflict of Interest Provisions The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33		The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Mississippi

Citation		
42 CFR 1002.203	4.30	Exclusion of Providers and Suspension of Practitioners and Other Individuals
AT-79-54		
48 FR 3742	(a)	All requirements of 42 CFR Part 1002, Subpart B are met.
51 FR 34772		/_/ The agency, under the authority of State law, imposes broader sanctions.

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Mississippi

Citation

(b) The Medicaid agency meets the requirements of--

1902(p) of the Act
P.L. 100-93
(secs. 7)

(1) Section 1902(p) of the Act by excluding from participation--

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that--

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: Mississippi

Citation	
1902(a)(39) of the Act P.L. 100-93 (sec. 8(f))	(2) Section 1902(a)(39) of the Act by--
	(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
	(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
	(c) The Medicaid agency meets the requirements of--
1902(a)(41) of the Act P.L. 96-272, (sec. 308(c))	(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and
1902(a)(49) of the Act P.L. 100-93 (sec. 5(a)(4))	(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Citation		
42 CFR §§ 455.104-455.106 1902(a) (38) 1128(b) (9)	4.31	Disclosure of Information by Providers and Fiscal Agent The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128 (b) (9) and 1902 (a) (38) of the Act.
42 CFR §§ 435.940-435.960; QI Program Supplemental Funding Act of 2008, Pub. L. No. 110-379, 122 Stat. 4075	4.32	Income and Eligibility Verification System (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (Section 1137 of the Act and 42 CFR 435.940 through 435.960.) (b) Attachment 4.32-A describes, in accordance with 42 CFR 435.948 (a) (6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested. (c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered Title XIX services consistent with applicable PARIS Agreements.

Revision: HCFA-PM-~~87~~-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Mississippi

Citation
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987—201-618/60437

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Mississippi

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/ / The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/X/ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/ / Total waiver

/X/ Alternative system Manual Secondary Verification from INS

/ / Partial implementation

TN No. 88-13
Supersedes
TN No. 88-4 NEW

Approval Date JAN 0 9 1989
Received 12/22/88

Effective Date OCT 01 1988

HCFA ID: 1010P/0012P

Revision: HCFA PM-90-2 (BPD) JANUARY 1990 OMB No.: 0938-0193

State/Territory: Mississippi

Citation	4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation
1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))	(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.
	/ / Not applicable to intermediate care facilities; these services are not furnished under this plan.
	/X/ (b) The agency uses the following remedy(ies):
	(1) Denial of payment for new admissions.
	(2) Civil money penalty.
	(3) Appointment of temporary management.
	(4) In emergency cases, closure of the facility and/or transfer of residents.
1919(h)(2)(B)(ii) of the Act	/X/ (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.
1919(h)(2)(F) of the Act	/ / (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:
	/ / (1) Public recognition.
	/ / (2) Incentive payments.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Mississippi

Citation 4.35 Enforcement of Compliance for Nursing Facilities

42 CFR 488.402 (f) (a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402 (f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR 488.434 (ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR 488.402 (f) (2) (iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR 488.456 (c) (d) (iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR 488.404 (b) (1) (i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404 (b) (1) & (2).

_____ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Mississippi

Citation

(c) Application of Remedies

42 CFR 488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR 488.417 (b)
Sec. 1919 (h) (2) (C) of the Act

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR 488.417
Sec. 1919 (h) (2) (D) of the Act

(iii) The State imposes the denial of payment for new admissions remedy as specified in 42 CFR 488.417 (or its approved alternative) and a State monitor as specified at 42 CFR 488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR 488.408
Sec. 1919 (h) (2) (A) of the Act

(iv) The State follows the criteria specified at 42 CFR 488.408 (c) (2), 488.408 (d) (2), and 488.408 (e) (2), when it imposes remedies in place of or in addition to termination.

42 CFR 488.412 (a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412 (a) are not met.

(d) Available Remedies

42 CFR 488.406 (b)
Sec. 1919 (h) (2) (A) of the Act

(i) The State has established the remedies defined in 42 CFR 488.406 (b).

X	(1)	Termination
X	(2)	Temporary Management
X	(3)	Denial of Payment for New Admissions
X	(4)	Civil Money Penalties
X	(5)	Transfer of Residents; Transfer of Residents with Closure of Facility
X	(6)	State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Mississippi

Citation

42 CFR 488.406 (b)
Sec. 1919 (h) (2) (B) (ii)
of the Act

(ii) _____ The State uses alternative remedies. The state has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406 (b).

_____ (1) Temporary Management
_____ (2) Denial of Payment for New Admissions
_____ (3) Civil Money Penalties
_____ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
_____ (5) State Monitoring

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR 488.303 (b)
Sec. 1919 (h) (2) (F)
of the Act

(e) _____ State Incentive Programs

_____ (1) Public Recognition
_____ (2) Incentive Payments

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91- 10 (BPD)
DECEMBER 1991

State/Territory: Mississippi

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38		Nurse Aide Training and Competency Evaluation for Nursing Facilities
		(a)	The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	X	(b)	The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
	X	(c)	The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
		(d)	The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
	___	(e)	The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	___	(f)	The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

State/Territory: Mississippi

Citation	
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
	(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
	(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
	(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
	(k) For program reviews other than the initial review, the State visits the entity providing the program.
	(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

State/Territory: Mississippi

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(m)	The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
		(n)	The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
		(o)	The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
		(p)	The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
	X	(q)	The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
		(r)	The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

State/Territory: Mississippi

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(s)	When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
		(t)	The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
		(u)	The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
		(v)	The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
		(w)	Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
	X	(x)	The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
		(y)	The State has a standard for successful completion of competency evaluations.

State/Territory: Mississippi

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	___	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	___	(cc)	The State includes home health aides on the registry.
	___	(dd)	The State contracts the operation of the registry to a non State entity.
	X	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	X	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Citation
Secs. 1902(a) (28)(D) (i) and 1919 (e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P .L. 101-508 (Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review (PASRR) in Nursing Facilities (NF)

(a) The Medicaid agency has in effect a written agreement with the State mental health and intellectual and developmental disability authorities that meet the requirements of 42 C.F.R. § 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 C.F.R. § 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR § 483.118(c)(1), the State does not claim as "medical assistance under the State Plan" the cost of NF services to individuals who are found not to require NF services.

X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Mississippi

Citation
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
P.L. 101-508
(Sec. 4801(b)).

4.39 Continued

___ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Mississippi

Citation 1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Mississippi

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on 01-01-07.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Citation 1902(a)(69) of the Act, P.L. 109-171 (section 6034)	4.43 Cooperation with Medicaid Integrity Program Efforts. The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Mississippi

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation	
Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)	_x_ The State shall not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside the United States.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State Mississippi

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Revision: HCFA-AT-~~81-~~ 82-10 (BPP)

State Mississippi

Citation
42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

TN # 82-10
Supersedes
TN # 76-4

Approval Date 8-25-82 Effective Date 7-1-82

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Mississippi

Citation
42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

☒ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☐ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Mississippi

SECTION 7 - GENERAL PROVISIONS

Citation	7.1	Plan Amendments
42 CFR 430.12(c)		The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938
August 1991

State / Territory: Mississippi

Citation		
	7.2	**Nondiscrimination**
45 CFR Parts 80 and 84		In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. Seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap. The Medicaid agency has methods of administration to assure that each program or activity for which it receives federal financial assistance will be operated in accordance with Title VI regulations. These methods for Title VI are described in ATTACHMENT 7.2-A

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: Mississippi

Citation

Section 7.3 Maintenance of AFDC Efforts, deleted per 3/92 memo from OMP.

Revision: **HCFA-PM-91-4 August 1991** **(BPD)** **OMB No. : 0938-**

State/Territory: Mississippi

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services (CMS) with such documents.

☐ Not applicable. The Governor –

☐ Does not wish to review any plan material.

☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Division of Medicaid, Office of the Governor
(Designated Single State Agency)

9/27/18
DATE

Signature

Executive Director
Title

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X___ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. __X__ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

The Mississippi Division of Medicaid (DOM) will allow additional coverage of telehealth services during the current emergency as listed below:

a. A beneficiary's residence may be an originating site without prior approval by the Division of Medicaid.
b. DOM approved emergency telehealth originating and distant site providers not listed in Mississippi Medicaid State Plan, Attachment 3.1-A, Introductory Page 1, Section 5 or Miss. Admin. Code Title 23, Part 225 are listed in DOM's Emergency Telehealth Policy at https://medicaid.ms.gov/coronavirus-updates/.
c. Emergency telehealth services are expanded to include use of telephonic audio that does not include video when authorized by the state.
d. A beneficiary may use the beneficiary's personal telephonic land line in addition to a cellular device, computer, tablet, or other web camera-enabled device to seek and receive medical care in a synchronous format with a distant-site provider.
e. When the beneficiary receives services in the home, the requirement for a telepresenter to be present may be waived.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

    a. ____ Published fee schedules –

    Effective date (enter date of change): _____

    Location (list published location): _____

    b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

    a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

    b. Payments are increased through:

        i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

        ii. ____ An increase to rates as described below.

        Rates are increased:

        _____ Uniformly by the following percentage: _____

        _____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. __X__ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. __X__ Are not otherwise paid under the Medicaid state plan;

   b. ____ Differ from payments for the same services when provided face to face;

   c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

1. Emergency Telehealth FFS rates are located at https://medicaid.ms.gov/coronavirus-updates/ 2. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will be reimbursed as a distant site provider as follows: a. DOM will pay the PPS rate for any services within the scope of services for an FQHC or RHC. b. For services provided by an FQHC or RHC that are not within the scope of services for an FQHC or RHC , DOM will pay a rate based on the state fee schedule. 3. In instances when the originating site is a beneficiary's residence or other location that is not a Mississippi Medicaid provider, no originating site fee will be paid. 4. Providers acting in the role of both a telehealth distant and originating site provider will be reimbursed either the originating or distant site fee-for-service rate, not both.

   d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. ____ The individual's total income

    b. ____ 300 percent of the SSI federal benefit rate

    c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have

comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

The Mississippi Division of Medicaid intends for this SPA to be effective for the length of the emergency period starting March 1, 2020.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

_X___ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. _X___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. _X___ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

This SPA is in addition to the Disaster Relief SPA approved on May 6, 2020 and does not superseded anything approved in that SPA.

c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

This SPA is in addition to the Disaster Relief SPA approved on May 6, 2020 and does not superseded anything approved in that SPA.

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

This SPA is in addition to the Disaster Relief SPA approved on May 6, 2020 and does not superseded anything approved in that SPA.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. __X__ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

The State waives cost-sharing for testing services (including in vitro diagnostic products), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies (including drugs), for any quarter in which the temporary increased FMAP is claimed.

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

This SPA is in addition to the Disaster Relief SPA approved on May 6, 2020 and does not superseded anything approved in that SPA.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

    a. ____ Published fee schedules –

    Effective date (enter date of change): _____

    Location (list published location): _____

This SPA is in addition to the Disaster Relief SPA approved on May 6, 2020 and does not superseded anything approved in that SPA.

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

This SPA is in addition to the Disaster Relief SPA approved on May 6, 2020 and does not superseded anything approved in that SPA.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. _____ Are not otherwise paid under the Medicaid state plan;

    b. _____ Differ from payments for the same services when provided face to face;

    c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

This SPA is in addition to the Disaster Relief SPA approved on May 6, 2020 and does not superseded anything approved in that SPA.

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

This SPA is in addition to the Disaster Relief SPA approved on May 6, 2020 and does not superseded anything approved in that SPA.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here. Effective date: April 1, 2020

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X___ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X___ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

a. _____ All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

a. ____ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

Please list all that apply.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. ____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. ___ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

    d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __X___ Other payment changes:

Please describe. **Community Mental Health Center (CMHC) Interim Payments:** The Division of Medicaid will make interim payments based on FFS utilization to the fourteen (14) CMHCs enrolled as providers with the Division. The average payment amount will be based on data from State Fiscal Year (SFY) 2019 which will be used to determine a provider-specific monthly payment amount. The provider specific payment amount will be calculated by increasing the monthly average payment amount by an additional 25% (average payment X 1.25). This amount will be used to make interim payments during the months of September 2020 through December 2020 or through the end of the PHE whichever comes sooner. Interim payment and

claims payments will not be made during the same time frame. Claims will continue to be adjudicated during the months of the interim payments, but only the interim payment amounts will be paid to the CMHCs.

At the end of the calendar quarter in which the emergency period ends, the state will reconcile the interim payments with billed claims and recoup any overpayment over a six month period.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
    a. ____ The individual's total income
    b. ____ 300 percent of the SSI federal benefit rate
    c. ____ Other reasonable amount: _____
2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

    The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the

information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-019 MAGI-Based Eligibility Group SPA	**STATE:** **Mississippi**

Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S54, S57, and S14 and related pages or sections of pages being deleted as obsolete

State Plan Section	Complete Pages Removed	Partial Pages Removed
Attachment 2.2-A	Page 1 Page 3 Page 3a Page 4 Page 4a Page 12 Page 13 Page 13a Page 14 Page 14a Page 21 Page 23 Page 23b Page 23d Page 23g	Page 2, A.2.b Page 2, A.2.c Page 2a, A. 3. Page 5, A.10. Page 9c, B.1 for caretaker relatives & pregnant women Page 20, B.14 Page 23c, B.19 Page 23f, B.23 Page 25, C.4.
Supplement 1 to Attachment 2.2-A	Page 1	
Attachment 2.6-A	Page 3b Page 11a Page 19 Page 19a Page 19b Page 21	Page 1, A.2.a.(i) & (iii) Page 6 related to AFDC recipients, pregnant women, infants, and children Page 7, 1.a(1) & (2) Page 12, 5.e.(2) Page 18, 5.e Page 25, 11.a.(3)
Supplement 1 to Attachment	Pages 1-4	

2.6-A		
Supplement 2 to Attachment 2.6-A	Pages 1-5	
Supplement 5 to Attachment 2.6-A	Page 1	
Supplement 5a to Attachment 2.6-A	Page 1	
Supplement 8a to Attachment 2.6-A	Page 5	Page 3, #2
Supplement 12 to Attachment 2.6-A	Pages 1-3	

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards — S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	227	X
+	2	306	X
+	3	384	X
+	4	462	X
+	5	541	X
+	6	619	X
+	7	697	X
+	8	775	X

Additional incremental amount
(•) Yes ( ) No

Increment amount $ 78

The dollar amounts increase automatically each year
( ) Yes (•) No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	218	X
+	2	293	X
+	3	368	X
+	4	443	X
+	5	518	X
+	6	593	X
+	7	668	X
+	8	743	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 75

The dollar amounts increase automatically each year

( ) Yes (•) No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

Medicaid Eligibility

	Household size	Standard ($)	
+	1	227	X
+	2	306	X
+	3	384	X
+	4	462	X
+	5	541	X
+	6	619	X
+	7	697	X
+	8	775	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 78

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

( ) Statewide standard

( ) Standard varies by region

( ) Standard varies by living arrangement

( ) Standard varies in some other way

The dollar amounts increase automatically each year

( ) Yes ( ) No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent TANF payment standard

Medicaid Eligibility

Income Standard Entry - Dollar Amount - Automatic Increase Option 813a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives **S25**

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☐ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ Options relating to the definition of caretaker relative (select any that apply):

☒ Options relating to the definition of dependent child (select the one that applies):

○ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

◉ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

○ The principal earner may work 100 or more hours per month and still qualify as unemployed.

Indicate the number of hours used: [ ] hours

○ The principal earner may earn up to a specific dollar amount and still qualify as unemployed.

Indicate the specific dollar limit of earnings: $ [ ]

◉ Other less restrictive standard

	Name of other standard	Description	
+	Under-employed	Two-parent households are only required to have income below the state established need standard for the family size.	X

■ Have household income at or below the standard established by the state.

Medicaid Eligibility

☑ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☑ Income standard used for this group

☑ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ Other dollar amount

☑ Income standard chosen:

Indicate the state's income standard used for this eligibility group:

◉ The minimum income standard

○ The maximum income standard

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

○ Another income standard in-between the minimum and maximum standards allowed

☑ There is no resource test for this eligibility group.

☑ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Pregnant Women	S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

◉ Yes ○ No

Enter the amount of the minimum income standard (no higher than 185% FPL): 185 % FPL

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

- ○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ○ 185% FPL

The amount of the maximum income standard is: 194 % FPL

☑ Income standard chosen

Indicate the state's income standard used for this eligibility group:

- ○ The minimum income standard
- ◉ The maximum income standard
- ○ Another income standard in-between the minimum and maximum standards allowed.

☑ There is no resource test for this eligibility group.

☑ Benefits for individuals in this eligibility group consist of the following:

- ◉ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- ○ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

☑ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

○ Yes ◉ No

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19 **S30**

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

◉ Yes ○ No

Enter the amount of the minimum income standard (no higher than 185% FPL): 185 % FPL

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

◉ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

Enter the amount of the maximum income standard: 194 % FPL

■ Income standard chosen

The state's income standard used for infants under age one is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age one through age five, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 143 % FPL

☑ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

☑ Income standard for children age six through age eighteen, inclusive

☑ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ 133% FPL

☑ Income standard chosen

The state's income standard used for children age six through eighteen is:

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Adult Group	S32
1902(a)(10)(A)(i)(VIII) 42 CFR 435.119	
The state covers the Adult Group as described at 42 CFR 435.119. ○ Yes ◉ No	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Former Foster Care Children	S33

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

■ **Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

☑ The state attests that it operates this eligibility group under the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under age 26.

■ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

■ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

○ Yes ◉ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL	S50
1902(a)(10)(A)(ii)(XX) 1902(hh) 42 CFR 435.218	
Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage **Optional Coverage of Parents and Other Caretaker Relatives**	**S51**
42 CFR 435.220 1902(a)(10)(A)(ii)(I)	
Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220. ○ Yes ◉ No	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21 **S52**

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

(•) Yes ( ) No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

■ Be under age 21, or a lower age, as defined within the reasonable classification.

■ Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

■ Not be eligible and enrolled for mandatory coverage under the state plan.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(•) Yes ( ) No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(•) Yes ( ) No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

☑ The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

An attachment is submitted.

Current Coverage of All Children under a Specified Age

The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

○ Yes ◉ No

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

◉ Yes ○ No

Indicate the reasonable classifications of children that were covered in the state plan in effect as of March 23, 2010 with income standards higher than the mandatory standards used for the child's age, using age limits and income standards that are not more restrictive than used in the state plan as of as March 23, 2010 and are not less restrictive than used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

Reasonable Classifications of Children **S11**

☒ Individuals for whom public agencies are assuming full or partial financial responsibility.

☒ Individuals placed in foster care homes by public agencies

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

☐ Individuals placed in foster care homes by private, non-profit agencies

☒ Individuals placed in private institutions by public agencies

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

☐ Individuals placed in private institutions by private, non-profit agencies

☒ Individuals in adoptions subsidized in full or part by a public agency

Indicate the age which applies:

◉ Under age 21 ○ Under age 20 ○ Under age 19 ○ Under age 18

☐ Individuals in nursing facilities, if nursing facility services are provided under this plan

☐ Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

☐ Other reasonable classifications

Enter the income standard used for these classifications. The income standard must be higher than the mandatory standard for the child's age. It may be no lower than the income standard used in the state plan as of March 23, 2010 and no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Click here once S11 form above is complete to view the income standards form.

Individuals placed in foster care homes by public agencies

■ Income standard used

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

■ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals placed in private institutions by public agencies

■ Income standard used

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

■ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals in adoptions subsidized in full or part by a public agency

☑ Income standard used

☑ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☑ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

○ Yes ◉ No

☑ The state certifies that it has submitted and received approval for its converted income standards for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for this classification of children under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should only be selected for children 19 and older, and only if the state has not elected to cover the Adult Group.

○ Other dollar amount

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

○ The minimum standard.

◉ The maximum income standard.

○ If not chosen as the maximum income standard, the state's effective income level for this classification under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for this classification under a Medicaid 1115 Demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

◉ Yes ○ No

The additional previously covered reasonable classifications to be included are:

Additional Previously Covered Reasonable Classifications Included

Reasonable Classifications of Children	S11
☐ Individuals for whom public agencies are assuming full or partial financial responsibility.	
☐ Individuals in adoptions subsidized in full or part by a public agency	

Medicaid Eligibility

☐ Individuals in nursing facilities, if nursing facility services are provided under this plan

☐ Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

☒ Other reasonable classifications

	Name of classification	Description	Age Limit	
+	Pregnant Minors	Pregnant minors not otherwise eligible for full Medicaid coverage in any other category of coverage	Under age 19	X

Enter the income standard used for these classifications (which must be higher than the mandatory standard for the child's age but may be no higher than the highest standard used in the state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013).

Click here once S11 form above is complete to view the income standards form.

Pregnant Minors

■ Income standard used

■ Minimum income standard

The minimum income standard for this classification of children must exceed the lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

■ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

■ No income test was used (all income was disregarded) for this classification under:

(check all that apply)

☐ The Medicaid state plan as of March 23, 2010.

☒ The Medicaid state plan as of December 31, 2013.

☐ A Medicaid 1115 Demonstration as of March 23, 2010.

☐ A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

■ Income standard chosen

Individuals qualify under this classification under the following income standard:

(•) This classification does not use an income test (all income is disregarded).

( ) Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

( ) Yes (•) No

[■] There is no resource test for this eligibility group.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance **S53**

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

[■] Are under the following age (see the Guidance for restrictions on the selection of an age):

(•) Under age 21

( ) Under age 20

( ) Under age 19

( ) Under age 18

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(•) Yes ( ) No

[■] Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

[■] Income standard used for this eligibility group

[■] Minimum income standard

The minimum income standard for this eligibility group is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

[■] Maximum income standard

Medicaid Eligibility

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

[■] No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

- [ ] The Medicaid state plan as of March 23, 2010.
- [☒] The Medicaid state plan as of December 31, 2013.
- [ ] A Medicaid 1115 Demonstration as of March 23, 2010.
- [ ] A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

[■] Income standard chosen

Individuals qualify under this eligibility group under the following income standard, which must be higher than the minimum for this child's age:

( ) The minimum standard.

(•) This eligibility group does not use an income test (all income is disregarded).

( ) Another income standard higher than both the minimum income standard and the effective income level for this eligibility group in the state plan as of March 23, 2010, converted to a MAGI-equivalent.

[■] There is no resource test for this eligibility group.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Optional Targeted Low Income Children	S54
1902(a)(10)(A)(ii)(XIV) 42 CFR 435.229 and 435.4 1905(u)(2)(B)	
Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals with Tuberculosis	S55
1902(a)(10)(A)(ii)(XII) 1902(z)	
Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services. ○ Yes ◉ No	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Independent Foster Care Adolescents **S57**

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] Are under the following age

(•) Under age 21

( ) Under age 20

( ) Under age 19

[■] Were in foster care under the responsibility of a state on their 18th birthday.

[■] Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

[■] Have household income at or below a standard established by the state.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(•) Yes ( ) No

[■] The state covers children under this eligibility group, as follows (selection may not be more restrictive than the coverage in the Medicaid state plan as of March 23, 2010 until October 1, 2019, nor more liberal than the most liberal coverage in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013):

( ) All children under the age selected

(•) A reasonable classification of children under the age selected:

( ) Individuals for whom foster care maintenance payments or independent living services were furnished under a program funded under title IV-E before the date the individual turned 18 years old.

(•) Other reasonable classification

Description : independent foster care adolescents who are in foster care under the responsibility of the Department of Human Services on their 18th birthday.

[■] Income standard used for this eligibility group

Medicaid Eligibility

☒ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☒ Maximum income standard

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

☒ No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

☒ The Medicaid state plan as of March 23, 2010.

☒ The Medicaid state plan as of December 31, 2013.

☐ A Medicaid 1115 demonstration as of March 23, 2010.

☐ A Medicaid 1115 demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

☒ Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

This eligibility group does not use an income test (all income is disregarded).

☒ There is no resource test for this eligibility group.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals Eligible for Family Planning Services	S59
1902(a)(10)(A)(ii)(XXI) 42 CFR 435.214	
Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214. ○ Yes ◉ No	

PRA Disclosure Statement

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SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: MS-13-0021-MM3	**STATE: Mississippi**
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:**
S10 - MAGI Income Methodology	Notwithstanding any other provisions of the Mississippi Medicaid State Plan, the financial eligibility methodologies described in State Plan Amendment 13-0021-MM3 will apply to all MAGI-based eligibility groups covered under Mississippi's Medicaid State Plan. The MAGI financial methodologies set forth in 42 CFR § 435.603 apply to everyone except those individuals described at 42 CFR § 435.603(j) for whom MAGI-based methods do not apply. This State Plan Amendment supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ○ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted as herself, plus one.
- ◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size
- ○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☒ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

○ Yes ◉ No

Medicaid Eligibility

☑ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

◉ Age 19

○ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

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STATE Mississippi

DEFINITION OF A HEALTH MAINTENANCE ORGANIZATION

Health Maintenance Organizations (HMO) are limited to any public or private entity paid on a prepaid or fixed-sum basis which provides health service insurance coverage or provides health services to recipients and which:

(1) Is organized primarily for the purpose of insuring or providing health care or other services of the type regularly offered to Medicaid recipients;

(2) Ensures that services meet the standards set by the agency for quality, appropriateness, and timeliness;

(3) Manages the care of Medicaid recipients and assigns patients to primary care physicians responsible for providing primary care services and authorizing specialty care;

(4) Makes provisions satisfactory to the agency for insolvency protection and ensures that neither enrolled Medicaid recipients nor the agency will be liable for the debts of the entity; and

(5) Makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid recipients within the area served by the HMO.

(6) Has a certificate of authority to operate as a health maintenance organization and is in compliance with the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act as established by authority of Mississippi Code Ann. § 83-41-301 et seq. (1972, as amended), and the Patient Protection Act of 1995 as established by authority of Mississippi Code Ann. § 83-41-401 et seq. (1972, as amended).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency* Citation(s) Groups Covered

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

IV-A 42 CFR 435.110
Division of Medicaid

1. Recipients of AFDC

The approved State AFDC plan includes:

/x / Families with an unemployed parent for the mandatory 6-month period and an optional extension of __ months.

/ / Pregnant women with no other eligible children.

/ / AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of Attachment 2.6-A.

IV-A 42 CFR 435.115
Division of Medicaid

2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

Page superseded by SPA 13-0019 S25 and S30

*Agency that determines eligibility for coverage.

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered
IV-A Division of Medicaid		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
		2. Deemed Recipients of AFDC
	1902(a)(10)(A)(i)(I) of the Act	~~b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.~~
	402(a)(22)(A) of the Act	~~c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.~~ [Superseded by SPA 13-0019 S25 effective: 01-01-14]
	406(h) and 1902(a)(10)(A)(i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered
IV-A Division of Medicaid		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
~~407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act~~		~~3. Qualified Family Members~~ ~~Effective October 1, 1990, qualified family members who would who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.~~ ~~/ / Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.~~ [Superseded by SPA 13-0019 S25 effective: 01-01-14]
1902(a)(52) and 1925 of the Act		4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
IV-A Division of Medicaid	42 CFR 435.113	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are: a. Families denied AFDC solely because of income and resources deemed to be available from-- (1) Stepparents who are not legally liable for support of stepchildren under a-State law of general applicability; (2) Grandparents; (3) Legal guardians; and (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent); b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit. c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

Page superseded by SPA 13-0019 S25 and S30

*Agency that determines eligibility for coverage.

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered
IV-A Division of Medicaid		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.114	6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under P.L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.
		_ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan)
		x Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).
		_ Not applicable with respect to intermediate care facilities; State did or does not cover this service.
	1902(a)(10)(A)(i)(III) and 1905(n) of the Act	7. Qualified Pregnant Women and Children
		a. A pregnant woman whose pregnancy has been medically verified who--
		(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

Page superseded by SPA 13-0019 8/28

*Agency that determines eligibility for coverage.

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered
Division of Medicaid	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	7. a. (2)	Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or
	(3)	Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
1902(a)(10)(A)(i)(III) and 1905(n) of the Act	b.	Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
	_	Children born after (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

Page superseded by SPA 13-0019 S25 and S30

Citation(s)

Groups Covered

Division of Medicaid

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act

8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(1)(1) (A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.

x The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State Plan, State legislation, or State appropriations as of December 19, 1989.

9. Children

1902(a)(10)(A)(i)(VI) and 1902(l)(1)(C) of the Act

a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

1902(a)(10)(A)(i)(VII) and 1902(1)(1)(D) of the Act

b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

/x / Children born after February 29, 1980 (specify the optional earlier date) who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.

Page superseded by SPA 13-0019 S2a and S30

Citation(s) Groups Covered

Division of Medicaid A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

~~1902(a)(10)(A)(i)(V) and 1905(m) of the Act~~ ~~10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.~~ [Superseded by SPA 13-0019 N/A to MS effective 01-01-14]

1902(e)(5) of the Act 11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State Plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

1902(e)(6) of the Act b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

Citation(s) Groups Covered

Division of Medicaid A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(e)(4) of the Act

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

42 CFR 435.120

13. Aged, Blind and Disabled Individuals Receiving Cash Assistance

x a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

x Aged
x Blind
x Disabled

Agency* Citation(s) Groups Covered

Division of Medicaid

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

435.121

13. / / b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

1619(b)(1)
of the Act

_ Aged
_ Blind
_ Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
SSI		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	14. Qualified severely impaired blind and disabled individuals under age 65, who--
		a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
		b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--
		(1) Continue to meet the criteria for blindness or have the disabling physical or mental Impairment under which the individual was found to be disabled;
		(2) Except for earnings, continue to meet all non-disability related requirements for eligibility for SSI benefits;

*Agency that determined eligibility for coverage

Agency* Citation(s) Groups Covered

SSI A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

/x / Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
SSI	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1619(b)(3) of the Act	/ /	The state applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
SSI		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1634(c) of the Act		15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who-- a. Are at least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility. c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in - determining the amount of countable income for categorically needy eligibility.
42 CFR 435.122 Division of Medicaid		16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under S435.230), because of requirements that do not apply under title XIX of the Act.

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
SSI		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
42 CFR 435.130 Dept. of Human Service		17. Individuals receiving mandatory State-supplements.
42 CFR 435.131		18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment. / / In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s): ___ Aged ___ Blind ___ Disabled /x / Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
SSI		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.132 Division of Medicaid	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX inter-mediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State Plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
	42 CFR 435.133 Division of Medicaid	20. Blind and disabled individuals who— a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determined eligibility for coverage

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered
SSI	42 C FR 435.134 Division of Medicaid	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under P. L. 92-336 (July 1, 1972) who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. / / Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). /x / Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care .facility (this group was included in this State's August 1972 plan). / / Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
SSI	42 CFR 435.135 Division of Medicaid	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 22. Individuals who a. Are receiving OASDI and were receiving SSI/SSP but becam6 ineligible for SSI/SSP after April 1977; and b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income. /x/ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients. / / Not applicable because the State applies more restrictive eligibility requirements than those under SSI. / / The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determined eligibility for coverage

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered
SSI 1634 of the Act Division of Medicaid	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of P. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

/x/ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

/ / The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for non-countable income for SSP only, when determining Medicaid categorically needy eligibility.

*Agency that determined eligibility for coverage

Agency* Citation(s) Groups Covered

SSI
1634(d) of the Act
Division of Medicaid

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

— The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

— In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in Section 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

— In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in S1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregard is specified in Supplement 4 to Attachment 2.6-A.

— In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in S 1634(d)(1)(A) in determining the income of the individual.

*Agency that determined eligibility for coverage

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

24a. Disabled widows and widowers and disabled surviving divorced spouses who would be eligible for SSI except for Division of Medicaid entitlement to an OASDI benefit resulting would be eligible for SSI except for entitlement to an OASDI benefit, and who are deemed, for the purposes of title XIX, to be SSI recipients under 1634 of the Act.

*Agency that determined eligibility for coverage

State: Mississippi

Agency	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

__ The State applies more restrictive eligibility standards than those under SSI and part or all of the amount of the benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act

24. Qualified Medicare Beneficiaries --

a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);

b. Whose income does not exceed 100 percent of the Federal poverty level; and

c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)

1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act

25. Qualified Disabled and Working Individuals --

a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;

b. Whose income does not exceed 200 percent of the Federal poverty level; and

State: Mississippi

Agency	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

c. Whose resources do not exceed two times the SSI resource limit.

d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act

26. Specified Low-Income Medicare Beneficiaries --

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);

b. whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and

c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

State: Mississippi

Agency	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	27. Qualifying Individuals -- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level: c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

State/Territory: Mississippi

Agency*	Citation(s)			Groups covered
IV-A		B.		Optional Groups Other Than the Medically Needy
	42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act	[ ]	1.	Individuals described below who meet the income and resources requirements of AFDC, SSI, or an optional state supplement as specified in 42 CFR 435.230, but who do not receive cash assistance. [ ] The plan covers all individuals as described above. [ ] The plan covers only the following group or groups of individuals: _ Aged _ Blind _ Disabled _ ~~Caretaker relatives~~ _ ~~Pregnant women~~ [Superseded by SPA13-0019 N/A to MS effective 01-01-14]
	Section 1902 (v)(1) (42 U.S.C. 1396(a)			[ ] The plan covers individuals not receiving SSI who the State finds blind or disabled and who are determined otherwise eligible for assistance during the period of time prior to which a final determination of disability or blindness is made by Social Security Administration. The State applies the definitions of disability and blindness found in Section 1614 (a) of the Social Security Act.
	42 CFR 435.211 Division of Medicaid	[x]	2.	Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determined eligibility for coverage

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered
IV-A	42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508 (section 4732)	B. Optional Groups Other Than the Medically Needy (Continued) 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or while enrolled in an entity described in section 1903(m)(2)(B)(111), (E) or (G) or 1903(m)(6) of the Act, or a Competitive Medical Plan (CHP) with a Medicare contract under section 1876 of the Act, but who have been enrolled in the HMO or entity for leas than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20(a). Coverage under this section is limited to HMO services and family planning services described in section 1905(a)(4)(C). _ The State elects not to guarantee eligibility. _ The State elects to guarantee eligibility. The minimum enrollment period is ___ months (not to exceed six). The State measures the minimum enrollment period from: _ The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility. _ The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

*Agency that determined eligibility for coverage

State/Territory: Mississippi

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

_ The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment of periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

1903(M)(2)(F) of the Act, P.L. 98-369 (section 2364), P.L. 99-272 (section 9517), P.L. 101-508 (section 4732)

The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of certain Federally qualified HMOs Competitive Medical Plans (CMPS) with Medicare contracts under section 1876 of the Act, and other organizations described in 42 CFR 434.27(d), in accordance with the regulations at 42 CFR 434.27. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

_ Disenrollment rights are restricted for a period of _ months (not to exceed 6 months).

During the first month of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least twice per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

_ No restrictions upon disenrollment rights.

*Agency that determined eligibility for coverage

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 (section 4732)	In the case of individuals who have become ineligible for of Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an entity having a contract under section 1903(m) when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.
		_ The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.
		_ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

*Agency that determined eligibility for coverage

State/Territory: Mississippi

Agency*	Citation(s)	Groups Covered
IV-A	B.	Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.217	X	4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
IV-A Division of Medicaid	B.	Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(VII) of the Act	/ / 5.	Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

/ / The State covers all individuals as described above.

/ / The State covers only the following group or groups of individuals:

_ Aged
_ Blind
_ Disabled
_ Individuals under the age of--
  _ 21
  _ 20
  _ 19
  _ 18
_ Caretaker relatives
_ Pregnant women

*Agency that determined eligibility for coverage

Agency*	Citation(s)			Groups Covered
IV-A		B.		Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.220		/ /	6.	Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC. / / The State covers all individuals as described above. / / The State covers only the following group or groups of individuals: __ Individuals under the ago of-- __ 21 __ 20 __ 19 __ 18 __ Caretaker relatives __ Pregnant woman
1902(a)(10)(A)(ii) and 1905(a) of the Act				
IV-A 42 CFR 435.222 1902(a)(10)(A)(ii) and 1905(a)(i) of the Act Division of Medicaid			7. /x / a.	All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21 as indicated below. __ 20 __ 19 x 18

Page superseded by SPA 13-0019 S30

*Agency that determined eligibility for coverage

Agency* | Citation(s) | Groups Covered

IV-A | B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.222
Dept. of Human Services

/x / b. Reasonable classifications of individuals described in (a) above, as follows:

x (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

x (a) in foster homes (and are under the age of 21).

x (b) in private institutions (and are under the age of 21).

__ (c) in addition to the group under b.(l)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___).

x (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21).

__ (3) Individuals in NFs (who are under the age of ___). NF services are provided under this plan.

__ (4) In addition to the group under (b)(3), individuals in ICFS/MR (who are under the age of ___).

Page superseded by SPA 13-0019 S52

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered

IV-A

B. Optional Groups Other Than the Medically Needy (Continued)

_ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

x (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

Page superseded by SPA 13-0019 S52 and S57

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
IV-A		B. Optional Groups Other Than the Medically Needy (Continued)
	1902(a)(10)(A)(ii)(VIII) of the Act Dept. of Human Services	/x / 8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act) who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement--

a. Was eligible for Medicaid under the State's approved Medicaid plan; or

b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of-

x 21
_ 20
_ 19
_ 18

Page superseded by SPA 13-0019 553

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.223	_ 9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:
	1902(a)(10)(A)(ii) and 1905(a) of the Act	_ Individuals under the age of--
		_ 21
		_ 20
		_ 19
		_ 15
		_ Caretaker relatives
		_ Pregnant women

Page superseded by SPA 13-0019 NA to MS

*Agency that determined eligibility for coverage

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

SSI
42 CFR 435.230

/ / 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act

The following groups of individuals who receive only a state supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

_ (1) All aged individuals.
_ (2) All blind individuals.
_ (3) All disabled individuals.

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
SSI	B.	Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435-230		

_ (4) Aged individuals in domiciliary facilities or other group living.

_ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

_ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

_ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

_ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

_ (9) Individuals in additional classifications approved by the Secretary as follows:

*Agency that determined eligibility for coverage

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

_ Yes

_ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

*Agency that determined eligibility for coverage

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.121
435.230
1902(a)(10)
(A)(ii)(XI)
of the Act

/ / 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

_ (1) All aged individuals.

_ (2) All blind individuals.

_ (3) All disabled individuals.

*Agency that determined eligibility for coverage

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

_ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

_ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

_ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

_ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

_ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

_ (9) Individuals in additional classifications approved by the Secretary as follows:

*Agency that determined eligibility for coverage

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

_ Yes

_ No

The standards for optional State supplementary payments are listed in Supplement 6 to ATTACHMENT 2.6-A.

*Agency that determined eligibility for coverage

Agency* | Citation(s) | Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

SSI
42 CFR 435.231
1902(a)(10)
(A)(ii)(V)
Of the Act
Division of Medicaid

/x/ 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

/ / The State covers all individuals as described above.

/x/ The State covers only the following group or groups of individuals:

1902(a)(10)(A)
(ii) and 1905(a)
of the Act

- x Aged
- x Blind
- x Disabled
- __ Individuals under the age of--
  - __ 21
  - __ 20
  - __ 19
  - __ 18
- __ Caretaker relatives
- __ Pregnant women

*Agency that determined eligibility for coverage

Agency*	Citation(s)			Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)	
Division of Medicaid	1902(e)(3) Of the Act	/x/	13.	Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. *Medical institution Supplement 3 to ATTACHMENT 2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
~~Division of Medicaid~~	~~IV-A 1902(a)(10)(A)(ii)(IX) and 1902(1) of the Act~~	~~/x/~~	~~14.~~	~~The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:~~ ~~a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and~~ ~~b. Infants under one year of age.~~ [Superseded by SPA 13-0019 S28 and S30 effective 01-01-14]

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
IV-A		/ / 15. The following individuals who are not mandatory categorically needy who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size.
1902(a)(10)(A)(ii)(IX) and 1902(1)(1)(D) of the Act		Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained--age 19* / / 7 years of age; or / / 8 years of age.

*A mandatory coverage group under OBRA 1990.

Page superseded by SPA 13-0019 S30

*Agency that determined eligibility for coverage

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(ii)(X) and 1902(m)(1) and (3) of the Act

_ 16. Individuals--

a. Who are 65 years of age or older or are disabled, as determined under Section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Citation(s)	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(47) and 1920 of the Act	_ 17. Pregnant women who are determined by a qualified provider" (as defined in S1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with S1920 of the Act.

Page superseded by SPA 13-0019 S28

Citation(s)

Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1906 of the Act

18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of 11 months.

1902(a)(10)(F) and 1902(u)(1) of the Act

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

Citation | Groups Covered

B. Optional Coverage Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(XIV) of the Act

_ 19. Optional Targeted Low Income Children who:

a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spend-down liability);

b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in 1902(l)(2)(D));

c. are not covered under a group health plan or other group health insurance (as such terms are defined in 2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program;

d. have family income at or below:

200 percent of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or

Page superseded by SPA 13-0019 554

Citation	Groups Covered		
			~~A percentage of the Federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in 2110(b)(4) of the Act) but by no more than 50 percentage points.~~ ~~The State covers:~~ ~~_ All children described above who are under age __ (18, 19) with family income at or below ___ percent of the Federal poverty level.~~ ~~_ The following reasonable classifications of children described above who are under age __ (18, 19) with family income at or below the percent of the Federal poverty level specified for the classification:~~ ~~(ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATION(S) AND THE PERCENT OF THE FEDERAL POVERTY LEVEL USED TO ESTABLISH ELIGIBILITY FOR EACH CLASSIFICATION.)~~ [Superseded by SPA 13-0019 S54 effective 01-01-14]
1902(e)(12) of the Act	x	20.	A child under age 19 (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

State/Territory: Mississippi

Citation	Groups Covered		
1902A of the Act	—	21.	Children under age 19 who are determined by a "qualified entity" (as defined in 1920A(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan. The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

Page superseded by SPA 13-0019 N/A to MS

Citation(s) Groups Covered

1902(a)(10)(A)(ii)(XVIII) of the Act
Division of Medicaid

B. Optional Coverage Groups Other Than the Medically Needy (Continued)

x 22. Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Center Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group, and,

d. have not attained age 65.

Citation(s)			Groups Covered
~~1902A(b) of the Act Division of Medicaid~~	B.		Optional Coverage Groups Other Than the Medically Needy (Continued)
	x	23.	~~Women who are determined by a "qualified entity" (as defined in 1902A(b)) based on preliminary information, to be a woman described in 1902(a)(10)(A)(ii)(XVIII) of the Act related to certain breast and cervical patients.~~ ~~The presumptive period begins on the first day of the month that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.~~ [Superseded by SPA 13-0019 S28 effective 01-01-14]
1902(a)(10)(A)(ii)(XIII) of the Act Division of Medicaid	x	24.	Disabled individuals whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See Page 12c of Attachment 2.6-A.

Citation(s)		Groups Covered
1902(a)(10)(A)(ii)(XVII) of the Act Division of Medicaid	B.	Optional Coverage Groups Other Than the Medically Needy (Continued)
	x 25.	Independent foster care adolescents who are in foster care under the responsibility of the Department of Human Services on their 18th birthday. Medicaid eligibility continues until age 21 without regard to income or resources.

Page superseded by SPA 13-0019 S57

Agency*	Citation(s)	Groups Covered
	C.	Optional Coverage of the Medically Needy
42 CFR435.301		This plan includes the medically needy.
		/x / No.
		/ / Yes. This plan covers:
		1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
1902(e) of the Act		2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State Plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.
1902(a)(10)(C)(ii)(I) of the Act		3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

Agency* Citation(s) Groups Covered

C. Optional Coverage of the Medically Needy (Continued)

~~IV-A~~
~~1902(e)(4) of the Act~~

~~4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.~~ [Superseded by SPA 13-0019 N/A to MS effective 01-01-14]

IV-A
42 CFR 435.308

5. // a. Financially eligible individuals who are not described in section C.3. above and who are under the age of—

_ 21
_ 20
_ 19
_ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

// b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

_ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

_ (a) In foster homes (and are under the age of ___).

_ (b) In private institutions (and are under the age of ___).

Agency* Citation(s) Groups Covered

C. Optional Coverage for the Medically Needy (Continued)

_ (c) In addition to the group under b.(l)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___).

_ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ___).

_ (3) Individuals in NFs (who are under the age of ___). NF services are provided under this plan.

_ (4) In addition to the group under (b)(3), individuals in ICF/MR (who are under the age of ___).

Agency* Citation(s) Groups Covered

C. Optional Coverage for the Medically Needy (Continued)

_ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of __). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

_ (6) Other defined groups (and ages), as specified in Supplement 1 to ATTACHMENT 2.2-A.

Agency*	Citation(s)		Groups Covered
	C.		Optional Coverage for the Medically Needy (Continued)
IV-A	42CFR 435.310	_ 6.	Caretaker Relatives
IV-A	42CFR 435.320 and 42CFR 435.330	_ 7.	Aged Individuals
IV-A	42CFR 435.322 and 42CFR 435.330	_ 8.	Blind Individuals
IV-A	42CFR 435.324 and 42CFR 435.330	_ 9.	Disabled Individuals
	42CFR 435.326	_ 10.	Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
	42CFR 435.340	_ 11.	Blind and disabled individuals who: a. meet all current requirements f or Medicaid eligibility except the blindness or disability criteria; b. were eligible as medically needy in December 1973 as blind or disabled; and c. for each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.
	1906 of the Act	12.	Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of ___ months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Mississippi

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER THE AGE OF 21, 20, 19, AND 18

7.b(6) **Other defined groups:**

Division of Medicaid

1. Individuals making a transition from foster care to independent living arrangements (who are under 21 years of age), with all or part of their maintenance costs paid by a public agency of this state.

2. Pregnant minors under the age of 19 who live with or separately from parent(s), who are not otherwise eligible in any mandatory or optional categorically needy covered group that provides full Medicaid coverage.

Page superseded by SPA 13-0019 S52 and S57

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

The method for determining cost effectiveness is through comparison of the financial data compiled on the costs of the "disabled children at home" category to the nursing facility services costs as reflected and substantiated through MAM reports from the MARS reporting system. Cost effectiveness does exist as there is no vendor payment for nursing facility services for these children, and the children are eligible for the medical services that all other Medicaid-eligible children receive regardless of their category of eligibility.

Financial data for each child will be reviewed and compared periodically by utilizing the cost-effectiveness plan described above. Since all eligible children under age 21 are entitled to expanded EPSDT services as mandated in OBRA '89, prior approvals are secured for those services which are in addition to the regular Medicaid program services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	~~(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.~~ [Superseded by SPA 13-0019 S25, S28 and S30 effective 01-01-14]
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	~~(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.~~ [Superseded by SPA 13-0019 S25, S28 and S30 effective 01-01-14]
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

Citation	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.402	~~3. Is residing in the United States and--~~
	~~a. Is a citizen;~~
Section 245A of the Immigration and the Nationality Act	~~b. Is an alien lawfully admitted for permanent residence or otherwise permanently residing in United States under color of law, as defined in 42 CFR 435.408;~~
1902(a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration and Nationality Act	~~c. Is an alien granted lawful temporary resident status under section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of P.L. 96-422;~~ [Superseded by SPA 13-0023 S89 effective 01-01-14]

Citation	Condition or Requirement
	d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of e. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or
	e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services). [Superseded by SPA 13-0023 S89 effective 01-01-14]
42 CFR 435.403 1902(b) of the Act	4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.
	☐ State has interstate residency agreement with the following States:
	☐ State has open agreement(s).
	☐ Not applicable; no residency requirement. [Superseded by SPA 13-0022 effective 01-01-14]

Citation	Condition or Requirement
435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities, and intermediate care facility for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. / / Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
433.145 435.604 1912 of the Act	6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met. /x/ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number), except for aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v)(2) of the Social Security Act (Section 1137[f]) and newborn children who are eligible under Section 1902(e)(4).

Citation	Condition or Requirement
	An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. /X/ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

Citation	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

Page superseded by SPA 13-0019 S28 and S30

State/Territory: Mississippi

Citation(s)		Condition or Requirement
1906 of the Act	10.	Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).
U.S. Supreme Court case *New York State Department Of Social Services v. Dublino*	11.	Is required to apply for coverage under Medicare Parts A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs, unless enrollment would result in a loss of coverage for non-Medicare dependent(s) in an employer-based cost-effective health plan. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

Citation	Condition or Requirement
	B. Posteligibility Treatment of Institutionalized Individuals' Incomes.
	1. The following items are not considered in the posteligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500-506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P.L. 100-383	d. Japanese and Aleutian Restitution Payments
1.(a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P.L. 103-66	h. VA pensions limited to $90 per month under 38 U.S.C. 5503.

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals $ 44.00 Couples $ _____ For the following persons with greater need: $88 for individuals who participate in work activity and receive wages of $44 or less, and, Individuals who participate in work activity and receive wages in an amount greater than $44 are allowed a work allowance equal to 50% of the current SSI FBR for an individual less the $44 PNA. Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

Citation | Condition or Requirement

b. AFDC related:
Children $ 44.00
Adults $ 44.00

For the following persons with greater need:

$88 for individuals who participate in work activity and receive wages of $44 or less, and,
Individuals who participate in work activity and receive wages in an amount greater than $44 are allowed a work allowance equal to 50% of the current SSI FBR for an individual less the $44 PNA.

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

c. Individual under age 21 covered in the plan as specified in Item B.7 of Attachment 2.2-A $ 44.00

For the following persons with greater need:

$88 for individuals who participate in work activity and receive wages of $44 or less, and,
Individuals who participate in work activity and receive wages in an amount greater than $44 are allowed a work allowance equal to 50% of the current SSI FBR for an individual less the $44 PNA.

Citation		Condition or Requirement
		Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.
1924 of the Act	3.	In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse.
		a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1942(d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.
		___ The poverty level component is calculated using the applicable percentage (set out §1942(d)(3)(B) of the Act) of the official poverty level.
		___ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____% of the official poverty level (still subject to maximum maintenance needs standard).
		_x_ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924 (d)(3)(C).

Citation | Condition or Requirement

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

In determining any excess shelter allowance, utility expenses are calculated using:

___ the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or,

___ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

_x_ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924(d)(3)(B)) exceeds the dependent family member's monthly income.

___ a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924(d)(1)

Citation | Condition or Requirement

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party.

(i) Medicaid, Medicare and other health insurance premiums, deductibles or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law, but not covered under the State plan. (Reasonable limits on amounts are described in [illegible])

435.725
435.733
435.832

4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:

a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the :

- AFDC level; or
- Medically needy level:

(Check one)

____ AFDC levels in Supplement 1-A

____ [illegible] Supplement 1

__x__ Other: same as the monthly income allowance for other dependent family members living with the community spouse.

Citation | Condition or Requirement

b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party: X-P+I' HCFA

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A)

435.725
435.733
435.832

5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

__X__ No

____ Yes (the applicable amount is shown on page 5a.)

____ Amount for maintenance of home is: $_____

____ Amount for maintenance of home is the actual maintenance costs not to exceed $_____

Citation	Condition or Requirement
	____ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home are different.
	_X_ Amount for maintenance of home is not deductible when countable income is determined under §1924(d)(1) of the Act.

Citation | Condition or Requirement

435.725
435.733
435.832

4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:

a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:

- AFDC level; or
- Medically needy level:

(Check one)

__X__ AFDC levels in Supplement 1-A
____ Medically needy level in Supplement 1
____ Other: $_____

b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)

435.725
435.733
435.832

5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

__X__ No
____ Yes (the applicable amount is shown on page 5a.)

Superseded by SPA 2001-01

Citation

Condition or Requirement

____ Amount for maintenance of home is:
$_____

____ Amount for maintenance of home is the actual maintenance costs not to exceed $____.

____ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home are different.

__X__ Amount for maintenance of home is not deductible when countable income is determined under §1924(d)(1) of the Act.

Superseded by
SPA 2001-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	C. Financial Eligibility For individuals who are ~~AFDC or~~ SSI recipients, the income and resource levels and methods for determining countable income and resources of the ~~AFDC and~~ SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not ~~AFDC or~~ SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply. Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level~~--pregnant women and infants or children~~ covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act. [Superseded by SPA 13-0019 S25, S28 and S30 effective 01-01-14]

State: Mississippi

Citation	Condition or Requirement
	X Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
	___ Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
	___ Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
	___ Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
	X Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.*
	x Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.**
	___ Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under section 1902(z)(1) of the Act.

* Formerly approved as Supplements 11 and 11A to Attachment 2.6-A.
** Formerly approved as Supplements 12 and 12A to Attachment 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income
	a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).
	~~(1) In determining countable income for AFDC-related individuals, the following methods are used:~~
	~~X (a) The methods under the State's approved AFDC plan only; or~~
	~~___ (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.~~
	~~(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.~~ [Superseded by SPA 13-0019 S25 and S30 effective 01-01-14]
1902(e)(6) the Act	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: ___ The methods of the SSI program only. __X__ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Citation	Condition or Requirement

☐ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

☒ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

☐ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

☐ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--(SSA administered OSS)

__ SSI methods only.

__ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

__ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

Citation	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: __ The methods of the SSI program only. x SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.* __ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. x For institutional couples, the methods specified under section 1611(e)(5) of the Act. __ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. __ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- __ SSI methods only. __ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. __ Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

*Formerly approved as Supplements 11 and 11A to Attachment 2.6-A.

Citation	Condition or Requirement
	In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used: __ The methods of the SSI program. _x_ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.* _x_ For institutional couples: the methods specified under section 1611(e)(5) of the Act. __ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. __ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

*Formerly approved as Supplements 11 and 11A to Attachment 2-6.A.

Citation	Condition or Requirement
	__ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- __ SSI methods only. __ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. __ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3)(E) and 1902(r)(2) of the Act	e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act:

(1) The following methods are used in determining countable income:

X The methods of the State's approved AFDC plan.

X The methods of the approved title IV-E plan.

X The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

___ The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Page superseded by SPA 13-0019, S28 and S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	~~(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.~~ [Superseded by SPA 13-0019 S30 effective 01-01-14]
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: ___ The methods of the SSI program only. X SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. X For institutional couples, the methods specified under section 1611(e)(5) of the Act.

State: Mississippi

Citation	Condition or Requirement
	If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g. Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.

Citation	Condition or Requirement

1902(u) of the Act

(h) COBRA Continuation Beneficiaries

In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

__X__ The disregards of the SSI program;

_____ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

State/Territory: ___Mississippi_____

Citation		Condition or Requirement
1902(a)(10)(A)(ii)(XIII) of the Act	(i)	Working Disabled Who Buy In to Medicaid

In determining countable income and resources for working disabled individuals who buy in to Medicaid, the following methodologies are applied:

____ The methodologies of the SSI program.

____ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

_X__ The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

__X_ The agency requires individuals to pay premiums or other cost-sharing charges. The premiums or other cost-sharing charges, and how they are applied, are described below:

State/Territory: Mississippi

Premiums for the Working Disabled are set on a sliding scale based on countable earned income of the Working Disabled individual or couple. The premium payable for individuals eligible as a Working Disabled recipient whose countable earned income is less than 150% of the poverty level is $0. For Working Disabled recipients with countable earned income above 150% of the poverty level, the monthly premium is calculated using 5% of countable earnings. The premium amount is set at a rate of 5% of countable earned income of the eligible individual or eligible couple with countable earnings between 150-250% of the Federal poverty level. The premium is based on the earnings of the Working Disabled individual or couple (if both qualify as Working Disabled). The poverty level/premium range is updated annually.

Citation	Condition or Requirement
1902(k) of the Act	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. /x/ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship.
1902(a)(10) of the Act	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only a. Medically Needy (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of ___ month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services. (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order: (a) Health insurance premiums, deductibles and coinsurance charges. (b) Expenses for necessary medical and remedial care not included in the plan. (c) Expenses for necessary medical and remedial care included in the plan. __ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.
1902(a)(17) of the Act	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	a. Medically Needy (Continued)
1903(f)(2) of	___(3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

Citation	Condition or Requirement
	b. Categorically Needy - Section 1902 (f) States
42 CFR 435.732	The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	4.b. Categorically Needy - Section 1902(f) States Continued
1903(f)(2) of	__ (6) Spenddown payments made to the State by the individual. **NOTE:** FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

Citation	Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

(b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation	Condition or Requirement

5. Methods for Determining Resources

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act

b. Aged individuals. For aged individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

__ The methods of the SSI program.

x SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.*

__ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

*Formerly approved as Supplements 12 (pages 1 and 2) and 12A to Attachment 2.6-A

Citation	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: __ The methods of the SSI program. x SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.* __ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

*Formerly approved as Supplement 12 (pages 1 and 2) of Attachment 2.6-A.

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: __ The methods of the SSI program. x SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.* __ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
~~1902(1)(3) and 1902(r)(2) of the Act~~	~~e. Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act.~~ ~~The agency uses the following methods in the treatment of resources.~~ ~~__ The methods of the SSI program only.~~ ~~__ The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.~~ [Superseded by SPA 13-0019 S28 effective 01-01-14]

*Formerly approved as Supplements 12 (pages 1 and 2) and 12A to Attachment 2.6-A

Citation	Condition or Requirement
	__ Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	x Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act. The agency uses the following methods for the treatment of resources: __ The methods of the State's approved AFDC plan.
1902(1)(3)(C) of the Act	__ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	__ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	x Not applicable. The agency does not consider resources in determining eligibility.

Page superseded by SPA 13-0019 S28 and S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)			Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g.	1.	Poverty level children covered under section 1902(a)(10)(A)~~(i)(VI)~~ (ii)(IX) of the Act. PIL HCFA 3-7-94 The agency uses the following methods for the treatment of resources: ___ The methods of the State's approved AFDC plan. ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A. ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5b to ATTACHMENT 2.6-A. X Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3)(C) of the Act			
1902(r)(2) of the Act			

Page superseded by SPA 13-0019 S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g.	2. Poverty level children under section 1902(a)(10)(A)(i)(VII) The agency uses the following methods for the treatment of resources: ___ The methods of the State's approved AFDC plan. ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A. ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A. _X_ Not applicable. The agency does not consider resources in determining eligibility. In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3)(C) the Act		
1902(r)(2) of the Act		

Page superseded by SPA 13-0019 530

Citation	Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5. h. For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act-- The agency used the following methods for treatment of resources: __ The methods of the SSI program only. _x_ The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.*
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: _X_ The methods of the SSI program only. ___ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

*Formerly approved as Supplements 12 (pages 1 and 2) and 12A to Attachment 2.6-A.

Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act-- The agency uses the same method as in 5.h. of Attachment 2.6-A.

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

___ Same as SSI resource standards.

___ More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan. X No. The agency does not apply a resource standard to these individuals.
1902(1)(3)(A) and (C) of the Act	d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan. X No. The agency does not apply a resource standard to these individuals.

Page superseded by SPA 19-0019 S28 and S30

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: _x_ Same as SSI resource standards. __ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

State: Mississippi

Citation	Condition or Requirement
	7. Resource Standard - Medically Needy
	a. Resource standards are based on family size.
1902(a)(10)(C)(i) of the Act	b. A single standard is employed in determining resource resource eligibility for all groups.
	__ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for-- __ Aged __ Blind __ Disabled Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.
1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B) and 1860D-14(a)(3)(D) of the Act	8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.

State: Mississippi

Citation	Condition or Requirement
1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act	9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.
1902(u) of the Act	10. For COBRA continuation beneficiaries, the resource standard is: X_ Twice the SSI resource standard for an individual. ___ More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

State: Mississippi

Citation	Condition or Requirement
1902(u) of the Act	10. Excess Resources a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries Any excess resources make the individual ineligible. b. Categorically Needy Only ___ This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources. c. Medically Needy Any excess resources make the individual ineligible.

Citation	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

x Aged, blind, disabled.
x AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

__ Aged, blind, disabled.
__ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

__ Aged, blind, disabled.
__ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

x Aged, blind, disabled.
x AFDC-related.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Conditions or Requirements
~~1920(b)(1) of the Act~~	___ (3) ~~For a presumptive eligibility for pregnant women only.~~ ~~Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider~~ ~~eligibility levels specified in Attachment 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the state agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.~~ [Superseded by SPA 13-0019 S28 effective 01-01-14]
1902(e) (8) and 1905(a) of the Act Division of Medicaid	_x_ b. For qualified Medicare beneficiaries defined in Section 1905(p)(1) of the Act, coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under Section 1905(p)(1). The eligibility determination is valid for – _x_ 12 months __ 6 months ___ months (no less than 6 months and no more than 12 months)

Citation	Condition or Requirement
1902(a)(18) and 1902(f) of the Act	12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.
1917(c)	13. Transfer of Assets - All eligibility groups The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets. Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.
1917(d)	14. Treatment of Trusts - All eligibility groups The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts. ____ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts; __X__ The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts. The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplements 9 (a) and 10 to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
1924 of the Act	15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: X the maximum standard permitted by law; ____ the minimum standard permitted by law; or $ a standard that is an amount between the minimum and the maximum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

Family Size	Need Standard	Payment Standard	Maximum Payment Amount

Please refer to Supplement 1 to Attachment 2.6-A, Page 1a.

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990, based on the following percent of the official Federal income poverty level--

[ ] 133 percent [x] 185 percent (no more than 185 percent) (specify)

of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

Page superseded by SPA 13-0019 S14, S25, S28 and S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Mississippi

now TANF

Page Superseded by SPA 13-0019 S14, S25, S28 and S30

AFDC
MONTHLY CONSOLIDATED STANDARD FOR BASIC REQUIREMENTS

No. of Persons	1	2	3	4	5	6	7	8	9	10	11
Requirements	218	293	368	443	518	593	668	743	818	893	968
185% Requirements	403	542	680	819	958	1097	1235	1374	1513	1652	1790

No. of Persons	12	13	14	15	16	17	18	19	20	21	22
Requirements	1043	1118	1193	1268	1343	1418	1493	1568	1643	1718	1793
185% Requirements	1929	2068	2207	2345	2484	2623	2762	2900	3039	3178	3317

f more than 22 are in the budget, add $75 to the requirements for each person above 22 nd compute 185% of that figure, rounded down to the nearest dollar, for the gross income est.

iis consolidated standard includes requirements for food, clothing, personal incidentals, ectricity, water, household supplies, fuel and shelter. The standard will be used for l budget groups who live in private living arrangements. Children who are away from e regular family unit's private living arrangement to attend the Blind School, Deaf hool, Addie McBryde Center, rehabilitation center, maternity home or boarding school ll be included in the regular budget as though they were at home, and the income will tested against the consolidated standard for the entire group.

TN NO. 88-8 SUPERSEDES
TN NO. ____

DATE/RECEIPT 9/15/88
DATE/APPROVED 9/16/88
DATE/EFFECTIVE 7/1/88

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

INCOME ELIGIBILITY LEVELS

P&I 3-7-94

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(A)(ii)(IX) ~~(i)(VI)~~ of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

P&I 3-7-94

4. For children under Section 1902(a)(10)(A)(ii)(IX) ~~(i)(VII)~~ of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

Page superseded by SPA 13-0019 S14, S25, S28 and S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(10)(A)(ii)(IX) and 1902(l)(2) of the Act are as follows:

Based on 185 percent of the official Federal income poverty level (more than 133 percent and no more than 185 percent)(as revised annually in the Federal Register) for the size family involved.

Page superseded by SPA 13-0019 S14, S25, S28 and S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

INCOME ELIGIBILITY LEVELS (Continued)

B. MANDATORY CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children Under the Age of 19

The levels for determining income eligibility for groups of children who are under the age of 19 and are born after September 30, 1983, under the provisions of section 1902(l)(2) of the Act are (as revised annually in the Federal Register) follows:

Based on 100 percent of the official Federal income poverty line (as revised annually in the Federal Register) for the size family involved.

Page superseded by SPA 13-0019 S14, S25, S28 and S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows:

Based on 100 percent of the official Federal income poverty line.

Family Size	Income Level
1	$ *
2	$ *
3	$ *
4	$ *
5	$ *

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a resultofa title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

* As revised annually in the Federal Register for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: /x/ 85 percent / / ___ percent (no more than 100)

Eff. Jan. 1, 1990: /x/ 100 percent / / ___ percent (no more than 100)

Eff. Jan. 1, 1991: 100 percent

Eff. Jan. 1, 1992: 100 percent

b. Levels:

(as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1989 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1987: /X/ 80 percent /_/ ____ percent (no more than 100)

Eff. Jan. 1, 1990: /X/ 85 percent /_/ ____ percent (no more than 100)

Eff. Jan. 1, 1991: /X/ 95 percent /_/ ____ percent (no more than 100)

Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size	Income Levels
1	$_____
2	$_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

INCOME ELIGIBILITY LEVELS (Continued)

E. Optional Groups Other Than the Medically Needy

1. Institutionalized Individuals Under Special Income Levels as follows:

300% of the SSI Federal Benefit Rate (FBR) for an individual in Title XIX facility.*

300% of the SSI Individual Federal Benefit Rate (FBR) for certain disabled children age 18 or under who are living at home but would qualify if institutionalized.*

*If amount should vary from the maximum allowed under CFR, plan amendment would be submitted to indicate the change.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

/ / Same as SSI resources levels.

/x/ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	None
2	None

b. Optional Groups

/ / Same as SSI resources levels.

/x/ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	None
2	None

Page superseded by SPA 13-0019 S28 and S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

RESOURCE LEVELS (Continued)

2. Infants

a. Mandatory Group of Infants

/x/ Same as resource levels in the State's approved AFDC plan.*

/x/ Less restrictive than the AFDC levels and are as follows:**

Family Size	Resource Level
1	None
2	None
3	None
4	None
5	None
6	None
7	None
8	None
9	None
10	None

Page superseded by SPA 13-0019 S28 and S30

*For qualified children.
**For 100% and 133% FPL groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

RESOURCE LEVELS (Continued)

b. Optional Group of Infants

/x/ Same as resource levels in the State's approved AFDC plan.*

/x/ Less restrictive than the AFDC levels and are as follows:**

Family Size	Resource Level
1	None
2	None
3	None
4	None
5	None
6	None
7	None
8	None
9	None
10	None

Page superseded by SPA 13-0019 S28 and S30

*For qualified children.
**For the 185% FPL group.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

3. Children

a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

___ Same as resource levels in the State's approved AFDC plan.

X Less restrictive than the AFDC levels and are as follows:**

Family Size	Resource Level
1	None
2	None
3	None
4	None
5	None
6	None
7	None
8	None
9	None
10	None

Page superseded by SPA 13-0019 S28 and S30

** For 100% and 133% FPL groups

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

RESOURCE LEVELS (Continued)

b. Optional Group of Children

/x/ Same as resource levels in the State's approved AFDC plan.*

/x/ Less restrictive than the AFDC levels and are as follows:**

Family Size	Resource Level
1	None
2	None
3	None
4	None
5	None
6	None
7	None
8	None
9	None
10	None

Page superseded by SPA 13-0019 S28 and S30

*For qualified children.
**For the 185% FPL group.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

RESOURCE LEVELS (Continued)

4. Aged and Disabled Individuals

[x] Same as SSI resource levels.

[ ] More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	

[ ] Same as medically needy resource levels (applicable only if State has a medically needy program)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

Post-Eligibility Treatment of Income deductions by institutionalized individuals for amounts of incurred expenses for medical or remedial care that are not subject to payment by the Division of Medicaid or other third party insurance.

Reasonable limits imposed are:

1. For medically necessary care, services and items not paid for under the Medicaid State Plan the actual billed amount will be used as the deduction, not to exceed the Mississippi Medicaid maximum payment or fee.
2. The services or items claimed as a deduction from the resident's income:
   a) Must:
      1) Be a medical or remedial care service recognized under state law,
      2) Be medically necessary as verified by the attending physician,
      3) Have been incurred no earlier than the three (3) months preceeding the month of current application, and/or
      4) Be reduced by the amount of any earmarked funds that a beneficiary specifically elected to earmark at application for payment of nursing facility expenses for which the beneficiary was then liable, in order to receive the resource disregard approved under the state plan relating to nursing facility expenses incurred in months prior to application, and
   b) Cannot have been:
      1) For cosmetic or elective purposes, except when medically necessary and prescribed by a medical professional, and/or
      2) A duplication of expenses previously authorized as a deduction.
3. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero (0).
4. If the equity in an individual's home exceeds the amount established under Section 6014 of Pub. L. 109-171, the income deduction for paid or unpaid medical and remedial care expenses incurred by restriction of Medicaid covered service is limited to zero (0).
5. If the institutionalized individual has medical or health insurance and is responsible for paying the premium(s), deductible(s), or coinsurance, the full amount of these payment(s) are an allowable deduction from the individual's income when calculating the medical care credit.
6. The expenses for the following medical items are allowable deductions from the individual's monthly recurring income up to the allowable amounts listed on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/:
   1. Eyeglasses, not otherwise covered by the Medicaid State Plan, per occurrence for lenses, frames and dispensing fee.
   2. Dentures – per plate or for one (1) full pair of new dentures.
   3. Denture repair – per occurrence.
   4. Hearing aids – for one (1) or for both.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Mississippi

METHODOLOGIES FOR TREATMENT OF INCOME AND RESOURCES
THAT DIFFER FROM THOSE OF THE SSI PROGRAM

For AFDC related coverage, there is no resource standard for the 100%, 133% and the 185% FPL groups.

Also, there is a "no look back" provision on income for pregnant women coverage.

Page superseded by SPA 13-0019 S28 and S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

No resource test for pregnant women and children at 100%, 133% and 185% FPL.

Page superseded by SPA 13-0019 S28 and S30

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State X Non-Section 1902(f) State

METHODOLOGIES FOR TREATMENT OF INCOME
THAT DIFFER FROM THOSE OF THE SSI PROGRAM

1. The following liberalized income policies apply to the following groups of Medicaid eligibles:

- Qualified Medicare Beneficiaries (QMB).
  1902(a)(10)(E)(i) and 1905(p)(1) of the Act
- Specified Low-Income Medicare Beneficiaries (SLMB).
  1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act
- Qualifying Individuals (QI-1).
  1902(a)(10)(E)(iv)(I) and (II), 1905(p)(3) (A)(ii) and 1933 of the Act
- Working Disabled (WD) under 250% of poverty.
  1902 (a)(10)(A)(ii)(XIII) of the Act

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

☐ Section 1902(f) State ☒ Non-Section 1902(f) State

The liberalized income policies are as follows:

- The value of in-kind support and maintenance is excluded. (Previously approved 04/19/93 in TN No. 92-03 effective 01/01/92.)
- The $20 General Exclusion is raised to a $50 General Exclusion. (Previously approved 03/22/00 in TN No. 99-15 effective 07/01/99.)
- Eliminate the SSI budgeting practice that requires an eligible individual who is married to an "ineligible" spouse (one that is neither aged or disabled) to be eligible as both an individual and as a member of a couple. It is replaced with one test whereby a couple's income is combined after allocating to the ineligible children from the ineligible's income. The couple's countable income is tested against the couple limit appropriate to the type of coverage group. (Previously approved 03/22/00 in TN No. 99-15 effective 07/01/99.)
- Interest, dividend and royalty income that does not exceed $5 per month per individual is excluded. (Previously approved 03/22/00 in TN No. 99-15 effective 07/01/99.)
- Allow couples to be budgeted for eligibility separately when living together and one member of the couple is enrolled in a HCBS Waiver Program or Hospice Care Coverage Group and evaluated for eligibility using institutional financial criteria and the other member of the couple is applying under a category of eligibility defined in #1. (Previously approved 10/02/00 in TN No. 2000-01 effective 07/01/00.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

☐ Section 1902(f) State ☒ Non-Section 1902(f) State

- Annual cost of living increases in federal benefits (such as VA, Railroad Retirement, Civil Service, etc. that are in addition to title II benefits) are disregarded in determining income through the month following the month in which the annual Federal Poverty Level (FPL) update is published.

- Annual cost of living increases in federal benefits (title II benefits, VA, Civil Service, Railroad Retirement) are disregarded when the Federal Poverty Level (FPL) update fails to increase at an equal or greater rate than the federal Cost of Living (COL) increase during the same year. The disregard of the COL increase in federal benefits will apply to increase(s) received by the eligible individual, couple and/or ineligible spouse. The COL increase will be disregarded as income until such time as the FPL increase is greater than the previous COL increase.

~~2. The following liberalized income policy applies to all pregnant women, infants and children eligible under specified federal poverty levels; specifically 1902(a)(10)(A)(i)(IV)~~

- ~~Income will not be deemed from parents to pregnant women. (Previously approved 03/07/94 in TN No. 93-19 effective 10/01/93.)~~ [Superseded by SPA 13-0019 S53 effective 01-01-14]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State X Non-Section 1902(f) State

3. The following liberalized income policy applies to the Working Disabled under 250% of poverty. 1902(a)(10)(A)(ii)(XIII) of the Act.

   - Unearned income between the SSI limit and 135% of the federal poverty limit is disregarded. (Previously approved 10/02/00 in TN No. 2000-01 effective 07/01/00.)

4. For all eligibility groups not subject to the limitations on payment explained in Section 1903(f) of the Act:

   - All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded. (Previously approved 10/02/00 in TN No. 2000-01 effective 07/01/00.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Mississippi**

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

___ Section 1902(f) State X Non-Section 1902(f) State

5. The following liberalized income policy applies to all pregnant minors under the age of 19 qualifying for Medicaid under 42 CFR 435.222 as a reasonable classification of covered children:

- All income is disregarded – no income test applies.

6. The following liberalized income policy applies to all non-IV-E Adoption Assistance children qualifying under 42 CFR 435.227:

- All income is disregarded – no income test applies.

Page superseded by SPA 13-0019 S52 and S53

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State X Non-Section 1902(f) State

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI PROGRAM

1. The following liberalized resource policies apply to the following groups of Medicaid Eligibles:

- Institutionalized individuals who would be eligible for SSI if not in an institution 1902(a)(10)(A)(ii)(IV) of the Act and 42 CFR 435.211
- Institutionalized individuals eligible under the 300% cap. 1902(a)(10)(A)(ii)(V) of the Act and 42 CFR 435.236
- Working Disabled (WD) under 250% of poverty 1902(a)(10)(A)(ii)(XIII) of the Act

The liberalized resource policies are as follows:

- Disregard of an additional $2000 in total resources for individuals and $3000 for couples. (Previously approved 10/02/00 in TN. No. 2000-01 effective 07/01/00 to increase limit to $4000/$6000 and approved 03/22/00 in TN No. 99-15 effective 07/01/99 to increase by $1000 to $3000/$4000.)

Page superseded by SPA 19-0018 with no language change

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

☐ Section 1902(f) State ☒ Non-Section 1902(f) State

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI PROGRAM

- Allow eligibility to exist for the entire month when an individual or couple meet the resource test at any time during the month, if using SSI policy would make them ineligible for Medicaid. (Previously approved 04/19/93 in TN No. 92-03 effective 01/01/92.)

- Exclude the value of home property, life estate interests, remainder interests, undivided heir interests, 16th-section land leases, ownership of mineral rights or timber rights or leaseholds that are not under production, and housing on government or Indian-owned land. These types of ownership interests are countable under SSI policy under certain conditions. (Previously approved 04/19/93 in TN No. 92-03 effective 01/01/92.)

- Exclude $6000 in revocable burial funds instead of the current $1500 allowed by SSI policy. (Previously a disregard of $3000 was approved 04/19/93 in TN No. 92-03 effective 01/01/92.)

- Exclude all burial spaces for family members with any degree of relationship instead of those limited for use by the immediate family. (Previously approved 04/19/93 in TN No. 92-03 effective 01/01/92.)

Page superseded by SPA 19-0018 with no language change

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

☐ Section 1902(f) State ☒ Non-Section 1902(f) State

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI PROGRAM

- Exclude up to $10,000 in total face values of all life insurance policies on an individual instead of the current $1500 allowed by SSI policy. (Previously, $5000 exclusion approved 04/19/93 in TN No. 92-03 effective 01/01/92.)

- Exclude two automobiles instead of one currently allowed under SSI policy. (Previously approved 04/19/93 in TN No. 92-03 effective 01/01/92.)

Superseded by SPA 19-0018 eff. 07/01/2019

- Exclude any vehicle that is not used for transportation due to the inoperable condition of the vehicle rather than considering it a countable resource under SSI policy. (Previously approved 04/19/93 in TN No. 92-03 effective 01/01/92.)

Superseded by SPA 19-0018 with no language change

- Exclude income-producing property if it produces a net annual income to the client of at least 6% of the equity value rather than excluding $6000 equity value of property producing 6% net annual return under SSI policy. (Previously approved 04/10/93 in TN No. 92-03 effective 01/01/92.)

- Exclude liquid promissory notes or mortgages as nonbusiness income-producing property, provided the note produces a 6% net annual return of the principal balance rather than excluding only non-liquid or non-negotiable promissory notes under the income-producing property exclusion as per SSI policy. (Previously approved 04/19/93 in TN No. 92-03 effective 01/01/92.)

Superseded by SPA 19-0018 with no language change

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

__ Section 1902(f) State X Non-Section 1902(f) State

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI PROGRAM

Page superseded by SPA 19-0018 with no language change

- Exclude non-excludable personal property up to $5,000 rather than excluding up to $2,000 per SSI policy.

- Allow Current Market Value (CMV) of real property to be established using the county tax assessed true value as shown on the county tax receipt rather than an initial evaluation using a knowledgeable source statement, per SSI policy. If an applicant or recipient disagrees with the tax assessed value of any countable real property, a knowledgeable source statement will be used to establish CMV.

2. The following liberalized resource policy applies to the following long term care coverage groups:

   - Institutional individuals who would be eligible for SSI if not in an institution. 1902(a)(10)(A)(ii)(IV) of the Act and 42 CFR 435.211

   - Institutionalized individuals eligible under the 300% cap. 1902(a)(10)(A)(ii)(V) of the Act and 42 CFR435.236

   The more liberal resource policy includes the exclusion of funds earmarked for payment of prior month(s) nursing facility expenses that would allow Medicaid eligibility in the current or retroactive month(s). (Previously approved 04/19/93 in TN No. 92-03 effective 01/01/92.)

3. The following liberalized policy applies to:

   - Working Disabled (WD) under 250% of poverty. 1902(a)(10)(A)(ii)(XIII) of the Act

   The more liberal resource policy includes the disregard of an additional $20,000 in total resources for individuals/couples who work and qualify for Medicaid under the Working Disabled category

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

____ Section 1902(f) State X Non-Section 1902(f) State

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI PROGRAM

4. The following liberalized resource policy applies to all reduced services coverage groups:

   - Qualified Medicare Beneficiaries (QMB's)
     1902(a)(10)(E)(i) and 1905(p)(1) of the Act
   - Specified Low Income Medicare Beneficiaries (SLMB's).
     1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act
   - Qualifying Individuals (QI-1's).
     1902(a)(10)(E)(iv), 1905(p)(3)(A)(ii) and 1933 of the Act

   The liberalized policy is the disregard of all resources. (Previously approved 03/22/00 in TN No. 99-15 effective 07/01/99.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

TRANSFER OF RESOURCES

1902(f) and 1917 of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1613(c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a. ☑ The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds $12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

NOTE: For Transfers of Resources Occurring Before July 1, 1988

Transfers prior to July 1, 1988, will be reviewed under the SSI policy in effect and approved in our State Plan as of June 30, 1988, with respect to resources disposed of before July 1, 1988. Transfers which took place prior to July 1, 1988, are reconciled with State Plan procedures which provide for penalties for transfers for less than fair market value prior to that date.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Mississippi

For Transfers of Resources On or After July 1, 1988

Under Section 303 of the MCCA, our State applies the new transfer of resources rules to any individuals who have transferred resources on or after July 1, 1988 except for interspousal transfers of resources which occur before October 1, 1989.

In determining the number of months of penalty for transfer of resources, the State will use the lesser of 30 months or the total uncompensated value of transferred resources divided by the average cost of care in the community in which the individual resides.

Interspousal Transfer of Resources

The State applies to interspousal transfers the laws and policies which were established as of June 30, 1988, up until and including September 30, 1989 for transfers occurring before October 1, 1989.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

b. /_/ The period of ineligibility is less than 24 months, as specified below:

c. /X/ The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

Inability to obtain medical care will be recognized as an undue hardship under the State Plan. Since Medicaid does not make a cash payment, as does SSI, the inability to secure appropriate medical care will constitute the definition of undue hardship for transfers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

2. Transfer of the home of an individual who is an inpatient in a medical institution.

/ / A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

b. /_/ Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

No individual is ineligible by reason of item A.2 if--

i. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

ii. Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;

iii. A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or

iv. The agency determines that denial of eligibility would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

3. 1902(f) States

/ / Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

2. If the uncompensated value of the transfer is more than $12,000:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which medical assistance is otherwise under the agency plan:

State: Mississippi

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

X the first day of the month in which the asset was transferred;

___ the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the agency;

___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

State: Mississippi

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

_X_ does not impose a penalty;

___ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

_X_ does not impose a penalty;

___ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap--
The agency:

_X_ totals the value of all assets transferred to produce a single penalty period;

___ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--
The agency:

_X_ assigns each transfer its own penalty period;

___ uses the method outlined below:

State: Mississippi

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

___ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

___ For transfers of individual income payments, the agency will impose partial month penalty periods.

_X_ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

___ The agency uses an alternate method to calculate penalty periods, as described below:

State: Mississippi

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship--
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Medicaid will not be denied to an individual under this provision if the individual would be forced to go without life sustaining services. Each caase will be determined individually as the provision is geared toward finacially and medically needy individuals with no possible means of recovering transferred assests.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

TRANSFER OF ASSETS

1917(c) **FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006,** the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services;

   Nursing facility level of care provided in a medical institution;

   Home and community-based services under a 1915(c) or (d) waiver.

2. Non-institutionalized individuals:

   ____ The agency applies these provisions to the following non-institutionalized groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

   The agency withholds payment to non-institutionalized individuals for the following services:

   Home health services (section 1905(a)(7));

   Home and community care for functionally disabled elderly adults (section 1905(a)(22));

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

TRANSFER OF ASSETS

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

____ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

3. Penalty Date - - the beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- for less than fair market value:

  _X_ The State uses the first day of the month in which the assets were transferred

  ___ The State uses the first day of the month after the month in which the assets were transferred, or

OR

- The date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

TRANSFER OF ASSETS

4. Penalty Period – Institutionalized Individuals - -

In determining the penalty for an institutionalized individual, the agency uses:

__X__ the average monthly cost to a private patient of nursing facility services in the State at the time of application;

_____ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period – Non-institutionalized Individuals - -

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

____ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty Period for amounts of transfer less than cost of nursing facility care –

____ where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

__X__ the state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

TRANSFER OF ASSETS

7. Penalty periods – transfer by a spouse that results in a penalty period for the individual - -

   (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

   (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income - -

   When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

   When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

   ____ For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

   __X__ For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

9. Imposition of a penalty would work an undue hardship - -

   The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

TRANSFER OF ASSETS

Application of a transfer of assets penalty would deprive the individual;

(a) Of medical care such that the individual's health or life would be endangered; or,

(b) Of food, clothing, shelter, or other necessities of life.

Undue hardship does not exist when the application of a transfer penalty merely causes an applicant/recipient or their family member(s) inconvenience or restricts their lifestyle.

Undue hardship does not exist when assets in excess of the spousal impoverishment federal maximum (less any assets transferred under the Income First provision) are transferred to the community spouse and the community spouse refuses to cooperate in making the excess resources available to the institutionalized spouse.

Undue hardship does not exist if assets are transferred to a person (spouse, child or other person) handling the financial affairs of an applicant/recipient unless it is established that transferred funds cannot be recovered, even through exhaustive legal measures.

Undue hardship exists when the applicant/recipient or their designated representative has exhausted all legal actions to have transferred assets causing the penalty period to be returned to the applicant/recipient.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

TRANSFER OF ASSETS

(b) A timely process for determining whether an undue hardship waiver will be granted; and,

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

11. Bed Hold Waivers for Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

__X__ payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed __30__ days (may not be greater than 30).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

Medicaid will not be denied to an individual under this provision if the individual would be forced to go without life sustaining services. Each caase will be determined individually as the provision is geared toward finacially and medically needy individuals with no possible means of recovering transferred assests.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is $No maximum written into policy, as this has never been abused for irrevocable burial trusts; however, there is a $3,000 limit on revocable burial.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

COST-EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES

1902(u) of the Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost-effectiveness by selecting one of the following methods:

X The methodology as described in SMM Section 3598.

___ Another cost-effective methodology as described below.

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Transitional Medical Assistance

MEDICAID | Medicaid State Plan | Eligibility | MS2019MS0004O | MS-19-0009-elig

Families with Medicaid eligibility extended for up to 12 months because of earnings.

Package Header

Package ID	MS2019MS0004O	**SPA ID**	MS-19-0009-elig
Submission Type	Official	**Initial Submission Date**	3/6/2019
Approval Date	5/13/2019	**Effective Date**	1/1/2019
Superseded SPA ID	99-015 Att2.6A Sup12 Pg 2		
	User-Entered		

The state covers the mandatory transitional medical assistance group in accordance with the following provisions:

A. Characteristics

1. An individual qualifying under this eligibility group must meet one of the following criteria:

a. Lost coverage under the parents and other caretaker relatives group (42 CFR 435.110) due to work hours or income from employment, or

b. Is the child of a parent or caretaker relative described in A.1.a.

2. In accordance with the requirements described in section 1925 of the Act, and in this reviewable unit, the state provides extended Medicaid eligibility, as follows:

- ○ a. The initial extended eligibility period is for 6 months, followed by a second extended eligibility period of 6 months.
- ◉ b. The initial extended eligibility period is for 12 months, with no second extended eligibility period.

Transitional Medical Assistance

MEDICAID | Medicaid State Plan | Eligibility | MS2019MS0004O | MS-19-0009-elig

Package Header

Package ID	MS2019MS0004O	**SPA ID**	MS-19-0009-elig
Submission Type	Official	**Initial Submission Date**	3/6/2019
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	User-Entered		

B. Individuals Covered

1. Parents or other caretaker relatives

a. A parent or other caretaker relative must meet the following criteria to qualify for an initial extended eligibility period:

i. Was eligible and enrolled in the parents and other caretaker relatives eligibility group, during the six months immediately preceding the month that eligibility was lost, for at least:

- ○ (1) 1 month
- ○ (2) 2 months
- ◉ (3) 3 months

ii. Lost eligibility under the parents and other caretaker relatives eligibility group because:

(1) The earnings of a parent or caretaker relative caused household income to exceed the income standard of that group; or

(2) The hours of employment of a parent or caretaker relative resulted in the individual no longer being considered to have a dependent child (as described in 42 CFR 435.4 and the Parents and Other Caretaker Relatives RU).

iii. Continues to live with a child.

2. A child qualifying under this eligibility group must meet all of the following requirements:

a. Lives with a parent or other caretaker relative who is eligible under this eligibility group.

b. Is not eligible for the infants and children under age 19 eligibility group (42 CFR 435.118).

Transitional Medical Assistance

Package Header

Package ID	MS2019MS0004O	**SPA ID**	MS-19-0009-elig
Submission Type	Official	**Initial Submission Date**	3/6/2019
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Superseded SPA ID	99-015 Att2.6A Sup12 Pg 2 User-Entered		

C. Initial Extended Eligibility Period

1. Income/Resource Standard Used

There is no income or resource standard.

2. Medical Assistance Provided

a. The amount, duration, and scope of coverage provided is the same as that provided to parents and caretaker relatives enrolled in the parents and other caretaker relatives eligibility group and to children enrolled in the eligibility group for infants and children under age 19.

b. The state's election to provide premium assistance for employer sponsored coverage is described in the benefits section of the state plan.

3. Termination of Extension

a. If the family ceases to include a child, the initial extension of eligibility will end prior to the scheduled end date. In such cases, eligibility is terminated at the close of the first month in which the family no longer includes a child.

b. Termination of eligibility will occur in accordance with all requirements described in the Eligibility Process RU.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State plan effective July 16, 1996:

X Pregnant women with no other eligible children.

X AFDC children under age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

___ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, without modification.

X In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications.

___ The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

___ The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increase in the CPI-U since July 16, 1996, as follows:

Page superseded by SPA 13-0019 S25 and S28

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

____ The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

X The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

- Eliminates quarterly reporting requirements for the Medicaid transition benefit and allows the State to provide 12 months of extended coverage without interruption for these Medicaid recipients. (Approved 07/29/97 effective 07/01/97 - TN No. 97-03.)
- All resources are disregarded.
- Excludes all increases in earnings or new earnings in the month in which the family would otherwise be ineligible caused by the earnings or the loss of the earnings disregards. The exclusion is limited to the month in which the family would otherwise be ineligible. The extended Medicaid period is applied beginning in the next month.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

- The quarterly reporting requirements for extended Medicaid benefits. (See HCFA letter dated March 4, 1997 and Enclosures 1 and 2). (Approved 07/29/97 effective 07/01/97 - TN No. 97-03.)

Page superseded by SPA 13-0019 S25 and S28

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

- The AFDC resource limit was $1000.
- There was no earnings exclusion and the extended Medicaid period began in the month of ineligibility due to earnings or the loss of the earnings disregard.

X The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

___ The agency continues to apply the following waivers of provisions of Part A of title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

Page superseded by SPA 13-0019 S25 and S28

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Individuals in institutions who participate in paid work activity such as sheltered workshops, work therapy programs, vocational skills training or any self employment activity such as the sales of handicrafts are allowed a PNA of $88 if total wages are equal to or less than $44 per month. This allows the individual a $44 PNA plus an additional $44 for greater needs associated with the work activity. For individuals who earn more than $44 per month, the work allowance is equal to 50% of the current SSI FBR for an individual less the $44 PNA. The PNA of $44 is then allowed as an additional deduction from total income.

Earnings equal to or less than $44 -	PNA = $88
Earnings greater than $44 -	PNA = $44 plus an additional work allowance equal to 50% of the current SSI FBR minus $44

Disclosure Statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is #0938-0673. The time required to complete this information collection is estimated at 5 hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D. C. 20503.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Mississippi

SECTION 1924 PROVISIONS

A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with section 1924.

B. In the determination of resource eligibility the State resource standard $ 60,000 .

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

Undue Hardship

If the Community Spouse holds resources that exceed the Community Spouse share of $60,000 and does not make the excess resources available to the Institutional Spouse, the excess will continue to be counted as the Institutional Spouse share of resources unless undue hardship exists. That is, if a denial of Medicaid eligibility for the Institutional Spouse would result in the Institutional Spouse inability to obtain medical care, counting the excess toward the Institutional Spouse share can be waived. Undue hardship situations must be reviewed individually. A statement from the Community Spouse is required in this situation citing the reason for the refusal to make resources available as required under federal law.

STATE PLAN UNDER XIX OF THE SOCIAL SECURITY ACT

State : Mississippi

ASSET VERIFICATION SYSTEM

1940 (a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).

(2) The system cannot be based on mailing paper-based requests.

(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institution of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipient, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

STATE PLAN UNDER XIX OF THE SOCIAL SECURITY ACT

State : Mississippi

ASSET VERIFICATION SYSTEM

2. System Development

__ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

X B. The agency will hire a contractor to develop an AVS.

In 3 below, provide any additional information the agency wants to include.

__ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVs requirements.

__ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

__ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

STATE PLAN UNDER XIX OF THE SOCIAL SECURITY ACT

State : Mississippi

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2. and any other information the agency may want to include.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

__X__ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

____ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____.

____ This higher standard applies statewide,

____ This higher standard does not apply statewide. It only applies in the following areas of the State:

____ This higher standard applies to all eligibility groups.

____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Telehealth Service

1) Telehealth service is defined as the practice of health care delivery by a provider to a beneficiary who is under the care of a provider at a different geographical location.

2) The Division of Medicaid covers medically necessary health services to eligible Medicaid beneficiaries as specified in the State Plan. If a service is not covered in an in-person setting, it is not covered if provided through telehealth.

3) Telehealth service must be delivered in a real-time communication method that is:
    a. Live;
    b. Interactive; and
    c. Audiovisual.

4) The originating or spoke site is defined as the physical location of the beneficiary at the time the telehealth service is provided via telecommunications system. Telehealth services are covered in the following originating sites:
    a. Office of a physician or practitioner;
    b. Outpatient Hospital (including a Critical Access Hospital (CAH));
    c. Rural Health Clinic (RHC);
    d. Federally Qualified Health Center (FQHC);
    e. Community Mental Health/Private Mental Health Centers;
    f. Therapeutic Group Homes;
    g. Indian Health Service Clinic; or
    h. School-based clinic.

5) The distant or hub site is defined as the physical location of the provider delivering the telehealth service via telecommunications system.

6) Telehealth services must be delivered by a participating Medicaid provider acting within their scope-of-practice at both the originating and distant site.

7) The following are not considered telehealth services and are not covered:
    a. Telephone conversations;
    b. Chart reviews;
    c. Electronic mail messages;
    d. Facsimile transmission;
    e. Internet services for online medical evaluations; or
    f. The installation or maintenance of any telecommunication devices or systems.

State of Mississippi
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ☐ No Limitations ☒ With Limitations

2. a. Outpatient hospital services.

   Provided: ☐ No Limitations ☒ With Limitations

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

   Provided: ☐ No Limitations ☒ With Limitations

   ☐ Not Provided

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-5).

   Provided: ☐ No Limitations ☒ With Limitations

3. Other laboratory and x-ray services.

   Provided: ☐ No Limitations ☒ With Limitations

State/Territory: MISSISSIPPI

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: No limitations X With limitations

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. *

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: No limitations X With limitations*

4.d. Face-to-face Tobacco Cessation Counseling Services for Pregnant Women

Provided: No limitations X With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: No limitations X With limitations*

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905 (a) (5) (B) of the Act.)

Provided: No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: No limitations X With limitations *

Not provided ___

* Description provided on attachment.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION, AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

b. Optometrists' services.

___ Provided: ___ No limitations ___ With limitations*

_X_ Not Provided

c. Chiropractor's services.

_X_ Provided: ___ No limitations ___ With limitations

___ Not provided.

d. Other practitioners' services.

_X_ Provided: Identified on attached sheet with description of limitations, if any.

___ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: ___ No limitations _X_ With limitations*

b. Home health aide services provided by a home health agency.

Provided: ___ No limitations _X_ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provide the home health service, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Provided: ___ No limitations _X_ With limitations*

*Description provided on attachment.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION, AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

__Provided: __ No limitations __ With limitations*

_X_ Not provided.

8. Private duty nursing services.

__ Provided: __ No limitations __ With limitations*

__X__Not provided.

*Description provided on attachment.

State Mississippi

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

10. Dental services.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

11. Physical therapy and related services.

a. Physical therapy.

[✓] Provided: [ ] No limitations [✓] With limitations*

[ ] Not provided.

b. Occupational therapy.

[✓] Provided: [ ] No limitations [✓] With limitations*

[ ] Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

[✓] Provided: [ ] No limitations [✓] With limitations*

[ ] Not provided.

*Description provided on attachment.

State Mississippi

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

b. Dentures.

[ ] Provided: [ ] No limitations [ ] With limitations*

[x] Not provided.

c. Prosthetic devices.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

d. Eyeglasses.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

[x] Provided: [ ] No limitations [x] With limitations*

[ ] Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Preventive services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

d. Rehabilitative services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

b. Nursing facility services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

*Description provided on attachment.

State of Mississippi
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. Services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined in accordance with section 1902(a)(31)(A), to be in need of such care.

Provided: ☐ No Limitations ☒ With Limitations*

☐ Not Provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided: ☐ No Limitations ☒ With Limitations*

☐ Not Provided

17. Nurse-midwife services.

Provided: ☐ No Limitations ☒ With Limitations*

☐ Not Provided

18. Hospice care (in accordance with section 1905(o) of the Act).

Provided: ☐ No Limitations ☒ With Limitations*

☒ Provided in accordance with section 2302 of the Affordable Care Act

☐ Not Provided

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

___ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/ / Provided: / / No limitations / /With limitations*

/X/ Not provided.

23. Certified Pediatric or family nurse practitioners' services.

Provided: / / No limitations /X/With limitations*

*Description provided on attachment.

State/ Territory: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL

AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services of Christian Science nurses.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Care and services provided in Christian Science sanitoria.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Nursing facility services for patients under 21 years of age.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

f. Personal care services in recipient's home prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

*Description provided on attachment.

State: Mississippi

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided __X__ not provided

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _____Mississippi_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ____ No limitations ____With limitations __X__None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ___No limitations ___With limitations (please describe below)

__X__ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

____ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).:

____ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

____ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

* For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Inpatient Hospital Services

Prior authorization (PA) by the Utilization Management and Quality Improvement Organization (UM/QIO) is required on all hospital admissions except newborns at birth. Upon approval of a hospital admission, a treatment authorization number (TAN) is issued for an inpatient stay up to nineteen (19) consecutive days. If a beneficiary is discharged during these nineteen (19) days and requires another inpatient stay, a new PA request must be submitted to the UM/QIO for a new TAN.

Continued stay authorizations by the UM/QIO are required when the beneficiary remains hospitalized more than nineteen (19) days.

All hospital admissions for deliveries must be reported to the UM/QIO to receive an automatic TAN for an inpatient stay up to nineteen (19) consecutive days.

Newborns do not require a PA for admission at birth. Well or sick newborns hospitalized more than five (5) days from the date of delivery require a PA with the begin date of the hospital stay as the newborn's date of birth. If a newborn is discharged and requires another inpatient stay, a PA by the UM/QIO must be obtained on admission.

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 1a

STATE Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

1a. Inpatient Hospital Services - Swing Bed:

Statutory Authority. Provision of swing bed services is authorized by Section 1913, Title XIX of the Social Security Act, as enacted by Congress through Section 904 of Public Law 96-499 and implemented by the Department of Health and Human Services through regulations 42 CFR Parts 405, 435, 440, 442 and 447.

Definition of Services. Swing bed services are extended care services provided in a hospital bed that has been designated as such and consist of one or more of the following:

a. Skilled nursing care and related services for patients requiring medical or nursing care.
b. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
c. On a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available to them only through institutional facilities.

Eligible Providers. Hospitals granted an approval to participate in the swing bed program by the Health Care Financing Administration and holding a valid certificate of need to provide swing bed care from the Mississippi State Department of Health may provide swing bed services to Medicaid recipients.

Duration of Service. Medicaid recipients will be eligible for swing bed care to the same extent allowed or provided under the Long Term Care program, except that swing-bed providers will not be reimbursed for hospital leave days or therapeutic home leave days. Prior to the admission of a Medicaid recipient, the swing bed facility must call the Mississippi Foundation For Medical Care (PRO) to receive certification or non-certification for the swing bed. Seven (7) days prior to the thirtieth (30th) consecutive swing bed day, the hospital must complete the Medicaid Swing Bed Extension Form and forward it to PRO along with the entire patient record for review. PRO will notify the swing bed facility if the swing bed extension has been approved or disapproved.

TN # 93-08

Supersedes TN # NEW

Date Received
Date Approved APR 11 1995
Date Effective JUL 01 1993

State of Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

2a. Outpatient Hospital Services

Visits for medically necessary outpatient hospital services are allowed for all beneficiaries.

Prior authorization is required for outpatient hospital physical therapy, occupational therapy, speech therapy and mental health services. Prior authorization is performed by the Utilization Management and Quality Improvement Organization (UM/QIO) contractor for the Division of Medicaid.

Emergency room services are allowed for all beneficiaries without limitations.

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

State of Mississippi
DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

2b. Rural Health Clinic Services:

Rural Health Clinic (RHC) services are limited to those services provided in rural health clinics as described in the Social Security Act, Section l86l (aa). RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the RHC are the same limitations as defined for those services in the state plan.

In order to participate in a Rural Health Clinic Program, a clinic must meet the certification requirements of 42 CFR 491 Subpart A and have an approved agreement to participate in the Medicaid program.

Scope of Services

A. Staffing Requirements

1. The RHC staff must include one or more physicians and one or more physician assistants or nurse practitioners.
2. The physician, physician assistant, nurse practitioner, nurse-midwife, clinical social worker, or clinical psychologist may be an owner or an employee of the clinic, or may furnish services under contract to the clinic.
3. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient to provide the services essential to the operation of the clinic.
4. The RHC must have a physician, nurse practitioner, physician assistant, nurse-midwife, clinical social worker, or clinical psychologist available at all times to furnish patient care services during the clinic's hours of operation. The RHC must also have a nurse practitioner, physician assistant, or certified nurse midwife available to furnish patient care services at least 60 percent of the time the RHC operates.
5. The physician must provide medical direction for the clinic's health care activities and consultation for, and medical supervision of, the health care staff.

6. The physician, in conjunction with the physician assistant and/or nurse practitioner, must participate in developing, executing, and periodically reviewing the clinic's written policies and the services provided to Medicaid beneficiaries, and must periodically review the clinic's patient's records, provide medical orders, and provide medical care services to the patients of the clinic.
7. A physician must be present for sufficient periods of time, at least once in every two week period (except in extraordinary circumstances), to provide the medical direction, medical care services, consultation and supervision and must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are to be documented in the records of the clinic or center.
8. The RHC program requires state licensure for physicians and nurses, as well as compliance with state law for all clinical staff credentialing. In addition, the clinic should establish written clinical protocols for managing healthcare problems. These protocols should be approved by the State Board of Nursing.
9. The RHC program has no requirements for hospital admitting privileges, but a practice must demonstrate that hospital services are available to patients.

B. Direct Services

Medicaid will reimburse those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions. In addition, the RHC must provide the following basic laboratory services on site:

1. Chemical examination of urine by stick or tablet
2. Hemoglobin or hematocrit
3. Blood sugar
4. Examination of stool specimens for occult blood
5. Pregnancy tests
6. Primary cultures for transmittal to a certified lab

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

C. Visits

1. Encounter

   A visit at an RHC can be a medical visit or an "other health" visit. A medical visit is a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, or nurse midwife. An "other health" visit is a face-to-face encounter between a clinic patient and a clinical psychologist, clinical social worker, or other health professional for mental health services. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except when the following circumstances occur:

   a. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

   b. The patient has a medical visit and a visit with a mental health professional, a dentist, or an optometrist. In these instances, the clinic is paid for more than one encounter on the same day.

2. Hospital and Nursing Home Visits

   RHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by an RHC and rendering services to clinic patients in a hospital must file under his own individual provider number. Nursing home visits will be reimbursed at the RHC PPS rate.

State of Mississippi
DESCRIPTION OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

2c. Federally Qualified Health Centers Services:

Federally Qualified Health Centers services are limited to those services provided in federally qualified health centers as described in the Social Security Act, Section 1861 (aa). FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and, for visiting nurse care, related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the state plan.

A center must meet the conditions set forth in 42 CFR 491 Subpart A and have an approved agreement to participate in the Medicaid program.

Scope of Services

A. Staffing Requirements

1. The FQHC staff must include one or more physicians and one or more physician assistants or nurse practitioners.

2. The physician, physician assistant, nurse practitioner, nurse-midwife, clinical social worker, or clinical psychologist may be an owner or an employee of the clinic, or may furnish services under contract to the center.

3. The staff may also include ancillary personnel who are supervised by the professional staff. The staff must be sufficient to provide the services essential to the operation of the center.

4. The FQHC must have a physician, nurse practitioner, physician assistant, nurse-midwife, clinical social worker, or clinical psychologist available at all times to furnish patient care services during the center's hours of operation. The physician must provide medical direction for the clinic's health care activities and consultation for, and medical supervision of, the health care staff except for services furnished by a clinical psychologist, which state law permits to be provided without physician supervision.

5. The physician, in conjunction with the physician assistant and/or nurse practitioner, must participate in developing, executing, and periodically reviewing the clinic's written policies and the services provided to Medicaid beneficiaries, and must periodically review the center's patient's records, provide medical orders, and provide medical care services to the patients of the center.

6. A physician must be present for sufficient periods of time, at least once in every two week period (except in extraordinary circumstances), to provide the medical direction, medical care services, consultation and supervision and must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are to be documented in the records of the center.

7. The FQHC program requires state licensure for physicians and nurses, as well as compliance with state law for all clinical staff credentialing.

8. The FQHC program has no requirements for hospital admitting privileges, but a practice must demonstrate that hospital services are available to patients.

B. Direct Services

Medicaid will reimburse those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

C. Visits

1. Encounter

A visit at a FQHC can be a medical visit or an "other health" visit. A medical visit is a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, or nurse midwife. An "other health" visit is a face-to-face encounter between a clinic patient and a clinical psychologist, clinical social worker, or other health professional for mental health services. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except when the following circumstances occur:

a. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

b. The patient has a medical visit and a visit with a mental health professional, a dentist, or an optometrist. In these instances, the clinic is paid for more than one encounter on the same day.

2. Hospital and Nursing Home Visits

FQHC services are not covered when performed in a hospital (inpatient or outpatient). A physician employed by a FQHC and rendering services to clinic patients in a hospital must file under his own individual provider number. Nursing home visits will be reimbursed at the FQHC PPS rate.

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries ages birth to twenty-one (21) in accordance with 1905 (a) of the Act, without regard to service limitations and with prior authorization.

DESCRIPTIONS OF AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

3. For dates of service on or after July 1, 2013, prior authorization is required for certain advanced imaging procedures. Prior authorization is performed by a Utilization Management and Quality Improvement Organization (UM/QIO) contractor for the Division of Medicaid.

   Prior authorization for certain advanced imaging procedures, as specified in the MS Administrative Code, Title 23, Part 220, is required except when performed during an inpatient hospitalization, during an emergency room visit or during a twenty-three (23) hour observation period.

   The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

State of Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4a. Nursing Facility Services:

The Division of Medicaid covers Nursing Facility services provided in a facility licensed and certified by the state survey agency as a Medicaid Nursing Facility and meets all the requirements in 42 CFR Part 483.

A Nursing Facility is defined as an institution, or distinct part thereof, that meets the requirements of Sections 1919(a), (b), (c) and (d) of the Social Security Act. The Nursing Facility primarily provides the following three (3) types of services and is not primarily for the care and treatment of mental diseases:

1. Skilled nursing care and related services for residents who require medical or nursing care,

2. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

3. Health-related care and services on a regular basis to individuals with mental or physical conditions requiring care and services that can only be made available through institutional facilities.

A nursing facility must provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as outlined in 42 CFR Part 483.

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4b. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under the Age of Twenty-one (21): Limited to Federal Requirements.

EPSDT Screenings:

The Division of Medicaid covers early and periodic screening and diagnosis of Medicaid-eligible beneficiaries under age twenty-one (21) to ascertain physical, mental, psychosocial and/or behavioral health conditions and provides treatment to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions found in accordance with Sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act. The Division of Medicaid has established procedures to:

1. Inform all eligible individuals, or their families, of the EPSDT program,
2. Provide or arrange for requested screening services including necessary transportation and scheduling assistance, and
3. Arrange for appropriate treatment of health problems found as a result of a screening.

EPSDT screenings must be provided by currently enrolled Mississippi Medicaid providers who have signed an EPSDT specific provider agreement and must adhere to the periodicity schedule of the American Academy of Pediatrics (AAP) Bright Futures. EPSDT screening providers include, but are not limited to:

1. The Mississippi State Department of Health (MSDH),
2. Public schools and/or public school districts certified by the Mississippi Department of Education,
3. Physicians,
4. Physician Assistants,
5. Nurse Practitioners,
6. Federally Qualified Health Centers (FQHC),
7. Rural Health Clinics (RHC), and
8. Comprehensive health clinics.

EPSDT screening providers must refer beneficiaries under the age of twenty-one (21) to other Mississippi Medicaid enrolled licensed practitioners for services necessary to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions discovered by the screening services, whether or not such services are covered under the State plan.

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4b. Early and Periodic Screening and Diagnosis of Individuals under 21 Years of Age. Treatment of Conditions Found: Exceeds General Requirements.

I. **Medical Risk Assessment**

In addition to the periodic screen, medical risk assessment (screening) is done by a physician, or by a registered nurse/nurse practitioner or a physician assistant under a physician's direction, to determine if the infant is high risk for mortality or morbidity. An infant is considered high risk if one or more risk factors are indicated on the Risk Screening Form, Mississippi Perinatal Risk Management/Infant Services System, or the Hollister Maternal/Newborn Record System, and is eligible for enhanced services, as specified in Section III, Enhanced EPSDT Services for High-Risk Infants.

An infant may be assessed (screened) for medical risk a maximum of two (2) times during the first year, i.e., at birth and again if risk factors are present, within the first year by the physician providing care. If the infant is found to be high risk, the physician is to make a referral to the High-Risk Case Management Agency of the client's choice. The physician may send a copy of the screening form to the High-Risk Case Management Agency or make a telephone referral. The High-Risk Case Management Agency will document referral information on the Risk Screening Form, if the referral is made by telephone.

Reimbursement for the medical risk assessment is to an approved physician provider.

II. **Enhanced EPSDT Services For High-Risk Infants**

Enhanced services (infant nutrition, infant psychosocial, and health education to the infant's caretaker) are to be provided on the basis of medical necessity to lessen the risk of infant mortality or morbidity through the EPSDT Program. Infants found to be at such risk shall be referred to as high-risk infants.

These services are currently provided in a lesser amount to all children receiving EPSDT Services. In order to prevent the demise or morbidity of the high-risk infant, the number of possible EPSDT

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screenings will be increased to one (1) per calendar month with a maximum of twelve (12) during the first year of life. At the discretion of the attending physician, abbreviated screenings may be provided to a high-risk infant and the full screening provided at the next visit. If the medical or medically-related risk factor(s) cease to exist during the first year of life, as determined by the infant's physician, the infant will return to the regular screenings as prescribed in the EPSDT periodicity schedule.

The screenings may be provided to the infant in any appropriate setting, such as home or office. Home visits are particularly encouraged.

The Child Health Record will be utilized for comments regarding feeding, development and other identified problems and will be subject to audit by the Division of Medicaid for quality of care purposes, as is currently done for the regular EPSDT Program.

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III. Medical Necessity

The only limitation on services covered is that they are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limits in the State Plan. Services not covered in the State Plan are covered provided they are described in Section 1905(a) of the Social Security Act. All services determined to be medically necessary will be covered. The Division of Medicaid will require that prior approval be obtained by the provider for medically necessary services which are not covered in the State Plan or which exceed the benefit limits addressed in the State Plan. Prior approval is through plans of care which are submitted by a physician for Division of Medicaid approval. Services requested and approved as a result of the plan of care may be provided by any Medicaid approved provider, as appropriate for the service.

Services in Section 1905(a) available to EPSDT recipients, if medically necessary, and not addressed elsewhere in the State Plan include:

1) Podiatrists' Services
2) Optometrists' Services
3) Chiropractors' Services
4) Dentists'
5) Private Duty Nursing
6) Christian Science Nurses
7) Personal Care Services
8) Case Management Services
9) Respiratory Care Services
10) Organ Transplants
11) Rehabilitative Services

IV. **Rehabilitative Services**

42 CFR 441.57
42 CFR 440.130 (d)

Medically necessary rehabilitative services include a range of coordinated services provided to children under 21 years of age in order to correct, reduce or prevent further deterioration of identified deficits in the child=s mental health.

Deficits are identified through comprehensive screening, assessment and evaluations by qualified mental health professionals and/or medical professionals. Services provided must be face-to-face, medically necessary, within the scope of practice of the provider and address identified problems in order that the beneficiarymay attain the best level of functioning for him/her. Services include provision of direct one-on-one treatment with the child and a provision for collaborations with and instruction to parents and/or other caregivers in addressing the child=s identified needs, as outlined on a treatment plan. Services provided to family members or caregivers that are independent of meeting the identified needs of the child or which are primarily focused on academic education are not covered by Medicaid.

Services must be community based and may be provided in a day care, at home, at school, in a doctor=s office, at a hospital outpatient clinic or in another appropriate clinical setting

Eligible Providers:

An eligible provider must enroll as a Medicaid individual provider. Eligible providers must be a physician who specializes in child/addescent psychiatry, a clinical psychologist, a licensed certified social worker or other mental health practitioner licensed independentlyto practice in the State and recognized by the Division of Medicaid. Providers of Day Treatment must be certified by the Department of Mental Health, meet the Minimum Standards for Day Treatment providers and have a Alead@ day treatment provider who meets the independent practice qualification.

Benefits and Limitations:

Day Treatment is a behavioral intervention, provided in the context of a therapeutic milieu, which provides the intensive treatment necessary to enable children to live in the community. It is the most intensive community-based treatment available. Day Treatment may be provided up to a maximum of 5 days per week with the maximum number of hours per day specified in the current Medicaid Provider Policy Manual. The minimum and maximum number of participants in each day treatment program are also specified in the Medicaid Provider Policy Manual. All Day Treatment program must be certified by the Department of Mental Health and each Medicaid beneficiaries participation in a Day Treatment program must be prior authorized. Prior authorization is granted by the Medicaid Agency and determined based upon the recommendation and documentation submitted by an appropriate mental health professional.

Evaluative Services are time-limited, formal processes that collect clinical information from many

sources in order to reach a diagnosis, determine a prognosis, render a biopsychosocial formulation, and determine treatment. Evaluative Services are used to assess personality, intelligence, and the presence, degree, and type of neuropsychological brain dysfunction. All Evaluative Services exceeding four (4) hours require prior authorization based on the recommendation of an appropriate mental health practitioner. Prior authorization may be required for any Evaluative Service as outlined in the Medicaid Provider Policy Manual.

Psychotherapeutic Services are intentional face-to-face interactions between a provider and a beneficiary in which a therapeutic relationship is established to help resolve symptoms of the beneficiary=s mental and/or emotional disturbance. Psychotherapeutic Services are directed toward helping the beneficiary attain the highest level of functioning in a community-based setting. Psychotherapeutic services include at a minimum, Individual psychotherapy, Group psychotherapy, and Family Psychotherapy. Psychotherapeutic services require prior authorization when the services provided exceed 100 hours per fiscal year or when services are provided to individuals under the age of three (3).

Mental Health services that are considered Amedically necessary@ must be (1) consistent with the diagnosis or treatment of the beneficiary=s condition or illness; (2) in accordance with the standards of good medical practice; (3) required for reasons other than the convenience of the beneficiary, beneficiary=s parents or legal guardian, or the servicing provider; (3) the most appropriate level of mental health services which can be safely and efficiently provided to the beneficiary in a community-based setting. Medical necessity for mental health services outlined as standard services in the Mississippi Medicaid Provider Policy Manual will be verified based on established post utilization review protocol.

Prior authorization may be requested through the submission of an authorization request by a qualified Medicaid provider. Additional documentation to substantiate medical necessity may be requested by the Medicaid Agency.

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Autism Spectrum Disorder (ASD) Services

A. Pursuant to 42 C.F.R. § 440.60 Other Licensed Practitioners (OLP), the following licensed qualified health care practitioners (QCHP), working within their scope of practice and licensure, may provide Autism Spectrum Disorder (ASD) services:
   a) Licensed Physician,
   b) Licensed Psychologist,
   c) Mental Health Nurse Practitioner,
   d) Licensed Clinical Social Worker (LCSW),
   e) Licensed Professional Counselor (LPC), or
   f) Board Certified Behavior Analyst (BCBA).

B. The following unlicensed practitioners may provide ASD services under the supervision of a QHCP:
   a) A Board Certified assistant Behavior Analyst (BCaBA) who has a current and active certification from the Behavior Analyst Certification Board and is licensed by the Mississippi Board of Autism to practice under the supervision of a MS licensed BCBA, or

   b) A Registered Behavior Technician (RBT) who has a current and active certification from the Behavior Analyst Certification Board and who is under the direct supervision and direction of a BCBA or BCaBA.

C. The state assures that:
   a) Supervision is included in the state's scope of practice act for the licensed practitioners,
   b) Licensed practitioners assume professional responsibility for the services provided by the unlicensed practitioners,
   c) Licensed practitioners are able to furnish the services being provided, and
   d) Licensed practitioners bill for the services provided by the unlicensed practitioners.

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Prescribed Pediatric Extended Care (PPEC) Services

The Division of Medicaid covers pediatric extended care services prescribed by a child's attending physician when medically necessary, prior authorized by the Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO when the child:

1. Is medically dependent or technologically dependent, and

2. Has complex medical conditions that require continual care.

Prescribed Pediatric Extended Care (PPEC) Service is defined as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) expanded benefit for EPSDT-eligible beneficiaries diagnosed with a medically-complex, medically fragile condition and who are medically dependent and/or technology dependent requiring continual care as prescribed by the beneficiary's attending physician.

PPEC services include at a minimum: development, implementation and monitoring of a comprehensive protocol of care, developed in conjunction with the parent or guardian, which specifies the medical, nursing, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served as well as the caregiver training needs of the child's legal guardian.

PPEC services must be provided by MS Medicaid enrolled PPEC Centers, licensed by the Mississippi State Department of Health (MSDH), and adhere to the MSDH Minimum Standards of Operation of PPEC Centers.

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Private Duty Nursing (PDN) Services

The Division of Medicaid covers medically necessary private duty nursing (PDN) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries when ordered by the beneficiary's primary physician or appropriate physician specialist and prior authorized by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO.

PDN services are defined as skilled nursing care services for EPSDT-eligible beneficiaries who require more individualized and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

PDN services must be provided by a Mississippi Medicaid enrolled PDN provider and comply with the provider requirements specified by the Division of Medicaid.

Personal Care Services (PCS)

The Division of Medicaid covers medically necessary personal care services (PCS) for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries when ordered by the beneficiary's primary physician and prior authorized by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO.

PCS are medically necessary personal care services for EPSDT-eligible beneficiaries who require assistance in order to safely perform the activities of daily living (ADLs) due to a diagnosed condition, disability, or injury. The delivery and receipt of these services must be medically necessary for the treatment of the beneficiary's condition, disability, or injury and exceed the level of care available through the home health benefit.

PCS services must be provided by a Mississippi Medicaid enrolled PDN provider and comply with the provider requirements specified by the Division of Medicaid.

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4.d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or*

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: □ No limitations* □X With limitations**

*The State is providing at least four (4) counseling sessions per quit attempt.

**Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt should be explained below.

Please describe any limitations:

*Face-to-Face tobacco cessation counseling services for pregnant women are limited to one (1) counseling session per quit attempt with mandatory referral to the MS Tobacco Quitline.

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5. The Division of Medicaid covers Physicians' Services, including those that an optometrist is legally authorized to perform within their scope of practice, with the following limitations:

   Hospital physician visits are limited to one (1) per day, except hospital physician visits to beneficiaries in Intensive or Coronary Care Units (ICU or CCU) are limited to two (2) per day. The Division of Medicaid covers additional medically necessary inpatient hospital physician visits with prior authorization from the Division of Medicaid or designee.

   Hospital emergency department (ED) physician visits are not limited.

   Nursing facility physician visits are limited to thirty-six (36) per state fiscal year (SFY).

   Physician office visits and hospital outpatient department physician visits are limited to:

   - For non-psychiatric physician visits a combined total of sixteen (16) visits per SFY.
   - For psychiatric physician visits a combined total of sixteen (16) visits per SFY.

   Physician services for EPSDT beneficiaries, if medically necessary, which exceed the limitations of the State Plan are covered with prior authorization from the Division of Medicaid or designee.

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5b Medical and surgical services by a dentist

Medical and surgical services furnished by a dentist in accordance with section 1905 (a) (5) (B) of the Social Security Act are limited to those to services which a dentist is legally authorized to perform and are covered in the Plan.

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Podiatry services are covered for all Medicaid eligible recipients. This means that the professional services provided by a doctor of podiatric medicine within the scope of applicable state law and licensing requirements (except those services such as routine foot care which are specifically excluded) are reimbursable by the Division of Medicaid.

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Chiropractic services are covered for all Medicaid eligible recipients. This means that a chiropractor's manual manipulation of the spine to correct a subluxation, if an x-ray demonstrates that a subluxation exists for which manipulation is the appropriate treatment, is reimbursable by Medicaid. There shall be no reimbursement for x-rays or other diagnostic of therapeutic services furnished or ordered by a chiropractor.

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6d. Other Practitioners' Services:

Nurse Practitioner Services: Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner including, but not limited to nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the Division.

Physician Assistant Services: Physician assistant services are those provided by physician assistants who are licensed by the State Board of Medical Licensure and are practicing with physician supervision under regulations adopted by the Division.

Pharmacy Disease Management Services: Disease management services are those provided by specially credentialed pharmacists for Medicaid recipients with specific chronic disease states of diabetes, asthma, lipids, or coagulation. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcome. The process provides cost-effective, high-quality health care for patients referred by their physician. The referring physician requests disease management services from any credentialed participating pharmacist in Mississippi. With the appropriate transfer of pharmacy care records, including a written referral from the physician to the pharmacist, the referral is considered documented. All laboratory test results must be included because the pharmacist is not allowed reimbursement for laboratory procedures. In order to be cost-effective for the Medicaid program, the disease management services performed by the pharmacist cannot duplicate those provided by the physician.

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The pharmacist is knowledgeable about pharmaceutical products and the design of therapeutic approaches which are safe, effective, and cost-efficient for patient outcomes. The pharmacist evaluates the patient and consults with the physician concerning the suggested/prescribed drug therapy. After the drug therapy review with the physician, the pharmacist counsels the patient concerning such topics as compliance and provides the patient with educational and informational materials specific to the disease or drug. The pharmacist functions in an educational capacity to ensure the patient understands and complies with the proper usage of all drugs prescribed by the physician. The involvement with the patient and the education of the patient about lifestyle changes and improved drug regimen compliance are aimed at reduction of or avoidance of costly hospitalizations and emergency care.

The State Pharmacy Practice Act in its Disease Management Protocol requires communication with the referring physician. Disease management services follow a protocol developed between the pharmacist and patient's physician. When nationally accepted clinical practice guidelines are introduced, they will be incorporated into the individual patient's therapy plan.

The primary components of this service are as follows:

1. Patient evaluation
2. Compliance assessment
3. Drug therapy review
4. Disease state management according to clinical practice guidelines
5. Patient/caregiver education

A copy of the pharmacy care records, including the documentation for services, is shared with the patient's physician and remains on file in the pharmacist's facility available for audit by the Division of Medicaid.

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6d. Other Licensed Practitioners' Services:

Nurse Practitioner Services: Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner including, but not limited to nurse anesthetists, nurse midwives, family nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the Division.

Physician Assistant Services: Physician assistant services are those provided by physician assistants who are licensed by the State Board of Medical Licensure and are practicing with physician supervision under regulations adopted by the Division.

Licensed Pharmacist Services: Licensed pharmacist, employed by a Mississippi Medicaid pharmacy provider, within their scope of practice under state law are limited to:

1) Vaccine administration.

   Effective December 11, 2020, qualified pharmacy technicians and pharmacy interns/externs, acting under the supervision of a qualified pharmacist, as authorized by the Mississippi State Board of Pharmacy to administer FDA-authorized or FDA-licensed COVID-19 vaccines.

2) Disease Management Services. Disease management services are those provided by specially credentialed pharmacists for Medicaid recipients with specific chronic disease states of diabetes, asthma, lipids, or coagulation. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcome. The process provides cost- effective, high quality health care for patients referred by their physician. The referring physician requests disease management services from any credentialed participating pharmacist in Mississippi. With the appropriate transfer of pharmacy care records, including a written referral from the physician to the pharmacist, the referral is considered documented. All laboratory test results must be included because the pharmacist is not allowed reimbursement for laboratory procedures. In order to be cost-effective for the Medicaid program, the disease management services performed by the pharmacist cannot duplicate those provided by the physician.

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Home Health Services

The Division of Medicaid covers the following home health services:

1. Skilled Nursing Visit for intermittent or part-time nursing services provided by a registered nurse employed by a home health agency in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards or a registered nurse when no home health agency exists in the area. The registered nurse must be a graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which they practice.

2. Home Health Aide Visit for personal care services provided directly by an aide employed by a home health agency and in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards. The home health aide must be an individual who has successfully completed a state-established or other home health aide training program approved by the State. Home Health aide services may be provided without a requirement for skilled nursing services and must be supervised by a registered nurse.

Home Health visits are limited to a combined total of thirty-six (36) visits per state fiscal year.

Home health services must be provided to a beneficiary at the beneficiary's place of residence defined as any setting in which normal life activities take place, other than:

1. A hospital,

2. Nursing facility,

3. Intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provide the home health service; or

4. Any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Home health services must be provided in accordance with the beneficiary's physician's orders as part of a written plan of care, which must be reviewed every sixty (60) days. The beneficiary's attending physician must document that a face-to-face encounter occurred no more than ninety (90) days before or thirty (30) days after the start of home health services. The face-to-face encounter must be related to the primary reason the beneficiary requires the home health service.

The home health agency providing home health services must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and comply with all

applicable state and federal laws and requirements.

The Division of Medicaid covers medical supplies, equipment, and appliances prescribed by a physician and prior authorized as specified by the Division of Medicaid. Medical supplies, equipment, and appliances may be provided regardless of whether a beneficiary is receiving services from a home health agency.

For the initial ordering of certain medical equipment the prescribing physician or allowed non-physician practitioner must document that a face-to-face encounter occurred no more than six (6) months prior to the start of services. The face-to-face encounter must be related to the primary reason the beneficiary requires the medical equipment. An allowed non-physician practitioner that performs the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

Medical supplies, equipment, and appliances are covered if they:

1. Are relevant to the beneficiary's plan of care,
2. Are medically necessary,
3. Primarily serve a medical purpose,
4. Have therapeutic or diagnostic characteristics enabling a beneficiary to effectively carry out a physician's prescribed treatment for illness, injury, or disease, and
5. Are appropriate for use in the non-institutional setting where the beneficiary's normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities (ICF/IID) unless the ICF/IID is not required to provide the home health service; or any setting in which payment is or could be made under Medicaid for inpatient service that include room and board.

The beneficiary's need for medical supplies, equipment and appliances must be reviewed by the beneficiary's physician annually.

Medical equipment and appliances must be provided through qualified DME providers. Medical supplies may be provided through a qualified home health agency or DME provider.

The Division of Medicaid covers all medically necessary services for Early, Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries without regard to service limitation and with prior authorization.

9. Clinic Services: Clinic services are limited to those services as described in CFR 42 § 440.90 provided in the Mississippi State Department of Health (MSDH) clinics.

   Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by a facility not part of a hospital but organized and operated to provide medical care to outpatients at the clinic by or under the direction of a physician or dentist, or to outpatients outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

   MSDH clinic services are covered for all Medicaid eligible beneficiaries and limited to one (1) encounter per day unless the beneficiary suffers illness or injury requiring additional diagnosis or treatment, or the beneficiary has a medical visit and a visit with a dentist. In these instances, the clinic is paid for more than one (1) encounter on the same day.

   The Division of Medicaid covers for all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

   Only medically necessary services are covered under the Medicaid program.

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9a. Ambulatory Surgical Center

Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed twenty-four (24) hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of 42 CFR Part 416.

Effective January 1, 2008, ASC services means the combined facility services and covered ancillary services that are furnished in an ASC in connection with covered surgical procedures.

Covered ancillary services means items and services that are integral to a covered surgical procedure performed in an ASC as provided in 42 CFR § 416.164(b), for which payment may be made under 42 CFR § 416.171 in addition to the payment for the facility services.

Effective January 1, 2008, covered surgical procedures means those surgical procedures that meet the criteria specified in 42 CFR § 416.166.

Effective January 1, 2008, facility services means services that are furnished in connection with covered surgical procedures performed in an ASC as provided in 42 CFR § 416.164(a) for which payment is included in the ASC payment established under 42 CFR § 416.171 for the covered surgical procedure.

Only medically necessary services are covered under the Medicaid program.

The Division of Medicaid covers for all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

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9b. End-Stage Renal Dialysis (ESRD) Services

The Division of Medicaid covers all end-stage renal dialysis (ESRD) services and items used to furnish outpatient maintenance dialysis in an ESRD facility or in a beneficiary's home. According to Section 1881 of the Act and 42 CFR § 413.174, ESRD facilities are classified as either:

(a) Hospital-Based ESRD Facilities as defined in 42 CFR § 413.174(c), or

(b) Freestanding ESRD Facilities as defined in 42 CFR § 413.174(b).

There is no distinction between the two facility types for the purposes of payment under the ESRD Prospective Payment System (PPS).

A renal dialysis facility or renal dialysis center must provide dialysis services, as well as adequate laboratory, social, and dietetic services to meet the needs of the ESRD beneficiary according to 42 CFR § 405.2102.

The Division of Medicaid covers for all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

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10. Dental Services

The Division of Medicaid requires prior authorization for certain medically necessary dental services in an office setting and all dental services provided in an outpatient hospital setting by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) or a contracted Coordinated Care Organization's (CCO's) UM/QIO for all beneficiaries except for emergencies.

The Division of Medicaid covers medically necessary dental services for non-Early and Period Screening, Diagnostic and Treatment (EPSDT)-eligible beneficiaries that:

a) Are an adjunct to treatment of an acute medical or surgical condition,

b) Include services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone, and

c) Include emergency dental extractions and treatment.

The Division of Medicaid covers medically necessary dental services for EPSDT-eligible beneficiaries including:

a) Diagnostic,

b) Preventive,

c) Therapeutic,

d) Emergency, and

e) Orthodontic.

Dental Benefit Limits:
For dates of service beginning July l, 2007, dental services (except orthodontia) are limited to $2,500 per beneficiary per fiscal year. Additional dental services in excess of the $2,500 annual limit may be provided with prior authorization from the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO.

Orthodontic Services:
Orthodontic services are covered when medically necessary and prior authorized by the Division of Medicaid or designated entity for EPSDT-eligible beneficiaries. Orthodontia-related services are limited to $4,200 per beneficiary per lifetime. Additional dental services in excess of the $4,200 lifetime limit may be provided with prior authorization from the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO.

Dentures:
Dentures are covered when medically necessary and prior authorized by the Division of Medicaid's UM/QIO or a contracted CCO's UM/QIO for EPSDT-eligible beneficiaries.

State: Mississippi

DESCRIPTION OF LIMITATIONS AS TO AMOUNT, DURATION, AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

I. **Physical Therapy** and related services are provided to all eligible individuals as follows:

A. Services are performed by a physical therapist who meets the state and federal licensing and certification requirements to perform physical therapy services. Physical therapists must meet the qualifications in 42 CFR §440.110 in order to provide these services.

B. Services are medically necessary for the treatment of the beneficiary's illness, condition, or injury.

C. Services for beneficiaries age 21 and over are performed in an individual therapy office or a therapy clinic, physician's office or clinic, nursing facility, or outpatient department of hospital.

D. Services for beneficiaries age 21 and over are performed in an individual therapy office or a therapy clinic, physician's office or clinic, nursing facility, or outpatient department of hospital.

E. Services are prior authorized through the agency's Utilization Management and Quality Improvement Organization as medically necessary.

F. Services are ordered by a physician, physician assistant, or nurse practitioner and provided in accordance with a written plan of care approved by the prescribing provider.

II. **Occupational Therapy** and related services are provided to all eligible individuals as follows:

A. Services are performed by an occupational therapist who meets the state and federal licensing and certification requirements to perform occupational therapy services. Occupational therapists must meet the qualifications in 42 CFR §440.110 in order to provide these services.

B. Services are medically necessary for the treatment of the beneficiary's illness, condition, or injury.

C. Services for beneficiaries age 21 and over are performed in an individual therapy office or a therapy clinic, physician's office or clinic, nursing facility, or outpatient department of hospital.

D. Services for beneficiaries under age 21 are performed in an individual therapy office or therapy clinic, physician's office or clinic, school, home, nursing facility, or outpatient department of hospital.

E. Services are prior authorized through the agency's Utilization Management and Quality Improvement Organization as medically necessary.

F. Services are ordered by a physician, physician assistant, or nurse practitioner and provided in accordance with a written plan of care approved by the prescribing provider.

III. **Speech-Language Pathology** and related services are provided to all eligible individuals as follows:

A. Services are performed by a speech-language pathologist or audiologist who meets the state and federal licensing and certification requirements to perform speech-language pathology or audiologist services. Speech therapists and audiologists must meet the qualifications in 42 CFR §440.110 in order to provide these services.

B. Services are medically necessary for the treatment of the beneficiary's illness, condition, or injury.

C. Services for beneficiaries age 21 and over are performed in an individual therapy office or a therapy clinic, physician's office or clinic, nursing facility, or outpatient department of hospital.

D. Services for beneficiaries under age 21 are performed in an individual therapy office or therapy clinic, physician's office or clinic, school, home, nursing facility, or outpatient department of hospital.

E. Services are prior authorized through the agency's Utilization Management and Quality Improvement Organization as medically necessary.

F. Services are ordered by a physician, physician assistant, or nurse practitioner and provided in accordance with a written plan of care approved by the prescribing provider.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

12a. **Prescribed Drugs**:

(1) Covered outpatient drugs are those produced by any manufacturer which has entered into and complies with an agreement under Section 1927 (a) of the Act which are prescribed for a medically acceptable indication. Compounded prescriptions (mixtures of two (2) or more ingredients) except for hyperalimentation are not covered.

(2) All Medicaid non-Early and Period Screening, Diagnostic and Treatment (EPSDT)-eligible beneficiaries are limited to six (6) prescriptions, which includes legend and prescribed OTC drugs, per month with no more than two (2) brand name (single source or innovator multiple source) drugs per month.

1. Preferred brand drugs listed on the Universal Preferred Drug List (PDL) do not count toward the two (2) brand limit, and

2. Over-the-counter (OTC) drugs prescribed by a physician listed on the Division of Medicaid's OTC PDL do not count toward the two (2) brand limit.

(3) Prescription limits are not applicable for Medicaid beneficiaries receiving institutional long-term care services.

(4) As provided in Section 1935 (d) (1) of the Act, effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible under Part A or Part B.

(5) As provided by Sections 1927 (d)(2) and 1935 (d)(2) of the Act, the Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses, to all Medicaid beneficiaries including full benefit dual eligible beneficiaries under the Medicare prescription Drug Benefit-Part D.

☐ (a) Agents when used for anorexia, weight loss or weight gain;

☐ (b) Agents when used to promote fertility;

☐ (c) Agents when used for cosmetic purposes or hair growth;

☐ (d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee;

☐ (e) Those drugs designated less than effective by the FDA as a result of the Drug Efficacy Study Implementation (DESI) program;

☐ (f) Nonparticipating rebate manufacturers;

☒ (g) Select agents when used for symptomatic relief of cough and colds:
antihistamines, decongestants, antihistamine/decongestant combination products, legend antitussive benzonatate;

☒ (h) Select prescription vitamins and mineral products, except prenatal vitamins and fluoride:
vitamin K, cyanocobalamin injection, vitamin D, folic acid as a single entity;

☒ (i) Select nonprescription (OTC) drugs:
Are defined by the Division of Medicaid, updated annually and located on the Division of Medicaid's website at https://medicaid.ms.gov/providers/ pharmacy /pharmacy-resources/

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

Supplemental Drug Rebate Agreements:

The Division of Medicaid, or the Division of Medicaid in consultation with the Sovereign States Drug Consortium, may negotiate supplemental drug rebate agreements (SDRAs) that would reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect. A SDRA between the Division of Medicaid and a drug manufacturer for drugs provided to the Medicaid program, submitted to the Centers for Medicare & Medicaid Services (CMS) on December 27, 2005 and entitled, "State of Mississippi Supplemental Rebate Agreement", was authorized by CMS. CMS authorized the State of Mississippi to enter into the "Sovereign States Drug Consortium (SSDC)" multi-state purchasing pool. The SDRA submitted to CMS on September 7, 2012, entitled, "State of Mississippi Supplemental Rebate Agreement", was authorized by CMS. CMS authorized the revised multi-state SSDC agreement submitted on March 17, 2014, for the Division of Medicaid population to cover supplemental drug rebates for fee-for-service and coordinated care Medicaid programs, effective July 1, 2014. CMS authorized the revised multi-state SSDC agreement submitted on November 3, 2017 to be effective January 1, 2018, with changes in references to various federal laws, to include the Covered Outpatient Drug Rule and to standardize the terms of the SDRA with that of the other states in the consortium.

An Agreement may not be amended or modified without the authorization of CMS.

Based on the requirements for Section 1927 of the Act, the Division of Medicaid will comply with the following policies for drug rebate agreements:

- The drug file permits coverage of participating manufacturers' drugs.
- The Division of Medicaid may require prior authorization for covered outpatient drugs. Non-preferred drugs are available with prior authorization.
- The prior authorization process for covered outpatient drugs will conform to the provisions of section 1927 (d) (5) of the Social Security Act.
- The Division of Medicaid will comply with the drug reporting requirements for state utilization information and restriction to coverage.
- Supplemental rebate agreement between the Division of Medicaid and a pharmaceutical manufacturer will be separate from federal rebates and are in excess of those required under the national drug rebate agreement.
- The state agrees to report all rebates from manufacturers to the Secretary for Health and Human Services. The state will remit the federal portion of any state supplemental rebates collected.
- The Division of Medicaid will allow all participating manufacturers to audit utilization data.
- The unit rebate amount will be held confidential and will not be disclosed for purposes other than rebate invoicing and verification.

State of Mississippi
DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED.

Preferred Drug List:

In accordance with Section 1927 of the Social Security Act, the state has established a preferred drug list (PDL).

The Preferred Drug List (PDL) is a list of drugs, which have been reviewed and recommended by the Pharmacy and Therapeutics (P&T) Committee, a group of physicians, pharmacists, and nurse practitioners, and approved by the Executive Director of the Division of Medicaid.

The Preferred Drug List contains a wide range of generic and preferred brand name products that have been approved by the FDA. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness. Drugs on the PDL are as effective as non-preferred drugs, but offer economic benefits for the beneficiaries and the State of Mississippi.

Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages. No payment will be made under the Medicaid program for services, procedures, supplies or drugs which are still in clinical trials and/or investigative or experimental in nature.

As of July 1, 2014, the Division of Medicaid's coordinated care organizations (CCO), otherwise known as MississippiCan, will follow the Division of Medicaid's PDL.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

12a. **Physician Administered Drugs and Implantable Drug System Devices:**

The Division of Medicaid defines Physician Administered Drugs and Implantable Drug System Devices as any covered diagnostic or therapeutic radiopharmaceutical, contrast imaging agent, drug, biological or implantable drug system device that is administered in a clinically appropriate manner to a beneficiary by a Mississippi Medicaid provider other than a pharmacy provider. Physician Administered Drugs and Implantable Drug System Devices are not counted toward the beneficiary's monthly prescription limit.

The Division of Medicaid covers Physician Administered Drugs and Implantable Drug System Devices as listed on the Physician's Fee Schedule located at www.medicaid.ms.gov/FeeScheduleLists.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

12c. Orthotics and Prosthetic Devices - Orthotics and prosthetic devices are provided to children under 21 years of age when prescribed by a physician and medically necessary.

Attachment 3.1-A

Exhibit 12d

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED.

12d. Eyeglasses:

Eligible beneficiaries age 21 years and over are qualified for eyeglasses as prescribed by an ophthalmologist or optometrist (including eyeglasses needed after eye surgery). The beneficiary is allowed one (1) pair of eyeglasses every five (5) years. Beneficiaries under age 21 are eligible for eyeglasses as determined through the EPSDT Screening Program.

TN # 2002-05

Superseded TN # 2000-08

Date Approved JUN 25 2002

Date Effective MAY 01 2002

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 13

State: Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services, i.e., other than those provided elsewhere in the plan.

Limited to preventive and rehabilitative services
(42CFR440.130[a] [b] [c] [d] and the following procedures:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A

State: Mississippi

Exhibit 13a

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13a. Diagnostic Services: Diagnostic services, except as otherwise provided in this Plan, includes any medical procedures or supplied recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, top enable them to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 13b

State: Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13b. Screening Services: Screening services means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13c. Preventive Services: Preventive services mean services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to:

1) Prevent disease, disability, and other health conditions or their progression;
2) Prolong life; and
3) Promote physical and mental health and efficiency.

Annual Physical Examination: The Division of Medicaid will cover annual physical examinations. Through this provision, eligible Mississippi Medicaid beneficiaries will be encouraged to choose a medical home and undertake a physical examination to establish a base-line level of health. Beneficiaries under age 21 will access the mandatory periodic screening services through EPSDT providers in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

A medical home is defined as the usual and customary source that provides both preventative and treatment or diagnosis of a specific illness, symptom, complaint, or injury. The medical home will serve as the focal point for a beneficiary's health care, providing care that is accessible, accountable, comprehensive, integrated, and patient-centered.

Dual eligibles whose Medicare Part B effective date is prior to January 1, 2005 will be eligible for the physical examination. For dual eligibles whose Medicare Part B effective date is on or after January 1, 2005, the annual physical examination is covered after twelve months have elapsed from the original effective date of Medicare Part B coverage. Beneficiaries enrolled in Medicare Part B coverage on and after January 1, 2005 are entitled to a one time only "Welcome to Medicare" physical examination with the first six months of Medicare coverage.

Radiology and laboratory procedures which are a standard part of a routine adult age/gender physical examination or well child periodic screening may be billed by the provider performing the procedure, and coverage will be determined based on current Mississippi Medicaid policies for the individual procedures.

Medication Checks: Regular and periodic monitoring by a psychiatrist or physician of the therapeutic effects of medications prescribed for mental health purposes.

Providers of medication checks must meet the standards as established under Sections 41-19-31 through 41-19-39 and/or Section 41-4-7(g), Mississippi code of 1972, as amended.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

13.d. Rehabilitative Services: Rehabilitative services, except as otherwise provided under this Plan, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level (42 CFR 440.130 (d)).

A. Assurances

1. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services:
   The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries ages birth to twenty-one (21) in accordance with 1905 (a) of the Act, without regard to service limitations and with prior authorization.
2. Adequacy of Service Provisions:
   The CMHC providers are responsible for ensuring that each individual's mental health needs are met throughout the course of treatment. If all mental health services reimbursable by Medicaid during the state fiscal year are exhausted, CMHC providers will continue servicing adults on a sliding scale fee based on income.
2. Freedom of Choice:
   Participants have freedom of choice of qualified enrolled provider agencies and team members within that agency.

B. Agency Requirements

1. All rehabilitative services are provided by quasi-governmental or private Community Mental Health Center (CMHC) agencies certified according to Mississippi state law and by the Mississippi Department of Mental Health (DMH). Quasi-governmental CMHCs are defined as entities operated under the supervision of regional commissions appointed by county boards of supervisors comprising their respective catchment areas.
   a. DMH issues a three (3) year certification for the agency and the services provided unless stated otherwise at the time of certification.
   b. DMH certification is based on the following:
      1) Adherence to DMH standards, DMH grant requirement guidelines, contracts, memoranda of understanding, and memoranda of agreement;
      2) Compliance with DMH fiscal management standards and practices outlined in the DMH Operational Standards based on a risk-based audit system;
      3) Evidence of fiscal compliance with external funding sources;

4) Compliance with ethical practices and codes of conduct of professional licensing entities related to provision of services and management of the organization; and
5) Evidence of solid business and management practices.

C. Team Member Qualifications

1. Psychiatrists must be a graduate of a medical or osteopathic school, be board-certified in psychiatry and be licensed by the Mississippi State Board of Medical Licensure.
2. Physicians must be a graduate of a medical or osteopathic school and have a minimum of five (5) years' experience in mental health and be licensed by the Mississippi State Board of Medical Licensure.
3. Psychologists must hold a Ph.D. degree in psychology and be licensed by the Mississippi Board of Psychology.
4. Licensed Certified Social Workers (LCSW) must hold a Master's degree in social work and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists at the LCSW level.
5. Licensed Master Social Workers (LMSW) must hold a Master's degree in social work, be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists at the LMSW level, and supervised by a LCSW, psychiatrist, physician or a psychologist.
6. Licensed Professional Counselors (LPC) must hold a Master's degree in counseling and be licensed by the Mississippi State Board of Examiners for Licensed Professional Counselors.
7. Licensed Marriage and Family Therapists (LMFT) must hold a Master's degree in marriage and family therapy and be licensed by the Mississippi State Board of Examiners for Social Workers and Marriage and Family Therapists.
8. Professional Art Therapists (ATR-BC) must hold a Master's degree in art therapy and be licensed by the Mississippi Department of Health.
9. Psychiatric Mental Health Nurse Practitioners (PMHNP) must hold a Master's degree in nursing with a specialty in psychiatry, be licensed by the Mississippi Board of Nursing, and must practice within a collaborative/consultative relationship with a physician within an established protocol or practice guidelines.
10. Physician Assistants (PA) must hold a Master's degree in a health related or science field, be licensed by the Mississippi Board of Medical Licensure, must be under the supervision of a psychiatrist or a physician and in order to provide medication management must have two (2) years of psychiatric training.
11. Registered Nurses (RN) must be a graduate from an approved or accredited RN nursing program, be licensed by the Mississippi Board of Nursing, and must be under the supervision of a psychiatrist, physician, PMHNP, or PA.
12. Licensed Practical Nurses (LPN) must be a graduate from an approved or accredited LPN nursing program, be licensed by the Mississippi Board of Nursing and supervised by a psychiatrist, physician, PMHNP, PA or RN.
13. DMH certifies the following team members:
    a. Certified Mental Health Therapists (CMHT), Certified Intellectual and Developmental Disabilities Therapists (CIDDT) and Certified Addiction Therapists (CAT) must hold a Master's degree in mental health, human services, intellectual disabilities, addictions, or behavioral health related fields from an approved educational institution. The Master's degree must be comprised of at

least thirty (30) semester hours or its equivalent. There are two (2) levels of certification:

1) Provisionally certified therapists are temporarily certified while fulfilling all the certification requirements, provide the same services as a CMHT, CIDDT and CAT and must be under the supervision of certified therapist of the same discipline. Provisional certification is valid for up to two years (24 consecutive months) from the date of issuance.
2) The certified credential is full certification and renewable every four (4) years as long as renewal requirements are met.

b. Community Support Specialists must hold a minimum of a Bachelor's degree in a mental health field, be certified by DMH as a Community Support Specialist and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LMSW, LPC, LMFT, CMHT, CIDDT, or a CAT.
c. Psychosocial Rehabilitation Program Director must hold a minimum of a Bachelor's degree in a mental health field, be certified by DMH as a Psychosocial Rehabilitation Program Director and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LMSW, LPC, LMFT, CMHT, CIDDT, or a CAT.
d. Peer Support Specialists must hold a minimum of a high school diploma or GED equivalent, demonstrate a minimum of six (6) months in self-directed recovery from mental illness or substance abuse within the last year, complete an initial and ongoing peer support training, such as Family-to-Family or Family Time Out, be certified by DMH as a Certified Peer Support Specialist and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, CAT or a Peer Support Specialist Supervisor who has been trained as a Peer Support Specialist with an emphasis on supervision.
e. Certified Wraparound Facilitators must hold a minimum of a high school diploma or GED equivalent, complete the "Introduction to Wraparound" 3-day training, be certified by DMH, and must be under the supervision of a psychiatrist, physician, PMHNP, PA, LCSW, LPC, LMFT, CMHT, CIDDT, or a CAT who has completed the "Introduction to Wraparound" 3-day training and hold a DMHs High Fidelity Wraparound certificate.

D. Rehabilitative Services medically necessary for the treatment of the individual's illness, condition, or injury are provided to all eligible individuals as follows.

1. Treatment Plan Development and Review

a. Treatment plan development and review is defined as the process through which a group of clinical team members meet to discuss the individual's treatment plan with the individual and his/her family members. The review utilizes a strengths-based approach and addresses strengths and natural resources, presenting symptoms/problems, diagnostic impressions, and initiate/update a treatment plan that includes goals, objectives and treatment strategies.
b. The clinical purpose of treatment plan development and review is to meet the needs of the individual by addressing the behaviors and making recommendations for treatment.
c. This process may also be called an individual's service plan, plan of care or wraparound plan.
d. The composition of the team members must include one of the following: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA, and may include any other team member listed in C. above.
e. The treatment plan must be approved by one of the following: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA.
f. Treatment plan development and review is limited to four (4) services per state fiscal year.

2. Medication Management

a. Medication management includes the evaluation, administration and monitoring of psychotropic medications.
b. Medication evaluation is performed by psychiatrists, physicians, PMHNP or PA. The clinical purpose is to assess an individual's mental health needs and to evaluate if psychopharmacological treatment of a mental disorder is necessary.
c. Only psychiatrists, physicians, PMHNP and PA can prescribe psychotropic medications.
d. Medication administration is defined as the administering of a prescribed medication. Only a psychiatrist, physician, PMHNP, PA, RN or LPN can administer medications.
e. Medication monitoring is defined as regular and periodic monitoring of the therapeutic and side effects of psychotropic medications prescribed for the treatment of a mental disorder.
f. Monitoring is performed by psychiatrists, physicians, PMHNP or PA.
g. The clinical purpose of medication monitoring is to ensure the individual receives the proper dosage and adjustment of medications resulting in the appropriate therapeutic effects of the medication.
h. Medication management is limited to seventy-two (72) services per state fiscal year.

3. Psychosocial Assessment

a. Psychosocial assessment is defined as the documentation of information from the individual and/or collaterals describing the individual's family background, educational/vocational achievements, presenting problem(s), history of problem(s), previous treatment, medical history, current medication(s), source of referral and other pertinent information to determine the nature of the individual's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment.
b. The clinical purpose of a psychosocial assessment is to create a comprehensive picture of the individual in order to develop treatment goals.
c. One of the following team members is required to provide this service: psychiatrist, physician, psychologist, LCSW, LMSW, LPC, LMFT, PA, PMHNP, CMHT, CIDDT, and CAT.
d. Psychosocial assessments are limited to four (4) hours per state fiscal year.

4. Psychological Evaluation

a. Psychological evaluation is defined as an evaluation for the purpose of assessing the individual's cognitive, emotional, behavioral and social functioning using standardized tests, interviews and behavioral observations.
b. The clinical purpose of a psychological evaluation is to identify therapy needs, highlight issues presented in treatment, recommend forms of intervention, and offer guidance about potential outcomes of treatment.
c. Psychological evaluations must be completed by a psychologist.
d. Psychological evaluations are limited to four (4) hours per state fiscal year.

5. Nursing Assessment

a. Nursing assessment is defined as an assessment of an individual's psychological, physiological and sociological history.
b. The clinical purpose of the nursing assessment is to assess and evaluate the medical history, medication history, current symptoms, effectiveness of the current medication regime, extra-pyramidal symptoms, progress or lack of progress since the last contact, and provide education about mental illness and available treatment to the individual and family.
c. A nursing assessment is completed by an RN.
d. Nursing assessment is limited to one hundred forty-four (144) fifteen (15) minute units per state fiscal year.

6. Individual Therapy

a. Individual therapy is defined as one-on-one therapy for the purpose of treating a mental disorder.
b. The clinical purpose of individual therapy is to assess, prevent, and relieve psychologically-based distress or dysfunction and to increase the individual's sense of well-being and personal development.

c. Individual therapy services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide individual therapy include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, ATR-BC, PMHNP, PA, LMSW, CMHT, CIDDT, or CAT.
d. Individual therapy is limited to thirty six (36) services per state fiscal year.

7. Family Therapy

a. Family therapy is defined as therapy for the family which is exclusively directed at the individual's needs and treatment. The individual is not required to be present during family therapy.
b. The clinical purpose of family therapy is to identify and treat family problems that cause dysfunction.
e. Family therapy services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide family therapy include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, ATR-BC, PMHNP, PA, LMSW, CMHT, CIDDT, or CAT.
c. Family therapy is limited to twenty-four (24) services per state fiscal year.

8. Group Therapy/Multi-Family Group Therapy

a. Group therapy is defined as face-to-face therapy addressing the needs of several individuals within a group.
b. The clinical purpose of group therapy is to prevent deterioration, to encourage remediation and to provide rehabilitation.
c. Multi-family group therapy is defined as therapy taking place between a mental health team member and family members of at least two different individuals in a group setting. It combines the power of a group process with the systems focus of family therapy. The individuals are not required to be present.
d. The clinical purpose of multi-family group therapy is to give individuals and/or the family a safe and comfortable place to work out problems and emotional disorders, gain insight into their own thoughts and behavior, and offer suggestions and support to others.
f. Group therapy/multi-family group therapy services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide group therapy/multi-family group therapy include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, ATR-BC, PMHNP, PA, LMSW, CMHT, CIDDT, or CAT.
e. Group therapy/multi-family group therapy is limited to forty (40) services per state fiscal year.

9. Psychosocial Rehabilitation

a. Psychosocial rehabilitation is defined as a rehabilitative service based on active treatment and is the most intensive day program available for individuals eighteen (18) and older, designed to support individuals requiring extensive clinical services to support community inclusion, prevent re-hospitalization, and alleviate psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation and withdrawal.

b. The clinical purpose of psychosocial rehabilitation is to assist individuals attain their highest level of functioning in their community.

c. Psychosocial rehabilitation services are provided in a program that provides active treatment through evidence-based curriculum, such as Illness Management and Recovery, and the components include:
   1) Treatment plan development and review.
   2) Individual therapy.
   3) Group therapy.
   4) Skill building groups such as social skills training, coping skills, reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion.

g. Psychosocial rehabilitation services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. The Psychosocial Rehabilitation Program Director provides administrative services for individuals receiving psychosocial rehabilitation. Team members who may provide psychosocial rehabilitation include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, PA, LMSW, CMHT, CIDDT, or CAT.

d. Psychosocial rehabilitation services must be prior authorized as medically necessary by the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO).

e. Psychosocial rehabilitation is limited to five (5) hours per day, five (5) days a week.

f. Similar services are available to individuals from birth to age twenty one (21) through Day Treatment services.

10. Day Treatment

a. Day treatment is the most intensive outpatient program available all individuals under the age of twenty-one (21) and is defined as a behavioral intervention program, provided in the context of a therapeutic milieu, which enables them to live in the community.

b. The clinical purpose of day treatment is to improve emotional, behavior, social and educational development of all individuals under the age of twenty-one (21) who need significant coping skills to appropriately function in the home, school, and community.

c. The service components for day treatment include:
   1) Treatment plan development and review.
   2) Individual therapy.
   3) Group therapy.
   4) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.

d. Day treatment services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team member who may provide day treatment include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, PA, LMSW or CMHT.

e. Services must be prior authorized as medically necessary by the UM/QIO.

f. Day treatment is limited to five (5) hours per day, five (5) days a week.

11. Acute Partial Hospitalization Services

a. Acute Partial Hospitalization Services are available only in a community based setting and not through the outpatient department of a hospital and defined as a non-residential treatment program for individuals who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. These individuals require more intensive and comprehensive services offered in an outpatient treatment program but require less than twenty-four (24) hour care provided on inpatient basis.

b. The clinical purpose of acute partial hospitalization is to provide an alternative to hospitalization for individuals not requiring twenty-four (24) hour supervision but still requiring a high degree of therapeutic support in order to return to normal daily activities in the home, school, work, and community.

c. The service components for acute partial hospitalization include:
   1) Treatment plan development and review.
   2) Medication management.
   3) Nursing assessment.
   4) Individual therapy.
   5) Group therapy.
   6) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.

d. Acute partial hospitalization must be prior authorized as medically necessary by the UM/QIO.

e. Acute partial hospitalization must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team member who may provide acute partial hospitalization include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, PA LMSW, CMHT, CIDDT, or CAT.

f. Acute Partial Hospitalization is limited to one hundred (100) days per state fiscal year.

12. Crisis Response Services

a. Crisis Response is defined as supports, services and treatments necessary to provide integrated crisis response, crisis stabilization, and prevention interventions available twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year. These services provide immediate evaluation, triage and access to services, treatment, and support in an effort to reduce symptoms and harm and, if appropriate, safely transition individuals in an acute crisis to the appropriate level of care for stabilization.

b. The clinical purpose of crisis response services is to assist the individual cope with immediate stressors, identify and use available resources and the individual's strengths, and develop treatment options in order to avoid unnecessary hospitalization and return to the individual's prior level of functioning.

c. The service components for crisis response services include:
   1) Treatment plan development and review.
   2) Medication management.
   3) Nursing assessment.
   4) Individual therapy.
   5) Family therapy.

d. Team members must be certified in a professionally recognized method of crisis intervention and de-escalation and must include one of the following: a psychiatrist, physician, psychologist, LCSW, LMSW, LPC, LMFT, PMHNP, PA, RN, CMHT, CIDDT, and CAT.

e. Crisis Response Services must be available by phone with a mobile crisis response team twenty-four (24) hours a day, seven (7) days a week.

h. Crisis response services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide crisis response services include a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, PA, LMSW, CMHT, CIDDT, CAT, or Community Support Specialist.

f. Crisis Response service is limited to thirty-two (32) fifteen (15) minute units per day with a state fiscal year limit of two hundred twenty-four (224) fifteen (15) minute units.

13. Crisis Residential Services

a. Crisis residential services are defined as services provided in a setting other than an acute care hospital or a long term residential treatment facility which consists of no more than sixteen (16) beds. The program provides medically monitored residential services for the purpose of providing psychiatric stabilization on a short-term basis serving as a transition or diversion from inpatient hospitalization.

b. The clinical purpose of crisis residential services is to provide treatment to an individual not requiring twenty-four (24) hour medical and nursing care, but may benefit from a twenty-four (24) hour supervised, structured living arrangement in order to return them to their pre-crisis level of functioning.

c. The service components for crisis response services include:
   1. Treatment plan development and review.
   2. Medication management.
   3. Nursing assessment.
   4. Individual therapy,
   5. Family therapy.
   6. Group therapy.
   7. Crisis response.
   8. Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.

d. The services must be ordered by a psychiatrist, physician, psychologist, PMHNP or PA.

e. The composition the team members must include one of the following: a psychiatrist, physician, psychologist, LCSW, LMSW, LPC, LMFT, PMHNP, PA, RN, CMHT, CIDDT, and CAT.

f. Services must be prior authorized as medically necessary by the UM/QIO.

g. Crisis Residential service is limited to sixty (60) days per state fiscal year.

h. Service does not include room and board (payment).

14. Peer Support Services

a. Peer support is defined as an evidenced-based person centered mental health model of care which allows individuals the opportunity to direct their own recovery of any mental illness or substance abuse.

b. The clinical purpose of peer support services is to provide peer-to-peer support assisting an individual with recovery from mental illness or substance abuse.

c. The service components of peer support services include:
   1) Treatment plan development and review.
   2) Skill building for coping with and managing symptoms while utilizing natural resources, and the preservation and enhancement of community living skills.

d. Services are provided by a Peer Support Specialist.

e. Peer support services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA.

f. Peer support is limited to six (6) fifteen (15) minute units per day with a state fiscal year limit of two hundred (200) fifteen (15) minute units.

15. Community Support Services

a. Community support services are defined as services provided by a mobile community-based Community Support Specialist which addresses the mental health needs of the individual, are focused on the individual's ability to succeed in the community and to identify and assist with accessing services.

b. The clinical purpose of community support services is to assist the individual in achieving and maintaining rehabilitation, resiliency, and recovery goals.

c. The service components for community support services include:
   1) Resource Coordination that directly increase the acquisition of skills needed to accomplish the goals set forth in the treatment plan.
   2) Monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and progress toward goals.
   3) Psychoeducation on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
   4) Direct interventions in escalating situations to prevent crisis.
   5) Home and community visits for the purpose of monitoring the individual's condition and orientation.
   6) Assisting the individual and natural supports in implementation of therapeutic interventions outlined in the treatment plan.
   7) Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.

d. Services are provided by a Community Support Specialist.

e. Community support services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA.

f. Services are limited to six (6) fifteen minute units per day with a state fiscal year limit of four hundred (400) fifteen (15) minute units per year.

16. Wraparound Facilitation

a. Wraparound facilitation is defined as the development and implementation of a treatment plan which addresses the prioritized needs of an individual up to the age of twenty-one (21). The treatment plan empowers the individual to achieve the highest level of functioning through the involvement of family, natural and community supports.

b. The clinical purpose of wraparound facilitation is to assist an individual to function at the highest level at home, school, and the community through an intensive, individualized treatment plan.

c. The service components for wraparound facilitation include:
   1) Treatment plan development and review.
   2) Identifying providers of services and other community resources to meet family and the individual's needs.
   3) Making necessary referrals for the individual.

d. Services are provided by a Certified Wraparound Facilitator.

e. Wraparound services must be included in a treatment plan approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA. Team members who may provide wraparound services include: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP or PA.

f. Services are limited to sixteen (16) fifteen (15) minute units per day with a fiscal year limit of two hundred (200) fifteen (15) minute units.

g. Similar services are provided to individuals over the age of twenty-one (21) through Program of Assertive Community Treatment (PACT).

17. Intensive Outpatient Psychiatric Services

a. Intensive outpatient psychiatric services are defined as treatment provided in the home or community to individuals up to the age of twenty-one (21) with serious mental illness for family stabilization to empower the individual to achieve the highest level of functioning. Based on a wraparound model, this service is a time-limited intensive family intervention to diffuse the current crisis, evaluate its cause, and intervene to reduce the likelihood of a recurrence.

b. The clinical purpose of intensive outpatient psychiatric services is to stabilize the living arrangement, promote reunification and prevent the utilization of out-of-home therapeutic resources to allow the individual to remain at home and in the community.

c. The components of intensive outpatient psychiatric services, based on an all-inclusive model that covers all mental health services the individual may need, may include:
   1) Treatment plan development and review.
   2) Medication management.
   3) Intensive individual therapy and family therapy provided in the home.
   4) Group therapy.
   5) Day Treatment.
   6) Peer support services.
   7) Skill building groups such as social skills training, self-esteem building, anger control, conflict resolution and daily living skills.
   8) Wraparound facilitation.

d. Intensive outpatient must be included in a treatment plan and approved by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LPC, LMFT, PMHNP, or PA. Team members who may provide day treatment include: a LMSW, CMHT, CIDDT, or CAT.

e. Services must be prior authorized as medically necessary by the UM/QIO.

f. Intensive outpatient psychiatric services are limited to two hundred seventy (270) days per fiscal year.

18. PACT

a. Program of Assertive Community Treatment (PACT) is defined as an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychosocial rehabilitation and recovery for individual over the age of twenty-one (21) with severe and persistent mental illness, severe symptoms and impairments who have not benefited from traditional outpatient programs. PACT is a multi–disciplinary, self-contained clinical team approach with team members providing long-term intensive care in community settings. The team members provide all mental health services rather than referring individuals to different mental health providers, programs, and other agencies.

b. The clinical purpose of PACT is to provide community-based interdisciplinary care to improve the individual's overall functioning at home, work, and in the community.

c. The components of PACT services, based on an all-inclusive evidence-based model that may include, but are not limited to, one or more of the following:
   1) Treatment plan review and development.
   2) Medication management.
   3) Individual therapy.
   4) Family therapy.
   5) Group therapy.
   6) Crisis response.
   7) Crisis response.
   8) Community support.
   9) Peer Support.

d. The composition of the ACT team members must include a psychiatrist, physician or PMHNP, and an RN, CAT and peer support specialist and must include one or more of the following: psychologist, LCSW, LMSW, LPC, or LMFT. The ACT team leader must be a psychiatrist, physician, psychologist, LCSW, or PMHNP and is the clinical and administrative leader of the team. The team leader, in conjunction with the psychiatrist, is responsible for supervising and directing all team members.

e. PACT services must be included in a treatment plan, approved by the team leader, and provided by one of the following team members: a psychiatrist, physician, psychologist, LCSW, LMSW, LPC, LMFT, PMHNP, PA, CMHT, CIDDT, or CAT.

f. Services must be prior authorized as medically necessary by the UM/QIO.

g. Similar services provided to individuals up to age twenty-one (21) through intensive outpatient psychiatric services.

h. PACT is limited to forty (40) fifteen (15) minute units per day with a state fiscal year limit of sixteen hundred (1600) fifteen (15) minute units.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

15. Intermediate Care Facilities for Individuals with Intellectual Disabilities

The Division of Medicaid covers Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) that meet the requirements of the State and 42 CFR Part 483.

According to Section 1905(d) of the Social Security Act, ICF/IIDs are defined as institutions, or distinct part thereof, for individuals with intellectual disabilities or persons with related conditions in which the facilities primary purpose is to provide health or rehabilitative services and provide active treatment as defined in 42 CFR Part 483 in the least restrictive setting. Services must be provided in a protected residential setting and must include ongoing evaluations, twenty-four (24) hour supervision, and coordination and integration of health or rehabilitative services to help each individual function at his/her greatest ability.

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

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16. Inpatient Psychiatric Services:

Inpatient psychiatric services for individuals under age 21 provided under the direction of a physician who is at least board eligible in psychiatry and has experience in child/adolescent psychiatry provided in either a licensed psychiatric hospital that meets the requirements of 42 CFR 482.60 and 1861(f) of the Social Security Act or a psychiatric unit of a general hospital that meets the requirements of subparts B and C of 42 CFR 482 and Subpart D of 42 CFR 441 or a licensed psychiatric residential treatment facility (PRTF) that meets the requirements Section 1905(h) of the Act. Licensed psychiatric hospitals must have Joint Commission on Accreditation of Health Care Organization (JCAHO) accreditation. Psychiatric Residential Treatment Facilities must be accredited by the Joint Commission on Accreditation of Health Care Organization (JCAHO) or Council on Accreditation of Services for Families and Children (COA). The psychiatric service must be provided in accordance with an individual comprehensive services plan as required by 42 CFR 441.155(b) before the individual reaches age 21 or, if the individual was receiving the services immediately before obtaining age 21, before the earlier of the date the individual no longer requires the services or the date the individual reaches age 22. The setting in which the psychiatric services are provided shall be certified in writing to be necessary as required by 42 CFR 441.152. The psychiatric services must be prior approved as medically necessary.

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

17. Nurse-midwife services - refers to services furnished by a nurse midwife within the scope of practice authorized by state law or regulation.

Certified nurse midwives may bill Medicaid for the covered services within the scope of practice allowed by their protocol. All services and procedures provided by certified nurse midwives should be billed in the same manner and following the same policy and guidelines as like physician services.

The reimbursement for certified nurse midwifery services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

State of Mississippi

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

18. Hospice Benefit

I. The hospice benefit is provided in accordance with Title 18, Section 1861 (dd) of the Social Security Act for the palliation or management of an individual's terminal illness. An individual is considered terminally ill if the medical prognosis is life expectancy of six (6) months or less. Election of the hospice option causes the beneficiary to forfeit all other Medicaid program benefits provided for in the State Plan that may also be available under the hospice benefit related to the treatment of the individual's terminal illness, except for children under the age of 21.

II. Hospice care provides the following items and services to a terminally ill individual by, or by others under arrangements made by, a hospice program under an individualized written plan of care established and periodically reviewed by the individual's attending physician, the medical director, and the hospice program interdisciplinary team:

a. nursing care provided by a registered nurse,
b. physical or occupational therapy, or speech-language pathology services,
c. medical social services under the direction of a physician,
d. services of a
    i. hospice aide who has successfully completed an approved training program, and
    ii. homemaker services,
e. medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,
f. physicians' services,
g. short-term inpatient care (including both respite care and procedures necessary for pain control and acute symptom management) in an inpatient facility meeting the special hospice standards regarding staffing and patient areas, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days,
h. counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death, and
i. any other item or service which is specified in the plan and for which payment may otherwise be made under this title.

The care and services described in subparagraphs a. and d. as noted above may be provided on a 24-hour, continuous basis only during periods of crisis and only as necessary to maintain the terminally ill individual at home.

III. The following providers and practitioners who furnish hospice services must meet all requirements in accordance with the rules and regulations as defined in the Minimum Standards of Operations for Hospice per the Mississippi State Department of Health including Miss.

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

Code §41-85-1 through §41-85-25 (1972, as amended):

a. Medical Director – must be a Doctor of Medicine or Osteopathy licensed to practice in the State of Mississippi. May be an employee or a volunteer of the hospice agency or contractual agreement.
b. Registered Nurse – must be licensed to practice in the State of Mississippi with no restrictions, at least one (1) year full-time experience and is an employee of the hospice or contracted by the hospice.
c. Bereavement Counselor – Must have documented evidence of appropriate training and experience in the care of the bereaved received under the supervision of a qualified professional.
d. Dietary Counselor - Must be a registered dietician licensed in the State of Mississippi who meets the qualification standards of the Commission on Dietetic Registration of the American Dietetic Association;
e. Spiritual Counselor – Must have documented evidence of appropriate training and skills to provide spiritual counseling, such as Bachelor of Divinity, Master of Divinity or equivalent theological degree or training.
f. Social Worker – Must have a minimum of a Bachelor's Degree from a school of social work accredited by the council of Social Work Education and licensed in the State of Mississippi with a minimum of one (1) year documented clinical experience appropriate to the counseling and casework needs of the terminally ill and be an employee of the hospice.
g. Hospice Aide/Homemaker – Must be a qualified person who provides direct patient care and/or housekeeping duties in the home or homelike setting under the direct supervision of a registered nurse. Documentation of all training and competence is required.
h. Occupational Therapist - Must be licensed by the State of Mississippi
i. Physical Therapist - Must be licensed in the State of Mississippi.
j. Speech Pathologist - Must be licensed by the State of Mississippi, or completed the academic requirements as directed by the State Certifying Body and work experience required for certification.

IV. Medicaid beneficiaries under the age of 21 may receive hospice benefits including curative treatment without foregoing any other service to which the child is entitled under the Medicaid program pursuant to section 2302 of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act.

V. Hospice election periods are: (1) An initial 90-day period; (2) A subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods are available provided a physician certifies that the recipient is terminally ill or that the condition of the beneficiary has not changed since the previous certification of terminal illness.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

19a Targeted case management services to chronically mentally ill community based recipients.

All Medicaid services are provided to the chronically mentally ill within the limits and policy of the Medicaid Program, as set forth in the State Plan.

Case management services may be provided as a component part of the service by any qualified Medicaid provider.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

19b Targeted Case Management services for beneficiaries with intellectual/ developmental disabilities (IDD) in community-based settings.

All Medicaid services are provided to IDD beneficiaries within the limits and policies of the Medicaid Program, as set forth in the State Plan. [Refer to Supplement 1C to Attachment 3.1-A]

Targeted Case Management services are only provided by a service provider certified by the Mississippi Department of Mental Health (DMH) as meeting the Operational Standards for Targeted Case Management for beneficiaries with IDD. [Refer to Supplement 1C to Attachment 3.1-A]

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

20a. & 20b. Extended services to pregnant women. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

All Medicaid services are provided to pregnant women within the limits and policy of the Medicaid Program, as set forth in the State Plan.

Extended services may be provided as component parts of the services of any qualified Medicaid provider.

Extended Services (Nutrition,
Psychosocial, Health
Education, Home Visits)

*Description of services provided on following pages.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

EXTENDED SERVICES

1. **Medical Risk Assessment**

A medical risk assessment (screening) is done by a physician, a registered nurse/nurse practitioner under a physician's direction, or a certified nurse-midwife to determine if the patient is high risk. A pregnant woman is considered high risk if one or more risk factors are indicated on the form used for risk screening. The enhanced services are made available in cases of medical necessity when a medical risk assessment has determined that a pregnant woman has one or more factors which may adversely affect the pregnancy outcome.

A pregnant woman may be assessed (screened) for medical risk a maximum of two (2) times per pregnancy. A second medical risk assessment (screening) would be necessary only if the woman changed the provider responsible for her obstetrical care, and the new provider was unable to obtain the prior records.

Reimbursement for the medical risk assessment (screening) is to an approved physician or certified nurse-midwife provider. This is a separate fee, just as lab services are reimbursed apart from an office visit.

Providers of medical risk assessment (screening) have the option of using the Hollister Maternal Record or the Risk Screening Form, Mississippi Perinatal Risk Management/Infant Service System. Attached is a copy of high-risk referral criteria that includes the guidelines for use of the Hollister Maternal Record and the Risk Screening Form. Referral may be made to a Case Management Agency by submitting a copy of the Risk Screening Form, or by making a telephone call. When a telephone call is made, the Case Management Agency will document the referral on the Risk Screening Form.

2. **Nutritional Assessment/Counseling**

A. **Definition:**

Assessment is a review of the pregnant woman's dietary pattern and intake, her resources for obtaining and preparing food and evaluation of her nutritional needs.

B. **Counseling means services to include:**

(1) The development of a nutritional care plan based on the health risks identified due to nutritional factors.

(2) The follow-up and reassessment needed to carry out the nutritional care plan.

(3) The Division of Medicaid will utilize guidelines as promulgated in Maternal and Infant Health Guidelines, prepared by the Association of Maternal and Child Health Programs in association with the State Medicaid Directors' Association, as criteria for monitoring this service.

Nutritional assessment/counseling is covered for pregnant women with one or more medical risk factors which may adversely affect the pregnancy outcome. Counseling is appropriate for women whose complications require the services of a dietician/nutritionist for treatment of a pregnancy-related complication, e.g., diabetes, over/under weight. The services are provided by a registered dietician or licensed nutritionist. A combination of this service and/or psychosocial assessment/counseling may be provided a maximum of eight (8) times during the pregnancy and postpartum. The nutritional assessment is done by the registered dietician or licensed nutritionist, and is considered as one unit of nutritional assessment/counseling. If the pregnant woman is eligible for WIC, the nutritional assessment for this program will build upon the WIC assessment in order to prevent two programs from doing duplicate assessments. A second nutritional assessment will be allowed during the pregnancy, if the woman changes her provider, and the new provider is unable to obtain records for the previous provider.

3. Psychosocial Assessment/Counseling

A. Definition:

Assessment is an evaluation of the pregnant woman and her environment to identify psychosocial factors that may adversely affect the woman's health status.

B. Counseling means services to include:

(1) The development of a social work care plan based upon the health risks due to psychosocial factors.

(2) The follow-up, appropriate intervention, and referrals to carry-out the social work care plan.

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TN No. NEW DATE/EFFECTIVE 10/1/88

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

(3) The Division of Medicaid will utilize guidelines as promulgated in Maternal and Infant Health Guidelines, prepared by the Association of Maternal and Child Health Programs in association with the State Medicaid Directors' Association, as criteria for monitoring this program.

Psychosocial assessment/counseling is covered for pregnant women with one or more medical risk factors which may adversely affect the pregnancy outcome. Counseling is appropriate for women whose complications require psychosocial intervention as an essential element of treatment in dealing with the complications, e.g., pregnant 15 year old with no place to live, battered woman. The services are provided by the MSW social worker licensed in Mississippi, a BSW social worker licensed in Mississippi in consultation with a MSW, or other Mississippi licensed social worker who is supervised by a MSW social worker. A combination of this service and/or nutritional assessment/counseling may be provided a maximum of eight (8) times during the pregnancy and postpartum period. The psychosocial assessment is done by a social worker, as specified above, and is considered as one unit of psychosocial assessment/counseling. A second psychosocial assessment will be allowed during the pregnancy, if the woman changes her provider, and the new provider is unable to obtain records from the previous provider.

4. Health Education

A. Health education is provided during pregnancy and the postpartum period on a one-to-one or group basis with the pregnant women who have one or more medical risk factors which may advsersely affect the pregnancy outcome. Health education is provided based on a written plan or written curriculum.

B. Education may include, but is not limited to, the following information:

(1) Prenatal care

(2) Danger signs in pregnancy

(3) Labor and delivery

(4) Nutrition

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DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

(5) Pregnancy risk reduction (smoking, substance abuse)

(6) Postpartum care

(7) Reproductive health

Health education is designed to prevent the development of further complications during pregnancy and to provide educational information to the pregnant woman in caring for herself during pregnancy. This service may be provided by a registered nurse, nurse practitioner, physician assistant, certified nurse-midwife, nutritionist/dietitian, or social worker. This service may be provided a maximum of ten (10) times during the pregnancy and postpartum period.

5. Home Visit

A. This service is provided at the pregnant woman's place of residence as part of the assessment and follow-up. The purpose of the home visit is to provide extended services and to address environmental factors that impinge upon her high-risk factors.

B. The services may be provided by a nurse, nurse practitioner, physician assistant, nutritionist/dietician, or social worker.

Home visit service for pregnant women and the need for home visits must be documented in the Plan of Care. It is designed to provide necessary services to the woman in the home. This service may be provided a maximum of five (5) times with at least one during the postpartum period.

STATE: Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

6. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services

A. SBIRT is an early intervention approach that targets pregnant women with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

B. SBIRT services must include:

1. Screening for risky substance use behaviors using evidence based standardized assessments or validated screening tools,

2. Brief intervention of a pregnant woman showing risky substance use behaviors in a short conversation, providing feedback and advice, and

3. Referral to treatment for brief therapy or additional treatment to a pregnant woman whose assessments or screenings indicate a need for additional services.

C. The Division of Medicaid covers one (1) SBIRT service per pregnancy when performed by one (1) of the following licensed practitioners:

1. Physician,

2. Nurse Practitioner,

3. Certified Nurse Midwife,

4. Physician Assistant,

5. Licensed Clinical Social Worker,

6. Licensed Professional Counselor, or

7. Clinical Psychologist.

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

STATE Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

23. Certified Pediatric or Family Nurse Practitioners' Services

Services provided by certified pediatric or family nurse practitioners are limited to those services authorized in the Plan and which a nurse practitioner is legally authorized to perform.

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

23d. Skilled Nursing Facility Services for Patients under 21 years of Age:
Prior Approval required.

Beginning coverage limited to day authorization (MMC 260) form signed by admitting physician, unless eligibility occurs after admission for a retroactive period.

App. 11/2/87 Eff. 4/1/87

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

24a. Transportation - The Division of Medicaid covers transportation through the following methods:

1) Emergency Ground Ambulance services which meet the following criteria:

- The transport requires a basic life support (BLS) or advanced life support (ALS) certified emergency ground ambulance, equipment and staff in order to transport a beneficiary to the nearest appropriate facility where the beneficiary will be accepted for treatment,

- The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the beneficiary's health, and

- The beneficiary's condition is of such severity that the absence of immediate medical care could reasonably result in permanently placing the beneficiary's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequence.

2) Emergency Air Ambulance services provided in a rotary wing aircraft which meet the following criteria:

- The transport requires a BLS or ALS certified emergency rotary-wing air ambulance, equipment, and staff in order to transport a beneficiary to the nearest appropriate facility where the beneficiary will be accepted for treatment,

- The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the beneficiary's health, and

- The beneficiary's condition is of such severity that the absence of immediate medical care could reasonably result in permanently placing the beneficiary's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequences.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

3) Emergency and Urgent Air Ambulance services provided in a fixed wing aircraft which meet all the following criteria:

   - The transport requires an emergency or urgent fixed-wing air ambulance equipped and staffed to provide medical care appropriate for the beneficiary's needs and transportation to the nearest appropriate facility,

   - The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the beneficiary's health, and

   - The beneficiary 's condition is of such severity that the absence of fixed-wing air ambulance transport to the nearest appropriate facility for treatment could reasonably result in permanently placing the beneficiary's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequence.

4) Non-emergency transportation (NET) services for eligible Medicaid beneficiaries are arranged and coordinated through the NET Broker as described in Attachment 3.1-D.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-A
Exhibit 24c

State Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Care and services provided in Christian Science sanitoria - Confinement limited to ten (10) days per fiscal year.

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DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

24d

~~23d.~~ Skilled Nursing Facility Services for Patients under 21 years of Age:
Prior Approval required.

Beginning coverage limited to day authorization (MMC 260) form signed by admitting physician, unless eligibility occurs after admission for a retroactive period.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION, AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

25. Licensed Physician Assistants

Services provided by licensed physician assistants are limited to those services authorized in the Plan and which a physician assistant is legally authorized to perform.

State of Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION, AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Family Planning Services and Supplies for Individuals of Child-Bearing Age

Family planning services shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services.

State MISSISSIPPI

HIGH-RISK CASE MANAGEMENT SERVICES

A. **Target Group:** Pregnant women who have been shown on the basis of a medical risk assessment to need High-Risk Case Management Services.

B. **Areas of State in which services will be provided:**

__X__ Entire State;

_____ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide):

C. **Comparability of Services:**

_____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act;

__X__ Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is involved to provide services with regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. **Definition of Services:**

High-Risk Case Management is a set of interrelated activities under which responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the High-Risk Case Management Agency. The purpose of High-Risk Case Management Services for pregnant women is to assist those eligible for Medicaid in gaining access to needed medical services and the enhanced services of nutritional and psychosocial assessment and counseling and health education to reduce low birthweight infants and infant mortality or morbidity; to encourage the use of cost-effective medical care by referrals to appropriate providers; and to discourage over-utilization or duplication of costly services. High-Risk Case Management Services will provide necessary coordination with providers of nonmedical services such as nutrition, psychosocial or health education programs, when services provided by these entities are needed. The Case Manager will coordinate these services with needed medical services.

The set of interrelated activities are as follows:

1. Medical risk assessment is done by the medical provider and is described in Exhibit 20a. and 20b., Attachment 3.1-A, Medical Risk Assessment.

2. Evaluation of the client's individual situation to determine the need for High-Risk Case Management when a physician has determined that the pregnant woman has one or more medical risk factors which may adversely affect the pregnancy outcome. The Case Manager must establish that the pregnant woman has Medicaid eligibility, is at medical risk, and has selected that particular High-Risk Case Management Agency. An explanation of High-Risk Case Management Services must be given to the woman.

   High-Risk Case Management Services include direct contact with the client as well as indirect work on the client's behalf. The client will be allowed one (1) initial High-Risk Case Management Service and nine (9) subsequent High-Risk Case Management Services per pregnancy. Once the woman is determined by her physician to no longer be at medical risk, High-Risk Case Management Services must be discontinued;

3. Needs assessment is the process by which the Case Manager identifies the service needs of the pregnant woman in order to assist in gaining access to the needed services, such as psychosocial, nutritional, medical, and educational;

4. Development and implementation of an individualized Plan of Care to meet the service needs of the client. A Plan of Care is needed by the Case Manager to:

   a. Determine how to assist in gaining access to needed services,

   b. Keep track of important activities over the course of time, and

   c. Know if the events that did occur met the goals as stated in the Plan of Care;

   This Plan of Care does not constitute a Medicaid prior authorization for Case Management Services.

5. Coordination of delivery of service when multiple providers and/or programs are involved to reduce travel and multiple appointments as much as possible by careful scheduling;

6. Assistance in locating providers and/or programs and making referrals to the providers and/or programs that can meet the service needs;

7. Monitoring and follow-up to ensure that services are received, are adequate to meet the client's needs, and are consistent with good quality of care.

E. Qualification of Providers:

1. Case Manager Qualifications:

   a. Physician licensed in Mississippi; or,

   b. Nurse-midwife certified in Mississippi; or,

   c. R.N. licensed in Mississippi with a minimum of one (1) year of experience in community nursing and knowledgeable about perinatal care; or,

   d. Medical Social Worker with a minimum of one (1) year of experience in health and/or human services and one of the following:

      (1) M.S.W. Medical Social Worker licensed in Mississippi;

      (2) B.S.W. Medical Social Worker licensed in Mississippi in consultation with a M.S.W.; or

      (3) Other Mississippi licensed Medical Social Worker supervised by a M.S.W.

      (4) Nutritionist licensed in Mississippi, or a Registered Dietician, each with a minimum of one (1) year's experience in providing nutrition services to pregnant women for whom nutritional needs are the high-risk factor.

2. High-Risk Case Management Qualifications:

   a. Must have qualified Case Manager(s);

   b. Must meet applicable State and Federal laws governing the participation of providers in the Medicaid Program;

   c. Must meet the criteria established by the Division of Medicaid as a provider of High-Risk Case Management Agency Services (Section 3, Enrollment Process) and be enrolled by the Division of Medicaid as a qualified High-Risk Case Management Agency provider.

Enrollment is open to all providers who can meet these qualifications. The Division of Medicaid will enter into Provider Agreements that establish criteria for High-Risk Case Management Services to this target group. The purpose of this activity is to help assure that High-Risk Case Management Services are provided by professionally qualified providers in accordance with Section 1902(a)(23) of the Act.

3. Enrollment Process

The Division of Medicaid will implement methods and procedures to enroll all agency providers for Case Management to pregnant women that can demonstrate:

a. Capacity to provide High-Risk Case Management Services;

b. Experience with delivery and/or coordination of services for pregnant women and children;

c. Maintenance of financial accountability rules as for any other provider participating in the Medicaid Program;

d. Capacity to provide full range of extended services, as specified in Exhibit 20a and 20b or demonstrate the ability to secure them, in a timely manner, through an agreement with another provider. However, nothing in this plan will be construed to require a Case Management Agency or a Case Manager to provide any other service under the Medicaid Program.

e. Agreement to maintain regular contact with the primary-care physician.

Enrollment is open to all providers who can meet these requirements.

F. The State assures that the provision of High-Risk Case Management Services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of High-Risk Case Management Services. Although the High-Risk Case Management Agency may have the capacity to provide the full range of extended services or demonstrate the ability to secure them, in a timely manner, through

an agreement with another provider, the eligible recipient may choose to receive any extended services through another High-Risk Case Management Agency.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. **Payment for High-Risk Case Management Services** under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

HIGH-RISK CASE MANAGEMENT FOR CHILDREN UNDER ONE YEAR

A. **Target Group:** High-risk infants, age birth to one (1) year old, as determined by a physician by using the Risk Screening Form, Mississippi Perinatal Risk Management/Infant Services System or the Hollister Maternal/Infant Record.

B. **Areas of State in which services will be provided:**

__X__ Entire State;

_____ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide):

C. **Comparability of Services:**

_____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act;

__X__ Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. **Definition of Services:**

High-Risk Case Management is a set of interrelated activities under which responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the High-Risk Case Management Agency. The purpose of High-Risk Case Management Services for high-risk infants is to assist those eligible for Medicaid in gaining access to needed medical, social, educational, and other services; to reduce infant mortality or morbidity; to encourage the use of cost-effective medical care by referrals to appropriate providers; and to discourage over-utilization or duplication of costly services. High-Risk Case Management Services will provide necessary coordination with providers of nonmedical services such as nutrition, psychosocial, educational programs or early intervention when services provided by these entities are needed. The Case Manager will coordinate these services with needed medical services.

The high-risk infant will be allowed one (1) High-Risk Case Management Service a calendar month with a maximum of twelve (12) High-Risk Case Management Services during the first year of life. High-Risk Case Management Services include direct contact with the client as well as indirect work on the client's behalf. The High-Risk Case Management Services will return to the services for a well-baby if the medical or medically related risk factor(s) cease to exist during the first year of life, as determined by the infant's physician.

The Case Manager's services are to be noted in the infant's Plan of Care.

The set of interrelated activities are as follows:

1. Evaluation of the client's individual situation to determine the need for High-Risk Case Management due to known medical or other medically related risk factors. The Case Manager must establish that the infant has Medicaid eligibility, is at medical risk, and that the parent/guardian/custodian has selected that particular agency. An explanation of High-Risk Case Management Services must be given to the parent/guardian/custodian to determine whether High-Risk Case Management Service is wanted. Once the infant is determined by the physician to no longer be at medical risk, High-Risk Case Management as a separate service will no longer be provided. Case Management as a required component of regular EPSDT services will continue to be provided to the extent permitted;

2. Needs assessment is the process by which the Case Manager identifies the service needs of the infant in order to assist in gaining access to the needed services, such as psychosocial, nutritional, medical, and educational;

3. Development and implementation of an individualized Plan of Care to meet the service needs of the infant. A Plan of Care is needed by the Case Manager to:

   a. Determine how to assist in gaining access to needed services,

   b. Keep track of important activities, and

c. Know if the events that did occur met the goals as stated in the Plan of Care;

This Plan of Care does not constitute Medicaid prior authorization for High-Risk Case Management Services.

4. Coordination of delivery of service when multiple providers and/or programs are involved to reduce travel and multiple appointments as much as possible by careful scheduling;

5. Assistance in locating providers and/or programs and making referrals to the providers and/or programs that can meet the service needs;

6. Monitoring and follow-up to ensure that services are received, are adequate to meet the client's needs, and are consistent with good quality of care.

E. Qualifications of Providers:

1. Case Manager Qualifications:

a. Physician licensed in Mississippi, or

b. R.N. licensed in Mississippi with a minimum of one (1) year of experience in community nursing, or

c. Medical Social Worker with a minimum of one (1) year of experience in health and/or human services, and one of the following:

(1) M.S.W. Medical Social Worker licensed in Mississippi,

(2) B.S.W. Medical Social Worker licensed in Mississippi in consultation with M.S.W., or

(3) Other Mississippi licensed Medical Social Worker supervised by a M.S.W.; or

d. Nutritionist licensed in Mississippi or a Registered Dietician, each with a minimum of one (1) year of experience in providing

infant nutrition service when nutritional needs are the high-risk factor.

2. High-Risk Case Management Agency:

   a. Must have qualified Case Manager(s);

   b. Meet applicable State and Federal laws governing the participation of providers in the Medicaid Program;

   c. Must meet the criteria established by the Division of Medicaid as a provider of High-Risk Case Management Services (Section 3, Enrollment Process).

   Qualifications for the providers of targeted Case Management to infants will be the same as qualifications for EPSDT providers. The Division of Medicaid will enter into Provider Agreements that establish criteria for High-Risk Case Management Agencies and services to this target group. The Division of Medicaid will enroll providers that are qualified to render High-Risk Case Management Services in accordance with professionally recognized standards for good care. The purpose of this activity is to help assure that High-Risk Case Management Services are provided by professionally qualified providers in accordance with Section 1902(a)(23) of the Act. Nothing in this plan will be construed to require a Case Management Agency or a Case Manager to provide any other service under the Medicaid Program.

3. Enrollment Process:

   The Division of Medicaid will implement methods and procedures to enroll all providers of EPSDT Services for High-Risk Case Management to high-risk infants that can demonstrate:

   a. Capacity to provide High-Risk Case Management Services;

   b. Experience with delivery and/or coordination of services for children;

   c. Maintenance of financial accountability rules as for any other provider participating in the Medicaid Program;

d. Agreement to maintain regular contact with the primary-care physician when the physician is not the Case Manager.

F. Freedom of Choice

The State assures that the provision of High-Risk Case Management Services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act;

1. Eligible recipients will have free choice of the providers of EPSDT High-Risk Case Management.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for High-Risk Case Management Services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TARGETED CASE MANAGEMENT FOR CHRONICALLY MENTALLY ILL COMMUNITY BASED RECIPIENTS.

A. **Target Group:** Chronically mentally ill individuals who need community based mental health services to reduce dysfunction and attain their highest level of independent living or self care.

B. **Areas of State in which services will be provided:**

X — Entire State;

_____ — Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than Statewide):

C. **Comparability of Services:**

_____ — Services are provided in accordance with Section 1902 (a) (10) (B) of the Act;

X — Services are not comparable in amount, duration and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provided services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. **Definition of Services:**

Case management is the provision and coordination of services which are an integral part of aiding eligible recipients to gain access to needed medical, social, educational and other services in order to attain their highest level of independent functioning. Case management services provide to the maximum extent possible that the person served has access to all available resources and receives available services necessary to reach and maintain an optimal level of functioning. Activities include client identification, assessment, reassessments, service planning, linkage to needed services, monitoring service delivery, supportive counseling and outreach services designed to seek out persons who have been screened and referred for case management and to make every effort to engage such persons in the receipt of case management services.

E. **Qualifications of Providers:**

Providers of case management services are to be persons with a minimum of a B.A. or B.S. degree or comparable degree level in the field of nursing, social work, counseling or other such qualification and training and who meet the standards established under Sections 41-19-31 through 41-19-39 and/or Section 41-4-7(g), Mississippi Code of 1972, as amended.

F. Freedom of Choice:

The state assures that the provision of case management services to the chronically mentally ill will not restrict an individual's free choice of providers in violation of Section 1902 (a) (23) of the Act:

1. Case management services will be available at the option of the eligible recipient.

2. An eligible recipient who wishes to receive case management services will have free choice to receive case management services from any qualified provider of these services.

3. Eligible recipients will have free choice of the providers of other medical care as covered elsewhere in this Plan.

G. Payment for targeted case management for the chronically mentally ill does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

TARGETED CASE MANAGEMENT SERVICES FOR BENEFICIARIES WITH INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITIES (IDD) IN COMMUNITY-BASED SETTINGS

A. Target Group:

The target group is defined as beneficiaries with a confirmed diagnosis of Intellectual and/or Developmental Disabilities (IDD) and Autism Spectrum Disorders as defined by 42 C.F.R. § 483.102 and 45 C.F.R. § 1385.3, and is likely to continue indefinitely resulting in substantial functional limitations with two (2) or more life activities which include receptive and expressive language, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

The target group does not include individuals between ages twenty-two (22) and sixty-four (64) who are served in Institutions for Mental Disease (IMD) or individuals who are inmates of public institutions.

B. Areas of the State in which services will be provided:

_X_ Entire State,

___ Only in the following areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide),

C. Comparability of Services:

____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act,

_X_ Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted Case Management services are defined as the coordination of services to assist beneficiaries, eligible under the State Plan within the target group, in gaining access to needed medical, social, educational and other services. Targeted Case Management is responsible for identifying individual problems, needs, strengths, resources and coordinating and monitoring appropriate services to meet those needs. Targeted Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the beneficiary access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the beneficiary's needs (42 CFR § 440.169(e)). Targeted Case Management ensures the changing needs of the beneficiary within the target group are addressed on an ongoing basis, that appropriate choices are provided from the widest array of options for meeting those needs, and includes the following services:

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

1. A Comprehensive Assessment

   A comprehensive assessment is completed annually to determine a beneficiary's needs for services and supports including identification of any medical, educational, social, or other service needs. The assessment must include obtaining a beneficiary's history, identifying and documenting the needs of the beneficiary, and gathering information from sources such as family members, medical providers, social workers, and educators, as appropriate. Reassessments are conducted when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs.

2. Plan of Services and Supports

   An individualized Plan of Services and Supports (PSS) is developed based on the information collected through the comprehensive assessment. The PSS will be reviewed at a minimum every twelve (12) months or when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs which includes the following:

   a) Specific goals to address the medical, social, educational, and other services needed by the beneficiary,

   b) Activities to meet identified goals ensuring the active participation of the beneficiary and/or the beneficiary's authorized representative for health care decisions, and

   c) A course of action to respond to the assessed needs of the beneficiary.

3. Referral and Related Activities

   Referral and related activities help the beneficiary to obtain needed medical, social, and educational services by scheduling appointments and coordinating resources with providers and other programs to address identified needs and achieve specified goals from the PSS.

4. Monitoring and Follow-up Activities
   Performance of monitoring and follow-up activities include activities and contacts necessary to ensure that the PSS is effectively implemented and adequately addresses the needs of the beneficiary. Monitoring and follow-up activities may include involvement of the beneficiary, family members, service providers, or other entities or individuals. Contacts with a beneficiary's family or others for the purpose of helping the beneficiary access services are included in Targeted Case Management. Monitoring and follow-up activities are conducted monthly, or more often, depending on the needs of the beneficiary, with quarterly face-to-face visits to determine if:

   a) Services are being furnished in accordance with the beneficiary's PSS,

   b) Services in the PSS are adequate to meet the beneficiary's needs, and

   c) Changes in the needs or status of the beneficiary require adjustments to the PSS and service arrangements.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

5. Case Records

   Targeted Case Management providers maintain case records that document for all individuals receiving targeted case management as follows:

   (a) The name of the individual,

   (b) The dates of the case management services,

   (c) The name of the provider agency and the person providing the case management service,

   (d) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved,

   (e) Whether the individual has declined services in the care plan,

   (f) The need for, and occurrences of, coordination with other case managers,

   (g) A timeline for obtaining needed services, and

   (h) A timeline for reevaluation of the plan.

E. Qualifications of Providers:

Targeted Case Management services must be provided by a service provider certified by the Mississippi Department of Mental Health (DMH) as meeting the Operational Standards for Targeted Case Management for beneficiaries within the target group.

1. Targeted Case Managers must:

   a) Have a minimum of a Bachelor's degree in a mental health/IDD related field, or

   b) Be a Registered nurse.

2. All Targeted Case Management staff must successfully complete training in Person-Centered Planning. Targeted Case Managers must demonstrate competencies in the application of the principles of Person Centered Planning (PCP) in Plans of Services and Supports (PSS) as identified in the DMH Record Guide. All PSSs are submitted to DMH for approval. The PSS must adhere to the DMH Record Guide requirements in order to demonstrate competencies in PCP.

3. The Division of Medicaid will implement methods and procedures to enroll DMH Targeted Case Management service providers who serve beneficiaries within the target group. Targeted Case Management providers must demonstrate:

   a) Capacity to provide Targeted Case Management services,

   b) At least one (1) year of experience with coordination of services for individuals within the target group, and

   c) Maintenance of financial accountability rules as for any other provider participating in the

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

Medicaid program.

F. Freedom of Choice:

The state assures that the provision of Targeted Case Management services to the target group will not restrict an individual's freedom of choice of providers in violation of Section 1902(a)(23) of the Act.

1. Targeted Case Management services will be available at the option of the beneficiary.

2. A beneficiary who wishes to receive Targeted Case Management services will have freedom of choice to receive Targeted Case Management services from any qualified provider of these services.

3. Beneficiaries will have freedom of choice of the qualified Medicaid providers of other medical care as covered elsewhere in this Plan.

G. Access to Services:

1. Targeted case management services will not be used to restrict an individual's access to other services under the state plan,

2. Individuals will not be compelled to receive targeted case management services, condition receipt of targeted case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of targeted case management services, and

3. Providers of targeted case management services do not have the authority to authorize or deny the provision of other services under the state plan.

H. Targeted Case Management services are not provided to beneficiaries who are in institutions except for individuals transitioning to a community setting. Case management services will be made available for up to one-hundred eighty (180) consecutive days of a covered stay in a medical institution.

I. Limitations:

Targeted Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 CFR § 440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Targeted Case Management does not include, and FFP is not available in expenditures for, services defined in 42 CFR § 440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which a beneficiary has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR § 441.18(c)).

FFP is only available for Targeted Case Management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).”

State Mississippi

Targeted Case Management Services for children birth to 3 participating in the Mississippi Early Intervention Program.

A. Target Groups: by invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Children birth to three years of age who have developmental disabilities and who are enrolled and participating in the Mississippi Early Intervention Program.

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

X Entire State

__ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provide services less than statewide):

C. Comparability Services:

__ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Acts is invoked to provide services with out regard to the requirements of Section 1902(a)(10)(B).

D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, educations, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

State Mississippi

Case management is an active, ongoing process that involves activities carried out by a case manager to assist and enable a child enrolled and participating in the Mississippi Early Intervention Program gain access to needed medical, social, educational and other services. Service Coordination assist the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs identified on the Individualized Family Services Plan(IFSP). Additionally, Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized.

These activities include:

1. Arranging for evaluation and assessment activities to determine the identification of services as it relates to the child's medical, social, educational and other needs.
2. Arranging for and coordinating the development of the child's IFSP;
3. Arranging for the delivery of the needed services as identified in the IFSP;
4. Assisting the child and his/her family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs;
5. Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs;
6. Obtaining, preparing and maintaining case records, documenting contacts, service needed, reports, the child's progress etc.;
7. Providing case consultation (i.e., with the service providers/collaterals in determining child's status and progress);
8. Coordinating crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services); and
9. Coordinating the transition of an enrolled child to on going services prior to the child's third birthday.

State Mississippi

Mississippi Division of Medicaid will assure that the state agencies, private and public providers meet the criteria to ensure case management services to children with developmental disability targeted group, will be given equal consideration. Enrollment in the case management program will be open to all state agencies, private and public providers who can meet the qualifications. The Division of Medicaid will participate in the review of the applications for provider enrollment.

E. Qualifications of Providers:

As provided for in Section 1915(g)(1) of the Social Security Act, qualified providers shall be state agencies, private and public providers and their subcontractors meeting the following Medicaid criteria to ensure that case managers for the children with developmental disabilities are capable of providing needed services to the targeted group:

1. Demonstrated successfully a minimum of three years of experience in all core elements of case management including:

   a) assessment;

   b) care/services plan development;

   c) linking/coordination of services; and

   d) reassessment/follow-up.

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population;

3. Demonstrated experience with the target population;

4. Demonstrated the ability to provide or has a financial management system that documents services delivered and costs associated.

State Mississippi

F. Qualifications of Case Managers (only the following can be case managers):

Each case manager must be a Mississippi Early Intervention Program certified service provider, and:

1. a. Have a bachelor's degree in child development, early childhood education, special education, social work; or
   b. Be a registered nurse;

2. a. Two years experience in service coordination for children with disabilities up to age 18; or
   b. Two years experience in service provision to children under six years of age.

G. The state assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of Section 1902(2)(23) of the Act.

A. Enrolled and participating recipients will have free choice of the available providers of case management services.

B. Enrolled and participating recipients will have free choice of the available providers of other medical care under the plan.

H. Payments for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

State Mississippi

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The State Agency has in operation a computerized surveillance and utilization system which supplies data and statistics in such form as to enable the State Agency to reasonably assure high quality and appropriate quantity of medical care and to satisfy specific reporting requirements.

The State Agency further seeks to assure quality care through payment of fees sufficiently high to attract participation by an adequate number of qualified providers.

The ability to deliver quality care in the Nursing Home Program is assured by the following methods: (1) By written agreement with the Mississippi State Department of Health, all skilled nursing facilities and intermediate care facilities are surveyed at least annually to insure compliance with 42 CFR Part 442 - Standards for Payment for skilled nursing and intermediate care facility services; (2) The need for and the quality of nursing home services is assured by review teams composed of Single State Agency staff which perform on-site IOCs every six months. (3) In-service training is given in the facilities on a request basis by the professional staff of the Single State Agency; and (4) Personal contact and correspondence is used by the Single State Agency's physician to encourage more physician participation in caring for nursing home patients.

The State Agency also uses the services of a Dental Consultant for advice and recommendations on questions and problems in the dental area.

The State Agency also has seven (7) Technical Advisory Committees made up of persons actively engaged in the rendering of health services in the fields of Hospital, Physicians, Nursing Homes, Dental, Optometrists, Home Health, and Drugs. Drugs that are added or deleted to the Drug Formulary are done so upon the recommendation of an anonymous Formulary Committee, which is composed of pharmacists and physicians.

State of Mississippi

METHODS OF PROVIDING TRANSPORTATION

The Division of Medicaid provides statewide, medically necessary non-emergency transportation (NET) services through a brokerage program in accordance with Section 1902(a)(70) of the Social Security Act and 42 C.F.R. § 440.170 in order to more cost-effectively provide transportation for Medicaid beneficiaries.

The Division of Medicaid will operate the broker program without regard to the requirements of Section 1902(a) (23), Freedom of Choice.

Persons excluded from the NET Broker program include beneficiaries who are:

- Residents of a nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or psychiatric residential treatment facility (PRTF),
- Qualified Medicare Beneficiaries (QMB),
- Specified Low-Income Beneficiaries (SLMB),
- Qualified Individuals (QI), and
- Family Planning Waiver Beneficiaries.

NET services include:

- Wheelchair vans,
- Taxis,
- Stretcher services,
- Bus passes,
- Tickets,
- Non-emergency ground ambulance,
- Non-emergency fixed-wing and commercial carrier air services,
- Other transportation, including but not limited to: private automobiles, non-profit transit systems, specialty carriers for non-emergency ambulatory disoriented persons, and specialty carriers using lift-equipped vehicles in compliance with the Americans with Disabilities Act (ADA) certified to provide non-emergency transportation for non-ambulatory persons.

NET services not included in the NET Broker program include:

Transportation provided by Prescribed Pediatric Extended Care (PPEC) facilities, and
NET ambulance hospital-to-hospital transports.

The contracted NET Broker:

- Is selected through a competitive bidding process based on the Division of Medicaid's evaluation of the NET Broker's experience, performance, references, resources, qualifications, and costs,
- Has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous,
- Is subject to regular auditing and oversight by the Division of Medicaid in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services, and
- Complies with such requirements related to prohibitions on referrals and conflicts of interest as the Secretary of Health and Human Services shall establish (based on the prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).
- Is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 42 C.F.R. § 440.170(4)(ii).

The Division of Medicaid reimburses the NET Broker based on the current contract which is located at https://medicaid.ms.gov/resources/procurement/completed-procurements/.

State of Mississippi

METHODS OF PROVIDING TRANSPORTATION

The Broker is reimbursed an implementation price of no more than the actual implementation costs up to the amount specified in the Contractor's Business Bid response set forth in Attachment B of the NET Services invitation for bids (IFB).

Payment of the implementation cost shall be made by the Division of Medicaid in two installments during the implementation phase of the contract. The schedule for the two (2) payments will be determined within thirty (30) calendar days of the contract signing and based on milestones and deliverables.

An incumbent Broker is not eligible for receipt of implementation payment, except for actual expenses incurred to acquire the infrastructure to support an increase in required staffing as specified in the NET Services IFB and approved by the Division of Medicaid.

During the operational phase of the contract, the Contractor shall be paid monthly in accordance with the Contractor's bid response based on a retrospective review of the prior month transportation claims.

The Contractor's monthly payment shall be based on:

1. The Contractor's bid rate: per beneficiary per month utilized by transportation trip type category, and

2. Per beneficiary per month non-utilizers.

If a beneficiary utilizes multiple trip types during the month, the Contractor's payment shall be based on the highest rate category for the trip types utilized by the beneficiary. The Contractor will only receive one (1) rate for that beneficiary.

The Contractor shall provide timely payment to each contracted NET Provider for the services rendered. The Contractor may reimburse NET Providers through any payment arrangement agreeable to both parties, including a sub-capitation arrangement. All payment arrangements must include an incentive or safeguard to ensure utilization data for every encounter is submitted to the Contractor.

Transportation for long-term care residents is reimbursed as part of the long-term care benefit using the methodology in Attachment 4.19-D.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of transportation provided by PPEC centers. The Division of Medicaid's fee schedule rate was set as of February 1, 2019 and is effective for services provided on or after that date. Reimbursement is the lesser of the provider's usual and customary charges or the fee from the state-developed fee schedule, which is published at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

NET ambulance hospital-to-hospital transports are reimbursed the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after July 1 of each year which can be located at https://medicaid.ms.gov/providers/fee-schedules-and-rates/# and is calculated as seventy percent (70%) of the Medicare ambulance fee schedule in effect as of January 1 of each year. If a Medicare fee is not established, then the fee is set at seventy percent (70%) of the Medicare fee for a comparable service.

The Division of Medicaid assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a NET Broker to contract for transportation services at a lesser rate and credit any savings to the program.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for transportation services billed directly to the Division of Medicaid by five percent (5%) of the allowed amount for that service

State of Mississippi

METHODS OF PROVIDING TRANSPORTATION

The NET Broker is responsible for the administration and operation of NET services including, but not limited to:

- Operating and appropriately staffing a call center within Hinds, Madison or Rankin County MS subject to approval by the Division of Medicaid, to ensure that beneficiaries have access to requested NET services. The NET Broker is responsible for ensuring that only eligible Medicaid beneficiaries receive transportation services to MS enrolled Medicaid providers for covered medically necessary services.

- Contracting with NET providers to ensure that a sufficient number of vehicles and drivers are available to transport beneficiaries based on their individual needs, and that appropriate modes of transportation are utilized to transport beneficiaries to their medical appointments in a timely manner.

- Maintaining appropriate documentation to support all NET services provided or denied.

- Providing timely payment to each contracted NET provider for the services rendered.

- Developing and implementing a plan for informing and educating beneficiaries, medical providers and NET providers about the NET Broker Program. The education process must include a complaint and grievance process for beneficiaries, medical providers, and NET providers.

- Developing and implementing a plan for monitoring NET providers' compliance with all applicable local, state and federal laws and regulations, the terms of their subcontracts and all NET provider related requirements of the NET Broker's contract with the Division of Medicaid.

- Providing the Division of Medicaid with specific reports that the Division of Medicaid will utilize to monitor the broker to ensure NET services are being provided in accordance with the terms and conditions of the NET Broker contract.

State of Mississippi

STANDARDS FOR THE COVERAGE OF TRANSPLANT SERVICES

Mississippi Medicaid covers cornea, heart, heart/lung, liver, kidney, small intestine, and bone marrow (includes peripheral stem cell) transplants if all four of the following criteria are satisfied:

1) The medical necessity for the procedure is established in accordance with the Division of Medicaid's medical criteria for coverage.
2) Prior approval is obtained when required by the Division of Medicaid.
3) The transplant procedure is not experimental/investigative.
4) The transplant procedure is performed in a Mississippi Medicaid approved transplant facility.

The Division of Medicaid will monitor procedures which are experimental/investigative or in clinical trials and will base future determinations regarding coverage on approved standards of medical care.

Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan.

For procedures requiring prior approval, the medical necessity review will be coordinated with the Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO) contractor. Specific medical criteria approved by the Division of Medicaid must be satisfied along with a psychosocial evaluation of the beneficiary and/or family if the candidate is a child. It must be documented that the beneficiary/family understand risks and benefits, gives informed consent, and has the capacity to and will comply with needed care. After the medical necessity review is complete, the Division of Medicaid provides coverage and reimbursement information to the transplant facility.

Medicaid reimbursement is available only to the extent that these services are not covered by other third party payers.

Routine Mississippi Medicaid benefits are applicable to transplant services. For services not available in Mississippi, the Division of Medicaid may pay an enhanced reimbursement rate for the transplant services to ensure access to care for adults and children. The transplant reimbursement rate may be inclusive of all charges for covered hospital and physician services provided during the transplant admission (inpatient or outpatient).

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State requires mandatory enrollment of certain Medicaid beneficiaries and voluntary enrollment of federally mandated Medicaid beneficiaries into coordinated care organizations (CCOs) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to enroll certain categories of Medicaid beneficiaries in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR § 431.50), freedom of choice (42 CFR § 431.51) or comparability (42 CFR § 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vi. below).

B. General Description of the Program and Public Process.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR § 438.50(b)(1)

1. The State will contract with an

__X__ i. MCO

____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)

____ iii. Both

42 CFR § 438.50(b)(2)
42 CFR § 438.50(b)(3)

2. The payment method to the contracting entity will be:

____ i. fee for service;

__X__ ii. capitation;

____iii. a case management fee;

____iv. a bonus/incentive payment;

____ v. a supplemental payment, or

____vi. other. (Please provide a description below).

Citation | Condition or Requirement

To meet the goals of beneficiary choice, financial stability of the program and administrative ease, no more than three (3) and no less than two (2) CCOs are awarded a contract to administer a care coordination program. The program is statewide with both voluntary and mandatory enrollment depending on the beneficiary's category of eligibility. Medicaid beneficiaries excluded from the program regardless of the category of eligibility are listed in B.5.

CCOs are defined as organizations that meet the requirements for participation as a contractor in the Mississippi Coordinated Access Network (MississippiCAN) program and that manage the purchase and provision of health care services to MississippiCAN enrollees.

Contracted CCOs are selected through a competitive Request for Proposals process.

CCOs are required to:

- Demonstrate information systems are in place to meet all of the operating and reporting requirements of the program, including the collection of third party liability payments;
- Operate both member and provider call centers. The member call center must be available to members twenty-four (24) hours a day, seven (7) days a week. The provider call center must operate during normal providers' business hours;
- Process claims in compliance with established minimum standards for financial and administrative accuracy and timeliness of processing with standards being no less than current Medicaid fee-for-service standards;
- Submit complete encounter data that meets federal requirements and allows DOM to monitor the program. CCOs that do not meet standards will be penalized.

CCOs are required to provide a comprehensive package of services that include, at a minimum, the current Mississippi Medicaid benefits. CCOs are required to:

- Participate as partners with providers and beneficiaries to arrange delivery of quality, cost-effective health care services, with medical homes and comprehensive care management programs to improve health outcomes.
- Ensure annual wellness physical exams to establish a baseline, to measure change and to coordinate care appropriately by developing a health and wellness plan with interventions identified to improve outcomes.

Citation	Condition or Requirement

- Develop disease management programs for chronic or very high cost conditions including, but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, organ transplants, and improved birth outcomes with a comprehensive health education program to support disease management.
- Establish quality assurance programs to assess actual performance and ensure that members receive medically appropriate care on a timely basis with positive or improved outcomes, access to effective complaint resolution and grievance processes and support for electronic medical records in provider offices to promote efficient coordinated care with improved outcomes.

1905(t)
42 CFR § 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR § 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

____v. Incentives will be made available to both public and private PCCMs.

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

__**X**__ vii. Not applicable to this 1932 state plan amendment.

42 CFR § 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

Citation		Condition or Requirement

The MississippiCAN program was authorized in 2010, with an effective date of 1/1/2011, through State legislation in accordance with Miss. Code Ann. Section 43-13-117(H). The Division of Medicaid initially issued a public notice requesting input on a proposed care coordination program. The public notice was e-mailed to various provider associations and advocacy groups in addition to posting it on the agency website seeking comments/revisions/input.

The agency also met with Mississippi legislative leaders and two (2) public hearings were held at the State Capitol to allow for a presentation of the proposed program by agency staff. Various providers, advocacy organizations and many legislators provided input at these hearings. The Governor also called a meeting with various provider groups to discuss the program, seek input, and answer any questions.

The initial program design summary, request for proposal (RFP) and responses to frequently asked questions were posted and updated on the State's website prior to the implementation of the program.

The State will continue to utilize every opportunity to talk with the various stakeholders such as consumers, providers, advocates, etc. At a minimum the State will meet with stakeholders two (2) times a year.

The Division of Medicaid will request comments on proposed changes to the MississippiCAN program by issuing a public notice(s) via e-mail to various provider associations and advocacy groups in addition to posting it on the agency's' website.

1932(a)(1)(A) 5. The State requires mandatory and allows voluntary enrollment depending on the beneficiary's code of eligibility into the MississippiCAN program on a statewide basis.

See Section D for Eligibility Groups.

Enrollment limit increased to the greater of:

1. Forty-five percent (45%) of the total enrollment of all Mississippi Medicaid beneficiaries; or

2. The total of eligible beneficiaries enrolled in MSCAN as of January 1, 2014, plus the categories of beneficiaries composed primarily of persons younger than nineteen (19) years of age.

Citation	Condition or Requirement

Medicaid beneficiaries excluded from the program regardless of the category of eligibility include persons:

- In an institution such as a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID),
- Eligible for Medicare,
- Locked-in any Medicaid waiver program, and
- With hemophilia.

All beneficiaries have freedom of choice in selecting the CCO. All beneficiaries initially enrolled in a CCO are allowed to change CCOs "without cause" during the first ninety (90) days of the initial enrollment effective for the first year. After the first year of enrollment in a CCO all beneficiaries are allowed to enroll in a different CCO during the Medicaid annual open enrollment period October 1 through December 15.

Beneficiaries exempt from mandatory enrollment may disenroll during the first ninety (90) days following their initial enrollment in a CCO. After the first year of enrollment, beneficiaries exempt from mandatory enrollment may disenroll during the Medicaid annual open enrollment period October 1 through December 15.

Refer to Section J.4. for disenrollment "with cause".

C. State Assurances and Compliance with Statutes and Regulations

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR § 438.50(c)(1)

1. __X__ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR § 438.50(c)(2)
1902(a)(23)(A)

2. ____The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)

3. __X__ The state assures that all the applicable requirements of section 1932

Citation		Condition or Requirement
42 CFR § 438.50(c)(3)		(including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR § 431.51 1905(a)(4)(C)	4. X	The state assures that all the applicable requirements of 42 CFR § 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR Part 438 42 CFR § 438.50(c)(4) 1903(m)	5. X	The state assures that all applicable managed care requirements of 42 CFR § Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR § 438.6(c) 42 CFR § 438.50(c)(6)	6. X	The state assures that all applicable requirements of 42 CFR § 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR § 447.362 42 CFR § 438.50(c)(6)	7. ____	The state assures that all applicable requirements of 42 CFR § 447.362 for payments under any non-risk contracts will be met.
45 CFR § 74.40	8. X	The state assures that all applicable requirements of 45 CFR § 92.36 for procurement of contracts will be met.
	D. Eligible groups	
1932(a)(1)(A)(i)	1.	List all eligible groups that will be enrolled on a mandatory basis. • Supplemental Security Income - 1902(a)(10)(A)(i)(II); Only beneficiaries age 19 to 65 in the eligibility category of low income and age 65 or older, blind, or disabled receiving SSI cash assistance or "deemed" to be cash recipients. • Working disabled – 1902(a)(10)(A)(ii)(XIII); Beneficiaries age 19 or older and disabled who work with earnings under 250% of FPL and unearned income under 135% of FPL with a resource limit of $24,000/$26,000. A premium is required in certain cases. • Breast/Cervical Cancer Group - 1902(a)(10)(A)(ii)(XVIII). Female beneficiaries ages 19 to 65 whose income level is 250% of FPL with no other health insurance who have been screened and diagnosed with breast or cervical cancer under the CDC's screening program

Citation	Condition or Requirement

administered by the MS State Dept. of Health.

- Pregnant Women
  Pregnant women, age 8 to 65, whose family income does not exceed 194% of FPL for the appropriate family size which includes the pregnant women, her spouse and children, if applicable, and unborn(s). A pregnant woman's eligibility includes a two (2)-month postpartum period following the month of delivery, miscarriage or other termination of pregnancy.

- Infants up to age 1
  Infants up to age 1 whose family income does not exceed 194% of FPL for the appropriate family size. Infants born from a Medicaid eligible mother automatically receive benefits for one subsequent year.

- Parents and Caretaker Relatives with Dependent Children under age 18
  Adults age 19 to 65. As a condition of eligibility, the adult must cooperate with child support enforcement requirements for each eligible child deprived due to a parent's continued absence from the home.

- Children age 1 up to 6
  Children age 1 up to 6 whose family income does not exceed 143% of FPL.

- Children age 6 up to 19
  Children age 6 up to 19 whose family income does not exceed 107% of FPL.

- Quasi-CHIP Children
  Children age 6 up to 19 whose family income is between 107% - 133% of FPL. These children would have previously qualified for CHIP under the pre-ACA MAGI rules.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR § 438.50.

   Use a check mark to affirm whether there is voluntary enrollment of any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR § 438.50(d)(1)

i. ____Recipients who are also eligible for Medicare.

   If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

Citation	Condition or Requirement
1932(a)(2)(C) 42 CFR § 438.50(d)(2)	ii. __X__ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR § 438.50(d)(3)(i)	iii. __X__ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR § 438.50(d)(3)(ii)	iv. __X__ Children under the age of 19 years who are eligible under Section 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR § 438.50(3)(iii)	v. __X__ Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR § 438.50(3)(iv)	vi. __X__ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR § 438.50(3)(v)	vii. ___ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.
	E. Identification of Mandatory Exempt Groups
1932(a)(2) 42 CFR § 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* **Not applicable.**
1932(a)(2) 42 CFR § 438.50(d)	2. Place a check mark to affirm if the state's definition of Title V children is determined by: ____ i. program participation, ____ii. special health care needs, or ____iii. both.

Citation		Condition or Requirement
1932(a)(2) 42 CFR § 438.50(d)	3.	Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. ____i. yes ____ii. no.
1932(a)(2) 42 CFR § 438.50 (d)	4.	Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; The State identifies these children by category of eligibility and age through the MMIS Eligibility Subsystem. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; The State identifies these children by category of eligibility through the MMIS Eligibility Subsystem. iii. Children under 19 years of age who are in foster care or other out-of-home placement; The State identifies these children by category of eligibility through the MMIS Eligibility Subsystem. iv. Children under 19 years of age who are receiving foster care or adoption assistance. The State identifies these children by category of eligibility through the MMIS Eligibility Subsystem.
1932(a)(2) 42 CFR § 438.50(d)	5.	Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* Any child not initially identified as having special needs may request exemption from mandatory enrollment through self-identification.
1932(a)(2)	6.	Describe how the state identifies the following groups who are exempt from

Citation	Condition or Requirement

42 CFR § 438.50(d)

mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

i. Recipients also eligible for Medicare.

The State identifies these individuals based on the Medicare indicator in the MMIS Eligibility System.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

The State identifies these individuals using information in the MMIS Eligibility Subsystem and through self-identification.

42 CFR § 438.50(2)

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Refer to B.5.

42 CFR § 438.50(2)

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

- Supplemental Security Income - 1902(a)(10)(A)(i)(II);
  Only beneficiaries under the age of 19 in the eligibility category of low income and age 65 or older, blind, or disabled receiving SSI cash assistance or deemed to be cash recipients.

- Disabled child at home – 1902(e)(3);
  Beneficiaries who are disabled and under the age of 19 qualify based on income under 300% of the SSI limit (nursing facility limit) meeting the level of care requirement for nursing facility/intermediate care facility for individuals with intellectual disabilities (ICF/IID) placement. Income and resource criteria are the same as for long term care rules and no parental deeming of income or other resources.

- Department of Human Services Foster Care and Adoption Assistance Children – 1902(a)(10)(A)(ii)(I) and 1902(a)(10)(A)(ii)(VIII);
  Beneficiaries up to age 19, if in the custody of the MS Dept. of Human

Citation	Condition or Requirement

Services and in a licensed foster home, with eligibility based on income/resources of the child and resources not to exceed $10,000.

H. Enrollment Process

1932(a)(4)
42 CFR § 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR § 438.50

2. State process for enrollment by default

Describe how the state's default enrollment process will preserve:

i. The existing provider-recipient relationship (as defined in H.1.i).

Enrollees failing to make a voluntary CCO selection within the initial thirty (30) days of the enrollment process are auto-assigned to a CCO. Auto-assignment rules include a provision to verify paid claims data within a minimum of the past six (6) months and assignment of the enrollee to a CCO which has a contract with the enrollee's primary care physician.

The use of claims data and CCO relationships for other family members is designed to preserve existing provider-recipient relationships.

ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.1.ii).

Enrollees failing to make a voluntary CCO selection within the initial thirty (30) days of the enrollment process are auto-assigned to a CCO. Auto-assignment rules include provisions to:

- Verify paid claims data within a minimum of the past six (6) months and assign the enrollee to a CCO which has a contract with the enrollee's primary care physician.

Citation | Condition or Requirement

- Determine if a family member is assigned to a CCO and assign the enrollee to that CCO.
- If no family member is assigned to a CCO, the enrollee is assigned to an open panel closest to the enrollee's home. If multiple CCOs meet this standard, auto-assignment occurs using a random process.

CCO provider networks for Medicaid beneficiaries are limited to Medicaid-participating providers. This ensures beneficiaries have a relationship with providers who have traditionally served Medicaid beneficiaries.

iii. The equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR § 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR § 438.56(d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Enrollees failing to make a voluntary CCO selection within thirty (30) days of enrollment are auto-assigned to a CCO. Auto-assignment rules include provisions to:

- Verify paid claims data within the past six (6) months and assign the enrollee to a CCO which has a contract with the enrollee's primary care physician.
- Determine if a family member is assigned to a CCO and assign the enrollee to that CCO.
- If no family member is assigned to a CCO, the enrollee is assigned to an open panel closest to the enrollee's home. If multiple CCOs meet this standard, auto-assignment will occur using a random process.

Auto-assignment is a hierarchy process, but in no case will auto-assignment exceed the capacity of the CCO's provider network.

The use of claims data and CCO relationships for other family members is designed to preserve existing provider-recipient relationships.

CCO provider networks for Medicaid beneficiaries are limited to Medicaid-participating providers. This ensures beneficiaries have a relationship with providers who have traditionally served Medicaid beneficiaries.

Citation	Condition or Requirement
1932(a)(4) 42 CFR § 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: i. The state will__X__ / will not____ use a lock-in for managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* Medicaid beneficiaries auto-enrolled receive State-generated correspondence informing of the assigned CCO. iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)* Medicaid beneficiaries auto-assigned to a CCO receive state-generated correspondence informing them that they may disenroll without cause during the first ninety (90) days of initial enrollment. CCO enrollment packets also provide information regarding disenrollment without cause during ninety (90) days of the initial enrollment date. v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)* If the beneficiary fails to choose a CCO within thirty (30) days of the distribution date of the enrollment packet, the State assigns the beneficiary to a CCO. If it is not possible to determine prior patient/provider relationship, the State randomly assigns members to ensure equitable enrollment among the plans. If the plans have equitable distribution, then a round robin methodology is used to ensure maintenance of an equitable distribution. vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Citation	Condition or Requirement
	The State monitors for any change in the rate of auto-enrollment through data available from the MMIS Eligibility Subsystem and monthly enrollment reports generated by the enrollment broker.
1932(a)(4) 42 CFR § 438.50	I. State assurances on the enrollment process Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment. 1. __X__ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program. 2. __X__ The state assures that, per the choice requirements in 42 CFR § 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR § 438.52(b)(3). 3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR § 438.52(a) for MCOs and PCCMs. __X__ This provision is not applicable to this 1932 State Plan Amendment. 4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.) __X__ This provision is not applicable to this 1932 State Plan Amendment. 5. __X__ The state applies the automatic reenrollment provision in accordance with 42 CFR § 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less. ___This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR § 438.50	J. Disenrollment 1. The state will__X__ /will not___ use lock-in for managed care. 2. The lock-in will apply for up to twelve (12) months.

Citation	Condition or Requirement

3. Place a check mark to affirm state compliance.

X The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR § 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

A beneficiary may request to disenroll from the CCO "with cause" if:

- The CCO, because of moral or religious objections, does not offer the service the beneficiary seeks,
- The beneficiary needs related services to be performed at the same time, but not all related services are available within the network; or, the beneficiary's primary care provider or another provider determines receiving the services separately would subject the beneficiary to unnecessary risk,
- Poor quality of care,
- There is a lack of access to services covered under the CCO, or
- There is a lack of access to providers experienced in dealing with the beneficiary's health care needs.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
CFR § 438.50
42 CFR § 438.10

X The state assures that its state plan program is in compliance with 42 CFR § 42 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Excluded services include:

- Long-term care services, including nursing facility and ICF/IID,
- Any waiver services, and
- Hemophilia services.

Citation	Condition or Requirement

CCOs are restricted from requiring its membership to utilize a pharmacy that ships, mails, or delivers drugs or devices.

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will__X__ /will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. __X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   The State limits the number of CCOs to no more than three (3) and no less than two (2) based on the number of potential enrollees. The State believes it is not in the best interest of the CCOs financially to divide the potential maximum among more than three (3) plans.

4. ____ The selective contracting provision is not applicable to this state plan.

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Day Services - Adult, Prevocational Services, Supported Employment Services, and Supported Living

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

●	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*
(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);
(b) the geographic areas served by these plans;
(c) the specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐ **A program operated under §1932(a) of the Act.**

		Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
	☐	**A program authorized under §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
●	The State plan HCBS benefit is operated by *(name of agency)*		
	Mississippi Department of Mental Health (DMH)		
	A separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☑	☐	☐
4 Prior authorization of State plan HCBS	☑	☑	☐	☐
5 Utilization management	☑	☑	☐	☐
6 Qualified provider enrollment	☑	☑	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☑	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

DMH, in addition to the Division of Medicaid (DOM) performs 2, 3, 4, 5, 6, 8, 9, 10. The Diagnostic and Evaluation (D&E) team, which is a part of DMH, performs #2.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	11/01/2018	10/31/2019	950
Year 2	11/01/2019	10/31/2020	1,150
Year 3	11/01/2020	10/31/2021	1,350
Year 4	11/01/2021	10/31/2022	1,550
Year 5	11/01/2022	10/31/2023	1,750

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
●	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

	DMH

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The D&E Team conducts the evaluation for initial eligibility. Each D&E Team consists of at least a psychologist and social worker. Additional team members may be utilized, dependent upon the needs of the individual being evaluated, such as physical therapists, dieticians, etc. All members of the D&E Teams are licensed and/or certified through the appropriate State licensing/certification body for their respective disciplines.

Targeted Case Managers conducts the reevaluation for eligibility. Targeted Case Management is provided by an individual with at least a Bachelor's degree in an intellectual/developmental disabilities or related field and at least one year experience in working with people with intellectual or developmental disabilities. Targeted Case Management can also be provided by a Registered Nurse with at least one year experience in working with people with intellectual or developmental disabilities.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The process for evaluation/reevaluating needs-based eligibility for State plan HCBS involves a review of current pertinent information in the individual's record, such as medical, social and psychological evaluations, and standardized instruments to measure intellectual functioning, the individual service plan, progress notes, case management notes and other assessment information. The review verifies the determination that the individual meets the needs-based eligibility criteria including the existence of significant functional limitations in two (2) or more areas of major life activity including: receptive/expressive language, learning, self-care, mobility, self-direction, capacity for independent living and economic self- sufficiency. The State determines whether an individual meets the needs-based criteria through the use of the Inventory for Client and Agency Planning (ICAP).

The ICAP is administered by both the Diagnostic and Evaluation Team during the initial evaluation and by the Targeted Case Managers during the annual reevaluation. In response to the COVID-19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, DOM has the flexibility to allow evaluations and reevaluations to be conducted telephonically, in accordance with HIPAA requirements.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The person has a need for assistance typically demonstrated by meeting the following criteria on a continuing or intermittent basis: The individual must have significant limitations of functioning in two (2) or more areas of major live activity including self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
The individual must have significant limitations of functioning in two (2) or more of the following seven (7) areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.	For an individual to qualify for the Elderly and Disabled, Independent Living, Traumatic Brain/Spinal Cord and Assisted Living waivers, the individual must be assessed and score 50 or less on a standardized preadmission screening tool designed and tested to determine whether the individual meets nursing home level of care. Additionally, the physician must certify level of care.	For an individual to be eligible for services in an ICF/IID, the individual must have an intellectual disability, a developmental disability, or Autism Spectrum Disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. The individual must have limitations of functioning in three (3) or more of the following seven (7) areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.	For an individual to be eligible for services in a Hospital, the individual must have continuous need of facilities, services, equipment and medical and nursing personnel for prevention, diagnosis, or treatment of acute illness or injury certified by a physician.

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The state is targeting Individuals with Intellectual Disabilities, Developmental Disabilities, or Autism Spectrum Disorder. Persons must be at a minimum 18 years old to receive

services through the IDD Community Support Program.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One	
ii.	**Frequency of services**. The state requires (select one):	
	●	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Each D&E Team consists of at least the following: psychologist and social worker. Additional team members, such as physical therapists, dieticians, etc. may be utilized depending upon the needs of the individual being evaluated. All members of the D&E Teams are licensed and/or certified through the appropriate State licensing/certification body for their respective discipline.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Targeted Case Managers (TCM) are responsible for the development of a Plan of Service and Supports (PSS) for each person receiving 1915(i) Services. Targeted Case Management is provided by an individual with at least a Bachelor's degree in an intellectual/developmental disabilities or related field and at least one year experience in working with people with intellectual or developmental disabilities. Targeted Case Management can also be provided by a Registered Nurse with at least one year experience in working with people with intellectual or developmental disabilities. Additionally, Targeted Case Managers must complete training in Person-Centered Planning and demonstrate competencies associated with that process.

TCM Education Needs: The TCM must be certified in order to provide case management. Additionally, TCMs must be recertified annually. DMH, as the operating agency, will be responsible for certification standards, as approved by the State.

TCM Supervisors: This is an administrative position involving the planning, direction, and administration of the case management program. Supervision of the TCM is a function that is required to ensure that all components of case management are carried out according to the Quality Assurance Standards. DMH, as the operating agency, will be responsible for certification standards for TCM supervisors, as approved by the State.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The active involvement of individuals and their families and/or legal guardians are essential to the development and implementation of a PSS that is person-centered and addresses the outcomes desired by the individuals. Individuals participating in HCBS and/or their family members and legal representatives will have the authority to determine who is included in their planning process. Case managers will work with the individuals and their families and/or legal guardians to educate them about the Person-Centered Planning process itself and encourage them to identify and determine who is included in the face-to-face process. Case Managers will encourage the inclusion of formal and informal providers of support to the individuals in the development of a person-centered plan. In response to the COVID-19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, DOM has the flexibility to allow the person centered planning process to be conducted by telephone in accordance with HIPAA requirements.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Targeted Case Managers will assist individuals in selecting qualified providers of the 1915(i) services. A qualified provider must be a Medicaid provider and be certified by DMH to provide the services. During the development of the PSS, Targeted Case Managers will educate the individual about the qualified providers certified to provide the services in the area the individual lives as identified on the plan of care. Individuals have a right to choose a provider and may change service providers at any time. Should additional qualified providers be identified, the Targeted Case Managers will inform the individuals of the new qualified providers. DMH, Division of Certification, is the entity responsible for notifying the Targeted Case Managers regarding providers who have received DMH certification to provide services.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

Each PSS is initially reviewed by DMH to verify the HCBS services are:

1. Addressed,
2. Appropriate and adequate to ensure the individual's health and welfare, and
3. Delivered by a DMH certified provider.

DMH then forwards the Plan of Services and Supports to the State for review and approval.

On an annual basis, DMH, in conjunction with the State, will verify through a representative sample of beneficiaries PSSs to ensure all service plan requirements have been met. PSSs are housed in a Document Management System allowing both agencies access to PSSs at any time.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☑	Medicaid agency	☑	Operating agency	☑	Case manager
☐	Other (*specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Day Services – Adult
Service Definition (Scope)*:*	
Day Services - Adult are designed to support meaningful day opportunities that provide structured, varied and age appropriate activities (both active and passive) and the option for	

individuals to make choices about the activities in which they participate. The activities must be designed to support and enhance the individual's independence in the community through the provision of structured supports to enhance an individual's acquisition of skills, appropriate behaviors and personal choice. Day Services -Adult activities must aim to improve skills needed for the individuals to function as independently as possible. Day Services – Adult will be provided based on a person-centered approach with supports tailored to the individual desires and life plan of the individual participant. Day Services – Adult takes place in a non-residential setting that is separate from the residence of the individuals receiving the service. In response to the COVID -19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, DOM has the flexibility to allow Day Services - Adult to also be provided in a residential setting.

Transportation is a component of Day Services – Adult. Transportation must be provided to and from the program and for community participation activities. Accessible transportation must be provided for those who need that level of assistance.

In response to the COVID -19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, DOM has the flexibility to allow Day Services - Adult to also be provided telephonically or virtually where appropriate in accordance with HIPAA requirements.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☑ Categorically needy *(specify limits):*

The State covers Day Services – Adult for individuals enrolled in the Community Support Program up to the maximum amount of six (6) hours per day. In instances in which a person requires additional amounts of services, as identified through Person- Centered Planning, those services must be authorized by DMH or the State.

In response to the COVID -19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, Day Services – Adult is covered up to three (3) hours per day and will be reimbursed at the lowest support level, when provided telephonically or virtually.

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Day Services – Adult Providers	DMH Certification	Certified every three years by DMH after initial certification. DMH conducts an annual provider compliance review. DOM has the flexibility to suspend the annual provider compliance review during the COVID19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions. Annual provider compliance reviews will be suspended to the end of the public health emergency, including any extensions. Should a provider fail to complete the compliance review after the end of the suspended review period, the provider will no longer be qualified to render services.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health. The minimum staffing ratio is based on the individuals ICAP Support Level.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Day Services - Adult Providers	Division of Medicaid	Annually

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Prevocational Services

Service Definition (Scope)*:*

Prevocational Services provide learning and work exposure experiences, including volunteer work, where the individual can develop general, non-job-task specific strengths and skills that contribute to employment in paid employment in integrated community settings. Services are expected to occur over a defined period of time with specific outcomes to be achieved as determined by the individual. Individuals receiving Prevocational Services must have employment related goals in their PSS; the general habilitation activities must be designed to support such employment goals.

Competitive integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, is considered to be the optimal outcome of Prevocational Services. Prevocational Services should enable each individual to attain the highest level of work in an integrated setting with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines.

Services are intended to develop and teach general skills that are associated with building skills necessary to perform work optimally in competitive, integrated employment. Teaching job specific skills is not the intent of Prevocational Services. Examples include, but are not limited to,:

Ability to communicate effectively with supervisors, coworkers and customers

Generally accepted community workplace conduct and dress

Ability to follow directions; ability to attend to tasks

Workplace problem solving skills and strategies

General workplace safety and mobility training

Attention span

Motor skills

Interpersonal relations

Ability to get around in the community as well as the Prevocational Services site

The distinction between Vocational and Prevocational Services is that Prevocational Services, regardless of setting, are developed for the purpose of furthering habilitation goals that will lead to greater job opportunities. Vocational services teach job specific task skills required by a participant for the primary purpose of completing these tasks for a specific job and are delivered in an integrated work setting through Supported Employment. Participation in Prevocational Services is not a prerequisite for Supported Employment. A person receiving Prevocational Services may pursue employment opportunities at any time to enter the general work force.

Prevocational Services may be furnished in a variety of locations in the community and are not limited to fixed program locations. In response to the COVID -19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, DOM has the flexibility to allow Prevocational Services to also be provided in a residential setting.

Individuals may be compensated in accordance with applicable Federal Laws.

Transportation is a component of Prevocational Services. Transportation must be provided to and from the program and for community integration/job exploration. Accessible transportation must be provided for those who need that level of assistance.

Any individual receiving Prevocational Services who is performing productive work as a trial work experience that benefits the organization or that would have to be performed by someone else if not performed by the individual must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor.

At least annually, providers will conduct an orientation informing individuals about Supported Employment and other competitive employment opportunities in the community. In response to the COVID-19 pandemic, DOM has the flexibility to allow for suspension of the annual orientation meeting/s from April 1, 2020 to the end of the public health emergency, including any extensions.

In response to the COVID -19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, DOM has the flexibility to allow Prevocational Service to also be provided telephonically or virtually where appropriate in accordance with HIPAA requirements.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑ Categorically needy *(specify limits):*

The State covers Prevocational Services for individuals enrolled in CSP up to the maximum amount of six (6) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State.

In response to the COVID-19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, Prevocational Services is covered up to three (3) hours per day and will be reimbursed at the lowest support level, when provided telephonically or virtually.

☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Prevocational Services Providers	DMH Certification	Certified every three years by DMH after initial certification. DMH conducts an annual provider compliance review. DOM has the flexibility to suspend the annual provider compliance review during the COVID-19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions. Annual provider compliance reviews will be suspended to the end of the public health emergency, including any extensions. Should a provider fail to complete the compliance review after the end of the suspended review period, the provider will no longer be qualified to render services.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health. The minimum staffing ratio is based on the individuals ICAP Support Level.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Prevocational Services Providers	Division of Medicaid	Annually

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications ***(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):***

Service Title:	

Service Definition (Scope)*:*

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):	
☐	**Categorically needy *(specify limits):***
☐	**Medically needy *(specify limits):***

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	**License *(Specify):***	**Certification *(Specify):***	**Other Standard *(Specify):***

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	**Entity Responsible for Verification *(Specify):***	**Frequency of Verification *(Specify):***

Service Delivery Method. *(Check each that applies)*:

☐	**Participant-directed**	☑	**Provider managed**

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Supported Employment**

Service Definition (Scope)*:*

Supported Employment is the ongoing support to individuals who, because of their support needs, will require intensive, ongoing services to obtain and maintain a job in competitive, integrated employment, or self-employment. Employment must be in an integrated work setting in the general workforce where an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Providers must reduce the number of hours of staff involvement as the employee becomes more productive and less dependent on paid supports. The plan for reduction in services is based on the individual's identified need for support as established in the PSS and must be documented

in the individual's record.

Supported Employment Services are provided in a work site where individuals without disabilities are employed; therefore payment is made only for adaptations, supervision, and training required by individuals receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Other workplace supports may include services not specifically related to job skills training that enable the individual to be successful in integrating into the job setting. Each individual must have an Activity Plan that is developed based on his/her PSS. In response to the COVID -19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, DOM has the flexibility to allow the Activity Plan to be developed by telephone in accordance with HIPAA requirements.

Providers must provide all activities that constitute Supported Employment:

1. **Job Seeking – Activities that assist an individual in determining the best type of job for him/her and then locating a job in the community that meets those stated desires. Job Seeking is limited to ninety (90) hours per certification year. Additional hours may be approved by the DMH Bureau of Intellectual and Developmental Disabilities on an individual basis with appropriate documentation. Job seeking includes:**
   - **a. Completion of IDD Employment Profile**
   - **b. Person-Centered Career Planning, conducted by Supported Employment provider staff, which is a discussion of specific strategies that will be helpful to assist job seekers with disabilities to plan for job searches**
   - **c. Job Development**
     - **(1) Determining the type of environment in which the person is at his/her best**
     - **(2) Determining in what environments has the person experienced success**
     - **(3) Determining what work and social skills does the person bring to the environment**
     - **(4) Assessing what environments are their skills viewed as an asset**
     - **(5) Determining what types of work environments should be avoided**
   - **d. Employer research**
   - **e. Employer needs assessment**
     - **(1) Tour the employment site to capture the requirements of the job**
     - **(2) Observe current employees**
     - **(3) Assess the culture and the potential for natural supports**
     - **(4) Determine unmet needs**
   - **f. Negotiation with prospective employers**
     - **(1) Job developer acts as a representative for the job seeker**
     - **(2) Employer needs are identified**
2. **Job Coaching – Activities that assist an individual to learn and maintain a job in the community. The amount of Job Coaching a person receives is dependent upon individual need, team recommendations, and employer evaluation. Job coaching includes:**
   - **a. Meeting and getting to know co-workers and supervisors**
   - **b. Learning company policies, dress codes, orientation procedures, and company culture**
   - **c. Job and task analysis**
     - **(1) Core work tasks**
     - **(2) Episodic work tasks**
     - **(3) Job related tasks**

(4) Physical needs

(5) Sensory and communication needs

(6) Academic needs

(7) Technology needs

d. Systematic instruction

(1) Identification and instructional analysis of the goal

(2) Analysis of entry behavior and learner characteristics

(3) Performance Objectives

(4) Instructional strategy

e. Identification of natural supports

(1) Personal associations and relationships typically developed in the community that enhance the quality and security of life

(2) Focus on natural cues

(3) Establish circles of support

f. Ongoing support and monitoring

If an individual moves from one job to another or advances within the current employment site, it is the Supported Employment provider's responsibility to update the profile/resume created during the job search

Transportation must be provided between the individual's place of residence and the site of the individual's job or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of Supported Employment. Transportation cannot comprise the entirety of the service. Accessible transportation must be provided for those who need that level of assistance.

Supported Employment includes services and supports that assist the individual in achieving self-employment through the operation of a business, either home-based or community-based. Such assistance may include: assisting the individual to identify potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and starting a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

Payment is not made for any expenses associated with starting up or operating a business. Referrals for assistance in obtaining supplies and equipment for someone desiring to achieve self-employment should be made through the Mississippi Department of Rehabilitation Services (MDRS). There must be documentation of the referral in the record.

For self-employment, the following limits apply: Up to fifty-two(52) hours per month of at home assistance by a job coach, including business plan development and assistance with tasks related to producing the product and up to thirty-five (35) hours per month for assistance in the community by a job coach.

Supported Employment does not include facility based or other types of services furnished in a specialized facility not part of the general workforce. Supported Employment cannot take place in a facility based program.

Supported Employment does not include volunteer work.

Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as incentive payments made to an employer to encourage or subsidize the employer's participation in the Supported Employment program or payments passed through to users of Supported Employment Services.

Staff are required to be present and supporting the individual during Supported Employment activities.

Assistance with toileting and hygiene may be a component part of Supported Employment, but may not comprise the entirety of the service.

Providers are prohibited from making incentive payments to an employer to encourage or subsidize the employer's participation in the Supported Employment Program and/or passing payments through to users of Supported Employment Services.

An individual must be at least 18 years of age to participate in Supported Employment and have documentation in their record to indicate they have received either a diploma, certificate of completion if they are under the age of 22, or verification from the school district the person is no longer in school.

The service is not otherwise available under a program funded through the Section 110 Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq). Records for people receiving ID/DD Supported Employment Services will document that the Mississippi Department of Rehabilitation Services (MDRS) was unable to serve the person.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	**Categorically needy *(specify limits):***
	The State covers Supported Employment Services for individuals enrolled in CSP up to the maximum amount of 100 hours per month. In instances in which a person requires additional amounts of services, as identified through Person Centered Planning, those services must be authorized by DMH or the State.
☐	**Medically needy *(specify limits):***

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	**License *(Specify):***	**Certification *(Specify):***	**Other Standard *(Specify):***

Supported Employment Providers	DMH Certification	Certified every three years by DMH after initial certification. DMH conducts an annual provider compliance review. DOM has the flexibility to suspend the annual provider compliance review during the COVID-19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions. Annual provider compliance reviews will be suspended to the end of the public health emergency, including any extensions. Should a provider fail to complete the compliance review after the end of the suspended review period, the provider will no longer be qualified to render services.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	**Entity Responsible for Verification *(Specify):***	**Frequency of Verification *(Specify):***
Supported Employment Provider	Division of Medicaid	Annually

Service Delivery Method. *(Check each that applies)*:

☐	**Participant-directed**	☑	**Provider managed**

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Supported Living

Service Definition (Scope)*:*

A new service, Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community. Supported living is for individuals who need less than 24-hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency.

Supported Living Services are provided in residences in the community with four (4) or fewer individuals.

Supported Living provides assistance with the following, depending on each individual's support needs:

- **Grooming**

- **Eating**
- **Bathing**
- **Dressing**
- **Other personal needs.**

Supported Living provides assistance with instrumental activities of daily living which include assistance with:

A. **Planning and preparing meals, including assistance in adhering to any diet prescribed by an M.D., Nurse Practitioner or Licensed Dietician/Nutritionist,**

B. **Cleaning**

C. **Transportation**

D. **Assistance with mobility both at home and in the community**

E. **Supervision of the individual's safety and security**

F. **Banking**

G. **Shopping**

H. **Budgeting**

I. **Facilitation of the individual's participation in community activities**

J. **Use of natural supports and typical community services available to everyone**

K. **Social activities**

L. **Participation in leisure activities**

M. **Development of socially valued behaviors**

N. **Assistance with scheduling and attending appointments**

Providers must facilitate meaningful days and independent living choices about activities/services/staff for the individual(s) receiving Supported Living services. Procedures must be in place for individual(s) to access needed medical and other services, as well as typical community services, available to all people.

Nursing services are a component part of Support Living. They must be provided as-needed, based on each individual's need for nursing services. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; administration of medication; setting up medication sets for self-administration; administration of medication; weight monitoring; periodic assessment, accompanying people on medical visits, etc.

If chosen by the person, Supported Living staff must assist the person in participation in community activities. Supported Living services for community participation activities may be shared by up to three (3) individuals who may or may not live together and who have a common direct service provider agency. In these cases, individuals may share Supported Living staff when agreed to by the individuals and when the health and welfare can be assured for each individual.

Each individual must have an Activity Plan that is developed based on his/her PSS. Information from the PSS and Initial Discovery (which takes place during the first thirty (30) days of services) is to be included in the Activity Support Plan and must address the outcomes on his/her approved PSS. In response to the COVID-19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions, DOM has the flexibility to allow the Activity Plan to be developed by telephone in accordance with HIPAA requirements.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

N/A

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	**Categorically needy *(specify limits):***
	The State covers Support Living Services for individuals enrolled in CSP up to the maximum amount of four (4) hours per day. In instances in which a person requires additional amounts of services, as identified through Person-Centered Planning, those services must be authorized by DMH or the State.
☐	**Medically needy *(specify limits):***

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	**License *(Specify):***	**Certification *(Specify):***	**Other Standard *(Specify):***
Supported Living Providers	DMH Certification	Certified every three years by DMH after initial certification. DMH conducts an annual provider compliance review. DOM has the flexibility to suspend the annual provider compliance review during the COVID-19 pandemic, from April 1, 2020 to the end of the public health emergency, including any extensions. Annual provider compliance reviews will be suspended to the end of the public health emergency, including any extensions. Should a provider fail to complete the compliance review after the end of the suspended review period, the provider will no longer be qualified to render services.	Enrolled as a provider by the MS Division of Medicaid and the MS Dept. of Mental Health.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	**Entity Responsible for Verification *(Specify):***	**Frequency of Verification *(Specify):***
Supported Living Providers	Division of Medicaid	Annually

Service Delivery Method. *(Check each that applies)*:

☐	**Participant-directed**		**Provider managed**

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (S*elect one):*

●	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

N/A

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
N/A	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

●	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

N/A

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

●	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

●	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	***Service plans a) address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of PSSs in which the services and supports align with assessed needs N: Number of PSSs reviewed in which the services and supports align with assessed needs D: Number of PSSs reviewed
Discovery Activity *(Source of Data &*	Data Source – DMH/DOM review of individual service plan prior to implementation Sample – 100%

sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH/DOM
Frequency	Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***Service plans a) address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	The proportion of participants reporting that Case Managers (CM) help them get what they need N: Number of individuals who report CM helps them get what they need D: Number of returned surveys
Discovery Activity *(Source of Data & sample size)*	Data Source – DOM Survey
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and*	DOM

aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans a) address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of services and supports that were provided in the type, scope, amount, duration and frequency as defined in the PSS. N: Number of PSSs reviewed in which services and supports were provided in the type, scope, amount, duration and frequency as defined in the individual service plan. D: Number of PSSs in review sample
Discovery Activity *(Source of Data & sample size)*	Data Source – Medicaid Management Information System (MMIS) Sample Size – 95% +/- 5% margin of error
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	4. DMH/DOM
Frequency *(of Analysis and Aggregation)*	4. Quarterly

Requirement	***Service plans b) are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of PSSs updated at least once per certification period N: Number of PSSs updated annually D: Number of PSSs requiring annual update
Discovery Activity *(Source of Data & sample size)*	Data Source –IDD Community Support Program PSS Review Checklists Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***Service plans c) document choice of services and providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of 1915 (i) Choice of Service forms completed N: Number of 1915(i) Choice of Service forms completed D: Number of individuals in the program
Discovery Activity *(Source of Data & sample size)*	Data Source –IDD Community Support Program PSS Review Checklists Sample Size – 100%
Monitoring Responsibilities	DMH

(Agency or entity that conducts discovery activities)	
Frequency	Discovery is continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***Eligibility Requirements: a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of new enrollees who N: Number of new enrollees who received LOC prior to the receipt of services D: Number of new enrollees
Discovery Activity *(Source of Data & sample size)*	Data Source – Long Term Services and Supports (LTSS) Sample Size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects,*	DMH/DOM

	analyzes, and aggregates remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***Eligibility Requirements: b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of initial LOC evaluations conducted where the LOC criteria outlined in the 1915(i) was accurately applied N: Number of initial LOC evaluations reviewed where the LOC criteria outlined in the 1915(i) was accurately applied D: Number of initial LOC evaluations conducted
Discovery Activity *(Source of Data & sample size)*	Data Source - IDD Community Support Program PSS Review Checklists Sample Size - 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM

Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***Eligibility Requirements: c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of individuals who are recertified to receive 1915(i) services who meet Medicaid eligibility requirements N: Number of individuals who are recertified to receive 1915(i) services who meet Medicaid eligibility requirements D: Total number of individuals recertified
Discovery Activity *(Source of Data & sample size)*	Data Source: Monitoring Checklist, LTSS Sample Size: 100% Review
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***

Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies that initially meet DMH certification requirements prior to service delivery N: Number of provider agencies meeting initial certification requirements prior to service delivery. D: Number of provider agencies approved for initial DMH certification.
	Discovery Activity *(Source of Data & sample size)*	Data Source - DMH Provider Management System Sample – 100% of initial applicants for DMH certification
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
	Frequency	One time upon initial certification
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***Providers meet required qualifications.***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of 1915 (i) provider agencies that meet DMH requirements for certification N: Number of 1915 (i) provider agencies who meet certification requirements D: Number of 1915 (i) provider agencies monitored
	Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Written Reports of Findings Sample Size – 100%

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	At least twice during the three year certification period.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies that initially meet Medicaid provider requirements prior to service delivery N: Number of provider agencies meeting initial Medicaid provider requirements D: Number of provider agencies seeking initial Medicaid Provider Status
Discovery Activity *(Source of Data & sample size)*	Initial provider applications submitted to DOM fiscal agent Sample size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	One time upon enrollment
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	DOM

remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of provider agencies who meet Medicaid provider requirements N: Number of 1915 (i) provider agencies who meet Medicaid provider requirements D: Number of 1915 (i) provider agencies
Discovery Activity *(Source of Data & sample size)*	DOM Fiscal Agent Sample size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***

Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of certified CSP provider settings assessed for compliance with HCBS Final Rule settings requirements N: Number of CSP settings meeting HCBS Final Rule setting requirements D: Total number of settings reviewed
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Written Report of Findings Sample size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of monthly quality improvement meetings held in accordance with the requirements of the 1915(i) N: Number of monthly quality improvement meetings held in accordance with the requirements in the 1915(i) D: Total number of monthly quality improvement meetings scheduled
Discovery Activity *(Source of Data & sample size)*	Data Source - DOM/DMH monthly quality improvement meeting agendas and meeting minutes Sample size – 100%
Monitoring	DOM/DMH

Responsibilities *(Agency or entity that conducts discovery activities)*	
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DOM/DMH
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number of and percent of claims for each payment made for services included in the beneficiary's PSS N: Number of claims paid that were included in the individuals PSS D: Number of total claims paid.
Discovery Activity *(Source of Data & sample size)*	Data Source - MMIS system. Data are claims paid for 1915(i) services. Sample Size -100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and*	DOM

aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of CSP individuals whose records document information of Rights and Options, which include the right to be free from abuse N: Number of individuals whose records indicate acknowledgement of Rights and Options D: Number of individuals in the program
Discovery Activity *(Source of Data & sample size)*	Data Source – IDD Community Support Program PSS Review Checklists Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of CSP individuals whose records document information of procedures for reporting grievances (inclusive of serious incidents) N: Number of individuals whose records indicate acknowledgement of grievance procedures (inclusive of serious incidents) D: Number of individuals in the program
Discovery Activity *(Source of Data & sample size)*	Data Source – IDD Community Support Program PSS Review Checklists Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of serious incidents reported to DMH within timelines N: Number of serious incidents received within timelines D: Number of serious incidents reported
Discovery Activity *(Source of Data &*	Data Source – DMH Serious Incident Management System Sample – 100%

sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of serious incidents received and inquiry was required N: Number of serious incidents that received an inquiry as required D: Number of serious incidents subject to inquiry
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Serious Incident Management System Sample Size– 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and*	DMH/DOM

aggregates remediation activities; required timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of serious incident that included follow up action that was completed as a result of inquiry N: Number of serious incidents that include completed follow up action D: Number of serious incident requiring follow up action
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Serious Incident Management System Sample Size – 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	

Discovery Evidence *(Performance Measure)*	Number and percent of individuals who feel safe in their home, neighborhood, workplace and day program/other daily activities N: Number of individuals who report feeling safe in their home, neighborhood, workplace, and day program/other activities D: Number of completed surveys
Discovery Activity *(Source of Data & sample size)*	Data Source – DOM Survey Sample Size –100% of surveys completed
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DOM
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of serious incidents with investigation initiated within the required timeframe N: Number of serious incident investigations initiated within the required timeframe D: Number of serious incidents reported which required investigation.
Discovery Activity *(Source of Data & sample size)*	Data Source – DMH Serious Incident Management System Sample Size – 100%

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMH
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMH/DOM
Frequency *(of Analysis and Aggregation)*	Annually

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

Data is gathered via on-site visits and administrative reviews conducted by DMH. DMH analyzes data against stated performance measures and prioritizes the needs for system improvement based on data gathered. Through Plans of Compliance, remediation is required of all providers when requirements are not met. All Plans of Compliance are reviewed by the DMH Division of Certification and the Bureau of Intellectual/Developmental Disabilities for completeness and appropriateness. Recommendations for approval/disapproval are made to DMH Review Committee which is comprised of DMH's Executive Leadership Team.

DOM's eligibility and claims data is gathered through Medicaid Management Information System (MMIS), also referred to as Envision. MMIS is the mechanized claims processing and information system for DOM. Payments are monitored through monthly reports by DOM's Office of Mental Health. System improvements to the MMIS are made through a Change Service Request (CSR).

DOM operates two (2) audit units to assure provider integrity and proper payment for Medicaid services rendered. The Office of Program Integrity investigates any suspicion of fraud, waste and abuse reported or identified through the SURS program. The Office of Financial and Performance Review conducts routine monitoring of cost reports and contracts with other agencies. In addition, these CSP services like all Medicaid services are subject to investigation by Program Integrity. Generally, providers who fall outside the expected parameters for payments are subject to review. It is also possible to set up filters specifically for the CSP program to identify areas of misuse.

Trends and patterns are analyzed and aggregated on both the provider and system level to identify areas of needed improvement and possible changes in DOM's Administrative Code, DMH Operational Standards, data collection and reporting methods, or records management practices.

2. Roles and Responsibilities

DMH's Division of Certification is responsible for the agency's quality assurance activities such as the development of provider certification standards and monitoring adherence to those standards. The Division of Certification will primarily be responsible for ensuring quality assurance reviews are conducted, data collection and analysis. Trends and patterns will be identified by the Division of Certification and the DMH BIDD.

DOM and DMH hold monthly quality improvement management meetings to assess required system changes, focus on trends and patterns identified, and develop strategies and/or interventions for improved outcomes.

3. Frequency

Data is aggregated and analyzed at least annually.

4. Method for Evaluating Effectiveness of System Changes

To determine if number of instances of remediation in identified areas decreases based on changes made to implement systems improvement. Remediation activities are monitored by DMH's Division of Certification.

DMH and DOM will utilize a number of sources to analyze effectiveness of system changes, including but not limited to on-site visits and administrative reviews, performance indicators, claims data, critical incident data, and Medicaid Fair Hearing data.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE MISSISSIPPI

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. [x] Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes [x] No [ ]

2. [x] Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes [x] No [ ]

3. [X] All individuals eligible under the State's approved title XIX plan.

4. [x] Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

   Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. All individuals eligible under the State's approved Title XIX plan who have Part A & B.

3.

SEP 27 '89 REC'D

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 4.11-A

State Mississippi

STANDARDS FOR INSTITUTIONS

Those standards as specified in State licensing law plus those specified in Federal law or regulations are kept on file and are available to the Department of Health and Human Services on request.

Approved 9-24-82
Effective 9-22-82

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 4.16-A

State Mississippi

COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AND VOCATIONAL REHABILITATION AGENCIES

The State Agency has cooperative agreements with State Health and State Vocational Rehabilitation Agencies which assure maximum utilization of such services in the provision of medical assistance under the Plan.

These agreements, when applicable, meet the requirements of paragraph (3) of 45 CFR 251.10.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State Division of Medicaid uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   Mississippi does not have a lien law; therefore a determination of when an individual can reasonably be expected to be discharged is not applicable to this state.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

   The statement of primary care giver, collateral contacts, and/or documentation of recipient's medical history may be used to establish that a specified person rendered care enabling the recipient to stay at home rather than in an institution.

3. The State Division of Medicaid defines the terms below as follows:

   - estate - any real or personal property owned by the individual in its entirety or by shared ownership.
   - individual's home - the recipient's residence prior to institutionalization in which he has an ownership interest.
   - equity interest in the home - the money value of property or of an interest in that property in excess of any claims or liens against it.
   - residing in the home for at least one or two years on a continuous basis - having possessions in that home, receiving mail at that address, sharing or paying all of the expenses, having no extended periods of absence, having no other place of residence.
   - lawfully residing - being able to use dwelling as principal place of residence.

4. The State Division of Medicaid defines undue hardship as follows:

   a. the property is the sole income-producing asset of the survivors and such income is limited;

   b. an adult relative who is a recognized heir has lived in the home of the decedent, depended upon that home for his principal place of residence for at least one (1) year prior to the recipient entering the nursing facility, has remained in the house continually, either has or has not an equity interest in the property, and has given care so that the person was kept from entering the nursing facility during the year;

   c. the asset in the estate totals $5,000 or less and there is no prepaid burial contract or other money set aside for burial;

   d. the estate is of modest value as defined by the Secretary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

5. The following standards and procedures are used by the State Division of Medicaid for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

The State Division of Medicaid receives notification of death from the Medicaid Regional Offices and the MMIS. Research is completed through use of the eligibility case file documentation and pertinent legal documents, tax receipts, etc. If there is evidence of undue hardship as defined in state/federal guidelines, no pursuit is affected. While the state will attempt to recover all amounts that are not waived for undue hardship, recovery is not deemed cost effective if the amount to be recovered is less than $2,000 or the value of the estate is less than 25 percent of the recovery amount if attempted recovery will require protracted litigation. The findings and conclusions are documented in physical and computer files.

6. The State Division of Medicaid defines cost-effective as follows:

While the State Division of Medicaid will attempt to recover all amounts that are not waived for undue hardship, recovery is not deemed cost effective if the amount to be recovered is less than $2,000 and protracted litigation is required to recover, or the value of the estate is less than 25 percent of the recovery amount making Medicaid's potential recovery less than 25 percent of the recovery amount and protracted litigation will be required to recover. These thresholds are based on the legal time and expense involved in pursuing recoveries through the courts.

7. The State Division of Medicaid uses the following collection procedures:

If an estate exists, within 30 days of death date, a letter is mailed to survivor indicating the basic law, value of estate, Medicaid's recovery amount, dates of service, and explanation of fair hearing. The letter can be used by the survivor as a formal request to the Division of Medicaid for a fair hearing or to write an undue hardship explanation. If no response is received from the survivor within 15 days of the date of the notice, the case is referred to the Legal Unit which files in the proper court as a creditor of the estate or notifies the survivor in writing of Medicaid's recovery amount. If a request for a fair hearing is timely received, the hearing date is set within 10 days of receipt of request. The survivor is notified of hearing date at least 10 days prior to the date. The time for hearing may be extended if survivor has good cause; i.e., illness, failure to receive notice timely, being out of the state, or any other reasonable explanation. If good cause for filing a timely request is shown, a hearing request will be accepted. After the hearing occurs, the hearing officer forwards a transcript with recommended action to the Executive Director for a final decision. The Executive Director renders a decision which is sent to the survivor in writing. The survivor is entitled to seek judicial review in the court of proper jurisdiction. The Division of Medicaid must take final administrative action on a hearing within 90 days from the date of the hearing request. Hearing procedures have been promulgated and are available to the survivor upon request for a hearing.

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

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905 (a) (1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Ambulance			X	$3.00 per trip
Ambulatory Surgical Center			X	$3.00 per visit
Dental Visits			X	$3.00 per visit
Durable Medical Equipment, orthotics, and prosthetics (excludes medical supplies)			X	Up to $3.00 per item (varies per State payment for each item)
Eyeglasses			X	$3.00 per pair
Home Health visits			X	$3.00 per visit
Hospital Inpatient Days			X	$10.00 per day up to one-half the hospital=s first day per diem per admission.
Hospital Outpatient visits			X	$3.00 per hospital outpatient visit
Physician Visits: office, home, emergency room, ophthalmological			X	$3.00 per visit
Prescription drugs			X	$3.00 per prescription, including refills
Rural Health Clinic visits, FQHC visits, and MSDH clinic visits			X	$3.00 per visit

When the average or typical State payments for the above services are taken into consideration, all copayments are computed at a level to maximize the effectiveness without causing undue hardship on the recipients, assuring that they do not exceed the maximum permitted under 42 CFR 447.54

The basis for determining the charge of each co-payment for all services except in-patient hospital was the standard co-payment amount described in 42 CFR Section 447.55. The maximum co-payment amount in 42 CFR Section 447.54 was applied to the agency's average or typical payment for the particular service. For in-patient hospital services, the amount was calculated so as not to exceed one-half the first day's per diem for each hospital per admission.

Providers are required by the agency's provider agreements and policy manuals to assume the responsibility for collecting the co-payment amounts from those beneficiaries who are required to pay co-payments. Providers are required to make the determination as to whether or not a Medicaid beneficiary is able to pay required co-payment amounts Providers are prohibited by the agency's provider agreements and policy manuals from denying services to Medicaid beneficiaries because of inability to pay the co-payment, in compliance with 42 CFR Section 447.15.

Providers are prohibited by the agency's provider agreements and policy manuals from charging co-payment amounts for those services and beneficiaries found in 42 CFR Section 447.53(b). Beneficiaries are educated regarding co-payment amounts and regarding those services and beneficiaries that are exempt from co-payments. The agency's claims payment system contains an edit that prohibits the reduction of the co-payment amount from an excluded service or beneficiary category.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

B. The method used to collect cost sharing charges for categorically needy individuals:

/X/ Providers are responsible for collecting the cost sharing charges from individuals.

/ / The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Policy concerning copayments is specified in each Provider manual, providing details on exactly what copayments are to be made by recipients, the amounts, etc. Also, the exceptions to copayments for children under 18 years of age, pregnant women, nursing home patients, family planning services, etc., are specified in the Manuals. The provider advises the recipient of his responsibility and the amount of the copayment at the time service is provided and collects the payment from the recipient unless the recipient states that he is unable to pay and the provider has no knowledge or indications to the contrary.

No provider participating under this State Plan may deny care or services to an individual eligible for such care or services under the Plan due to the individual's inability to pay a copayment charge.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Mississippi

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers have been advised through bulletins and Provider Manuals of the services subject to copayments and the exclusions, such as to children under 18, to pregnant women, to patients in nursing homes, emergency services, family planning services, etc., and of the method for filing such claims. Refer to Item C. above for details.

Enforcement procedures for cost sharing exclusions consist of edits in the claims processing system which identify services subject to cost sharing and processing as though the cost share had been collected and notifying the provider to collect. Also, the edits identify any cost share collected in error, process the claim correctly and notify the provider to refund the cost share to the recipient.

E. Cumulative maximums on charges:

/X/ State policy does not provide for cumulative maximums.

/ / Cumulative maximums have been established as described below:

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR

DIVISION OF MEDICAID

STATE PLAN

GUIDELINES FOR THE REIMBURSEMENT

FOR MEDICAL ASSISTANCE RECIPIENTS

OF

HOSPITALS

State of Mississippi
Title XIX Inpatient Hospital Reimbursement Plan

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Introduction

This plan is for use by providers, their accountants, the Division of Medicaid, and its fiscal agent in determining the allowable and reasonable costs of and reimbursement for hospital inpatient services furnished to Medicaid recipients. The plan contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Division of Medicaid. The inpatient payment to hospital providers except for Choctaw Indian Health Services will be under an All Patient Refined Diagnosis Related Group (APR-DRG) reimbursement system. Choctaw Indian Health Services will be reimbursed on a per diem basis in accordance with Miss. Code Ann. § 43-13-121; Sec. 1911 [42 U.S.C. 1396j] (a)(b)(c)(d); Section 1905(b).

The program herein adopted is in accordance with Federal Statute, Sec. 1396 [42 U.S.C. 1396a]. The applicable Federal Regulations are 42 CFR 430; 42 CFR 440.10; 42 CFR 440.160; 42 CFR 440.230; 42 CFR 441.12; 42 CFR 441, Subpart D; 42 CFR 447, Subparts A, B, C and E; 42 CFR 455, Subparts A, B, C and D; 42 CFR 456, Subpart B; 42 CFR 482; and 42 CFR 489 Subparts A, B, C, D and E. Each hospital that has contractually agreed to participate in the Title XIX Medical Assistance Program will adopt the procedures set forth in this plan; each must file the required cost report and will be paid for the services rendered on an APR-DRG basis. The objective of this plan is to reimburse providers at a rate that is reasonable and adequate for efficiently and economically operated hospitals that comply with all requirements of participation in the Medicaid program.

State of Mississippi
Title XIX Inpatient Hospital Reimbursement Plan

As changes to this plan are made and approved by the Centers for Medicare and Medicaid Services (CMS), the plan document will be updated on the Medicaid website at http://www.medicaid.ms.gov.

Questions related to this reimbursement plan or to the interpretation of any of the provisions included herein should be addressed to:

Office of the Governor
Division of Medicaid
Suite 1000, Walter Sillers Building
550 High Street
Jackson, Mississippi 39201

CHAPTER 1
PRINCIPLES AND PROCEDURES

1-1 Plan Implementation

A. Payments under this plan will be effective for services with admission dates October 1, 2012 and thereafter. The reimbursement period will run from October 1 through September 30 of each year.

B. The Division of Medicaid will provide an opportunity for interested members of the public to review and comment on changes to the reimbursement methodology before it is implemented. This will be accomplished by publishing a public notice on the Agency's website prior to implementing the reimbursement methodology. A period of thirty (30) days will be allowed for comment. The Division of Medicaid will notify the administrator of each hospital of their inpatient Medicaid DRG base rate and inpatient cost-to-charge ratio used to pay cost outlier payments.

C. The Division of Medicaid shall maintain any comments received on the plan, subsequent changes to the plan, or APR-DRG parameters for a period of five (5) years from the date of receipt.

1-2 Plan Evaluation

Documentation will be maintained to effectively monitor and evaluate experience during administration of the plan.

1-3 Durational Limit Prohibition

In compliance with Section 6404 of the Omnibus Budget Reconciliation Act of 1990, no durational limit will be imposed for medically necessary inpatient services 1) provided in disproportionate share hospitals to children under the age of 19 years, or 2) provided in any hospital to an individual under the age of 1 year.

1-4 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 hospitals 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.

1-5 Payments to Providers

A. Assurance of Payments

The State will pay each hospital which furnishes the services in accordance with the requirements of the State Plan the amount determined for services furnished by the hospital according to the standards and methods set forth in the Mississippi Title XIX Inpatient Hospital Reimbursement Plan.

In all circumstances where third party payment is involved, Medicaid will be the payer of last resort.

B. Acceptance of Payments

Participation in the program shall be limited to hospitals who accept, as payment in full for services rendered to Medicaid recipients, the amount paid in accordance with this State Plan.

C. Overpayments – An overpayment is an amount which is paid by the Division of Medicaid to a provider in excess of the amount that is computed with the provisions of this plan. All overpayments must be reported and returned by the later of either (1) the date which is 60 days after the date on which the overpayment was identified, or (2) the date any corresponding cost report is due, if applicable. Any overpayment retained by a provider after the deadline for reporting and returning the overpayment is an obligation as defined in Section 3729 (b)(3) of Title 31, United States Code. Failure to repay an overpayment to the Division of Medicaid may result in sanctions.

D. Underpayments – An underpayment occurs when an amount which is paid by the Division of Medicaid to a provider is less than the amount that is computed in accordance with the provisions of this plan. Underpayments, likewise determined, will be reimbursable to the provider.

E. Credit Balances – A credit balance, or negative balance, on a provider's account is an amount which is due to the Division of Medicaid. The credit balance is treated as an overpayment by the Division of Medicaid and is subject to the rules described above for overpayments.

1-6 Hospital Classes

A. Bed Class of Facilities

The following statewide bed class of facilities shall be used as a basis for evaluating adequate access to care and reasonableness of payments in Mississippi and other reasons as outlined in the Plan. General hospitals will be classified based on the number of beds available per the annual cost report. This number is determined as follows: Total hospital beds less nursery beds, NICU beds and beds for provider components paid at a different rate or not participating in the Medicaid program. Free-standing psychiatric hospitals are a separate class of hospitals with all bed sizes combined. Services provided in long-term acute care hospitals, (freestanding Medicare-certified hospitals with an average length of inpatient stay greater than twenty-five (25) days and primarily engaged in providing chronic or long-term medical care), are only reimbursable for Medicaid beneficiaries under the age of twenty-one (21). A separate bed class is set up for these hospitals providing services as to Medicaid beneficiaries under twenty-one (21) years of age.

CLASS OF FACILITIES

1. General Hospitals with 0 - 50 Beds
2. General Hospitals with 51 - 100 Beds
3. General Hospitals with 101 - 150 Beds
4. General Hospitals with 151 - 200 Beds
5. General Hospitals with 201 or more Beds
6. Free-Standing Psychiatric Hospitals
7. Long-term Acute Care Hospital Pediatric Services

B. Calculation of Average Cost-to-Charge Ratio of Bed Classes

The setting of the average inpatient cost-to-charge ratio for each bed class of facilities is determined by using the inpatient cost-to-charge ratio computed for each hospital using the Medicare cost report FORM CMS-2552-96, or its successor, and the desk review procedures outlined in Section 2-1.H.

CHAPTER 2
COST REPORTING AND COST FINDING

2-1 Cost Reporting

A. Reporting Period

Each Mississippi hospital participating in the Mississippi Medicaid Hospital program will submit a Uniform Cost Report using the appropriate Medicare FORM CMS- 2552-96, or its successor. All references to the cost report in this document refer to CMS-2552-96, or its successor. A hospital which voluntarily or involuntarily ceases to participate in the Mississippi Medicaid Program or experiences a change of ownership must file a cost report. Short period cost reports may also be required for changes in status such as a change from a general acute care hospital to a critical access hospital. In cases where there is a change in fiscal year end, the most recent filed cost report will be used to perform the desk review. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII.

B. When to File

Each facility must submit a completed cost report postmarked no later than five (5) calendar months after the close of its cost reporting year. Should the due date fall on a weekend, a State of Mississippi holiday or a federal holiday, the due date shall be the first business day following such weekend or holiday.

C. Failure to File a Cost Report

A hospital which does not file a cost report within six (6) calendar months after the close of its reporting period may be subject to cancellation of its Provider Agreement at the discretion of the Division of Medicaid, Office of the Governor.

D. Extensions for Filing

No routine extensions will be granted. Extensions of time to file may be granted due to unusual situations or to match a Medicare filing. Extraordinary circumstances will be considered on a case-by-case basis. Extensions may only be granted by the Executive Director of the Division of Medicaid. All other filing requirements shall be the same as those for Title XVIII. If the granted cost report due date extension causes a delay in the calculation of the Medicaid inpatient cost-to-charge ratio (CCR), the current inpatient CCR on file prior to October 1 of each year will be used to pay cost outlier payments. The Division of Medicaid will perform a desk review on the late filed cost report(s) upon receipt. After the desk review is completed and the thirty (30) day appeal option has been exhausted, the new inpatient CCR is entered into the Mississippi Medicaid Management Information System and is in effect through the end of the current reimbursement period. No retroactive adjustments will be made.

E. Delinquent Cost Reports

Cost reports that are submitted after the due date will be assessed a penalty in the

amount of $50.00 per day the cost report is delinquent. This penalty may only be waived by the Executive Director of the Division of/Medicaid for good cause. Good cause is defined as a substantial reason that affords a legal excuse for a delay or an intervening action beyond the provider's control, e.g. flood, fire, natural disaster or other equivalent occurrence. Good cause does not include ignorance of the law, hardship, inconvenience or a cost report preparer engaged in other work.

F. What to Submit

1. The cost report and related information listed below must be uploaded electronically to the cost report data base as designated by the Division of Medicaid.
2. A signed signature page with either a scanned wet signature or digitally signed;
3. Working trial balance;
4. Depreciation expense schedule;
5. Supporting workpapers for:
    a. Worksheet S-3
    b. Worksheet A-6;
    c. Worksheet A-8;
    d. Worksheet A-8-1;
6. Worksheet C, Part I total charges workpaper;

7. Medicare Title XVIII information for the Worksheet D series:
    a. Worksheet D, Parts V & VI. Define what types of services are included on line 76 OP Psych Therapy, IOP, PHP, etc. and what revenue codes are included. Distinguish what part of these costs and charges are related to geriatric patients. The MS Division of Medicaid does not reimburse for partial hospitalization programs or day treatment programs and geriatric psychiatric services;
    b. Worksheet D-1, Parts I, II & III;
    c. Worksheet D-3;
8. Medicaid Title XIX information for the Worksheet D series:
    a. Worksheet D, Parts V & VI. Define what types of services are included on line 76 OP Psych Therapy, IOP, PHP, etc. and what revenue codes are included. Distinguish what part of these costs and charges are related to geriatric patients. The MS Division of Medicaid does not reimburse for partial hospitalization programs or day treatment programs and geriatric psychiatric services;
    b. Worksheet D-1, Parts I, II & III;
    c. Worksheet D-3;
9. Medicaid Worksheet E-3, Part VII, specifically lines 8 and 9.
10. General Information Survey.
11. For cost reporting periods ending on and after December 31, 2015, providers must combine Medicaid fee-for-service and Coordinated Care Organization (CCO) hospital inpatient and outpatient claims data (days, charges, etc.) from the respective Provider Statistical and Reimbursement Reports (PS&Rs) and report the amounts as one number throughout the cost report where Medicaid data is reported including, but not limited to, the Worksheets listed in numbers 5.a., 8, and 9 above. Providers must submit to DOM the CCO PS&Rs used for each cost reporting period as part of the original cost report submission.

G. Where to File

The cost report and related information must be uploaded electronically to the cost report data base as designated by the Division of Medicaid.

H. Desk Reviews

The Division of Medicaid will conduct cost report reviews, as deemed necessary, prior to the reimbursement period. The objective of the desk reviews is to evaluate the necessity and reasonableness of facility costs in order to determine the allowable costs used in the calculation of the inpatient cost-to-charge ratio used to pay cost outlier payments. Desk reviews will be performed using desk review programs developed by the Division of Medicaid. Providers will be notified via the database web portal of all adjustments made to allowable costs. Facilities have the right of appeal as described in Section 3-1 of this plan.

The desk review procedures will consist of the following:

1. The latest cost report available to Medicaid in each calendar year for each hospital will be reviewed for completeness, accuracy, consistency and compliance with the Mississippi Medicaid State Plan, Medicare Principles of Reimbursement as described in the Medicare Provider Reimbursement Manual, 15-1, and

the Mississippi Administrative Code, Title 23 Medicaid, Part 200 General Provider Information, Chapter 2 Benefits, Rule 2.2 Non-Covered Services and Part 202 Hospital Services, Chapter 1 Inpatient Services, Rule 1.5 Non-Covered Services, regarding non-covered services.

2. The provider must submit a complete cost report. When it is determined that a cost report has been submitted that is not complete enough to perform a desk review, the provider will be notified. Providers will be allowed a specified amount of time to submit the requested information. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information will be made. The provider will be given five (5) working days from the date of the provider's receipt of the second request for information. Information that is requested that is not submitted following either the first or the second request may not be submitted for reimbursement purposes. Providers will not be allowed to: submit the information at a later date; submit the information at the time of audit; or amend the cost report in order to submit the additional information. An appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including cost findings, is omitted.

For cost reports submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If there is no response to the request, an additional five (5) working days will be allowed for submission of the requested information. Providers will not be allowed to: submit the information at a later date; submit the information at the time of audit; or amend the cost report in order to submit the additional information. An appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including cost findings, is omitted;

3. Once all the information required for the desk review is received, the cost report will be reviewed and adjusted:
   a. to reflect the results of desk review and/or field audits;
   b. to adjust for excessive costs;
   c. to determine if the hospital's general routine operating costs are in accordance with 42 CFR 413.53. For hospitals having excessive general routine operating costs, appropriate adjustments shall be made.
   d. to remove the costs of non-covered services.
4. Total cost allocated to the Medicaid Program on the appropriate cost reporting forms for the purposes of the inpatient cost-to-charge ratio used to pay outlier payments shall include capital costs and operating costs. Capital costs are defined

by this plan to include those costs reported for Medicare reimbursement purposes such as depreciation, non-employee related insurance, interest, rent, and property taxes (real and personal). Operating costs are defined as total Medicaid costs less capital costs apportioned to the Medicaid Program. Medical education costs will not be included in the calculation of the inpatient cost-to-charge ratio used to pay outlier payments because these costs will be paid outside the APR-DRG payments as noted in section 4-1.O. of this plan. Those Mississippi hospitals that file a cost report with no Medicaid activity or that fail to provide all information listed in 2-1F. will be assigned the average inpatient cost-to-charge ratio for the bed class in which the hospital falls.

5. All desk review findings will be sent to the provider.
6. Desk reviews amended after the inpatient cost-to-charge ratio (CCR) is determined due to an amended cost report will be used only to adjust the CCR from the date the amended CCR is calculated and input into the MMIS, through the end of the current reimbursement period. No retroactive adjustments to cost outlier payments will be made as a result of the change to the inpatient CCR.

2-2 Amended Cost Reports

The Division of Medicaid accepts amended cost reports if the cost report is submitted prior to the end of the reimbursement period in which the cost report is used for payment purposes. Amended cost reports must include all information in Section F. above; an explanation for the amendment; and workpapers for all forms that are being amended. Each form and schedule submitted should be clearly marked "Amended" at the top of the

page. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the amended cost report, no retroactive adjustments will be made to cost outlier payments using the amended cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System and will be in effect from the date of entry through the end of the current reimbursement period.

Cost reports may not be amended after an audit has been initiated.

2-3 Cost Finding

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. The cost report must be prepared in accordance with the methods of reimbursement and cost finding in accordance with Title XVIII (Medicare) Principles of Reimbursement, as described in the Medicare Provider Reimbursement Manual, 15-1, or as modified by this plan.

2-4 Allowable Costs

Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.5 - 413.178 (excluding the inpatient routine salary cost differential) and the Mississippi Administrative Code, Title 23 Medicaid, Part 200 General Provider Information, Chapter 2 Benefits, Rule 2.2 Non-Covered Services

and Part 202 Hospital Services, Chapter 1 Inpatient Services, Rule 1.5 Non-Covered Services, regarding non-covered services, or as modified by Title XIX of the Act and this Plan.

A. Title XIX reimbursement will not recognize the above average cost of inpatient routine nursing care furnished to aged, pediatric, and maternity patients. The inpatient routine nursing salary cost differential reimbursed by the Title XVIII program will reduce the reasonable cost for determining Title XIX reimbursement as required in the applicable CMS cost reporting forms;

B. Section 42 CFR 413.35 Limitations on Coverage of Costs: Charges to Beneficiaries if Cost Limits are Applied to Services - This section will not be applicable to inpatient hospital services rendered to Title XIX beneficiaries to prevent a form of supplementation reimbursement. However, Section 42 CFR 413.30 Limitations on Reimbursable Costs will be applied for determining Title XIX reimbursement;

C. All items of expense may be included which hospitals must incur in meeting:

1. The definition of a hospital contained in 42 CFR 440.10 and 42 CFR 440.140 in order to meet the requirements of Sections 1902(a), (13) and (20) of the Social Security Act;
2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610; and
3. Any other requirements for the licensing under state law which are necessary for providing hospital inpatient services.

D. Implicit in any definition of allowable costs is that those costs should not exceed what a prudent and cost conscious buyer pays for a given service or item. If costs are determined to exceed the level that a prudent buyer would incur, then excess costs would not be reimbursable under the plan. Such cost is allowable to the extent that it is related to patient care, is necessary and proper, and is not in excess of what would be incurred by a prudent buyer.

E. The costs of implantable programmable baclofen drug pumps used to treat spasticity implanted on an inpatient basis are allowable costs for Medicaid cost report purposes. The cost of the pumps should not be removed from allowable costs on the cost report.

F. The hospital assessment referred to in Section 43-13-145(4), *Mississippi Code of 1972*, will be considered allowable costs on the cost report filed by each hospital, in accordance with the Medicare Provider Reimbursement Manual, 15-1, Section 2122.

G. Legal costs and fees resulting from suits against federal and state agencies administering the Medicaid program are not allowable costs.

H. Notwithstanding any other subparagraph, depreciation and interest expense shall not exceed the limitations set forth in Section 2-9.

I. Inpatient hospital services provided under the Early Periodic Screening Diagnostic and Testing (EPSDT) program will be reimbursed at the APR-DRG amount.

J. The State has in place a public process which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act.

2-5 Cost Report Audits

A. Background - The Division of Medicaid may periodically audit the financial and statistical records of participating providers. The hospital common audit program was established to reduce the cost of auditing costs reports submitted under Medicare (Title XVIII) and Medicaid (Title XIX) and to avoid duplicating audit effort. The purpose is to have one audit of a participating hospital which will serve the needs of all participating programs reimbursing the hospital for services rendered.

B. Common Audit Program - The Division of Medicaid has entered into agreements with Medicare intermediaries for participation in a common audit program of Titles XVIII and XIX. Under this agreement, the intermediaries for participation in a common audit program shall provide the Division of Medicaid the results of the field audits of those hospitals located in Mississippi, upon the Division of Medicaid request to the Medicare intermediary. The Division of Medicaid may also request a copy of the final cost report from the provider.

C. Other Hospital Audits - For those hospitals not covered by the common audit agreements with Medicare intermediaries, the Division of Medicaid shall be responsible for performance of the desk reviews, field reviews and field audits in accordance with Title XVIII standards. On-site audits will be made when desk reviews indicate such are needed.

D. Retention - All cost reports received from Medicare intermediaries or issued by

Medicaid will be kept for a period of at least five (5) years following the date all audit findings are resolved.

2-6 Availability of Hospital Records

All hospitals are required to maintain financial and statistical records. All records must be available upon demand to the Division of Medicaid staff, other State and Federal agencies and its contractors, thereof.

2-7 Records of Related Organizations

Records of related organizations as defined by 42 CFR 413.17 must be available upon demand to the Division of Medicaid staff, other State and Federal agencies and its contractors, thereof.

2-8 Record Keeping Requirements

The Division of Medicaid shall retain all uniform cost reports submitted for a period of at least five (5) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 431.17 and in accordance with Mississippi State Law. Access to submitted cost reports will be in conformity with Mississippi statutes and the Division of Medicaid policy.

2-9 Change of Ownership

A. Change in Ownership of Depreciable Assets - For purposes of this plan, a change in ownership of assets includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship. In a case in which a change in ownership of a provider's depreciable assets occurs, and if a bona fide sale is established, the Title XIX basis for depreciation will be the lower of:

1. The portion of the purchase price properly allocable to a depreciable asset; or
2. The fair market value of the depreciable asset determined by an independent appraiser who is a member of the Society of Real Estate Appraisers; or
3. The allowable cost basis under Title XVIII (Medicare) cost principles to the owner of record on July 18, 1984.

If the basis of a provider's depreciable assets is limited to 3 above, then the estimated useful life of the assets as used by the seller must be used by the buyer.

B. Interest Expense – Where interest expense is incurred to finance the purchase of a hospital of a depreciable asset used therein and the purchase price exceeds the allowable cost basis, interest expense on that portion of the debt or other interest

bearing instrument used to finance the excess of the purchase price over the allowable cost basis is not considered reasonably related to patient care and is not allowable.

C. Loss on Sale of a Hospital – The sale of depreciable assets, or a substantial portion thereof, at a price less than the Title XIX cost basis of the property as reduced by accumulated depreciation calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement indicates a loss on the sale of the assets. Such losses are not reimbursable under this plan.

A Mississippi facility which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the sale. The seller must file a final cost report with the Division of Medicaid from the date of the last cost report to the effective date of the sale. The filing of a final cost report may be waived by the Division of Medicaid, if the cost report will not be needed for reimbursement purposes. The new owner must file a cost report from the date of the change of ownership through the end of the Medicare cost report year end. The new owner must submit provider enrollment information required under Division of Medicaid policy.

The inpatient cost-to-charge ratio of the old owner is used to pay cost outlier payments for the new owner. The new owner's inpatient cost-to-charge ratio used to pay cost outlier payments is calculated for the first rate year beginning October 1, for which the

new owner's cost report is available. There are no retroactive adjustments to a new owner's inpatient cost-to-charge ratio used to pay cost outlier payments.

2-10 New Providers – Mississippi hospitals beginning operations during a reporting year will file an initial cost report from the date of certification to the end of the cost report year end. Each rate year the inpatient cost-to-charge ratio used to pay outlier payments for each Mississippi hospital is grouped by bed class (as described in Section 1-6) and an average inpatient cost-to-charge ratio is determined for each class. The initial inpatient cost-to-charge ratio used to pay cost outlier payments to a new hospital will be the average inpatient cost-to-charge ratio used for the bed class of a Mississippi hospital as of the effective date of the Medicaid provider agreement until the inpatient cost-to-charge ratio is recalculated based on the new hospital's initial cost report. There will be no retroactive adjustments to a new hospital's inpatient cost-to-charge ratio used to pay cost outlier payments. After the desk review is completed for the new provider's cost report and the thirty (30) day appeal option has been exhausted, the new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System and will be in effect through the end of the current reimbursement period.

2-11 Out-of-State Hospitals

A. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each

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 average billed charges for transplant services as published in the *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion* in effect as of July 1, 2019. The transplant case rates are published on the agency's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.
2. The *Milliman* categories comprising the sum of average 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.

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.
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.

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 *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion* in effect as of July 1, 2019, 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

CHAPTER 3
APPEALS AND SANCTIONS

3-1 Appeals and Sanctions

A. Appeal Procedures – Desk Reviews and Field Audits

Mississippi inpatient hospital providers who disagree with an adjustment to their allowable cost or a calculation in the inpatient cost-to-charge ratio used to pay outlier payments may file an appeal to the Division of Medicaid. The following reasons would be grounds to file an appeal with the Division of Medicaid:

1. The addition of new and necessary services not requiring Certificate of Need (CON) approval. Notification must be made in writing to the Division of Medicaid within thirty (30) days of implementing the services. The submitted cost figures must be allocated between capital costs, education costs, and operating costs.
2. The cost of capital improvements receiving CON approval after inpatient cost-to-charge ratios were set if those costs were not considered in the calculation. Notification must be made in writing to the Division of Medicaid within thirty (30) days of implementing the services. The submitted cost figures must be allocated between capital costs, education costs, and operating costs.
3. Cost of improvements incurred because of certification or licensing requirements established after inpatient cost-to-charge ratios used to pay cost outlier payments were set if those costs were not considered in the calculation. The appeal must be

submitted within thirty (30) days of the change in certification or licensing and must be sent to the Division of Medicaid in writing.

4. Incorrect data were used or an error was made in the inpatient cost-to-charge ratio calculation.
5. Extraordinary circumstances which may include but are not limited to riot, strike, civil insurrection, earthquakes or flood.

The appeal must be in writing, must include the reason for the appeal, and must be made within thirty (30) calendar days after the Division of Medicaid notified the provider of the adjustment. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the appeal. The request for an appeal adjustment must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The burden of proof shall be on the hospital to demonstrate that costs for which the additional reimbursement is being requested are necessary, proper and consistent with efficient and economical delivery of covered patient services.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, by hand delivery, or e-mail, and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, (b) if by hand delivery, on the date delivered, or (c) if by

e-mail, on the date an e-mail delivery receipt is received. The hospital will be notified of Medicaid's decision in writing within thirty (30) days of receipt of the hospital's written request, or within thirty (30) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the thirty (30) day period shall be grounds for denial of the request. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the appeal, no retroactive adjustments will be made to cost outlier payments using the amended cost-to-charge ratio. The new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System immediately after the appeal decision is rendered and will be in effect through the end of the current reimbursement period.

B. Application of Sanctions

1. Sanctions may be imposed by the Division of Medicaid against a provider for any one of the following reasons:

   a. Failure to disclose or make available to the Division of Medicaid, or its authorized agent, any records of services provided to Medicaid recipients and records of payment made therefore.

   b. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by the Mississippi Division of Medicaid, the Mississippi State Department of Health, or

the Information Quality Healthcare.

c. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid Claim form.

d. Documented practice of charging recipients for services over and above that paid by the Division of Medicaid.

e. Failure to correct deficiencies in provider operations after receiving written notice of the deficiencies from the Director of the Mississippi State Department of Health, Peer Review Organization, or the Division of Medicaid.

f. Failure to meet standards required by State or Federal law for participation.

g. Submission of a false or fraudulent application for provider status.

h. Failure to keep and maintain auditable records as prescribed by the Division of Medicaid.

i. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

j. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid Program.

k. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.

l. Presenting, or causing to be presented, for payment any false or fraudulent

claims for services or merchandise.

m. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation to which the provider is legally entitled (including charges in excess of the fee schedule as prescribed by the Division of Medicaid or usual and customary charges as allowed under the Division of Medicaid regulations).

n. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Conviction of a criminal offense relating to performance of a provider agreement with the state, or for the negligent practice resulting in death or injury to patients.

2. The following sanctions may be invoked against providers based on the grounds specified herein above:

   a. Suspension, reduction, or withholding of payments to a provider;

   b. Suspension of participation in the Medicaid Program and/or

   c. Disqualification from participation in the Medicaid Program.

   Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to recipients or their families.

3. Within thirty (30) calendar days after notice from the Executive Director of the Division of Medicaid of the intent to sanction, the provider may request a formal

hearing. Such request must be in writing and must contain a statement and be accompanied by supporting documents setting forthwith particularly the facts which the provider contends places him in compliance with the Division of Medicaid regulations or his defenses thereto. Suspension or withholding of payments may continue until such time as a final determination is made regarding the appropriateness of the claims or amounts in question. Unless a timely and proper request for a hearing is received by the Division of Medicaid from the provider, the findings of the Division of Medicaid shall be considered a final and binding administrative determination.

The hearing will be conducted in accordance with the Procedures for Administrative and Fair Hearings as adopted by the Mississippi Division of Medicaid.

C. Appeals – APR-DRG Parameters

Providers cannot appeal the APR-DRG base price or any other APR-DRG parameters established by the Division of Medicaid described herein.

CHAPTER 4
REIMBURSEMENT

4-1 Payment Methodology Effective October 1, 2012

A. Applicability

Except as specified in this paragraph, the inpatient prospective payment method applies to all inpatient stays in all acute care general, rehabilitation and mental health (psychiatric/substance ahuse treatment) hospitals. It does not apply to stays where Medicare is the primary payer or to "swing bed" stays. It also does not apply to Indian Health Services hospitals, where payment is made on a per-diem hasis per federal law.

B. Primacy of Medicaid Policy

Many features of the Medicaid inpatient prospective payment method are patterned after the similar method used by the Medicare program. When specific details of the payment method differ between Medicaid and Medicare the Medicaid reimbursement methodology described here-in prevails.

C. APR-DRG Reimbursement

For admissions dated October 1, 2012 and after, the Division of Medicaid will reimburse all hospitals a per stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs). APR-DRGs classify each case based on information contained

on the inpatient Medicaid claim: diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG determines the reimbursement when the APR-DRG hospital-specific relative value (HSRV) relative weight is multiplied by the APR-DRG base price. (The term "relative weight" used throughout this document refers to the HSRV relative weight.)

D. DRG Relative Weights

Each APR-DRG version has a set of DRG-specific relative weights assigned to it. The APR-DRG relative weights are calculated by 3M Health Information Systems from the Nationwide Inpatient Sample (NIS) created by the Agency for Healthcare Research and Quality. Each APR-DRG relative weight reflects the typical resources consumed per case. Version 35 relative weights under the hospital-specific relative value (HSRV) methodology were calculated as follows:

1. A one-year dataset of ICD-10 NIS records was compiled, representing 1 million stays.
2. All stays were grouped using APR-DRG V.35.
3. Hospital charges are used as the basis for establishing consistent relative resource use across differentiated case types. To mitigate distortion caused by differences from hospital to hospital in marking up charges over cost, claims charges that contribute to relative weights are normalized to a standard value such that each hospital has a similar charge level for a similar case mix.
4. A single hospital is omitted from the standardized value for each DRG so that each hospital's charges are standardized to the charges of the omitted hospital.
5. The standardized average cost of each DRG is normalized by multiplying through the number of cases in each DRG and computing a scaling factor to match the total weight of the total number of cases, which is applied uniformly to each weight such that average weight across the set of DRG weights is 1.0. The result is a set of relative weights that reflect differences in estimated hospital cost per APR-DRG.

An evaluation performed by the Division of Medicaid determined that the national relative weights calculated by 3M Health Information Systems corresponded closely

to relative weights calculated from Mississippi Medicaid stays. The Division of Medicaid therefore chose to use the national weights, for two reasons. First, relative weights for low-volume DRGs are more stable when calculated from the large national dataset than from relatively small Mississippi Medicaid dataset. Second, the national weights are available on an annual basis, so it is not necessary for the Division of Medicaid to incur the time and expense to recalibrate relative weights.

It is the intention of the Division of Medicaid to update the relative weights whenever the Division of Medicaid adopts a new version of the APR-DRG algorithm. A state plan amendment will be submitted any time the relative weights are updated.

The relative weight is applied to determine the APR-DRG Base Payment that will be paid for each admit-through-discharge case regardless of the specific services provided or the exact number of days of care. The weights are applied prospectively and no retroactive claims adjustments are made. The APR-DRG weights are posted on the Medicaid website at http://www.medicaid.ms.gov.

E. Policy Adjustors

When the Division of Medicaid determines that adjustments to relative weights for specific DRGs are appropriate to meet Medicaid policy goals, a "policy adjustor"

may be applied to increase or decrease these relative weights. Policy adjustors are typically implemented to ensure that payments are consistent with efficiency and access to quality care. They are typically applied to boost payment for services where Medicaid represents a large part of the market and therefore Medicaid rates can be expected to affect hospitals' decisions to offer specific services and at what level. Policy adjustors may also be needed to ensure access to very specialized services offered by only a few hospitals. By definition, policy adjustors apply to any hospital that provides the affected service.

The specific values of each policy adjustor are reflected in Appendix A.

F. DRG Base Price

The same base price is used for all stays in all hospitals. The base price was set at a budget-neutral amount per stay based on an analysis of hospital inpatient stays from the previous state fiscal year. The Division of Medicaid will not make retroactive payment adjustments.

The base price is reflected in Appendix A.

G. DRG Base Payment

For each stay, the DRG Base Payment equals the DRG Relative Weight multiplied by the DRG Base Price with the application of policy adjustors, as applicable. Additional payments and adjustments are made as described in this section and in Appendix A.

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H. Parameters

The parameters of base price, policy adjustors, relative weights, and outliers interact with payment methodology to determine payments. Changes to any of the parameters will be updated through a state plan amendment.

The parameters are prospective and will not be implemented retroactively.

I. Cost Outlier Payments

Extraordinarily costly cases in relation to other cases within the same DRG because of the severity of the illness or complicating conditions may qualify for a cost outlier payment. This is an add-on payment for expenses that are not predictable by the diagnoses, procedures performed, and other statistical data captured by the DRG grouper.

The additional payment for a cost outlier is determined by calculating the hospital's estimated loss. The estimated loss is determined by multiplying the Medicaid covered charges for each claim by the hospital's inpatient cost-to-charge ratio minus the DRG base payment. The hospital's inpatient cost-to-charge ratio is limited to a maximum of 100%. If the estimated loss is greater than the DRG cost outlier threshold established by the Division of Medicaid (see Appendix A), then the cost outlier payment equals the estimated loss minus the DRG cost outlier threshold multiplied by the DRG Marginal Cost Percentage (see Appendix A). For purposes of

this calculation, the DRG base payment is net of any applicable transfer adjustment (see Section J of this chapter).

Stays assigned to mental health DRGs are not eligible for cost outlier payments, but may qualify for a day outlier payment if the mental health stay exceeds the DRG Long Stay Threshold (see Section I of this chapter and Appendix A).

1. Cost-to-Charge Ratio – The inpatient cost-to-charge ratio used to pay inpatient cost outlier payments will be calculated as noted in Section 2-1, H.
2. Requests for Change in Inpatient Cost-to-Charge Ratio
   a. Changes Due to a Certificate of Need (CON) - A hospital may at times offer to the public new or expanded services, purchase equipment, drop such services, or retire equipment which requires (CON) approval. Within thirty (30) calendar days of implementing a CON approved change, the hospital must submit to the Division of Medicaid a budget showing the allocation of the approved amount to the Medicaid Program. This amount must be separated as applicable between capital costs, educational costs and operating costs. The budget must show an estimate of any increase or decrease in operating costs and charges applicable to the Medicaid Program due to the change, as well as the effective date of the change. Such amounts will be subject to desk review and audit by the Division of Medicaid. Allowance for such changes shall be made to the hospital's inpatient cost-to-charge ratio as provided elsewhere in

this plan. Failure to submit such required information within thirty (30) days will be a basis for disallowance of all expenses associated with the change. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the CON, no retroactive adjustments will be made to cost outlier payments using the amended inpatient cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System and will be in effect through the end of the current reimbursement period.

b. Significant Change in Overall Costs - A hospital should request a revision to its inpatient cost-to-charge ratio used to pay cost outlier payments to the Division of Medicaid whenever a provider can demonstrate that the allowable Medicaid inpatient cost-to-charge ratio using the most recently filed cost report has changed by 5% or more as compared to the existing cost-to-charge ratio. Requests which do not result in a percentage change of at least 5% more or less than the current cost-to-charge ratio will not be granted. The request must be submitted in writing to the Division of Medicaid, clearly identifying the grounds of the request and the percentage change in question. Copies of documenting support for the request must be included. Such amounts will be subject to desk review and audit by the Division of Medicaid. Facilities should make every effort possible to ensure that requests which do not meet the criteria are not submitted. If the provider's inpatient cost-to-

charge ratio used to pay cost outlier payments is changed, no retroactive adjustments will be made to cost outlier payments using the amended inpatient cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted, the new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System and will be in effect through the end of the current reimbursement period.

c. Intentional Misrepresentation and/or Suspected Fraud and/or Abuse of Cost Report Information – Such adjustment shall be made retroactive to the date of the original inpatient cost-to-charge ratio. At the discretion of the Division of Medicaid, this shall be grounds to suspend the hospital from the Mississippi Medicaid program until such time as an administrative hearing is held, if an administrative hearing is requested by the hospital.

d. Appeals – Appeals are made to the Division of Medicaid as provided in Section 3-1 of this plan.

J. Day Outlier Payments

Inpatient psychiatric hospital services are reimbursed under the APR-DRG methodology. Day outlier payments may be made only to stays assigned to mental health DRGs for mental health long lengths of stay for exceptionally expensive cases.

A stay becomes a day outlier when it exceeds the DRG Long Stay Threshold

determined by the Division of Medicaid (see Appendix A). In addition to the DRG base payment, all days after the threshold are paid per diem at the DRG Day Outlier Statewide Amount.

K. Transfer Payment Adjustments

The transfer payment adjustment applies when a patient is transferred to another acute care hospital or leaves the hospital against medical advice. It does not apply when a patient is discharged to a post-acute setting such as a skilled nursing facility. The receiving hospital is not impacted by the transfer payment adjustment unless it transfers the patient to another hospital.

The transfer payment is initially calculated as a full payment. The full payment calculation is divided by the nationwide average length of stay for the assigned DRG to arrive at a per diem amount. The per diem amount is then multiplied by the actual length of stay, except that payment is doubled for the first day. The payment is the lesser of transfer-adjusted payment or what the payment would have been if the patient had not been transferred.

See Appendix A for the discharge status values that define an acute care transfer for purposes of APR-DRG payment.

L. Prorated Payment Adjustment

When a beneficiary has Medicaid coverage for fewer days than the length of stay, then payment is prorated. The payment amount is divided by the nationwide average length of stay for the assigned DRG to arrive at a per diem amount. The per diem amount is then multiplied by the actual length of stay, except that payment is doubled for the first day. The payment will be the lesser of prorated payment or regular payment for the entire stay.

M. DRG Payment Amount, Allowed Amount and Paid Amount

The DRG Payment Amount equals the DRG Base Payment with any applicable policy adjustors, plus outlier payments if applicable, with transfer and/or prorated adjustments made if applicable. If the sum of these amounts is more than the total billed charges on the claim, the DRG Payment Amount will be limited to the total billed charges. The Allowed Amount equals the DRG Payment Amount plus applicable add-on payments such as medical education. The Paid Amount equals the Allowed Amount minus copayments and third-party liability.

N. Three-Day Payment Window

The three-day payment window applies to inpatient stays in hospitals. The window applies to services provided to a patient by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital. Under the three-day window, certain services are considered to be included in the fee-for-service inpatient stay. Services included in the inpatient stay may not be separately billed to the Division of

Medicaid or to a Medicaid managed care plan when a beneficiary has managed care coverage for outpatient care but fee-for-service coverage for inpatient care. Specific provisions are as follows.

1. Diagnostic services provided to a patient within three (3) days prior to and including the date of an inpatient admission are included within the inpatient stay.
2. Therapeutic (non-diagnostic) services related to an inpatient admission and provided to a beneficiary within three (3) days prior to and including the date of the inpatient admission are included within the inpatient stay. Therapeutic services clinically distinct or independent from the reason for the beneficiary's inpatient admission may be separately billed on an outpatient claim with the appropriate code. Such separately billed services are subject to review. Medical record documentation must support that the services are unrelated to the inpatient admission.
3. Maintenance renal dialysis provided on an outpatient basis within the three days prior to and including the date of the inpatient admission may be separately billed and separately paid.
4. Although the Division of Medicaid's policy is based on Medicare policy, Medicaid's policy applies if there is a difference.

O. Baclofen Pumps

Reimbursement for baclofen pumps, as for other supplies, services and devices, will be included within the DRG payment. No separate reimbursement will be made.

P. Payment Adjustment for Provider Preventable Conditions

Citation - 42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

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.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A:

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

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 hospital inpatient provider-preventable conditions (PPC) and health care-acquired conditions (HCAC) for dates of service effective October 1, 2011, for individuals for which Medicaid is

primary and those dually eligible for both the Medicare and Medicaid programs. This policy applies to all Mississippi Medicaid enrolled hospitals except for Indian Health Services. Reduced payment to providers is limited to the amounts directly identifiable as related to the PPC and the resulting treatment. The payment reduction will not apply to Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) as related to a total knee replacement or hip replacement for children under age twenty-one or pregnant women.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19A:

__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 (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied).

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to

the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

1. The identified provider-preventable conditions would otherwise result in an increase in payment.
2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

The following method will be used to determine the related reduction in payments for hospital inpatient Health Care-Acquired Conditions and Other Provider Preventable Conditions which includes Never Events as defined by the National Coverage Determination for dates of service beginning on or after October 1, 2012, through June 30, 2014:

Once per quarter, paid claims identified in the Mississippi Medicaid Management Information System (MMIS) with a POA indicator of "N" or "U", will be run through a Medicare DRG Grouper, once without the appropriate POA indicator with the application of the Medicare list of Health Care-Acquired Conditions and Other Provider-Preventable Conditions, and once with the appropriate POA indicator with the application of the Medicare list of Health Care-Acquired Conditions and Other

Provider-Preventable Conditions. If a difference in payment between the two claims is indicated, the following steps will be performed.

a. The original claim will be voided.

b. The original claim will be reprocessed and manually re-priced to reflect the reduction in payment due to the PPC. The payment amount will be calculated by taking the original APR-DRG Medicaid allowed amount, less the difference in payment resulting in the paragraph above.

Calculation of the Provider-Preventable Conditions (PPC) Reduction in Payment for Hospital Inpatient Services

The following example reflects the calculation and application of the reduction in hospital inpatient payments for Provider-Preventable Conditions (PPC) including Health Care-Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC).

PPC Payment Reduction Calculation for Dates of Service beginning on or after October 1, 2012, through June 30, 2014 – Once quarterly a report will be run by the Division of Medicaid to identify those paid claims with a Present on Admission (POA) indicator of "N" or "U" with Health Care-Acquired Conditions and Other Provider Preventable Conditions. The payment reduction will be based on the Medicare DRG grouper for claims with dates of service on or after October 1, 2012, through June 30, 2014, as calculated below.

Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	Col. G
Provider Number	TCN number	Dates of Service	Original XIX APR-DRG Allowed Amount per MMIS before PPC reduction	Medicare grouper payments for HCAC/OPPC w/o POA*	Medicare grouper payments for HCAC/OPPC with POA*	Reduction in XIX Payments for PPCs (Col. E – Col. F)
0022XXX1	XXXXXXXXXXXXXXXX	10/01/12 – 10/14/12	$8,144.63	$11,500	$12,800	($1,300)
00020XX9	XXXXXXXXXXXXXXXX	10/10/12 – 10/14/12	$6,374.68	$5,720	$5,720	($0)
00020XX5	XXXXXXXXXXXXXXXX	11/09/12 – 11/14/12	$5,695.10	$6,000	$6,540	($540)
0022XXX4	XXXXXXXXXXXXXXXX	11/15/12 – 11/24/12	$13,326.66	$10,898	$11,280	($382)
00020XX4	XXXXXXXXXXXXXXXX	12/03/12 – 12/08/12	$6,790.60	$8,350	$8,350	($0)
	Total		$40,331.67	$44,690	$42,468	($2,222)

*Please note that the Medicare grouper payment amounts are for illustrative purposes only and do not reflect actual grouper amounts.

The original paid claims indicated above would be voided and reprocessed and manually re-priced to reflect the reduction in Column G. For instance, the first claim that originally paid $8,144.63 would be voided and manually re-priced to pay $6,844.63 ($8144.63 - $1,300.00). The payment reduction of $1,300.00 would be recovered from the provider on their remittance advice.

PPC Payment Reductions for Dates of Service ending on or after July 1, 2014 – Effective for hospital inpatient dates of service ending on or after July 1, 2014, payment reductions for HCACs and Other Provider Preventable Conditions will be made through the claims payment system through the use of the 3M APR-DRG HCAC utility under the All Patient Refined Diagnosis Related Group payment methodology.

Q. Medical Education Payments

The Mississippi Division of Medicaid (DOM) reimburses Mississippi hospitals which meet the following criteria: (1) accreditation from the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA), (2) has a Medicare approved teaching program for direct graduate medical education (GME) costs, and (3) is eligible for Medicare reimbursement. The hospital must be accredited at the beginning of the state fiscal year in order to qualify for the quarterly payments during the payment year. To be eligible for payment, services must be performed on the campus of the teaching hospital or at a participating hospital site. Only the teaching hospital or the participating hospital site is eligible for reimbursement. DOM does not reimburse for indirect GME costs.

Medical education payments are calculated annually on July 1, as a per resident amount based on the total Medicaid hospital inpatient stays as calculated by DOM. During the year of implementation, effective October 1, 2019, the payments will be made to eligible hospitals in three (3) equal installments in December, March and June. Thereafter, the payments will be made to eligible hospitals on a quarterly basis in September, December, March and June. The number of residents per hospital is defined as the sum of the number of Medicare approved resident full time equivalents (FTEs) reported on the applicable lines on the most recent Medicare cost report filed with DOM for the calendar year immediately prior to the beginning of the state fiscal year for established programs. Any hospital which establishes a new accredited teaching program or is in a five (5) year resident cap building period for the teaching program must submit

documentation of accreditation, Medicare approval, the most recent Medicare interim rate letter, and start date of the GME program prior to the July 1 calculation of the payments. The number of residents used to calculate medical education payments during cap building years will be the number of FTEs as reported on the Medicare interim rate letter. If the number of FTEs reported on the Medicare interim rate letter does not cover the entire cost reporting period, the reported FTEs will be annualized and used to calculate medical education payments. The program must be in operation as of July 1 of the payment year.

The per resident rate will be as follows:

A. For residencies of Mississippi academic health science centers with a Level 1 trauma center:
   1. $65,000 per FTE for hospitals with 7,500 or more Medicaid hospital inpatient stays, or
   2. $55,000 per FTE for hospitals with fewer than 7,500 Medicaid hospital inpatient stays.

B. For residencies of all other accredited hospitals:
   1. $35,000 per FTE for hospitals with greater than 7,500 Medicaid hospital inpatient stays,
   2. $27,500 per FTE for hospitals with 2,000 to 7,500 Medicaid hospital inpatient stays, or
   3. $25,000 per FTE for hospitals with fewer than 2,000 Medicaid hospital inpatient stays.

Medical education costs will not be reimbursed to out-of-state hospitals.

R. Long-term Ventilator-dependent Patients Admitted Prior to October 1, 2012

Payment for ventilator-dependent patients admitted to the hospital prior to October 1, 2012 will continue to be reimbursed on a per diem basis until they are discharged from the hospital, the per diem in effect in the preceding year will be increased by the percentage increase. For hospitals with these patients, for rate years beginning October 1, 2012, and thereafter of the most recent Medicare Inpatient Hospital PPS Market Basket Update as of October 1 of each year as published in the Federal Register. All patients admitted to a hospital on or after October 1, 2012 will be reimbursed under the APR-DRG methodology.

S. Post-Payment Review

All claims paid under the APR-DRG payment methodology are subject to post-payment review.

T. Payments Outside of the DRG Base Payment

The following payments are made outside of, and in addition to, the DRG base payment: Long Acting Reversible Contraceptives (LARCs) and their insertion at the time of delivery will be reimbursed separately from the APR-DRG payment. A separate outpatient claim may be submitted by the hospital for reimbursement for LARCs and their insertion at the time of delivery. Reimbursement for the insertion of LARCs at the time of delivery will be based on the Physician Fee Schedule effective July 1, 2016, and updated annually as described in Attachment 4.19-B. The LARC will be reimbursed at the lesser of the provider's usual and customary charge or the fee listed on the Physician Administered Drugs and Implantable Drug System Devices Fee Schedule effective July 1, 2016, and updated quarterly as described in Attachment 4.19-B. All fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

CHAPTER 5
DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

5-1 Qualifying Criteria

Disproportionate Share Hospitals - All hospitals satisfying the minimum federal DSH eligibility requirements (Section 1923(d) of the Social Security Act) shall, subject to OBRA 1993 payment limitations, receive a DSH payment. This DSH payment shall expend the balance of the federal DSH allotment and associated state share not utilized in DSH payments to state-owned institutions for treatment of mental diseases.

A hospital will qualify as a disproportionate share hospital if the criteria listed below are met.

A. Except as provided in a. and b. below, no hospital may qualify as a disproportionate share hospital for Medicaid unless the hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid under an approved State Plan. In the case of a hospital located in a rural area (an area located outside of a Metropolitan Statistical Area, or MSA, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

Paragraph A., above, shall not apply to a hospital:

a. the inpatients of which are predominantly individuals under eighteen (18) years of age; or

b. which did not offer non-emergency obstetric services as of December 22, 1987.

and;

B. 1. The hospital's Medicaid inpatient utilization rate must be not less than 1%. For purposes of this paragraph, the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under an approved Medicaid State Plan in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere, or

2. The hospital's low-income utilization rate exceeds twenty-five percent (25%). For purposes of this paragraph, the term "low-income utilization rate" means, for a hospital, the sum of:

a. a fraction (expressed as a percentage) the numerator of which is the sum (for a

period) of the total revenues paid the hospital for patient services under an approved Medicaid State Plan and the amount of the cash subsidies for patient services received directly from State and local governments, and the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and;

b. a fraction (expressed as a percentage) the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies for patient services received directly from State and local governments. The total charges attributable to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan); and the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

3. No hospital may qualify as a disproportionate share hospital under this State Plan unless it is domiciled within the State of Mississippi.

5-2 Computation of Disproportionate Share Payments

A. Disproportionate share payments to hospitals that qualify for disproportionate share may not exceed one hundred percent (100%) of the costs of furnishing hospital

services (including GME program costs approved in accordance with Section 4-1.Q. of this plan) by the hospital to patients who either are eligible for medical assistance under this (or another state's) State Plan, or have no health insurance (or other source of third party coverage) for services provided during the year less any payments made by Medicaid, other than for disproportionate share payments, and less any payments made by uninsured patients. For purposes of this section, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment. For Medicaid DSH payment purposes, Medicaid costs include costs of treating Medicaid-eligible patients with additional third-party coverage, including Medicare, along with the offsetting Medicare and third party payments. .

B. The payment to each hospital shall be calculated by applying a uniform percentage required to allocate 100% of the MS DSH allotment to all DSH eligible hospitals for the rate year to the uninsured care cost of each eligible hospital, excluding state-owned institutions for treatment of mental diseases; however, that percentage for a state-owned teaching hospital located in Hinds County shall be multiplied by a factor of two (2).

C. For each state fiscal year from 2015 forward, the state shall use uninsured costs from the hospital data related to the most recently filed and longest cost reporting period ending in the calendar year prior to the beginning of the state fiscal year.

1. Those hospital assessments removed on the facility's cost report in accordance with the Medicare Provider Reimbursement Manual, 15-1, Section 2122, should be identified on the hospital DSH survey for add-back in the computation of the uncompensated care costs for Medicaid DSH payment purposes.

D. The Division of Medicaid shall implement DSH calculation methodologies that result in the maximization of available federal funds.

5-3 Disproportionate Share Payment Period

The DSH payment period is from October 1 through September 30. The determination of a hospital disproportionate share status is made annually for hospitals that meet the DSH requirements as of October 1. Once the list of disproportionate

share hospitals is determined for a rate fiscal year, no additional hospitals will receive disproportionate share status. A hospital will be deleted from disproportionate share status if the hospital fails to continue providing nonemergency obstetric services during the DSH rate year, if the hospital is required to provide such services for DSH eligibility.

5-4 Timing of Disproportionate Share Payments

The DSH payments shall be paid on or before December 31, March 31, and June 30 of each fiscal year, in increments of one-third (1/3) of the total calculated DSH amounts.

5-5 Audit of Disproportionate Share Payments

As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Division of Medicaid will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits bave not been exceeded.

Any funds recouped as a result of audits or other corrections shall be redistributed to other DSH eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit. Funds sball be redistributed to the state hospital with the highest Medicaid Inpatient Utilization Rate (MIUR). Any remaining funds available for redistribution shall be redistributed first to other state hospitals in the order of MIUR

from highest to lowest, then to government non-state hospitals in the order of MIUR from highest to lowest, then to private hospitals in the order of MIUR from highest to lowest.

5-6 DSH Allotment Adjustments

If the federal government adjusts the DSH allotment available to Mississippi prior to the month of a scheduled payment within the DSH payment year, this revised Mississippi DSH allotment will be utilized in the next scheduled DSH payment. However, if the federal government revises the Mississippi DSH allotment after June 1 of the DSH payment year, this revised DSH allotment will be incorporated into an additional DSH distribution, negative or positive, that will be with the next DSH payment but based on the DSH calculation for the DSH payment year. All DSH payments are subject to the State's lower DSH payment limit.

State of Mississippi
Title XIX Inpatient Hospital Reimbursement Plan

APPENDIX A

APR-DRG KEY PAYMENT VALUES

The table below reflects key payment values for the APR-DRG payment methodology described in this Plan.

These values are effective for discharges on and after July 1, 2020.

Payment Parameter	Value	Use
3M™ APR-DRG version	V.35	Groups every claim to a DRG
DRG base price	$6,590	Rel. wt. X DRG base price = DRG base payment
Policy adjustor – obstetrics and normal newborns	1.50	Increases relative weight and payment rate
Policy adjustor – neonate	1.40	Increases relative weight and payment rate
Policy adjustor – mental health pediatric	1.95	Increases relative weight and payment rate
Policy adjustor – mental health adult	1.50	Increases relative weight and payment rate
Policy adjustor – Rehabilitation	2.00	Increases relative weight and payment rate
Policy adjustor – Transplant (adult and pediatric)	1.50	Increases relative weight and payment rate
DRG cost outlier threshold	$53,500	Used in identifying cost outlier stays
DRG cost outlier marginal cost percentage	60%	Used in calculating cost outlier payment
DRG long stay threshold	19	All stays above 19 days require TAN on days
DRG day outlier statewide amount	$450	Per diem payment for mental health stays over 19 days
Transfer status - 02 – transfer to hospital	02	Used to identify transfer stays
Transfer status - 05 –transfer other	05	Used to identify transfer stays
Transfer status – 07 – against medical advice	07	Used to identify transfer stays
Transfer status – 63 – transfer to long-term acute care hospital	63	Used to identify transfer stays
Transfer status – 65 – transfer to psychiatric hospital	65	Used to identify transfer stays
Transfer status – 66 – transfer to critical access hospital	66	Used to identify transfer stays
Transfer status – 82 – transfer to hospital with planned	82	Used to identify transfer stays
Transfer status – 85 – transfer to other with planned readmission	85	Used to identify transfer stays
Transfer status – 91 – transfer to long-term hospital with planned readmission	91	Used to identify transfer stays
Transfer status – 93 – transfer to psychiatric hospital with planned readmission	93	Used to identify transfer stays
Transfer status – 94 – transfer to critical access hospital with planned readmission	94	Used to identify transfer stays
DRG interim claim threshold	30	Interim claims not accepted if < 31 days
DRG interim claim per diem amount	$850	Per diem payment for interim claims

State of Mississippi
Methods and Standards For Establishing Payment Rates-Other Types of Care

Citation

42 CFR 434.6, 438.6, 447.26 and 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act

Payment Adjustment for Other 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 with respect to non-payment for other provider preventable conditions.

Other Provider Preventable Conditions

The State identifies the following Other Provider Preventable Conditions for non-payment under Section 4.19(B) of this plan.

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.

Effective June 1, 2012, Medicaid will make zero payments to providers for Other Provider Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determinations (NCD). The Never Events (NE) as defined in the NCD include Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NEs. Practitioners are defined in Attachment 4.19 B-Pages 2b, 3, 5, 6b, 6d, 9, and 17 and 4.19E-Page 9.

Reimbursement for conditions described above is defined in Attachment 4.19-B, Page 1a.1, of this State Plan.

__ Additional Other Provider Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied.)

State of Mississippi
Methods and Standards For Establishing Payment Rates-Other Types of Care

Payment for Other Provider Preventable Conditions to include the three Never Events:

Effective June 1, 2012, and in accordance with Title XIX of the Social Security Act-Sections 1902(a)(4), 1902(a)(6), and 1903 and 42 CFR's 434.6, 438.6, 447.26, Medicaid will make no payments to providers for services related to Other Provider Preventable Conditions (OPPC's) that at a minimum must include the Never Events (NE).

Never Events will be identified with the appropriate ICD-10 diagnosis codes for:

- Performance of wrong operation (procedure) on correct patient
- Performance of operation (procedure) on patient not scheduled for surgery
- Performance of correct operation (procedure) on the wrong side/body part

No reduction in payment for the Other Provider Preventable Condition that include at a minimum the Never Events will be imposed on a provider when the surgery or procedure defined as a Never Event for a particular patient existed prior to the initiation of treatment for the patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

1. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the Other Provider Preventable Condition that include at a minimum the Never Events.

Non-payment of Other Provider Preventable Conditions that include at a minimum the Never Events shall not prevent access to services for Medicaid beneficiaries.

The following method will be used to determine the payment adjustment for Other Provider Preventable Conditions that at a minimum include the Never Events as defined by the National Coverage Determination for dates of services beginning on or after June 1, 2012:

Once quarterly, paid claims identified in the Mississippi Medicaid Information System (MMIS) with a diagnosis code for any of the three Never Events will be reviewed to ensure the State can reasonably isolate for non-payment the portion of the payment directly related to the treatment for, and related to, the Other Provider Preventable Condition that include at a minimum the Never Events.

State of Mississippi
Methods and Standards for Establishing Payment Rates – Other Types of Care

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

Citation- 42 CFR 447. 434. 438 and 1902(a)(4). 1902(a)(6), and 1903

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.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 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.

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 October 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 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 for Other Provider-Preventable Conditions which includes Never Events as defined by the National Coverage Determination:

A. Dates of service beginning on or after October 1, 2011, through June 30, 2014:

   1. The claims identified with a Present on Admission (POA) indicator of "Y" or "U" 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.

B. For dates of services beginning on or after July 1, 2014, claims identified in Medicaid Management Information System (MMIS) with a diagnosis code for any of the three Never Events will be denied, reviewed and adjusted to ensure no payment is made for treatment directly related to Other Provider Preventable Conditions that include, at a minimum, the three Never Events.

C. No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

D. Reductions in provider payment may be limited to the extent that the following apply:

   1. The identified provider-preventable conditions would otherwise result in an increase in payment.

   2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

E. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

Hospital Outpatient Services

A. Except as otherwise specified, outpatient hospital services for all hospitals except Indian Health Services will be reimbursed under a prospective payment methodology as follows:

1. Medicaid Outpatient Prospective Payment System (OPPS), Ambulatory Payment Classification (APC) Groups

   Outpatient hospital services will be reimbursed on a predetermined fee-for-service basis. The parameters published annually in the Code of Federal Regulations (CFR) (national APC weights, APC group assignments and Medicare fees) and MS Medicaid OPPS status indicators, will be used by the Division of Medicaid (DOM) in calculating these predetermined rates and will be updated July 1 of each year.

   a. The Medicaid OPPS fees, including Clinical Diagnostic Laboratory OPPS fees, are calculated using 100% of the applicable APC relative weight or the payment rate for codes listed in the Medicare outpatient Addendum B effective as of January 1 of each year as published by the Centers for Medicare and Medicaid Services (CMS). Codes with no applicable APC relative weight or Medicare payment rate established in Addendum B are reimbursed using the applicable MS Medicaid fee effective July 1 of each year, multiplied by the units (when applicable). No retroactive adjustments will be made. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1 and is effective for services provided on or after that date. All fees are published on the agency's website at medicaid.ms.gov/providers/fee-schedules-and-rates/.

   b. The Medicaid conversion factor used by DOM is the SFY18 Jackson, MS Medicare conversion factor. This conversion factor is used for all APC groups and for all hospitals. Each APC rate equals the Medicare Addendum B specific relative weight at 100% multiplied by the Medicaid conversion factor, with the exception of observation fee which is reimbursed using a MS Medicaid fee. Except as otherwise noted in the plan, MS

Medicaid OPPS fee schedule rates are the same for both governmental and private providers of hospital outpatient services. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1 and is effective for services provided on or after that date.

c. Subject to documentation of medical necessity, in addition to any Medicaid covered service received during observation in an outpatient hospital setting, DOM will pay an hourly fee for each hour of observation exceeding seven (7) hours, up to a maximum of twenty-three (23) hours (i.e., the maximum payment will be sixteen (16) hours times the hourly fee).

   The hourly fee for observation is calculated based on the relative weight for the Medicare APC which corresponds with comprehensive observation services multiplied by the SFY18 Jackson, MS Medicare conversion factor divided by the twenty-three (23) maximum payable hours. The MS Medicaid OPPS fee schedule is set and updated each year as of July 1 and is effective for services provided on or after that date. All fees are published on the agency's website at medicaid.ms.gov/providers/fee-schedules-and-rates/.

d. The total claim allowed amount will be the lower of the provider's allowed billed charges or the calculated Medicaid OPPS allowed amount.

e. A MS Medicaid OPPS status indicator is assigned to each procedure code determining reimbursement under Medicaid OPPS. A complete list of MS Medicaid OPPS status indicators and definitions is located within the OPPS Fee Schedule that is published on the agency's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

f. Claims with more than one (1) significant procedure, assigned a MS Medicaid OPPS status indicator "T" or "MT", are discounted. The line item with the highest allowed amount on the claim for certain significant procedures identified on the MS OPPS fee schedule

assigned a MS Medicaid OPPS status indicator "T" or "MT" is priced at one hundred percent (100%) of the allowed amount or published fee. All other lines with significant procedures identified on the MS OPPS fee schedule assigned a MS Medicaid OPPS status indicator of "T" or "MT" is priced at fifty percent (50%) of the allowed amount or published fee.

Effective July 1, 2019, claims with more than one (1) significant dental procedure code, assigned a MS Medicaid OPPS status indicator "T" or "MT" are discounted. The dental procedure code line item with the highest allowed amount on the claim assigned a MS Medicaid OPPS status indicator "T" or "MT" is priced at one hundred percent (100%) of the allowed amount or published fee. All other lines with significant dental procedures identified on the MS OPPS fee schedule assigned a MS Medicaid OPPS status indicator of "T" or "MT" are priced at twenty-five percent (25%) of the allowed amount or published fee.

g. Medicare has set guidelines for procedures it has determined should be performed in an inpatient setting only. The DOM follows Medicare guidelines for procedures defined as "inpatient only".

2. Outpatient Payment Methodology Paid Under Medicaid OPPS

Except in cases where the service is non-covered by DOM, outpatient services will be priced as follows:

a. For each outpatient service or procedure, the fee is no more than 100% of the Ambulatory Payment Classification (APC) rate multiplied by the units (when applicable).

b. Where no APC relative weight has been assigned, the outpatient services fee will be no more than 100% of any applicable Medicare payment rate in the Medicare outpatient Addendum B as of January 1 of each year as published by the CMS multiplied by the units (when applicable).

c. If there is no APC relative weight or Medicare payment rate established in the Medicare outpatient Addendum B as of January 1 of each year as published by the CMS, payment will be made using the applicable MS Medicaid fee multiplied by the units (when applicable).

d. If there is (1) no APC relative weight, Medicare payment rate, or MS Medicaid fee for a procedure or service, or a device, drug, biological or imaging agent, or (2) when it is determined, based on documentation, that a procedure or service, or device, drug, biological or imaging agent reimbursement is insufficient for the Mississippi Medicaid

population or results in an access issue, a manual review of the claim will be made to determine an appropriate payment based on the resources used, cost of related equipment and supplies, complexity of the service and physician and staff time. The rate of reimbursement will be limited to (1) a MS Medicaid fee calculated as 90% of the Medicare rate of a comparable procedure or service or (2) the provider submitted invoice for a device, drug, biological or imaging agent.

B. Miscellaneous

The topics listed below from Attachment 4.19-A will apply to hospital outpatient services:

1. Principles and Procedures
2. Availability of Hospital Records
3. Records of Related Organizations
4. Appeals and Sanctions.

2b. RURAL HEALTH CLINICS (RHC)

I. Introduction

The purpose of this State Plan is to set forth policies and guidelines to be administered by the Mississippi Division of Medicaid (DOM) for Rural Health Clinics (RHCs) operating in the State of Mississippi. All RHCs shall be reimbursed in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) and the principles and procedures specified in this plan.

II. Payment Methodology

This state plan provides for reimbursement to RHC providers at a prospective payment rate per encounter. Reimbursement is limited to a single encounter, also referred to as a "visit", per day except as described in Attachment 3.1-A exhibit 2b.

A. Prospective Payment System

In accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, the state plan shall provide for payment for core services and other ambulatory services provided by RHCs at a prospective payment rate per encounter. The rate shall be calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the RHCs reasonable costs of providing Medicaid covered services provided during fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during fiscal year 2001. For RHCs that qualified for Medicaid participation during fiscal year 2000, their prospective payment rate for fiscal year 2001 shall be calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the RHCs reasonable costs of Medicaid covered services provided during fiscal year 2000.

For services furnished during calendar year 2002 and each subsequent calendar year, the payment rate shall be equal to the rate established in the preceding calendar year increased by the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4^{th}) quarter of the preceding calendar year. Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

B. New Clinics

For new clinics that qualify for the RHC program after January 1, 2001, the initial prospective payment system (PPS) rate shall be based on the rates established for other RHCs located in the same or adjacent area with a similar caseload. In the absence of such RHCs, the rate for the new provider will be based on projected costs.

The RHC's Medicare final settlement cost report for the initial cost report period year will be used to calculate a PPS base rate that is equal to one hundred percent (100%) of the RHC's reasonable costs of providing Medicaid covered services. If the initial cost report period represents a full year of RHC services, this final settlement rate will be considered the base rate. If the initial RHC cost report period does not represent a full year, then the rate from the first full year cost report will be used as the clinic's base rate.

For each subsequent calendar year, the payment rate shall be equal to the rate established in the preceding calendar year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4^{th}) quarter of the preceding calendar year.

C. Alternative Payment Methodology

1. The Division of Medicaid reimburses an RHC a fee in addition to the encounter rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the RHC's established office hours but before or after the Division of Medicaid's office hours, or (2) outside of the Division of Medicaid's office hours or the RHC established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or the RHC established office hours. The Division of Medicaid's office hours are defined as the hours between 8:00 a.m. and 5 p.m., Monday through Friday, excluding Saturday, Sunday, and federal and state holidays. These codes will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. The Division of Medicaid reimburses an RHC an additional fee for telehealth services provided by the RHC as the originating site provider. The RHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The RHC may not bill for an encounter visit unless a separately identifiable service is performed. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

3. If an RHC's base year cost report is amended, the clinic's PPS base rate will be adjusted based

on the Medicare final settlement amended cost report. The RHC's original PPS base rate and the rates for each subsequent fiscal year will be recalculated per the payment methodology outlined above. Claims payments will be adjusted retroactive to the effective date of the original rate. The amended PPS base rate will be no less than the original base rate.

D. Fee-For-Service

1. RHCs acting in the role of a telehealth originating site provider with no other separately identifiable service being provided will only be paid the telehealth originating site fee per completed transmission and will not receive reimbursement for an encounter. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. The Division of Medicaid reimburses an RHC the encounter rate for the administration of certain categories of physician administered drugs (PADs), referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs), reimbursed under the pharmacy benefit to the extent the CADDs were not included in the calculation of the RHC's encounter rate.

E. Change of Ownership

When an RHC undergoes a change of ownership, the PPS rate of the new owner will be equal to the PPS rate of the old owner. There will be no change to the RHC's PPS rate as a result of a change of ownership.

F. Change in Scope of Services

A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services occurs if: (1) the clinic RHC has added or has dropped any services that meets the definition of an RHC service as provided in section 1905(a)(2)(B) and (C), and (2) the service is included as a covered Medicaid service under the Mississippi Medicaid state plan. A change in intensity could be a change in the amount of health care services provided by the RHC in an average encounter.

A change in the scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not generally constitute a change in the scope of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

An RHC must notify the Division of Medicaid in writing of any change in the scope of services by the end of the calendar year in which the change occurred, including decreases in scope of services. The Division of Medicaid will adjust an RHC's PPS rate if the following criteria are met: (1) The RHC can demonstrate that there is a valid and documented change in the scope of services, and (2) The change in scope of services results in at least a five percent (5%) increase or decrease in the RHC's PPS rate for the calendar year in which the change in scope of service took place.

An RHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of the RHC's Medicare final settlement cost report for the RHC's first full fiscal year of operation with the change in scope of services. The request must include the first final settlement cost report that includes twelve (12) months of costs for the new service. The adjustment will be granted only if the cost related to the change in scope of services results in at least a five percent (5%) increase or decrease in the RHC's PPS rate for the calendar year in which the change in scope of services took place. The cost related to a change in scope of services will be subject to reasonable cost criteria identified in accordance with 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 C.F.R. Part 413 Principles of Reasonable Cost Reimbursement.

It is the responsibility of the RHC to notify the Division of Medicaid of any change in the scope of services and provide proper and valid documentation to support the rate change. Such required documentation must include, at a minimum, a detailed working trial balance demonstrating the increase or decrease in the RHC's PPS rate as a result of the change in scope of services. The Division of Medicaid will require the RHC to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid will also request additional information as it sees fit in order to sufficiently determine whether any change in scope of services has occurred. The instructions and forms for submitting a request due to a change in scope of services can be found at http:/www.medicaid.ms.gov/resources/forms/.

Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place. The revised PPS rate generally cannot exceed the cost per visit from the most recent audited cost report.

G. Change in Ownership Status

The RHC's PPS rate will not be adjusted solely for a change in ownership status between freestanding and provider-based.

H. Allowable Costs

Allowable costs are those costs that result from providing covered services. They are reasonable in amount and are necessary for the efficient delivery of those services. Allowable costs include the direct cost center component (i.e., salaries and supplies) of providing the covered services and an allocated portion of overhead (i.e., administration and facility).

I. Out of State Providers

The Division of Medicaid does not enroll out-of-state providers to provide RHC services, except in those circumstances specified at 42 CFR 431.52.

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

Federally Qualified Health Centers (FQHCs)

I. Introduction

The purpose of this State Plan is to set forth policies and guidelines to be administered by the Mississippi Division of Medicaid (DOM) for Federally Qualified Health Centers (FQHCs) operating in the State of Mississippi. All FQHCs shall be reimbursed in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) and the principles and procedures specified in this plan.

II. Payment Methodology

This state plan provides for reimbursement to FQHC providers at a prospective payment rate per encounter. Reimbursement is limited to a single encounter, also referred to as a "visit", per day except as described in Attachment 3.1-A exhibit 2c.

A. Prospective Payment System

In accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, effective January 1, 2001, the state plan shall provide for payment for core services and other ambulatory services provided by FQHCs at a prospective payment rate per encounter. The rate shall be calculated (on a per visit basis) in an amount equal to one hundred percent (100%) of the average of the FQHC's reasonable costs of providing Medicaid covered services provided during fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during fiscal year 2001. The average rate will be computed from FQHC Medicaid cost reports by applying a forty percent (40%) weight to fiscal year 1999 and a sixty percent (60%) weight to fiscal year 2000 and adding those rates together. For FQHC's that qualified for Medicaid participation during fiscal year 2000, their prospective payment rate will only be computed from the fiscal year 2000 Medicaid cost report.

For services furnished during calendar year 2002 and each subsequent calendar year, the payment rate shall be equal to the rate established in the preceding calendar year increased by the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4^{th}) quarter of the preceding calendar year. Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place.

B. New Centers

For new centers that qualify for the FQHC program after January 1, 2001, the initial prospective payment system (PPS) rate shall be based on the rates established for other centers located in the same or adjacent area with a similar caseload. In the absence of such an FQHC, the rate for the new provider will be based on projected costs. After the FQHC initial year, a Medicaid cost report

must be filed in accordance with this plan. The cost report will be desk reviewed and a rate shall be calculated in an amount equal to one hundred percent (100%) of the FQHC reasonable costs of providing Medicaid covered services. The FQHC may be subject to a retroactive adjustment based on the difference between projected and actual allowable costs. Claims payments will be adjusted retroactive to the effective date of the original rate.

For each subsequent calendar year, the payment rate shall be equal to the rate established in the preceding calendar year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services that is published in the Federal Register in the fourth (4^{th}) quarter of the preceding calendar year.

C. Alternative Payment Methodology

1. The Division of Medicaid reimburses an FQHC a fee in addition to the encounter rate when billing with codes 99050 or 99051 when the encounter occurs: (1) during the FQHC's established office hours but before or after the Division of Medicaid's office hours, or (2) outside of the Division of Medicaid's office hours or the FQHC established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or FQHC established office hours. The Division of Medicaid's office hours are defined as the hours between 8:00 a.m. and 5 p.m., Monday through Friday, excluding Saturday, Sunday, and federal and state holidays. These codes will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. The Division of Medicaid reimburses an FQHC an additional fee for telehealth services provided by the FQHC as the originating site provider. The FQHC will receive the originating site facility fee per completed transmission when billing claims with code Q3014. The FQHC may not bill for an encounter visit unless a separately identifiable service is performed. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

D. Fee-For-Service

1. FQHCs acting in the role of an originating site provider with no other separately identifiable service being provided will only be paid the telehealth originating site fee per completed transmission and will not receive reimbursement for an encounter. This service will be paid at the existing fee-for-service rate on the MS Medicaid Physician Fee Schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

2. The Division of Medicaid reimburses an FQHC the encounter rate for the administration of certain categories of physician administered drugs (PADs), referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs), reimbursed under the pharmacy benefit to the extent the CADDs were not included in the calculation of the FQHC's encounter rate.

E. Change in Scope of Services

A change in the scope of services is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of services shall occurs if: (1) the FQHC has added or has dropped any services that meets the definition of an FQHC service as provided in section 1905(a)(2)(B) and (C) of the SSA; and, (2) the service is included as a covered Medicaid service under the Mississippi Medicaid state plan. A change in intensity could be a change in the amount of health care services provided by the FQHC in an average encounter.

A change in the scope of services does not mean the addition or reduction of staff members to or from an existing service. An increase or decrease in the number of encounters does not generally constitute a change in the scope of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.

An FQHC must notify the Division of Medicaid in writing of any change in the scope of services by the end of the calendar year in which the change occurred, including decreases in scope of services. The Division of Medicaid will adjust an FQHC PPS rate if the following criteria are met: (1) the FQHC can demonstrate that there is a valid and documented change in the scope of services, and (2) the change in scope of services results in at least a five percent (5%) increase or decrease in the FQHC PPS rate for the calendar year in which the change in scope of service took place.

An FQHC must submit a request for an adjustment to its PPS rate no later than one hundred eighty (180) days after the settlement date of FQHC Medicare final settlement cost report for the FQHC's first full fiscal year of operation with the change in scope of services. The request must include the first final settlement cost report that includes twelve (12) months of costs for the new service. The adjustment will be granted only if the cost related to the change in scope of services results in

at least a five percent (5%) increase or decrease in the FQHC PPS rate for the calendar year in which the change in scope of services took place. The cost related to a change in scope of services will be subject to reasonable cost criteria identified in accordance with 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 C.F.R. Part 413 Principles of Reasonable Cost Reimbursement.

It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of services and provide proper and valid documentation to support the rate change. Such required documentation must include, at a minimum, a detailed working trial balance demonstrating the increase or decrease in the FQHC PPS rate as a result of the change in scope of services. The Division of Medicaid will require the FQHC to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid will also request additional information as it sees fit in order to sufficiently determine whether any change in scope of services has occurred. The instructions and forms for submitting a request due to a change in scope of services can be found at www.medicaid.ms.gov/resources/forms/.

Adjustments to the PPS rate for the increase or decrease in scope of services are reflected in the PPS rate for services provided in the calendar year following the calendar year in which the change in scope of services took place. The revised PPS rate generally cannot exceed the cost per visit from the most recent audited cost report.

F. Allowable Costs

Allowable costs are those costs that result from providing covered services. They are reasonable in amount and are necessary for the efficient delivery of those services. Allowable costs include the direct cost center component (i.e., salaries and supplies) of providing the covered services and an allocated portion of overhead (i.e., administration and facility).

G. Out-Of-State Providers

The Division of Medicaid does not enroll out-of-state providers to provide FQHC services, except in those circumstances specified at 42 CFR 431.52.

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 90 percent of the current Medicare fee schedule and is updated each year as of July 1st and is effective for services provided on or after that date. All fees are published on the agency's website at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

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 of Mississippi

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under the Age of Twenty-one (21): Limited to Federal Requirements.

(a) EPSDT Screenings -

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of EPSDT screenings. All rates are published on the agency's website at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

(1) EPSDT screening fee(s) will be reimbursed using the Current Procedural Terminology (CPT) codes based on Centers for Medicare and Medicaid Services (CMS) methodology for determining Medicare preventive medicine service fees and applying the state law of 90% in accordance with nationally recognized evidence-based principles of preventive health care services periodicity schedule as set forth by the American Academy of Pediatrics (AAP) Bright Futures. Fees are updated July 1 of each year and reimbursed at ninety percent (90%) of the Medicare Physician Fee Schedule in effect on January 1of each year. These reimbursement rates will be paid only to Mississippi Medicaid enrolled EPSDT providers. Age appropriate laboratory testing fees are reimbursed according to applicable state plan reimbursement methodologies.

(2) Interperiodic visits are provided for other medically necessary health care, screens, diagnosis, treatment and/or other measures to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions. Such services are covered whether or not they are included elsewhere in the State Plan provided they are described in Section 1905(a) of the Social Security Act. These services will be reimbursed using the CPT codes updated July 1 of each year and are reimbursed at ninety percent (90%) of the Medicare Physician Fee Schedule in effect on January 1 of each year.

(3) [Reserved]

STATE: Mississippi

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

Early and Periodic Screening, Diagnosis, and Treatment and Extended EPSDT Services.

(4) Interperiodic Dental Screens: Between periodic screens, coverage is provided for other medically necessary services. Payment for problem focused evaluation will be reimbursed using the Healthcare Common Procedure Coding System (HCPCS) codes as provided by the Centers for Medicare and Medicaid based on a statewide fixed fee schedule authorized by MS State Legislation. These reimbursement rates will be paid to dentists only.

(b) High-Risk assessment - Reimbursement is based on 75% of the current Medicaid allowable for an antepartum visit. These reimbursement rates will be paid to Perinatal High Risk Management (PHRM) providers only.

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 of Mississippi

Methods and Standards for Establishing Payment Rates – Other Types of Care

Reimbursement for non-Autism Spectrum Disorder services to Psychologists, Licensed Clinical Social Workers (LCSW), and Licensed Professional Counselors (LPC) for EPSDT-eligible beneficiaries is the lesser of the usual and customary charge or based on ninety percent (90%) of the most recent final Medicare fee schedule published by the Centers for Medicare and Medicaid Services (CMS) as of April 1 each year and effective July 1 and updated annually.

The Division of Medicaid reimburses Autism Spectrum Disorder (ASD) services in accordance with the most recent publication of the Current Procedural Terminology (CPT) ©American Medical Association. Reimbursement for ASD service codes is the lesser of the usual and customary charge or a rate calculated by an actuarial firm based on Division of Medicaid anticipated mix of providers delivering each service, Bureau of Labor Statistics (BLS) wage and benefit information, provider overhead cost estimates, and annual hours at work and percentage of work time that is billable. The rates effective for July 1st for 2017, 2018 and 2019 were updated annually based on changes in the seasonally adjusted health care and social assistance compensation for civilian workers as reported by BLS on July 1. Effective July 1, 2020, the rates will remain the same as those effective July 1, 2019.

Rates for ASD services are the same for private and governmental providers and are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

State of Mississippi

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

The Division of Medicaid reimburses Prescribed Pediatric Extended Care (PPEC) providers the lesser of the provider's usual and customary charge or at an hourly rate for each completed hour up to six (6) completed hours of services or at a daily rate for over six (6) hours of services from a statewide uniform fee schedule that was calculated utilizing the costs used to set the 2018 average small nursing facility rates, adjusting the staff costs to reflect the minimum requirements for a PPEC and removing food costs, dietary salaries and benefits, and other expenses not related to costs incurred by a PPEC.

Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers of PPEC services. The Division of Medicaid's fee schedule rate was set as of January 1, 2020, and is effective for services provided on or after that date. All fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

The Division of Medicaid reimburses for transportation provided by PPECs as described in Attachment 3.1-D.

The Division of Medicaid, as required by state law, will reduce the rate of reimbursement to providers for PPEC services by five percent (5%) of the total allowed amount for all services on a claim. The published fees do not include the five percent (5%) reduction.

State of Mississippi

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Private Duty Nursing

The Division of Medicaid reimburses private duty nursing (PDN) services for a registered nurse (RN) by adding the Federal Insurance Contributions Act (FICA) percentage of 7.65% and an administrative allowance of 0.53% to the May 2018 National Bureau of Labor Statistics (BLS) Highest Median Hourly rate for an RN in the Memphis, TN-MS-AR area . An additional $17.00 per hour is added to the rate calculation for RN PDN ventilator services.

The Division of Medicaid reimburses private duty nursing (PDN) services for a licensed practical nurse (LPN) by adding the Federal Insurance Contributions Act (FICA) percentage of 7.65% and an administrative allowance of 16.51% to the May 2018 National Bureau of Labor Statistics (BLS) Highest Median Hourly rate for an LPN in the Memphis, TN-MS-AR area.

Personal Care Services

The Division of Medicaid reimburses personal care services (PCS) for a certified nursing assistant (CNA) by adding the Federal Insurance Contributions Act (FICA) percentage of 7.65% and an administrative allowance of 21.35% to the May 2018 National Bureau of Labor Statistics (BLS) Mean Hourly rate for a CNA in the Memphis, TN-MS-AR.

Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers of PDN services and PCS. The Division of Medicaid's fee schedule rate was set as of July 1, 2020, and is effective for services provided on or after that date. All fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

The Division of Medicaid reimburses one hundred percent (100%) of the maximum allowable rate for the first beneficiary and fifty percent (50%) of the maximum allowable rate for the second beneficiary when a private duty nurse is caring for two (2) beneficiaries simultaneously in the same home.

The Division of Medicaid will reduce the rate of reimbursement to PDN and PCS providers for EPSDT services by five percent (5%) of the allowed amount for that service. The five percent (5%) reduction has been in place since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction. The federal match will be paid based on the reduced amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE MISSISSIPPI

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

Family Planning Services and Supplies for Individuals – Payment is made from a statewide uniform fee schedule based on at ninety percent (90%) of the Medicare fee schedule.

Payment to providers, such as federally qualified health center and rural health clinics, do not exceed the reasonable costs of providing services. Payments to health departments are on an encounter rate and are determined annually.

Family planning 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.

State of Mississippi
Methods and Standards for Establishing Payment Rates – Other Types of Care

Physicians' services – Fees for Medicaid physician services are updated July 1 of each year and are reimbursed at ninety percent (90%) of the Medicare Physician Fee Schedule in effect as of January 1 of each year. All rates are published at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

Primary Care Physician Payment:

The Division of Medicaid will continue to reimburse for services provided by physicians who self-attest as having a primary specialty designation of family medicine, pediatric medicine or internal medicine formerly authorized by 42 C.F.R. § 447.400(a).

Effective July 1, 2016, the Division of Medicaid will reimburse for services provided by obstetricians and gynecologists (OB/GYNs) with a primary specialty/subspecialty designation in obstetric/gynecologic medicine who attest to one (1) of the following:

1) Physician is board certified by the American Congress of Obstetricians and Gynecologists (ACOG) as a specialist or subspecialist in obstetric/gynecologic medicine, or

2) Physician with a primary specialty/subspecialty designation in obstetric/gynecologic medicine and has furnished the evaluation and management services and vaccines administration services listed below that equal at least sixty percent (60%) of the Medicaid codes they have billed during the most recently completed calendar year but does not have an ACOG certification, or

3) Physician, newly enrolled as a Medicaid provider, with a primary specialty/subspecialty designation in obstetric/gynecologic medicine and attests that the evaluation and management services and vaccines administration services listed below will equal at least sixty percent (60%) of the Medicaid codes they will bill during the attestation period, or

4) Non-physician practitioner providing primary care services in a Practice Agreement with a qualified physician enrolled for increased primary care services.

Primary Care Services' reimbursement applies to certain Evaluation and Management (E&M) and Vaccine Administration Codes. The state reimburses vaccine administration services at the Mississippi regional maximum administration fee set by the Vaccines for Children (VFC) program for self-attested primary care physicians and self-attested primary care OB/GYN physicians. To receive reimbursement for vaccine administration to a VFC-eligible beneficiary, a self-attested primary care physician or self-attested primary care OB/GYN physician provider must also be enrolled as a VFC provider.

State of Mississippi
Methods and Standards for Establishing Payment Rates – Other Types of Care

Primary Care Services' fees are updated July 1 of each year and are reimbursed at one hundred percent (100%) of the Medicare Physician Fee Schedule in effect as of January 1 of each year. All rates are published at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

Physician services not otherwise covered by the State Plan but determined to be medically necessary for EPSDT beneficiaries are reimbursed according to the methodology described above.

State of Mississippi

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

Supplemental Payments for Physician and Professional Services Practioners at Qualifying Hospitals

Effective for dates of payment on or after January 1, 2021, the Division of Medicaid will make supplemental payments for physicians and other professional services practitioners who are employed by or contracted with a qualifying hospital for services rendered to Medicaid beneficiaries. These supplemental payments will be equal to the difference between the average commercial payment rate and the amount otherwise paid pursuant to the fee schedule for physicians' services under Attachment 4.19-B.

1. Qualifying Criteria

   Physicians and other eligible professional service practitioners as specified in 2. below who are employed by a qualifying hospital or who assigned Mississippi Medicaid payments to a qualifying hospital. The term "qualifying hospital" means a Mississippi state-owned academic health science center with a Level 1 trauma center, Level 4 neonatal intensive care nursery, an organ transplant program, and more than a four hundred (400) physician multispecialty practice group. To qualify for the supplemental payment, the physician or professional service practitioner must be:

   a. Licensed by the State of Mississippi, and
   b. Enrolled as a Mississippi Medicaid provider.

2. Qualifying Provider Types

   For purposes of qualifying for supplemental payments under this section, services provided by the following professional practitioners will be included:

   a. Physicians,
   b. Physician Assistants,
   c. Nurse Practitioners,
   d. Certified Registered Nurse Anesthetists,
   e. Certified Nurse Midwives,
   f. Clinical Social Workers,
   g. Clinical Psychologists,
   h. Dentists, and
   i. Optometrists.

State of Mississippi

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

3. Payment Methodology

The supplemental payment will be determined in a manner to bring payments for these services up to the average commerical rate level. The average commerical rate level is defined as the rates paid by commercial payers for the same service. Under this methodology the terms physician and physician services include services provided by all qualifying provider types as set forth in 2. above.

The specific methodology to be used in establishing the supplemental payment for physician services is as follows:

a. For services provided by physicians at a qualifying hospital, the Division of Medicaid will collect from the hospital its current commercial physician fees by the current procedural terminology (CPT) code for the hospital's top five (5) commercial payers by volume.

b. The Division of Medicaid will calculate the average commercial fee for each CPT code for each physician practice plan or physician that provides services at the qualifying hospital.

c. The Division of Medicaid will extract from its paid claims history file for the preceding fiscal year all paid claims for those physicians who will qualify for a supplemental payment. The Division of Medicaid will align the average commercial fee for each CPT code as determined in 3.b. above to each Medicaid claim for that physician or physician practice plan and calculate the average commercial payments for the claims.

d. The Division of Medicaid will also align the same paid Medicaid claims with the Medicare fees for each CPT code for the physician or physician practice plan and calculate the Medicare payment amounts for those claims. The Medicare fees will be the most currently available national non-facility fees.

e. The Division of Medicaid will then calculate an overall Medicare to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio will be re-determined every three (3) years.

State of Mississippi

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

f. For each quarter the Division of Medicaid will extract paid Medicaid claims for each qualifying provider types for that quarter.

g. The Division of Medicaid will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the national non-facility fees that were effective at the time the Medicaid claims were paid.

h. The total amount that Medicare would have paid for those claims is then multiplied by the Medicare to commercial conversion factor and the amount Medicaid actually paid for those claims is subtracted to establish the supplemental payment amount for the qualifying provider types for that quarter.

The supplemental payments will be made on a quarterly basis and the Medicare equivalent of the average commercial rate of 158.63% factor will be rebased/updated every three (3) years by the Division of Medicaid. Supplemental payments will be directly remitted to the qualifying hospital or the physician practice plan to which particpating physicians have assigned the Mississippi Medicaid payment.

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

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

Podiatry services are reimbursed from the same fee schedule as physicians' services.

Podiatrists' services for EPSDT recipients, if medically necessary, include those services that would be covered as physicians' services when performed by a doctor of medicine for osteopathy and are reimbursed as physicians' services, Attachment 4.19-B, Page 5.

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

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

Chiropractic services are reimbursed from the same fee schedule based on 70 percent of Medicare as authorized by the Legislature

Chiropractors' services for EPSDT recipients, if medically necessary, are reimbursed from the fee schedule based on 70 percent of Medicare as authorized by the Legislature.

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 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

6d. Other Licensed Practitioners' Services:

Nurse Practitioner and Physician Assistant Services: Reimbursement for nurse practitioner and physician assistant services shall be at 90% of the fee for reimbursement paid to licensed physicians under the statewide physician fee schedule for comparable services under comparable circumstances.

Nurse practitioner and physician assistant 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.

Reimbursement to a pharmacy provider, for vaccine administration by a pharmacist, is the same fee as a primary care physician outlined in Attachment 4.19-B page 5a.

Pharmacy Disease Management Services: The pharmacy disease management services are reimbursed on a per encounter basis with an encounter averaging between fifteen and thirty minutes. The reimbursement is a flat fee established after reviewing Medicaid's physician fee schedule and reimbursement methodologies and fees of other states and third party payers.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private other licensed practitioner providers. The Division of Medicaid's fee schedule rate was set as of September 1, 2020, and is effective for services provided on or after that date. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#. The Division of Medicaid will reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The 5% reduction has been in effect since July 1, 2002, and the fee schedule already incorporates the 5% adjustment. The federal match will be paid based on the reduced amount. Prescription drugs and other covered drugs and services as may be determined by the division are exempt from the 5% exemption.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: 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.

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.

Home Health Care Services - Payment for home health service's shall be on the basis of cost or charges, whichever is less, as determined under standards and principles applicable to Title XVIII, not to exceed in cost the prevailing cost of skilled nursing home services under Medicaid. Effective July 1, 1981, payment for Home Health Services is in accordance with thc Mississippi Title XIX Home Health Agency Reimbursement Plan (see Exhibit "A", pages 1-9); however, under no circumstances will the cost of Home Health Services exceed the cost of skilled nursing home services per month under the Medicaid Program.

Home Health care 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 and in Exhibit A of Attachment 4.19-B.

Durable Medical Equipment Services - Payment for Durable Medical Equipment (DME) is in accordance with the Mississippi Title XIX Durable Medical Equipment Reimbursement Plan at Exhibit "A", page 10.

Medical Supplies - Payment for medical supplies is in accordance with Mississippi Title XIX Medical Supply Reimbursement at Exhibit "A", page 11.

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

Private Duty Nursing Services for EPSDT recipients, if medically necessary, reimbursed on a fee for service basis.

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 of Mississippi

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

Clinic Services

Reimbursement is for services rendered by the Mississippi State Department of Health (MSDH) clinics. Reimbursement is based on cost reports submitted by the provider. In order to be reimbursed at cost, the provider must demonstrate its cost finding methodology and use a cost report approved by CMS. The provider is required to submit a cost report for each clinic type using the Medicare Cost Report Form 222. The encounter 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 rate for an encounter is limited to one (1) visit per day per beneficiary. An encounter is defined as services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers. A clinic's encounter rate covers the beneficiary's visit to the clinic, including all services and supplies, such as drugs and biologicals that are not usually self-administered by the patient, furnished as an incident to a professional service. The established rate setting period is July 1 to June 30. The Division of Medicaid requires the MSDH to submit the cost report by November 30 of each year, five (5) calendar months after the close of the cost reporting period. An interim rate is paid until the end of the reporting period when there is a retrospective cost settlement. The interim rate is the established rate for the prior fiscal year. 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.

The encounter rates are updated annually on July 1 and are effective for services provided on or after July 1. Rates for the MSDH clinics are published on the Division of Medicaid's website at www.medicaid.ms.gov/FeeScheduleLists.aspx.

The Division of Medicaid covers for all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

State of Mississippi

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

Ambulatory Surgical Center Facility Services

Reimbursement of ambulatory surgical center (ASC) services is calculated at eighty percent (80%) of the current Medicare Ambulatory Surgical Center Payment System.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental, if any, and non-governmental providers of ambulatory surgical center services. Mississippi Medicaid's fee schedule for ambulatory surgical center services is updated annually with an effective date of October 1 for services provided on or after that date. All rates may be viewed at www.medicaid.ms.gov/FeeScheduleLists.aspx.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to both governmental and non-governmental providers for any service by five percent (5%) of the allowed amount for that service. The published fee does not include the five percent (5%) reduction.

Dialysis Center Services

A. Payment Methodology

Effective January 1, 2014, dialysis centers shall be reimbursed at a bundled end-stage renal disease (ESRD) prospective payment system (PPS) rate. The ESRD PPS rate is equal to the Medicare ESRD bundled PPS rate as of January 1, published in the Federal Register in the fourth (4^{th}) quarter of the preceding calendar year. The ESRD PPS rate provides a single payment to freestanding and hospital-based dialysis centers –covering all resources used in providing dialysis treatment in the centers or at a beneficiary's home, including supplies, equipment, drugs, biologicals, laboratory services, and support services. A complete listing of drugs, biologicals and lab services included in the ESRD PPS rate can be viewed at www.medicaid.ms.gov/FeeScheduleLists.aspx.

B. Rate Setting

New dialysis centers are assigned an ESRD PPS rate equal to the prevailing Medicare bundled ESRD base PPS rate, adjusted by the ESRD PPS Wage Index for the provider's Core-Based Statistical Area (CBSA) labor market area.

For each subsequent year, the dialysis center's ESRD PPS rate shall be equal to the bundled ESRD base PPS rate established by Medicare as of January 1, for that year, adjusted by the ESRD PPS Wage Index.

State of Mississippi
Methods and Standards For Establishing Payment Rates-Other Types of Care

Dental and Orthodontic Services - Payment for dental services is the lesser of:

1. The provider's usual and customary charge,
2. A fee from the Mississippi Medicaid statewide uniform dental fee schedule in effect July 1, 2018,
3. The fiftieth (50th) percentile fee reflected in the 2019 National Dental Advisory Service (NDAS) Fee Report, or
4. The fiftieth (50^{th}) percentile fee reflected in the most current NDAS Fee Report for any new dental or orthodontic services not previously priced.

   Once a dental or orthodontic service has been assigned a fee using the methodology above, that dental or orthodontic service will not be repriced. When a dental or orthodontic services Current Dental Terminology (CDT) code is discontinued and replaced with a new CDT code, the new CDT code will not be repriced. All fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

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.

Medically necessary dental services for EPSDT-eligible beneficiaries which exceed the scope for Medicaid beneficiaries as covered in this Plan are reimbursed according to the methodology in the above paragraphs.

The Division of Medicaid will reduce the rate of reimbursement to providers for any service by five percent (5%) of the total allowed amount for all services on a claim. The five percent (5%) reduction has been in place since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction. 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

Therapy Services (provided in a non-hospital setting)

Physical therapy services – Fees for physical therapy services are updated July of each year for services rendered on or after that date and are reimbursed at ninety percent (90%) of the current Medicare rate.

Occupational therapy services – Fees for occupational therapy services are updated July of each year for services rendered on or after that date and are reimbursed at ninety percent (90%) of the current Medicare rate.

Speech-language pathology services – Fees for speech-language pathology services are updated July of each year for services rendered on or after that date and are reimbursed at ninety percent (90%) of the current Medicare rate.

Physical therapy, occupational therapy, and speech-language pathology services 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 described above.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of physical therapy, occupational therapy, and speech-language pathology services in a non-hospital setting. Mississippi Medicaid's fee schedule for physical therapy, occupational therapy, and speech-language pathology services is updated annually with an effective date of July 1 for services provided on or after that date. All rates may be viewed at http://www.medicaid.ms.gov/Providers.aspx.

Notwithstanding any other provision of the Plan, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service as noted above 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

Prescribed Drugs

The Division of Medicaid reimburses for certain legend and non-legend drugs, as authorized under the State Plan, prescribed by a Mississippi enrolled Medicaid prescribing provider licensed to prescribe drugs and dispensed by a Mississippi enrolled Medicaid pharmacy in accordance with Federal and State laws.

The Division of Medicaid Prescription Drug Program conforms to the Medicaid Prudent Pharmaceutical Purchasing Program as set forth in the Omnibus Budget Reconciliation Act of 1990 (OBRA'90) and complies with the Centers for Medicare and Medicaid (CMS) Covered Outpatient Drug Final Rule in accordance with 42 C.F.R. Part 447.

I. The Division of Medicaid reimburses the following drugs as described below:

A. Brand Name drugs – Ingredient cost based on actual acquisition cost (AAC) which is defined as the lesser of:
   1. National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee of $11.29, or
   2. Wholesale Acquisition Cost (WAC) plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
   3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
   4. The provider's usual and customary charge.

B. Generic drugs – Ingredient cost based on AAC which is defined as the lesser of:
   1. NADAC plus a professional dispensing fee of $11.29, or
   2. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
   3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
   4. The provider's usual and customary charge.

C. Reimbursement for 340B covered entities as described in section 1927(a)(5)(B) of the Act, including an Indian Health Service, tribal and urban Indian pharmacy as follows:
   1. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the covered outpatient drug plus a professional dispensing fee of $11.29.
   2. Drugs purchased outside of the 340B program by covered entities – Ingredient cost based on AAC which is defined as the lesser of:
      a. NADAC plus a professional dispensing fee of $11.29, or
      b. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
      c. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no WAC is available, or
      d. The provider's usual and customary charge.
   3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

D. Drugs acquired via the Federal Supply Schedule (FSS) – Ingredient cost based on AAC plus a professional dispensing fee of $11.29.

E. Drugs acquired at Nominal Price (outside of 340B or FSS) – Ingredient cost based on AAC plus a professional dispensing fee of $11.29.

F. Specialty drugs are defined by the Division of Medicaid, updated no less than monthly, and listed at https://medicaid.ms.gov/providers/pharmacy/pharmacy-reimbursement/. Ingredient cost is defined as the lesser of:
   1. For a 340B covered entity:
      a. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the outpatient drug plus a professional dispensing fee of $61.14.
      b. Drugs purchased outside of the 340B program by covered entities – Ingredient cost is defined as the lesser of:
         1) WAC plus zero percent (0%) plus a professional dispensing fee of $61.14, or
         2) A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $61.14 when no WAC is available, or
         3) The provider's usual and customary charge.
   2. For a non-340B covered entity:
      a. WAC plus zero percent (0%) plus a professional dispensing fee of $61.14, or
      b. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $61.14 when no WAC is available, or
      c. The provider's usual and customary charge.

G. Drugs not dispensed by a retail community pharmacy (e.g., institutional or long-term care pharmacy when not included as part of an inpatient stay) – Ingredient cost based on AAC which is defined as the lesser of:
   1. NADAC plus a professional dispensing fee of $11.29, or
   2. WAC plus zero percent (0%) plus a professional dispensing fee of $11.29 when no NADAC is available, or
   3. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $11.29 when no NADAC or WAC are available, or
   4. The provider's usual and customary charge.

H. Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers (HTCs), or Centers of Excellence – Ingredient cost defined as:
   1. For a 340B covered entity:
      a. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the clotting factor product plus a professional dispensing fee of $0.02 per Unit.
      b. Drugs purchased outside of the 340B program by covered entities – Ingredient cost which is defined as the lesser of:
         1) WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit, or
         2) A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02 when no WAC is available, or
         3) The provider's usual and customary charge.

2. For a non-340B covered entity – Ingredient cost is defined as the lesser of:
   a. WAC minus ten percent (10%) plus a professional dispensing fee of $0.02 per Unit, or
   b. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of $0.02 when
   c. The provider's usual and customary charge.

I. Physician Administered Drugs and Implantable Drug System Devices as defined in Attachment 3.1-A, Exhibit 12a, Page 5 and reimbursed:
   1. Using the lesser of methodology under the pharmacy benefit as described in A - H above, or
   2. As described in Attachment 4.19-B, pages 12a.3-12a.4.

II. The Division of Medicaid does not reimburse for Investigational Drugs.

III. Usual and Customary Charges

The Division of Medicaid defines usual and customary charge as the lowest price the pharmacy would charge to a particular customer if such customer were paying cash for the identical prescription drug services on the date dispensed. This includes any applicable discounts including, but not limited to, senior discounts, frequent shopper discounts, and other special discounts offered to attract customers such as four dollar ($4.00) flat rate generic price lists. A pharmacy cannot have a usual and customary charge for prescription drug programs that differs from either cash customers or other third-party programs. The pharmacy must submit the accurate usual and customary charge with respect to all claims for prescription drug services.

IV. Overall, the Division of Medicaid's payment will not exceed the federal upper limit (FUL) based on the NADAC for ingredient reimbursement in the aggregate for multiple source drugs.

Hospital Outpatient Drugs

a. Drugs paid outside the Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC) rate will be reimbursed by a Medicare fee. If there is no Medicare fee the drug will be reimbursed using a MS Medicaid OPPS Chemotherapy fee.

b. The APC and the Medicare fees on the MS Medicaid OPPS fee schedule will be calculated based on the Medicare outpatient Addendum B published by the Centers for Medicare and Medicaid Services (CMS) as of January 1 of each year. The MS Medicaid OPPS fee schedule is updated and effective July 1 of each year with no retroactive adjustments.

c. Chemotherapy drugs and concomitant non-chemotherapy drugs administered during the chemotherapy treatment billed on the same claim as the chemotherapy treatment will be paid a MS Medicaid OPPS Chemotherapy fee. The MS Medicaid OPPS Chemotherapy fee will be the amount listed on the Medicare Average Sales Price (ASP) Drug Pricing File, titled Payment Allowance Limits for Medicare Part B, published by CMS as of January 1 of each year. The ASP files are one-hundred six percent (106%) of the ASP calculated from data submitted by drug manufacturers. The MS Medicaid OPPS Chemotherapy fee is updated and effective July 1 of each year with no retroactive adjustments.

d. If there is no APC relative weight, Medicare payment rate, MS Medicaid OPPS Chemotherapy fee or ASP for a drug, reimbursement is made at no more than one-hundred percent (100%) of the provider's acquisition cost.

e. All fees are published on the agency's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

Physician Administered Drugs and Implantable Drug System Devices

Drugs and Biologicals

Drugs and Biologicals are reimbursed at the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using the April 1 Medicare Part B Drug Fee Schedule of each year.

1) If there is no Medicare Part B Drug Fee Schedule a fee will be calculated at one hundred percent (100%) of the current April 1 Medicare Addendum B Outpatient Prospective Payment System (OPPS) Fee Schedule updated July 1 of each year and effective for services provided on or after that date.

2) If there is no Medicare Part B Drug Fee Schedule or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using Wholesale Acquisition Cost (WAC) + 0% in effect on April 1 of each year and updated July 1 of each year and effective for services provided on or after that date.

3) If there is no (a) Medicare Part B Drug Fee Schedule, Medicare Addendum B OPPS Fee or WAC + 0% or (b) when it is determined, based on documentation, that a drug or biological fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, the price will be one hundred percent (100%) of the current invoice submitted by the provider including:

   (1) A matching National Drug Code (NDC) as the product provided, and

   (2) Medical documentation of the dosage administered.

Implantable Drug System Devices

Implantable drug system devices are reimbursed at the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using the April 1 Medicare Part B Drug Fee Schedule of each year.

1) If there is no Medicare Part B Drug Fee Schedule a fee will be calculated at one hundred percent (100%) of the current April 1 Medicare Addendum B OPPS Fee Schedule updated July 1 of each year and effective for services provided on or after that date.

2) If there is no Medicare Part B Drug Fee Schedule or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using WAC + 0% in effect on April 1 of each year and updated July 1 of each year and effective for services provided on or after that date.

3) If there is no (a) Medicare Part B Drug Fee Schedule, Medicare Addendum B OPPS Fee Schedule or WAC + 0% or (b) when it is determined, based on documentation, that an implantable drug device system fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, the price will be one hundred percent (100%) of the current invoice submitted by the provider including:

   (1) A matching National Drug Code (NDC) as the product provided, and

   (2) Medical documentation of the dosage administered.

Diagnostic or Therapeutic Radiopharmaceuticals and Contrast Imaging Agents

Diagnostic or therapeutic radiopharmaceuticals and contrast imaging agents are reimbursed at the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after that date. The statewide uniform fee schedule will be calculated using one hundred percent (100%) of the April Medicare Radiopharmaceutical Fee Schedule.

1) If there is no Medicare Radiopharmaceutical Fee a fee will be calculated at one hundred percent (100%) of the current April 1 Medicare Addendum B OPPS Fee Schedule updated July 1 of each year and effective for services provided on or after that date.

2) If there is no Medicare Radiopharmaceutical Fee or Medicare Addendum B OPPS Fee Schedule a fee will be calculated using WAC + 0% in effect on April 1 of each year and updated July 1 of each year and effective for services provided on or after that date.

3) If there is no (a) Medicare Radiopharmaceutical Fee, Medicare Addendum B OPPS Fee Schedule or WAC + 0% or (b) when it is determined, based on documentation, that a diagnostic or therapeutic radiopharmaceuticals and contrast imaging agent fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, the price will be one hundred percent (100%) of the current invoice submitted by the provider including:

   (1) A matching National Drug Code (NDC) as the product provided, and

   (2) Medical documentation of the dosage administered.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician Administered Drugs and Implantable Drug System Devices. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#. The Division of Medicaid will reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service when applicable. The five percent (5%) reduction has been in place since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction. The federal match will be paid based on the reduced amount.

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.

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.

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

Hearing Aids - Payment is from a statewide uniform fixed fee schedule based on actual acquisition cost, plus a professional and fitting cost of $80.00.

Hearing aids 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.

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.

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

Eyeglasses - Payment is made from a statewide uniform fixed fee schedule for the professional services of the eye doctor plus actual acquistion cost for the frames and lenses. Effective

Eyeglasses 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 paragarph.

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.

13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services: Mental Health Services described in Attachment 3.1-A, Exhibit 13.d are reimbursed as follows:

Covered services billed using Current Procedural Terminology (CPT) codes for psychiatric therapeutic procedures are reimbursed based on ninety percent (90%) of the most recent final Medicare fee schedule published by the Centers for Medicare and Medicaid Services (CMS) as of April 1 each year and effective July 1 and updated annually.

Covered services billed using Healthcare Common Procedure Coding System (HCPCS) are reimbursed according to a statewide uniform fixed fee schedule. In establishing the fee schedule, the Division of Medicaid (DOM) engaged an actuarial firm to establish fees. DOM provided service descriptions and other information for the existing mental health services offered and the proposed new services. The relationships between comparable services for Medicaid programs in other states were examined to develop factors to apply to existing Mississippi fees to calculate the new service group fees with the fees for the existing mental health services. Consideration was given to the service descriptions, required provider credentials and current costs associated with services. Preliminary fees were modified to better reflect the expected provider cost relative to other mental health services. The agency's state developed fee schedule rate is set as of July 1, 2012, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, state-developed uniform fixed fee schedule rates are the same for both governmental and private providers of mental health rehabilitative services as described in Attachment 3.1-A, Exhibit 13.d. All rates are published on the agency's website at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

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 five percent (5%) reduction in reimbursement is made after the published rate is applied. This provision is not applicable to Indian Health Services or for services provided by the University of Mississippi Medical Center or a state agency, a state facility or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to the division, or a service for which the federal government sets the reimbursement methodology and rate.

State of Mississippi

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

13c. Preventive Services:

The Division of Medicaid reimburses for vaccines and vaccine administration the lower of the provider's usual and customary charge or the below:

Vaccine Ingredient Cost:

The federal Vaccine for Children (VFC) program provides vaccines free of charge to VFC enrolled providers. The Division of Medicaid does not reimburse for the cost of vaccines supplied through the VFC program.

Vaccines not covered through the VFC program are reimbursed:

1. In the pharmacy setting, at the actual acquisition cost (AAC) of the vaccine and are listed on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#. The AAC is defined as the wholesale acquisition cost (WAC) plus 0% for any claim type.

2. In the office setting, according to Attachment 4.19B, page 12a.3.

Vaccine administration for VFC vaccines is outlined in Attachment 4.19-B, page 5a.

Vaccine administration for non-VFC vaccines:

1. For a pharmacist is located in Attachment 4.19-B, page 6d.

2. For practitioners is located on the physician fee schedule at https://medicaid.ms.gov/ providers/fee-schedules-and-rates/.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Division of Medicaid's fee schedule rate was set as of ~~July~~ September 1, 2020, and is effective for services provided on or after that date. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#. The Division of Medicaid will reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The 5% reduction has been in effect since July 1, 2002, and the fee schedule already incorporates the 5% adjustment. The federal match will be paid based on the reduced amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL-SECURITY ACT

State Mississippi

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

17. Nurse-midwife services

The reimbursement for certified nurse midwifery services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

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

Descriptions of Limitations as to Amount, Duration and Scope of Medical Care and Services Provided

Hospice

Mississippi Medicaid's hospice fee schedule is updated annually with an effective date of October 1 for services provided on or after that date. All rates may be viewed at http://www.medicaid.ms.gov/HospiceFees.aspx.

The fee schedule reimburses for the hospice benefit, including routine home care, continuous home care, inpatient respite care and general inpatient care. These rates are authorized by section 1814(i)(c)(ii) of the Social Security Act, which also provides for annual increases in payment rates for hospice care services.

If a Medicaid beneficiary elects the Hospice Program and is admitted to nursing facility as an individual on hospice at the same time or while residing in a nursing facility when the hospice election is made, the State pays the hospice provider a room and board rate that is 95% of the Medicaid Nursing Facility per diem rate for each Medicaid or dually eligible individual on hospice residing in a nursing facility. This rate is required by Section 1902 (a)(13)(B) of the Social Security Act and is an additional per diem rate paid on routine home care and continuous home care days. Any Medicaid payment to the nursing facility ceases when the rate is paid to the hospice provider. The hospice provider pays the 95% rate to the nursing facility for room and board. All nursing facility rates may be viewed at http://www.medicaid.ms.gov/Providers.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MISSISSIPPI

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

Targeted Case Management

1. Targeted Case Management for High-Risk Pregnant Women - The case management fee is a negotiated rate of payment. Potential providers indicated participation was contingent upon establishing a fee that allowed them to recover the cost of providing the services recognizing the additional effort required to initialize each case. The rate will be evaluated annually.

2. Targeted Case Management for High-Risk Infants - The case management fee is based upon the current negotiated fee of:

   $12.00 for open and ongoing EPSDT case management contracts

   $6.00 for closure of EPSDT case management

3. All services - In the case of a public agency, reimbursement determined to be in excess of cost will be recouped by means of a rate adjustment for the next year.

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 Mississippi

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

Targeted Case Management:

Targeted case management for chronically mentally ill community based recipients is reimbursed on a fee-for-service basis based on the number of units provided on behalf of the recipient.

State of Mississippi

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

Targeted Case Management:

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of TCM as described in Supplement 1C to Attachment 3.1-A. The agency's fee schedule rate was set as of January 1, 2019, and is effective for services provided on or after that date. All rates are published on the agency's website at www.medicaid.ms.gov/FeeScheduleLists.aspx.

TCM is billed using the Healthcare Common Procedure Coding System (HCPCS) and reimbursed according to a statewide uniform fixed fee schedule. In establishing the fee schedule, the Division of Medicaid engaged an actuarial firm to establish the TCM fee based on a comparable service for the target population in other Mississippi Medicaid programs. Consideration was given to the service description, required provider credentials and current costs associated with the service. The preliminary fee was modified to better reflect the expected provider cost relative to other TCM services. The agency's state developed fee schedule rate is set as of January 1, 2019, and is effective for services provided on or after that date.

The Division of Medicaid, as required by state law, will reduce the rate of reimbursement to providers for TCM services by five percent (5%) of the allowed amount for that service. The five percent (5%) reduction in reimbursement is made after the published rate is applied to providers who are paid the fee schedule rate.

Payments for TCM for IDD beneficiaries in community-based settings do not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES OTHER TYPES OF CARE

Targeted Case Management Services for children birth to three participating in the Mississippi Early Intervention Program

Payment for Targeted Case Management (TCM) Services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TCM Services by Public Providers

TCM for children, ages birth to three years of age, provided by public providers will be reimbursed through an encounter fee. The TCM encounter fee will be based on the actual costs associated with allowable case management service delivery. 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 July 1 to June 30. The TCM encounter fee will be prospectively determined for an interim period until the end of the reporting period when there is a retrospective cost settlement. The cost report will include both the direct and indirect costs of providing case management services and statistical information regarding the number of children served, including the number of encounters. The cost report will include allocations between the different programs administered by the provider and the computation of the actual cost of case management. The provider must submit a copy of the two most current Random Moment Time Studies (RMTS) with each cost report. The RMTS must show the times allocated to each program administered by the provider.

TCM Services for Non-Public Providers

TCM for children, ages birth to three years of age, provided by non-public providers are reimbursed on a fee-for-services basis.

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

Extended Services for Pregnant Women

1. Reimbursement- Reimbursement will be on a fee-for-service basis, billed monthly on the HCFA-1500 form. Payment will be the lesser of the charge or the established fee.

   The established fees were based on like procedures and services currently paid in the Medicaid program.

   Examples are:

   a. In-home visits pay the rate of the visits in the home by a physician plus estimated travel costs.

   b. High-risk assessment reimbursement is based on physician office visits reimbursement, currently in Mississippi.

2. All Services- In the case of a public agency, reimbursement determined to be in excess of cost will be recouped by means of a rate adjustment for the next year.

3. Reimbursement for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services - The Division of Medicaid reimburses for SBIRT services according to Healthcare Common Procedure Coding System (HCPCS) guidelines and in accordance with provider reimbursement methodologies applicable in the 4.19B pages.

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 PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Mississippi

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

Item 1. Payment of Title XVIII Part A and Part B Deductible/ Coinsurance

The Medicaid agency uses the following method:

	Medicare-Medicaid Individual	**Medicare-Medicaid/ QMB Individual**	**Medicare-QMB Individual**
Part A Deductible Inpatient Hospital	___ limited to State Plan rates _X_ full amount	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount
Part A Coinsurance Inpatient Hospital	___ limited to State plan rates _X_ full amount	___limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount
Part A Deductible Nursing Facility Hospice Home Health	_X_ limited to State plan rates* ___ full amount	X limited to State plan rates ___ full amount	X limited to State plan rates ___ full amount
Part A Coinsurance Nursing Facility Hospice Home Health	X limited to State plan rates* __ full amount	_X_ limited to State plan rates ___ full amount	X limited to State plan rates ___ full amount
Part B Deductible	__ limited to State plan rates X full amount	__ limited to State plan rates _X_ full amount	__ limited to State plan rates _X_ full amount
Part B Coinsurance	__ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount

*The Medicaid agency will not reimburse for services that are not covered under the Medicaid State Plan.

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

Respiratory Care Services for EPSDT recipients, if medically necessary, reimbursed on a fee for service scale.

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.

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

Christian Science Nurses for EPSDT recipients, if medically necessary, are reimbursed according to an established fee for service scale.

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.

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

Christian Science Sanatoria Services for EPSDT recipients, if medically necessary, reimbursed according to an established reimbursement rate.

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 : Mississippi

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

Personal Care Services for EPSDT recipients, if medically necessary, reimbursed on a fee for service scale.

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 of Mississippi

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

24a. Transportation

Emergency Ground Ambulance

The Division of Medicaid reimburses emergency ground ambulance services, including mileage beginning with the twenty-sixth (26th) mile, the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule set as of July 1, 2020 and effective for the services provided on or after July 1, 2020. The fees are calculated at one hundred percent (100%) of the Medicare ambulance urban fee schedule in effect as of January 1, 2020. If a Medicare fee is not established, then the fee is set at one hundred percent (100%) of the Medicare fee for a comparable service.

Emergency Air Ambulance

The Division of Medicaid reimburses the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule updated July 1 of each year and effective for the services listed below provided on or after July 1 of each year and is calculated as seventy percent (70%) of the Medicare ambulance fee schedule in effect as of January 1 of each year. If a Medicare fee is not established, then the fee is set at seventy percent (70%) of the Medicare fee for a comparable service.

1) Emergency Air Ambulance Services provided in a rotary-wing aircraft, including mileage, and
2) Emergency and Urgent Air Ambulance Services provided in a fixed-wing aircraft, including mileage.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of emergency ambulance transportation services. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

The Division of Medicaid will reduce the rate of reimbursement to providers for emergency ambulance transportation services by five percent (5%) of the allowed amount for that service. The five percent (5%) reduction has been in place since July 1, 2002 and the fee schedule already incorporates the five percent (5%) reduction. The federal match will be paid based on the reduced amount.

Non-Emergency Transportation

The Division of Medicaid reimburses for Non-Emergency Transportation (NET) services through a Broker Program or Broker as described in Attachment 3.1-D.

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.

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

Care and services provided in Christian Science sanitoria - Reimbursement is a prospective per diem based on cost report data.

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

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation
	Based on statistical analysis conducted as part of the national norming of the ICAP, the instrument produces a Service Score to reflect the level of care, supervision, and training that a person needs. The Service Scores range from 0 to 100, with lower scores indicating more significant needs. The Service Scores are then combined into nine service levels. The State, in turn, has further collapsed the ICAP service levels into five levels of support, with Level 1 including people with the relatively fewest support needs (ICAP Service Scores of 90 or greater), and Level 5 including people with the greatest support needs (ICAP Service Scores below 30). Day Services - Adult - Low Support (Level 1 & 2) $3.78 per 15 min. unit Day Services - Adult - Medium Support (Level 3) $4.10 per 15 min. unit Day Services - Adult - High Support (Level 4 & 5) $4.66 per 15 min. unit Prevocational Services Low Support (Level 1 & 2) $12.48 per hour Prevocational Services Medium Support (Level 3) $13.28 per hour Prevocational Services High Support (Level 4 & 5) $14.64 per hour Supported Employment – Job Development, $8.80 per 15 minute Supported Employment – Job Maintenance (1 person) $8.35 per 15 minute Supported Employment – Job Maintenance (2 person) $5.22 per 15 minute Supported Employment – Job Maintenance (3 person) $4.17 per 15 minute Supported Living (1 person) $6.34 per 15 minute Supported Living (2 person) $3.97 per 15 minute Supported Living (3 person) $3.17 per 15 minute
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)	

Except as otherwise noted in the plan, state-developed uniform fixed fee schedule rates are the same for both governmental and private providers of habilitation services as described in Attachment 3.1-i.

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

Telehealth Services

Payment for telehealth services is made as follows:

The originating or spoke site provider is paid a Mississippi Medicaid telehealth originating site facility fee per completed transmission. The originating site provider may not bill for an encounter or Evaluation and Management (E&M) visit unless a separately identifiable service is performed.

The distant or hub site provider is paid the current applicable Mississippi Medicaid fee for the telehealth service provided.

The Mississippi Medicaid telehealth originating site facility fee was calculated by an actuarial firm using the May 2013 Bureau of Labor Statistics (BLS) mean wage for Nurse Practitioners in MS adjusted by 35% for benefits and 2% for wage growth at half of the rate for 30 minute increments and is effective for services provided on or after January 1, 2015. The Mississippi Medicaid telehealth originating site facility fee is updated July 1 of each year based on the annual percentage change in the Medicare physician fee schedule for Level III Established Patient E&M code effective on January 1 of each year.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of telehealth services. All rates are published on the Division of Medicaid's website at http://www.medicaid.ms.gov/providers/fee-schedules-and-rates/.

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MISSISSIPPI TITLE XIX HOME HEALTH AGENCIES REIMBURSEMENT PLAN

I. Cost Finding and Cost Reporting

A. Each home health agency participating in the Mississippi Medicaid Program will submit a uniform cost report using the appropriate Medicare/Medicaid forms, CMS-1728-94 or CMS-2552-10, postmarked no later than five (5) calendar months after the close of its cost reporting year. Extensions will be granted only if the provider submits documentation of an extension granted by CMS or a waiver granted by the Executive Director of the Division of Medicaid (DOM). The year-end adopted for the purpose of this plan shall be the same as for Title XVIII, if applicable. One (1) completed copy of the cost report, with original signature, must be submitted to the Division of Medicaid.

B. Cost reports must be submitted by the specified due date, unless a waiver is granted by the Executive Director of the Division of Medicaid, in order to avoid a penalty in the amount of fifty dollars ($50.00) per day for each day the cost report is delinquent. Cost reports with a due date that falls on a weekend, a State of Mississippi holiday or a federal holiday will be due the following business day.

A home health agency which does not file a cost report within five (5) calendar months after the close of its cost reporting year may be subject to cancellation of its provider agreement at the discretion of the Division of Medicaid.

In order for cost reports to be considered complete, the following information must be submitted:

1. Cost report with original signature (1 copy),
2. Working trial balance including assets and liabilities (1 copy),
3. Depreciation schedule (1 copy),
4. Home office cost report and other related party support, i.e., a detailed statement of total costs with adjustments for non-allowable costs and a description of the basis used to allocate the costs, along with a narrative description or a copy of contracts of management services provided by the related party or home office (1copy),
5. Medicaid cost reporting schedules, i.e., Medicaid costs and visits by discipline and a schedule to reflect the lower of reasonable costs or customary charges as applicable to Medicaid (1copy),
6. Medicare provider questionnaire and related exhibits (1copy),
7. Supporting work papers for the Medicare cost report worksheets for reclassifications, adjustments, and related party expenses (1 copy),
8. A narrative description of purchased management services or a copy of contracts for managed services (1 copy), and
9. Verification of the Medicare and Medicaid surety bond premiums included in the cost report (1 copy).

If all required information is not submitted with the original cost report by the due date, the provider will be notified via fax or email to the provider's designee on file with the Division of Medicaid. The notification will contain the specific items missing. The provider will have ten (10) business days from the date of the notification to submit the requested information. If the information has not been received by the tenth (10th) business day, a second request will be faxed or emailed to the provider's designee on file with the Division of Medicaid. The provider will have five (5) business days from the date of the second notification to submit the requested information. Failure to submit the requested information by the fifth (5th) business day after the second notification will result in the related costs being disallowed. The provider will not be allowed to submit the information at a later date, amend the cost report in order to submit the requested information, or appeal the desk review and/or audit as a result of the omission of the requested information.

C. All home health agencies are required to maintain financial and statistical records. For purposes of this plan, statistical records shall include beneficiaries' medical records. All records must be available upon demand to representatives, employees or contractors of the Division of Medicaid, Mississippi Office of the State Auditor, General Accounting Office (GAO) or the United States Department of Health & Human Services (HHS).

D. Records of related organizations as defined by 42 C.F.R. § 413.17 must be available upon demand to representatives, employees or contractors of the Division of Medicaid, Mississippi Office of the State Auditor, GAO, or HHS.

E. The Division of Medicaid shall retain all uniform cost reports submitted for a period of at least five (5) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 45 C.F.R. § 205.60 and Mississippi state law. Access to submitted cost reports will be in conformity with the Mississippi Public Records Act.

II. Audits

A Background

Medicaid (Title XIX) requires that home health agencies be reimbursed on a reasonable cost related basis. Medicare (Title XVIII) is reimbursed based on a prospective payment system. To assure that payment of reasonable cost is being achieved, a comprehensive audit program has been established.

The common audit program has been established to reduce the cost of auditing submitted cost reports under the above programs and to avoid duplicate auditing efforts. The purpose then is to have one audit which will serve the needs of participating programs reimbursing home health agencies for services rendered.

B. Common Audit Program

The Division of Medicaid has entered into agreements with Medicare intermediaries for participation in a common audit program of Titles XVIII and XIX. Under this agreement, the intermediaries shall provide the Division of Medicaid the results of desk reviews and field audits of those agencies located in Mississippi.

C. Other Audits

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

For those home health agencies not covered by the common audits agreement with Medicare intermediaries, the Office of Compliance and Financial Review of the Division of Medicaid shall be responsible for performance of field reviews and field audits. The Office of Reimbursement of the Division of Medicaid will be responsible for performance of desk reviews.

D. Retention

All audit reports received from Medicare intermediaries or issued by the Division of Medicaid will be retained for a period of at least five (5) years.

E. Overpayment

Overpayments as determined by desk review or audit will be reimbursable to the Division of Medicaid. All overpayments shall be reported to HHS as required.

F. Appeal Procedures – Desk Reviews

A provider who disagrees with the results of their original desk review may request a reconsideration. The request for reconsideration must be made in writing to the Division of Medicaid and must include the reason for the request and any supporting documentation, and must be made within thirty (30) calendar days after receipt of the notification of the desk review results. Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received, if by certified mail or overnight mail, on the day the delivery receipt is signed, or if by hand delivery, on the date delivered. The written request for reconsideration should include the provider's name, provider number, cost reporting period, and a detailed description of the adjustment(s) or issues to be reconsidered. If the provider does not request a reconsideration, the Division of Medicaid will consider the provider’s nonresponse as acceptance of the final desk review results. Therefore, no administrative hearing request will be considered.

If the reconsideration is submitted on a timely basis and includes all required information, the Division of Medicaid will review the reconsideration request and respond to the provider within thirty (30) calendar days of the date of receipt of all the required information.

If the provider disagrees with the results of the reconsideration, the provider may request an administrative hearing by the Division of Medicaid as described in Miss. Admin. Code Part 300, within thirty (30) calendar days of the receipt date of the final reconsideration letter.

Unless a timely and proper request for an administrative hearing is received by the Division of Medicaid from the provider, the findings of the Division of Medicaid shall be considered a final and binding administrative determination. Any administrative hearing will be conducted in accordance with the procedures for administrative hearings as adopted by the Division of Medicaid.

G. Final Cost Reports

The final cost reports received from Medicare intermediaries will be used as received from the intermediary to adjust rates. Providers may not appeal to the Division of Medicaid regarding the results of final cost reports. Appeals should be made to the Medicare intermediary under the procedures established by the

intermediary. Once appealed adjustments have been resolved by the Medicare intermediary, the provider's rates will be adjusted if necessary, based on the amended final cost report.

III. Allowable Costs

Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement and the guidelines in the Provider Reimbursement Manual except as modified by Title XIX of the Act, the State Plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Mississippi Medicaid Program.

A. Allowable costs include all expense items that home health agencies incur in meeting:

1. The definition of a home health agency as described in Section 1901(a)(13) of the Social Security Act.

2. Requirements established by the State Agency responsible for establishing and maintaining health standards.

3. Any other requirements for licensing under the state law which are necessary for providing home health services.

B. Implicit in any definition of allowable costs is that those costs should not exceed what a prudent and cost conscious buyer pays for a given service or item. If costs are determined to exceed the level that a prudent buyer would incur, then the excess costs would not be reimbursable under the State Plan.

C. A proportion of costs incurred by a home health agency for services to an eligible Medicaid beneficiary for whom payments are received from third parties are not reimbursable under the State Plan. Appropriate adjustments shall be made.

D. Cost reports for years ended within a calendar year will be used to establish the class ceilings and home health agency rates beginning the following October 1. For example cost reports ended during 1996 will be used to compute the rate effective October 1, 1997. If a provider experiences a change of ownership and files two cost reports during the calendar year, the last filed cost report will be used. Providers will be notified of their respective rates by type of visit and rate ceilings by type of visit prior to implementation of the rates. Any provider of home health services under the Medicaid Program may appeal its prospective rates in accordance with Attachment 4.19-B, Exhibit A, Section VI of the State Plan.

E. The Division of Medicaid shall maintain any responses received on the State Plan, subsequent changes to the State Plan, or rates for a period of five (5) years from the date of receipt. Such comments shall be available to the public upon request.

F. A home health agency may offer to the public new or expanded services or may drop a service. Within sixty (60) days after such an event, the home health agency may submit a budget which shall take into consideration new and expanded services or dropped services. Such budgets will be subject to desk review and audit by the Division of Medicaid. Upon completion of the desk review, new reimbursement rates will be established. Failure to submit budgets within sixty (60) days shall require disallowance of all expenses, direct and indirect, associated with the service. Overpayments as a result of the differences between budget and

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actual costs shall be refunded to the Division of Medicaid. New reimbursement rates shall not exceed the established class ceilings.

G. Type of visit ceilings and individual provider's reimbursement rates will not include amounts representing growth allowances.

H. Payment by type of visit and type of visit ceilings will be established prospectively.

I. The prospectively determined individual home health agency's rate will be adjusted under the following circumstances:

1. Administrative errors on the part of the Division of Medicaid or the home health agencies that result in erroneous payments. Overpayments or underpayments resulting from errors will be corrected when discovered. Overpayments will be recouped by the Division of Medicaid and underpayments will be paid to the home health agency. In no case will payment adjustments be made for administrative error or audit findings prior to notifying the appropriate agency and affording an opportunity to present facts and evidence to dispute the exception.

2. The amendment of a previously submitted cost report. Such amendments must be submitted within eighteen (18) months following the close of the cost report period that is being amended. If an increase or decrease in the rate is computed as a result of the amended cost report, claims history will be adjusted retroactive to the effective date of the original rate.

3. The information contained in the cost report is found to be intentionally misrepresented. Such an adjustment shall be made retroactive to the date of the original rate. At the discretion of the Division of Medicaid, this shall be grounds to suspend the home health agency from the Mississippi Medicaid Program until such time as an administrative hearing is held, if requested by the home health agency.

4. The home health agency experiences extraordinary circumstances which may include, but are not limited to riot, strike, civil insurrection, earthquakes or flood.

5. Under no circumstances shall such adjustment exceed the class ceiling established for the respective classes.

6. The receipt of the final or amended final cost report from the Medicare intermediary.

7. Resolution by the Medicare intermediary of a provider appealed adjustment on a previous year final cost report that was applied to an original desk review. The rates for all years affected by the appealed adjustment for which the final cost report has not been received will be recalculated and claims history adjusted retroactive to the effective date of the original rate.

J. Costs incurred for the acquisition of durable medical equipment, appliances and supplies related to the use of durable medical equipment are non-allowable costs since they are reimbursed outside of the home health agency visit rate.

IV. Rate Methodology

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A. The Division of Medicaid will utilize a prospective rate of reimbursement and will not make retroactive adjustments except as specified in the State Plan. The prospective rates will be determined from cost reports and will be set on a yearly (October 1 -September 30) basis and will be applicable to all facilities with a valid provider agreement. Total payments per month for each home health beneficiary may not exceed the average Medicaid nursing facility rate per month as determined based on the nursing facility rates computed July 1 of each year. The average Medicaid Nursing Facility rates are posted on the Mississippi Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

Providers will be paid the lower of their prospective rate as computed in accordance with the State Plan or their usual and customary charge.

B. Payments of medical supplies which are directly identifiable supplies furnished to individual beneficiaries and for which a separate charge is made will be reimbursed as described in Section IV. D. 5., of this plan. Payments of durable medical equipment, appliances and supplies are reimbursed as described In Section VIII, of the State Plan.

Prospective rates and ceilings will be established for the home health visits.

C. Trend Factor

In order to adjust costs for anticipated increases or decreases due to changes in the economy, a trend factor is computed using the Centers for Medicare and Medicaid Services (CMS) Home Health Market Baskets that are published in the Integrated Healthcare Strategies (IHS) Economic Healthcare Cost Review, or its successor, in the fourth (4^{th}) quarter of the previous calendar year, prior to the start of the rate period. The moving averages for the following market basket components are used: Wages and Salaries, Benefits, Utilities, Malpractice Insurance, Administrative Support, Financial Services, Medical Supplies, Rubber Products, Telephone, Postage, Other Services, Other Products, Transportation, Fixed Capital, and Movable Capital. Relative weights are obtained from the same period National Market Basket Price Proxies-Home Health Agency Operating Costs.

D. Rate Setting

1. Home health agencies are reimbursed for skilled nursing visits at the lower of the following:

(a) trended cost, plus a profit incentive, but not greater than 105% of the median, which is computed as follows:

(1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;

(2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;

(3) array the trended costs from the lowest to the highest with the total number of skilled nursing visits and determine the cost associated with the median visit (interpolate, if necessary);

(4) multiply the median visit trended cost by 105% to determine the ceiling;

(5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;

(6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above; or,

(b) the sum of the following:

(1) the ceiling for direct care and care related costs for nursing facilities at a case mix score of 1.000 as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period; and

(2) the ceiling for administrative and operating costs for Large Nursing Facilities as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period.

(c) plus the medical supply add-on as computed in Section IV. D. 5.

2. Physical therapy visits for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries are reimbursed on a fee-for-service basis at an all-inclusive, per visit rate of $65.00 plus the medical supply add-on as computed in Section IV. D. 5.

3. Speech therapy visits for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries are reimbursed on a fee-for-service basis at an all-inclusive, per visit rate of $65.00 plus the medical supply add-on as computed in Section IV. D. 5.

4. Home health agencies are reimbursed for home health aide visits based on the following methodology:

(a) trended cost, plus a profit incentive, but not greater than 105% of the median, plus the medical supply add-on, which is computed as follows:

(1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;

(2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;

(3) array the trended costs from the lowest to the highest with the total number of home health aide visits and determine the cost associated with the median visit (interpolate, if necessary);

(4) multiply the median visit trended cost by 105% to determine the ceiling;

(5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;

(6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above, plus the medical supply add-on as computed In Section IV. D. 5.

5. The Medical Supply payment amount that will be added on to each discipline will be reimbursed at the lower of the following:

(a) trended medical supply cost per visit computed as follows:

(1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk. review; divide this number by total Medicaid visits);

(2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period; or

(b) 105% of the median medical supply trended cost, which is computed as follows:

(1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1through September30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk review; divide this number by total Medicaid visits);

(2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;

(3) array the trended costs from the lowest to the highest with the total number of Medicaid visits per the desk review and determine the cost associated with the median visit (interpolate, if necessary);

(4) multiply the median visit trended cost by 105% to determine the ceiling.

V. New Providers

1. Changes of Ownership

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For purposes of this plan, a change of ownership of a home health agency includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash, transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the agency. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship.

A home health agency which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the change of ownership. The new owner will be assigned the previous owner's rate. The Division of Medicaid will update the provider's information in the Medicaid Management Information System (MMIS).

The new owner, upon consummation of the transaction affecting 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 of Medicaid.

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.

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.

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 beneficiaries 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.

VIII. Durable Medical Equipment

A. The payment for the purchase of new Durable Medical Equipment (DME) is the lesser of the provider's usual and customary charge or a fee from statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after July 1. The statewide uniform fee schedule will be calculated using eighty percent (80%) of the Medicare rural rate, if available, or the non-rural rate if there is no rural rate, on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year.

1. When it is determined by DOM, based on documentation, that the DMEPOS fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, then a fee will be calculated using market research from the area.

B. If there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid based on the lower of the Division of Medicaid's average/established fee or the average of the fees from other states, when available, or determine the fee from cost information from providers and/or manufacturers, survey information from national fee analyzers, or other relevant fee-related information. The fees will be updated every three (3) years effective July 1 of that third (3rd) year.

C. If there is no DMEPOS fee or a fee determined by the Division of Medicaid, the provider will be reimbursed a fee calculated through the following manual pricing:

1. Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%), or

2. If there is no MSRP, then the provider's invoice received from a wholesaler or manufacturer plus twenty percent (20%).

D. The payment for rental of DME is made from a statewide uniform fee schedule based on ten percent (10%) of eighty percent (80%) of the Medicare DMEPOS or Medicaid established fee as described in letter A or B not to exceed ten (10) months. After rental benefits are paid for ten (10) months, the DME becomes the property of the Mississippi Medicaid beneficiary unless otherwise authorized by the Division of Medicaid through specific coverage criteria.

E. The payment for purchase of used DME is made from a statewide uniform fee schedule based on fifty percent (50%) of eighty percent (80%) of the Medicare DMEPOS or Medicaid established fee as described in letter A or B.

F. The payment for repair of DME is the cost of the repair, not to exceed fifty percent (50%) of eighty percent (80%) of the Medicare DMEPOS or Medicaid established fee as described in letter A or B.

G. Any durable medical equipment not listed on the fee schedule may be requested for coverage by submitting documentation to the Division of Medicaid's UM/QIO who will determine medical necessity on a case-by-case basis.

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DME for Early and Periodic Screening, Diagnosis, and Treatment (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 paragraphs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of DME. The Division of Medicaid's fee schedule rate was set as of July 1, 2020, and is effective for services provided on or after that date. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#. Notwithstanding any other provision of this section, the Division of Medicaid shall reduce the rate of reimbursement to DME providers for any service by five percent (5%) of the allowed amount for that service. The 5% reduction has been in effect since July 1, 2002. The federal match will be paid based on the reduced amount.

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Medical Supplies

A. The payment for the purchase of Medical Supplies is the lesser of the provider's usual and customary charge or a fee from a statewide uniform fee schedule updated July 1 of each year and effective for services provided on or after July 1. The statewide uniform fee schedule will be calculated using eighty percent (80%) of the rural rate, if available, or the non-rural rate if there is no rural rate, on the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1 of each year.

1. When it is determined by DOM, based on documentation, that the DMEPOS fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, then a fee will be calculated using market research from the area.

B. If there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid based on the lower of the Division of Medicaid's average/established fee or the average of the fees from other states, when available, or determine the fee from cost information from providers and/or manufacturers, survey information from national fee analyzers, or other relevant fee-related information. The fees will be updated every three (3) years effective July 1 of that third (3rd) year.

C. If there is no DMEPOS fee or a fee determined by the Division of Medicaid, the provider will be reimbursed a fee calculated through the following manual pricing:

1. Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%), or

2. If there is no MSRP, then the provider's invoice received from a wholesaler or manufacturer plus twenty percent (20%).

D. Any medical supplies not listed on the fee schedule may be requested for coverage by submitting documentation to the Division of Medicaid's UM/QIO who will determine medical necessity on a case-by-case basis.

Medical Supplies 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 paragraphs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of medical supplies. The Division of Medicaid's fee schedule rate was set as of July 1, 2020, and is effective for services provided on or after that date. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#. Notwithstanding any other provision of this section, the Division of Medicaid shall reduce the rate of reimbursement to medical supply providers for any service by five percent (5%) of the allowed amount for that service. The 5% reduction has been in effect since July 1, 2002. The federal match will be paid based on the reduced amount.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Pursuant to the provisions of Section 25-14-1, et seq., Mississippi Code of 1972, as Amended, individual providers of medical care under Title XIX are eligible to participate in the Deferred Compensation Plan administered by the Mississippi Public Employees Retirement System Board. The Medicaid fiscal agent defers compensation of individual providers in accordance with the agreement between the provider and the Public Employees Retirement Board. All such deferred payments are made in accordance with State and Federal legal requirements pertaining to deferred compensation plans.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Coverage for Aliens — Payment to a provider who renders a covered service to an alien due to an emergency medical condition shall be at the same rate that is payable for that same service when rendered to any other Medicaid recipient who is not an alien.

TN No. 87-22 DATE/RECEIPT 10-30-
SUPERSEDES DATE/APPROVED 1-15-
TN No. New DATE/EFFECTIVE 10-1-

State of Mississippi

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

REIMBURSEMENT FOR INDIAN HEALTH SERVICES

AND TRIBAL 638 HEALTH FACILITIES

Services provided by or through facilities of the Indian Health Services (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act, also known as Tribal 638 facilities, are paid at the most current rates published in the Federal Register.

The most current published outpatient per visit rate, also known as the outpatient all-inclusive rate, is paid for up to five (5) outpatient visits per beneficiary per calendar day for professional services.

An outpatient visit is defined as a face-to-face or telemedicine contact between any health care professional, at or through the IHS facility as described above, authorized to provide services under the State Plan and a beneficiary for the provision of Title XIX defined services, as documented in the beneficiary's medical record.

To be included in the outpatient per visit rate are certain pharmaceutical/drugs, dental services, rehabilitative services, behavioral health services, any and all ancillary services, and emergency room services provided on-site and medical supplies incidental to the services provided to the beneficiary.

State of Mississippi

POLICY REGARDING PAYMENT FOR RESERVING BEDS DURING A RECIPIENT'S ABSENCE FROM A LONG-TERM CARE FACILITY

Reserved Bed Days Payments

The Division of Medicaid will reimburse a long-term care facility for bed days held for Title XIX beneficiaries under the following conditions and limitations.

A. Hospital Leave

Facilities will be reimbursed a maximum of fifteen (15) days for each hospital stay for residents requiring acute hospital care. Residents must receive continuous acute care during acute hospital leave. Should a resident be moved from an acute care hospital bed to a bed in the hospital that is certified for a less than acute care service, the Medicaid program may not be billed for any period of time in which services other than acute care services are received by the resident. The period of leave will begin the calendar day the resident was admitted to an inpatient hospital for continuous acute care. A new leave of absence for hospitalization does not begin until the resident returns to the facility for a period of twenty-four (24) hours or longer.

The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed may not be filled with another resident during the covered period of hospital leave. Facilities which submit hospital bed hold may not refuse to readmit a resident from the hospital when the resident has not been hospitalized for more than fifteen (15) consecutive days and still requires nursing facility services.

Each facility must establish and follow a written bed-hold and resident return policy which conforms to requirements of the Medicaid State Plan and other state and federal regulations. Hospital leave days may not be billed if the facility refuses to readmit the resident under their resident return policy. Repayment will be required of a facility which bills Medicaid for fifteen (15) consecutive days of hospital leave, discharges the resident, and subsequently refuses to readmit the resident under their resident return policy when a bed is available. Leave days must be billed in accordance with the applicable Mississippi Division of Medicaid Provider Billing Handbook and Administrative Code.

B. Home/Therapeutic Leave

The Division of Medicaid will reimburse long-term care facilities for home/therapeutic leave days with limits per resident, per state fiscal year (July 1 - June 30), as determined by the Mississippi State Legislature. Nursing Facility residents are allowed forty-two (42) days per state fiscal year in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) residents are allowed sixty-three (63) days per state fiscal year in addition to

State of Mississippi

POLICY REGARDING PAYMENT FOR RESERVING BEDS DURING A RECIPIENT'S ABSENCE FROM A LONG-TERM CARE FACILITY

Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. Psychiatric Residential Treatment Facility (PRTF) residents are allowed eighteen (18) days per state fiscal year. Leave days must be determined, authorized and billed in accordance with the applicable Mississippi Division of Medicaid Provider Billing Handbook and Administrative Code. Therapeutic leave days must be included in the resident's plan of care in accordance with 42 C.F.R § 447.40.

C. Bed Hold Days Payment

A facility will be paid its per diem rate for the allowed bed hold days. For purposes of calculating the case mix average of the facility, residents on allowable leave will be classified at the lower of the case mix weight as computed for the resident on leave using the assessment being utilized for payment at the point in time the resident starts the leave, or a case mix score of 1.000.

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR

DIVISION OF MEDICAID

STATE PLAN

GUIDELINES FOR THE REIMBURSEMENT

FOR MEDICAL ASSISTANCE

BENEFICIARIES OF

LONG TERM CARE FACILITIES

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Introduction

This plan is for use by providers, their accountants, the Division of Medicaid, and its fiscal agent in determining the allowable and reasonable costs of and corresponding reimbursement for long-term care services furnished to Medicaid beneficiaries. The plan contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Division of Medicaid. These procedures will be used in determining the payment to the provider of its allowable and reasonable costs. The payment to nursing facility providers only will be under a case mix reimbursement system.

The program herein adopted is in accordance with Federal Statute, 42 U.S.C.A., section 1396a(A)(13) and (28). The applicable

Federal Regulations are 42 CFR 440.160; 42 CFR 441, Subpart D; 42 CFR 447, subparts B and C; and 42 CFR 483, subparts B, D, F, and I. Each long-term care facility that has contractually agreed to participate in the Title XIX Medical Assistance Program will adopt the procedures set forth in this plan; each must file the required cost reports and will be paid

for the services rendered on a rate related to the allowable and reasonable costs incurred for care and services provided to Medicaid beneficiaries. Payments for services will be on a prospective basis.

In adopting these regulations, it is the intention of the Division of Medicaid to pay the allowable and reasonable costs of covered services and establish a trend factor to cover projected cost increases for all long-term care providers. For nursing facility providers only, the Division of Medicaid will include an adjustable component in the rate to cover the cost of service for the facility specific case mix of residents as classified under the Centers for Medicare and Medicaid Services Minimum Data Set Resident Utilization Group IV, Set F01, 48-Group, Nursing Only (MDS RUG IV). While it is recognized that some providers will incur costs in excess of the reimbursement rate, the objective of this plan is to reimburse providers at a rate that is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated nursing facilities that comply with all requirements of participation in the Medicaid program.

As changes to this plan are made, the plan document will be updated on the Medicaid website.

Questions related to this reimbursement plan or to the interpretation of any of the provisions included herein should be addressed to:

Office of the Governor
Division of Medicaid
Suite 1000, Walter Sillers Building
550 High Street
Jackson, Mississippi 39201

CHAPTER 1

PRINCIPLES AND PROCEDURES

1-1 General Principles

A facility's direct care costs, therapy costs, care related costs, administrative and operating costs and property costs related to covered services will be considered in the findings and allocation of costs to the Medical Assistance Program for its eligible beneficiaries. Costs included in the per diem rate will be those necessary to be incurred by efficiently and economically operated nursing facilities that comply with all requirements of participation in the Medicaid program with the exception of services provided that are reimbursed on a fee for service basis or as a direct payment outside of the per diem rate.

1-2 Classes of Facilities

Specific classes are used as a basis for evaluating the reasonableness of an individual provider's costs. The classes consist of Small Nursing Facilities (1 - 60 beds), Large Nursing Facilities (61 or more beds), Nursing Facilities for the Severely Disabled (NFSD), Psychiatric Residential Treatment Facilities (PRTF), and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

1-3 Cost Reporting

A. Reporting Period

All Nursing Facilities, PRTFs, and ICF/IIDs shall file cost reports based on a standard year end as prescribed by the provisions of this plan. State owned facilities shall file cost reports based on a June 30 year end. County owned facilities shall file cost reports based on a September 30 year end. All other facilities shall use a standard year end of December 31. Standard year end cost reports should be filed from the date of the last report. Facilities may request to change to a facility specific cost report year end, if the requested year end is the facility's Medicare or corporate year end.

Other provisions of this plan may require facilities to file a cost report for a period other than their standard reporting year. Facilities which previously filed a short period cost report that includes a portion of their standard reporting year must file a cost report for the remainder of their standard reporting year, excluding the short period for which a report was previously required. For example, a facility that has a standard reporting year of January 1 through December 31 and undergoes a change of classification on April 1, would be required to file the following cost reports:

1. a cost report for the period January 1 through March 31;

2. a short-period cost report would be required per Section 1-3, Q, for the period April 1 through June 30; and

3. a regular year-end cost report for the period July 1 through December 31.

B. When to File

Each facility must submit a completed cost report on or before the last day of the fifth month following the close of the reporting period. Should the due date fall on a weekend, a State of Mississippi holiday or a federal holiday, the due date shall be the first business day following such weekend or holiday.

C. Extension for Filing

Extensions of time to file may be granted due to unusual situations or to match a Medicare filing extension for a provider-based facility. The extensions may only be granted by the Director of the Division of Medicaid.

D. Delinquent Cost Reports

Cost reports that are submitted after the due date will be assessed a penalty in the amount of $50.00 per day the cost report is delinquent. This penalty may only be waived by the Director of the Division of Medicaid.

E. What to Submit

For facilities with costs allocated from hospitals, home offices and related management companies the listed information is required for all entities. All cost reports must be filed in electronic format, with the following:

1. Working Trial Balance, facility and home office (if applicable);

2. Grouping schedule showing the general ledger accounts grouped together and reported on the various lines of the cost report.

3. Depreciation Schedule(s). If the facility has different book and Medicaid depreciation schedules, copies of both depreciation schedules must be submitted.

4. Any work papers used to compute the reclassifications and adjustments made in the cost report(s);

5. Narrative description of purchased management services or a copy of contracts for managed services, if applicable;

6. Form 2 with an original signature on the Certification by Officer or Administrator of Provider. Scanned signatures are acceptable.
7. Work papers that support the ventilator dependent care unit form, if applicable.

When it is determined that a cost report has been submitted that is not complete enough to perform a desk review, the provider will be notified. The provider must submit a complete cost report. If the request is made and the completed cost report is not received on or before the due date of the cost report, the provider will be subject to the penalties for filing delinquent cost reports. When it is determined that the cost report submitted is complete but is missing certain information, providers will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit

the additional information. For cost reports which are submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information will be made. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. Information that is requested that is not submitted following either the first or the second request may not be submitted for reimbursement purposes. Providers will not be allowed to submit the information at a later date, at the time of audit, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including revenue cost findings, is omitted.

F. Where to File

The cost report and related information must be uploaded electronically to the cost report data base as designated by the Division of Medicaid.

G. Cost Report Forms

All cost reports must be filed using forms and instructions that

are adopted the Division of Medicaid.

H. Amended Cost Reports

The Division of Medicaid accepts amended cost reports in electronic format for a period of thirty-six (36) months following the end of the reporting period. Amended cost reports should include Form 1, in order to explain the reason for the amendment in the Section II; Form 2 with original signature; and all forms that are being amended along with work papers for any revised reclassifications and/or adjustments. Each form and schedule submitted should be clearly marked "Amended" at the top of the page. Amended cost reports submitted after the annual base rate is determined will be used only to adjust the individual provider's rate. Cost reports may not be amended after an audit has been initiated.

I. Desk Reviews

The Division of Medicaid will conduct cost report reviews, as deemed necessary, prior to rate determination. The objective of the desk reviews is to evaluate the necessity and reasonableness of facility costs in order to determine the allowable costs used in the calculation of the prospective per diem rate.

Desk review will be performed using desk review programs developed by the Division of Medicaid. Providers will be notified, in writing, of all adjustments made to allowable costs.

Copies of desk review work papers will be furnished to the provider upon written request. Facilities have the right of appeal as described in Section 1-7 of this plan.

The desk review procedures will consist of the following:

1. Cost reports will be reviewed for completeness, accuracy, consistency and compliance with the Mississippi Medicaid State Plan and Division of Medicaid policy. All adjustments (whether in the provider's favor or not) will be made. All adjustments will include written descriptions of the line number on the cost report being adjusted, the reason for the adjustment and the amount of the adjustment, and the reference that is being used to justify the change (Ex. applicable section of the state plan).
2. Providers

may be requested to submit additional information prior to the completion of the desk review.

3. All desk review findings will be sent to the provider or its designated representative.
4. All desk reviews may be amended multiple times.
5. Desk reviews amended after the annual base rate is determined will be used only to adjust the individual provider's rates.
6. Desk reviews may not be the final determination of allowable costs used in the calculation of the provider's rate. All cost reports have the potential to be audited.

J. Audits of Financial Records

The Division of Medicaid will conduct audits as necessary to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost report. Audit adjustments (whether in the provider's favor or not) will be made. All adjustments will include written descriptions of the line number on the cost report being adjusted, the reason for the adjustment, the amount of the adjustment, and the applicable section of the State Plan or CMS Pub. 15-1 that is being used to justify the change.

Audits issued after the annual base rate is determined will be used only to adjust the individual provider's rate.

K. Record Keeping Requirements

Providers must maintain adequate financial records and statistical data for proper determination of costs payable under the program. The cost report must be based on the financial and statistical records maintained by the facility. All non-governmental facilities must file cost reports based on the accrual method of accounting. Governmental facilities have the option to use the cash basis of accounting for reporting. Financial and statistical data must be current, accurate and in sufficient detail to support costs contained in the cost report. This includes all ledgers, books, records and original evidence of cost (purchase requisitions for supplies, invoices, paid checks,

inventories, time cards, payrolls, basis for allocating costs, etc.) which pertain to the determination of reasonable costs. Statistical data should be maintained regarding census by payment source, room numbers of residents, hospital leave days and therapeutic leave days.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant changes are made to the Division of Medicaid. This disclosure should be made as a footnote on the cost report and should include the effect of the change.

All financial and statistical records, including cost reports, must be maintained for a period of three (3) years after submission to the Division of Medicaid. Records pertaining to amended cost reports must be maintained for a period of three (3) years after the submission date of the amended cost report. Records pertaining to open reviews or audits must also be maintained until the review or audit is finalized.

A provider must make available any or all financial and statistical records to the Division of Medicaid or its contract auditors for the purpose of determining compliance with the provisions of this plan or Medicaid policy.

For those cost reports selected for audit, all records which substantiate the information included in the cost report will be made

available to the Division of Medicaid reviewers during the scheduled audit, including any documentation relating to home office and/or management company costs. Records of a non-related management company will be made available to support the non- related party status of the management company. Information requested during an audit that is submitted after the provider's receipt of the Medicaid adjustment report will not be accepted. Providers will not be allowed to submit this information at a later date, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made.

The provider being audited is required to make available within the boundaries of the State of Mississippi, when it is reasonable to do so, all information required for the Division to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. When the Division of Medicaid concurs with the provider that it is not reasonable to make all necessary information available for review within the boundaries of the State of Mississippi (for example, when the records to be reviewed are too costly to ship compared to the costs of travel necessary travel will be paid by the division of Medicaid. However, if, in the opinion of the Division of Medicaid, the necessary information may be reasonably made available within the boundaries of the State of Mississippi and the provider being audited chooses not to make the necessary information available within the State's boundaries, the provider will bear all expenses and costs related to the audit, including, but not limited to travel and reasonable living expenses, and those costs will not be allowable on any subsequent cost report. Travel expenses and costs will include those allowed per policy issued by the Mississippi Department of Finance and Administration, Office of Purchasing and Travel for state employees traveling on official state business. The provider is required to make available to the Division of Medicaid reviewers, whenever possible, adequate space and privacy for the auditors to conduct the audit.

L. Failure to File a Cost Report

Providers that do not file a required cost report within six (6) months of the close of the reporting period will be subject to sanctions as described in Sanctions, Chapter 1 Section 7-C.

M. Change of Ownership

For purposes of this plan, a change of ownership of a facility includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility operations. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer - seller relationship.

Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset whether by acquisition or merger for which any payment has previously been made shall not be considered reasonable in the provision of health care services and, therefore, shall not be included in allowable costs. These costs include, but are not limited to, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies.

Facilities that undergo a change of ownership must file a cost report from the date of change of ownership through the end of the standard year end or other approved year end, as outlined in Section 1-3, A. The cost report must cover a reporting period of at least one month, defined as beginning on or before the fifteenth day of the month. If needed, to comply with this requirement, the initial cost report may cover up to thirteen months.

The cost report for the old owner, used in setting the old owner's rate just prior to the effective date of the change of ownership, will be used to set the base rates of the new owner until such time that the new owner's initial cost report is used under the regular rate setting schedule. Asset additions will be incorporated into the property rate using the regular schedule each January 1. Adjustments to the old owner's cost report otherwise required under this plan will apply to the new owner (i.e. audit adjustments, trend factors). The new owner's initial cost report will be used to rebase the new owner's rate for the second calendar year following the end of the initial cost report.

Example for January 1, 2013 Change of Ownership:

Effective Date	Base Rate	Cost Report Used	Trend Multiplier
December 31, 2012	$174.00	Calendar year 2010	2.0
January 1, 2013	$179.00	Calendar Year 2010	3.0
January 1, 2014	$182.00	Calendar Year 2010	4.0
January 1, 2015	$185.00	Calendar year 2013	2.0

The seller must file a final cost report with the Division of Medicaid from the date of the last cost report to the effective date of the sale. The filing of a final cost report may be waived by the Division, if the cost report will not be needed for a trend factor calculation.

A facility which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the sale. The new owner must submit provider enrollment information required under Division of Medicaid policy.

For sales of assets finalized on or after July 1, 1993, there will be no recapture of depreciation.

N. Increase or Decrease in Number of Medicaid Certified Beds

Facilities which either increase or decrease the number of certified beds by less than one-third (1/3) the current number of certified beds will not be required to file a short-period cost report when the increase or decrease in the number of certified beds does not result in a change of facility classification. The per diem rate

will be revised whenever the number of Medicaid-certified beds changes, however, to reflect the correct number of certified beds and to reflect the proper annualized patient days for the property and return on equity portions of the rate.

Changes that either increase or decrease by one-third (1/3) or more the number of certified beds, must be approved effective the first day of a month. Facilities must file a cost report from the effective date of the increase or decrease of one-third (1/3) or more certified beds through the end of the third calendar month following the effective date of the increase or decrease. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than two (2) months or not more than four (4) months. These facilities must also file a cost report for the period from the date of the last cost report to the effective date of the increase or decrease in the number of beds that results in a change of one-third or more the number of certified beds.

Effective the date of the one-third (1/3) or more change, the interim per diem rate will be revised from the existing rate only to reflect the correct number of certified beds and to reflect the proper annualized patient days for the property and return on equity portions of the rate. Upon request, the facility's interim rate will also be revised to pay the ceilings for direct care and care related and administrative and operating costs. The facility's interim rates will be adjusted retroactively based on the initial cost report, after desk review. The rates computed based on the initial cost report of the facility will be effective beginning the same date the increase or decrease in the number of beds occurred.

O. New Providers

Nursing Facilities and ICF/IIDs beginning operations during a reporting year will file an initial cost report from the date of certification to the end of the third (3rd) month of operation. The Division of Medicaid may lengthen the reporting period of the initial cost report to not more than six (6) months. PRTF's beginning operations during a reporting year will file a cost report from the date of certification to the end of the sixth (6th) month of operation. Facilities will be paid the maximum rate for their classification until the initial cost report is received and the rate is calculated. The maximum rate for nursing facilities is

defined as the ceiling for direct care and care related costs paid based on a case mix of 1.000 plus the ceiling for administrative and operating costs and the gross rental per diem payment as computed under the plan. Quarterly rate adjustments will be made to adjust for changes in the case mix score, once available. The maximum rate for ICF/IIDs and PRTFs is defined as the ceiling for direct care, therapies, care related, administrative and operating plus the gross rental per diem as computed under the plan. New facilities will not be paid a return on equity per diem or a property tax and insurance per diem until the initial cost report is filed.

A retroactive rate adjustment to the initial certification date will be made based on the initial cost report, after desk review. Applicable facility-average case mix score(s) will be applied to nursing facility rates.

For example, a new nursing facility provider enrolls in the Medicaid program effective August 15, 2000. The facility's interim per diem rate is set at the maximum rate for its classification, as defined above. The direct care and care related payment would equal the ceiling, due to use of a case mix score of 1.000. A cost report would be required for the period August 15, 2000 through October 31, 2000. The Division of Medicaid would issue a desk review after receipt and review of

the cost report. In addition, the Division of Medicaid would prepare an "Annual" case mix report to determine the case mix score for the cost report period. A "Quarter Final" case mix report would be prepared to determine the case mix score for each quarter beginning with the quarter July 1, 2000 through September 30, 2000. The facility's rates for the period August 15, 2000 through December 31, 2001 would be calculated using actual cost and census data from the August 15 through October 31 cost report, after desk review. The case mix reports would also be used in calculating the rates. The initial Quarter Final case mix score would be used for the rate periods beginning August 15, 2000; October 1, 2000; and January 1, 2000. The following quarters' rates would be set on the normal schedule using the quarter Final roster score from the second preceding quarter.

P. Out-of-State Providers

For services not available in Mississippi, Nursing Facilities, PRTFs ICF/IIDs and swing beds from states other than Mississippi may file claims for services provided to Mississippi Medicaid beneficiaries that are

considered residents of Mississippi. These providers must provide documentation of their certification for Title XIX and the facility's Medicaid rate for the domicile state. In most cases, payment will be made based on the lesser of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for their classification. The rates may be negotiated. However, the negotiated rate for ICF/IIDs and PRTFs may not exceed the higher of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for their classification. The negotiated rate for NFs may not exceed the higher of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for nursing facilities, as case mix adjusted. The maximum Mississippi Medicaid rate for out-of-state providers is defined for nursing facilities as the ceilings for direct care and care related costs paid based on a case mix of 1.000 plus the ceiling for administrative and operating costs and the gross rental per diem payment as computed under the plan. Classifications which have a case mix adjustment will be computed using a case mix score of 1.000 unless the facility submits an MDS form that is classifiable. The case mix adjustment will be applied to the maximum Mississippi Medicaid rate only when the maximum Mississippi Medicaid rate is determined to be lower than the Medicaid rate of the domicile state and when the Mississippi Medicaid rate is negotiated. The maximum Mississippi Medicaid rate for out-of-state providers is defined for ICF/IIDs and PRTFs as the ceiling for direct care, therapies, care related, administrative and operating plus the gross rental per diem as computed under the plan. The maximum Mississippi Medicaid rate for out-of-state providers will not include a

return on equity per diem or a property tax and insurance per diem. The gross rental per diem used in determining the maximum rate will be based on submitted property information from the provider or a thirty year age in the absence of provider information.

Q. Change of Classification

Changes in the number of Medicaid certified beds resulting in a change of classification must be approved effective the first day of a month. Facilities that undergo a change of classification must file a cost report from the date of the change of classification through the end of the third month following the change. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than one (1) month or not more than four (4) months. Facilities must also file a cost report for the period from the last cost report period to the date of the change.

Effective the date of the change, the interim per diem rate will be changed from the existing rate to reflect the correct number of certified beds and to reflect the proper annualized patient days for the property and return on equity portions of the rate. In addition, the existing rate will be revised to apply the Administrative and Operating ceiling for the new classification. Upon request, the facility's interim rate will also be revised to pay the ceilings for direct care and care related and administrative and operating costs. The facility's interim rates will be adjusted retroactively based on the initial cost report,

after desk review. The rates computed based on the initial cost report of the facility will be effective beginning the same date the change of classification occurred.

1-4 Resident Fund Accounts

Nursing Facilities, ICF/IIDs, and PRTFs must account for the facility's resident fund accounts in accordance with policies and procedures adopted by the Division of Medicaid. These policies and procedures are contained in the appropriate provider manuals. The resident trust fund accounts of each facility will be reviewed annually. Results of the resident trust fund reviews will be reported to the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification. The Division of Medicaid may impose certain sanctions, established by the Division of Medicaid, on those facilities found to be in non-compliant status, based on criteria approved by the Division of Medicaid.

1-5 Admission, Transfer, and Discharge Rights

The facility must establish and practice admission, discharge, and transfer policies which comply with federal and state regulations. Long-term care facilities that participate in the Medicaid program are prohibited from requiring any resident or any resident's family member or representative to give a notice prior to discharge in order to require payment from that resident, family member or representative for days after the discharge date.

1-6 Payments to Providers

A. Acceptance of Payment

Participation in the Title XIX Program will be limited to those providers that agree to accept, as payment in full, the amounts

paid by the Division of Medicaid plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual for all covered services provided to Medicaid patients.

B. Assurance of Payment

The State will pay a certified Title XIX long-term care facility with a valid provider agreement, furnishing services in accordance with these and other regulations of the Mississippi Medical Assistance Program in accordance with the requirements of applicable State and Federal regulations and amounts determined under this plan. Payment rates will be reasonable and adequate to meet the actual allowable costs of a facility that is efficiently and economically operated.

C. Upper limit based on Customary Charges

In no case may the reimbursement rate for services provided under this plan exceed an individual facility's customary charges to the general public for such services, applied in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge. The Division of Medicaid recognizes the requirement that facilities give notice to residents thirty (30) days in advance of a rate change. Presuming that facilities set their private pay rates on the first day of the month, if a facility receives notice from Medicaid less than thirty-five (35) days in advance of their Medicaid rate increase, additional time to properly notify their residents will be granted before the upper limit is applied. However, the facility must adjust the private pay rate as soon as possible and no later than sixty-seven (67) days following the receipt of the rate notification, in order to comply with this limit.

D. Overpayments

An overpayment is an amount which is paid by the Division of Medicaid to a provider in excess of the amount that is computed in accordance with the provisions of this plan. Overpayments must be repaid to the Division of Medicaid within sixty (60) days after the date of discovery. Discovery occurs either (1) on the date the Division of Medicaid first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, or (2) on the date a provider acknowledges an overpayment to the Division of Medicaid in writing, whichever date is earlier. Failure to repay an overpayment to the Division of Medicaid may result in sanctions.

Overpayments documented in audits will be accounted for on the Form CMS-64 Quarterly Statement of Expenditures not later than the second quarter following the quarter in which the overpayment was found.

E. Underpayments

An underpayment occurs when an amount which is paid by the Division of Medicaid to a provider is less than the amount that is computed in accordance with the provisions of this plan. Underpayments will be reimbursed to the provider within sixty (60) days after the date of discovery.

F. Credit Balances

A credit balance, or negative balance, on a provider's account is an amount which is due to the Division of Medicaid. The credit balance is treated as an overpayment by the Division of Medicaid and is subject to the rules described above for overpayments.

1-7 Appeals and Sanctions

A. Appeal Procedures - Desk and Field Reviews

Long-term care providers who disagree with an adjustment to their allowable costs made as a result of a desk review or an audit may request a reconsideration in writing and must include the reason for the reconsideration and any supporting documentation, and must be made within thirty (30) calendar days after receipt of the notification of the adjustment. If the provider disagrees with the reconsideration decision, the provider may file a request for an administrative hearing to the Division of Medicaid. The hearing request must be in writing, must include the reason for the appeal and any supporting documentation, and must be made within thirty (30) calendar days after receipt of the notification of the final reconsideration letter. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the reconsideration request or administrative hearing request. If the provider does not request a reconsideration, the Division of Medicaid will consider the provider’s nonresponse as acceptance of the adjustments made. Therefore, no administrative hearing request will be considered.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, or (b) if by hand delivery, on the date delivered.

Long-term care providers who disagree with an adjustment to the Minimum Data Set (MDS) that changes the classification of the resident to a different MDS RUG IV group than the MDS RUG IV group originally determined by the facility may request a reconsideration in writing and must include the reason for the reconsideration, and must be made within thirty (30) calendar days after the date of the notification of the final case mix review findings report. This request must contain the specific classification adjustment(s) in dispute and the reason(s) the provider believes his/her documentation complies with the Mississippi Supportive Documentation Requirements. If the provider disagrees with the reconsideration decision, the provider may file a request for an administrative hearing to the Division of Medicaid. These adjustments may have been made by either a desk review or an on-site visit. The hearing request must be in writing, must contain the reason for the appeal, and must be made within thirty (30) calendar days after the provider was notified of the final reconsideration letter. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the reconsideration request or administrative hearing request. If the provider does not request reconsideration, the Division of Medicaid will consider the provider’s nonresponse as acceptance of the final case mix review findings report. Therefore, no administrative hearing request will be considered.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, or (b) if by hand delivery, on the date delivered.

The provider may appeal the decision of the Division of Medicaid in matters related to cost reports, including, but not limited to, allowable costs and cost adjustments resulting from desk reviews and audits in accordance with Medicaid policy.

The provider may appeal the decision of the Division of Medicaid in matters related to the Minimum Data Set (MDS) including but not limited to reviews and classifications in accordance with Medicaid policy. Final Roster Reports upon the close of the quarter are not subject to an informal reconsideration or an appeal.

The action of the Division of Medicaid under review shall be stayed until all administrative proceedings have been exhausted.

Appeals by nursing facility providers involving any issues other than those specified above in this section shall be taken in accordance with the administrative hearing procedures set forth in Medicaid policy.

B. Grounds for Imposition of Sanctions

Sanctions may be imposed by the Division of Medicaid against a provider for any one or more of the following reasons:

1. Failure to disclose or make available to the Division of Medicaid, or its authorized agent, records of services provided to Medicaid beneficiaries and records of payment made therefrom.
2. Failure to provide and maintain quality services to Medicaid beneficiaries within accepted medical community standards as adjudged by the Division of Medicaid or the MS Department of Health.
3. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid claim form.

4. Documented practice of charging Medicaid beneficiaries for services over and above that paid by the Division of Medicaid.
5. Failure to correct deficiencies in provider operations after receiving written notice of deficiencies from the Mississippi State Department of Health or the Division of Medicaid.
6. Failure to meet standards required by State or Federal law for participation.
7. Submission of a false or fraudulent application for provider status.
8. Failure to keep and maintain auditable records as prescribed by the Division of Medicaid.
9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.
10. Violating a Medicaid beneficiary's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid program.
11. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.
12. Presenting, or cause to be presented, for payment any false or fraudulent claims for services or merchandise.

13. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.
14. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.
15. Exclusion from Medicare because of fraudulent or abusive practices.
16. Conviction of a criminal offense relating to performance of a provider agreement with the State, or for the negligent practice resulting in death or injury to patients.
17. Failure to submit timely and accurately all required resident assessments.
18. Submitting, or causing to be submitted, false information for the purpose of obtaining a greater case mix facility average score in order to increase reimbursement above what is allowed under the plan.
19. Non-compliance with requirements for the management of beneficiaries' personal funds, as stated in 42 CFR, Section 483.10, and as hereafter amended.
20. Failure to submit timely and accurately all required cost reports.

C. Sanctions

After all administrative proceedings have been exhausted, the following sanctions may be invoked against providers based on the grounds specified above:

1. Suspension, reduction, or withholding of payments to a provider,
2. Imposition of Civil Money Penalties upon Medicaid only, Title XIX participating long-term care facilities found to be in noncompliance with division and certification standards in accordance with federal and state regulations, including interest at the same rate calculated by the Department of Health and Human Services and/or the Centers for Medicare and Medicaid Services under federal regulations set forth in CFR 42, Section 488.400 - 488.456 and as hereafter amended.
3. Suspension of participation in the Medicaid Program,

   and/or
4. Disqualification from participation in the Medicaid Program. Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to beneficiaries, their families or any other third party.

1-8 Public Notification

Public notice of any changes in the statewide methods and standards for setting payment rates shall be provided as required by applicable law.

1-9 Plan Amendments

Amendments to the Mississippi Medicaid State Plan will be made in accordance with Section 43-13-117 of the Mississippi Code of 1972.

The state has in place a public process which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act and 42 CFR, section 447.205.

1-10 Special Services

A. Swing Bed Services Reimbursement. Swing-bed providers will be reimbursed for the eligible days of care rendered Medicaid beneficiaries in each calendar month. The rates will be redetermined annually for the reimbursement period July 1 through June 30. The methods and standards for determining the

reimbursement rate for swing-bed services will be the statewide average rate paid under the State Plan during the previous calendar year to Nursing Facilities.

The swing-bed provider will be responsible for collecting that portion of the total amount (days X rate) owed by the Medicaid beneficiary as indicated on the Division of Medicaid Form DOM-317. Hospitals operated in conjunction with a distinct part nursing facility will not receive swing-bed reimbursement for those patient days when empty distinct part long-term care beds are available. Hospitals may bill for those ancillary services rendered to swing-bed patients and not customarily furnished by nursing facilities such as a hospital outpatient claim or lab referral claim.

Cost Reporting. Swing-bed providers will not file separate cost reports required of other nursing facilities, nor will rates or amounts paid for swing- bed care be considered in the determination of nursing facility rates.

B. Services for Children Under Age 21

Any services required for children under age 21, that are not covered elsewhere in this plan, will be provided.

Reimbursement for these services will be at an amount not greater than ninety percent (90%) of the provider's usual and customary charges for the services.

Services that are required for children under age 21 that are available only in a state other than Mississippi will be reimbursed at the lower of the provider's Medicaid rate, as defined by the Medicaid agency in the provider's state of operation, or the Mississippi Medicaid maximum rate for that classification of facility. If the services are required at a type of facility for which the Mississippi Medicaid plan does not provide payment methodology, reimbursement will be made at the lesser of the provider's Medicaid rate, as defined by the Medicaid agency in the provider's state of operation or an amount not greater than ninety percent (90%) of the provider's usual and customary charges for the services. The Division of Medicaid will not reimburse a facility at a rate greater than the provider's customary charges to the general public for the services.

CHAPTER 2

STANDARDS FOR ALLOWABLE COSTS

2-1 Allowable and Non-Allowable Costs

The Division of Medicaid defines allowable and non-allowable costs to identify expenses which are reasonable and necessary to provide care to Nursing Facility, PRTF and ICF/IID residents. The standards listed below are established to provide guidance in determining whether certain selected cost items will be recognized as allowable costs. In the absence of specific instructions or guidelines in this plan, facilities will submit cost data for consideration for reimbursement. Allowable costs must be compiled on the basis of generally accepted accounting principles (GAAP). In cases where Division of Medicaid cost reporting rules conflict with GAAP, IRS or CMS PRM 15-1, Division of Medicaid rules take precedence for Medicaid provider cost reporting purposes. Allowable costs are based on CMS PRM 15-1 standards except as otherwise described in this plan. If the Division of Medicaid classifies a particular type of expense as non-allowable for the purpose of determining the rates, it does not mean that individual providers may not make expenditures of this type.

A. Allowable Costs

In order for a cost to be an allowable cost for Medicaid reimbursement purposes, it must be reasonable and necessary in the normal conduct of operations related to providing patient care in accordance with CMS PRM 15-1 guidelines.

The following list of allowable costs is not comprehensive, but serves a general guide and clarifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is not an allowable cost.

1. Accounting Fees. Accounting fees incurred for the preparation of the cost report, audits of the financial records, bookkeeping services, tax return preparation of the nursing facility and other related services are allowable costs.

   Accounting fees incurred for personal tax planning and income tax preparation of the owner are not allowable costs. Accounting fees resulting from suits against federal and or state agencies administering the Medicaid program are not allowable costs and, should not be claimed until all appeal remedies have been exhausted and the provider has prevailed in their appeal or litigation. Once the provider has prevailed and all appeal remedies have been exhausted, the provider may claim these accounting fees in the current cost report period open at that time.

2. Advertising Costs-Allowable. The allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing

covered services to Medicaid beneficiaries by providers of services. In determining the allowability of these costs, the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions will be considered. To be allowable, such costs must be common and accepted occurrences in the field of the provider's activity.

Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples are: visiting hours information, conduct of management-employee relations, etc. Costs connected with fund-raising are not included in this category.

Costs of advertising for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in patient care activities or in the development and maintenance of the facility.

Costs of advertising for procurement of items or services related to patient care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.

Costs of advertising incurred in connection with obtaining bids for construction or renovation of the provider's facilities should be included in the capitalized cost of the asset.

Costs of informational listings of providers in a telephone directory, including the "yellow pages," or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry.

Costs of advertising for any purpose not specified above or not excluded in the non-allowable cost section of this plan may be allowable if they are related to patient care and are reasonable.

3. Barber and Beauty Expense. The cost of providing barber and beauty services to residents is considered an allowable cost only if the residents are not charged for these services.

4. Board of Directors Fees. Fees paid to board members for actual attendance at Board of Directors' meetings are allowable costs, subject to the test of reasonableness. For this purpose, the table below will assist in the determination of reasonable fees. Related travel expenses, as long as determined reasonable, will also be considered an allowable cost. This table is effective for the calendar year 1991. The Division of Medicaid will update the table annually based on the change in the Consumer Price Index for all urban consumers (all items). The Division of Medicaid will issue a new table each year that will contain the limitations, as computed above, for the previous calendar year. The new limits will be published in the Medicaid Bulletin. The table for calendar year 1991 is as follows:

Nursing Facilities and ICF/IID Facilities	Annual Director's Fees
0 to 99 Beds	Total fees of $2,288 per meeting, maximum of 4 meetings per year
100 to 199 Beds	Total fees of $3,432 per meeting, maximum of 4 meetings per year
200 to 299 Beds	Total fees of $4,576 per meeting, maximum of 4 meetings per year
300 to 499 Beds	Total fees of $5,720 per meeting, maximum of 4 meetings per year
500 or More Beds	Total fees of $6,864 per meeting, maximum of 4 meetings per year

5. Compensation of Outside Consultants. This includes, but is not limited to, activities consultants, medical directors, registered nurses, pharmacists, social workers, dieticians, medical records consultants, psychologists, physical therapists, speech therapists, occupational therapists, dentists, and other outside services related to patient care.

6. Contract Labor. This includes, but is not limited to, payments for contract registered nurses, licensed practical nurses, aides, therapists, dietary services, housekeeping services and maintenance services and agreements.

7. Depreciation Expense.

a. Administrative and Operating Depreciation Expense.

Assets purchased on or after January 1, 2013, excluding vehicles, for an amount of $5,000 or greater but collectively less than the amount determined to be the cost of a new bed as defined in Chapter 3 for nursing facilities, Chapter 4 for ICF/IIDs, or Chapter 5 for PRTFs should be depreciated using the straight line method over three (3) to five (5) years. Vehicles purchased for facility use that are related to patient care should be depreciated using the straight line method over three (3) to five (5) years. These depreciation expenses should be included in Administrative and Operating Costs on the cost report.

b. Property and Equipment Depreciation Expense.

Assets purchased on or after January 1, 2013, excluding vehicles, for an amount of $5,000 or greater and collectively equal to or greater than the new bed value determined for the year of the purchase, as defined by other portions of this plan, should be considered as either new beds, replaced beds, or a renovation. These depreciation expenses should be included in Property and Equipment Costs on the cost report.

c. Shared Assets.

In facilities with distinct parts, purchases not solely related to the certified beds for the classification being considered will be allocated between the certified beds for the classification being considered and the other beds in the facility. The allocation will be based on the number of beds in the classification being considered to total facility beds at year end. The portion allocated to the classification being considered is combined with assets solely to the certified beds for comparison to the new bed value for type of depreciation expense determinations. Assets purchased for use solely by the portion of the facility other than the classification being considered will not be considered as

new beds, replaced beds, renovated beds, or for depreciation expense.

d. Assets less than $5,000.

Assets purchased for an amount less than $5,000 should be included in allowable costs as a current period expense.

Additionally, the portion of assets allocated to the certified unit for less than $5,000 should be expensed in the current period. The expense should be included in the Miscellaneous Administrative and Operating Costs on the cost report.

e. Facility depreciation.

A facility may choose to depreciate an asset that cost less than $5,000 or was allocated at less than $5,000. In these cases, the Division of Medicaid will not adjust the depreciation expense nor enter an adjustment to allow the asset as an expense in the cost report period. Similarly, the provider should not adjust depreciation expense and expense these assets, for cost report purposes only, either. However, if the provider chooses to do so, a separate depreciation schedule, for Medicaid purposes only, must be prepared and submitted with these expensed assets removed. Additionally, the capitalized asset will not be used for comparison to the new bed value to determine depreciation type. Only assets greater than or equal to $5,000 are used for the comparison.

8. Dues.

Providers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary provider operating costs. Some of those organizations promote objectives in the provider's field of health care activity. Others have purposes or functions which bear little or no relationship to this activity. In order to determine for Medicaid purposes the allowable costs incurred as a result of membership in various organizations, memberships have been categorized into three basic groups: (A) professional, technical or business related; (B) civic; and (C) social, fraternal, and other. The Division of Medicaid will look to comparable providers, as well as to the justification by the individual provider, in determining the reasonableness of the number of organizations in which the provider maintains memberships and the claimed costs of such memberships.

A. Professional, Technical, or Business Related Organizations. Organizations are classified in this category if their functions and purposes can be reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services. Memberships in these organizations are generally comprised of provider, provider personnel, or others who are involved or interested in patient care activities. Costs of memberships in such organizations are allowable for purposes of program reimbursement.

B. Civic Organizations. These organizations function for the purpose of implementing civic objectives. Reasonable costs of membership are an allowable cost. Examples of these types of dues are: American Legion, Chamber of Commerce, Rotary Club, Kiwanis Club, Lions Club, and Jaycees.

C. Social, Fraternal, and Other Organizations. Generally, these organizations concern themselves with activities unrelated to their members' professional or business activities. Their objectives and functions cannot be considered reasonably related to the care of beneficiaries.

Consequently, provider costs incurred in connection with memberships in social, fraternal, and other organizations are not allowable.

9. Legal Fees. Legal fees, expenses and costs incurred by nursing facilities shall be allowable, in the period incurred, if said costs are reasonable, necessary and patient-related. These legal fees, expenses and costs shall be documented in the provider's file, and shall be clearly identifiable, including identification by case number and title, if possible. Failure to clearly identify these costs shall result in disallowance.

Legal fees resulting from suits against federal and/or state agencies administering the Medicaid program are not allowable costs and should not be claimed until all appeal remedies have been exhausted and the provider has prevailed in their appeal or litigation. Once the provider has prevailed and all appeal remedies have been exhausted, the provider may claim these legal fees in the current cost report period open at that time.

10. Management Fees Paid to Related Parties and Home Office Costs.

The allowability of the cost of management fees paid to related parties and home office costs will be based on CMS PRM 15-1 standards.

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11. Management Fees Paid to Unrelated Parties. The allowability of the cost of purchased management services will be based on CMS PRM 15-1 standards.

12. Organization Costs. Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the costs of future periods of operation.

Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to States for incorporation.

The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate state or federal authorities, stamp taxes, etc.

Allowable organization costs should be amortized over a period of not less than sixty (60) months.

13. Owners' and Officer's Salaries. A reasonable allowance of compensation for services of owners and officers is an allowable cost, provided the services are actually performed in a necessary function. The requirement that the function be necessary means that had the owner or officer not rendered the services, the institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the facility.

Compensation paid to an employee who is an immediate relative of the owner or officer of the facility is also reviewable

under the test of reasonableness. For this purpose, the following persons are considered "immediate relatives": husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild.

The maximum salary allowed for owners or officers, including owner administrators shall be computed at 150% of the average salary paid to non-owner administrators for the previous calendar year for each classification of facilities. For example: The average salary of non-owner administrators for calendar year 1992 for each classification of facilities would be multiplied by one hundred and fifty percent (150%) to determine the maximum allowable owner administrator or officer salary for calendar year 1993. Limits are published each year in the Medicaid Bulletin. The maximum compensation is considered to include forty or more work hours per week. The maximum will be decreased ratably for owners or officers average time worked which is less than forty hours per week. Owners and officers are allowed to receive compensation from more than one facility. Total hours

worked per week at all owned facilities cannot exceed sixty hours for each individual to be considered allowable. This limitation applies for salaries that are paid by the facility and/or by the home office.

14. Personal Hygiene Items. The cost of routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing, over-the-counter drugs that are not covered by the Mississippi Medicaid drug program, and basic personal laundry. Basic hair cuts and shampoos must be provided by the facility at no additional cost to the resident. Basic haircuts and shampoos may be done by facility staff or a licensed barber or beautician. If the facility elects to use a licensed barber or beautician, the resident may not be charged a fee for the service. Barber and beauty services requested by the resident that are in addition to basic haircuts and shampoos may be billed to the residents.

15. Salaries and Fringe Benefits. Allowable costs include payments for salaries and fringe benefits for those employees who provide services in the normal conduct of operations related to patient care. These employees include, but are not limited to, registered nurses, licensed practical nurses, nurses aides, other salaried direct care staff, director of nursing, dietary employees, housekeeping employees, maintenance staff, laundry employees, activities staff, pharmacy employees, social workers, medical records staff, non-owner administrator, non-owner assistant administrator, accountants and bookkeepers and other clerical and secretarial staff. Fringe benefits include:

A. Payroll taxes and insurance. This includes Federal Insurance Contributions Act (FICA), Social Security, unemployment compensation insurance and worker's compensation insurance.

B. Employee benefits. This includes employer paid health, life, accident and disability insurance for employees; uniform allowances; meals provided to

employees as part of their employment; contributions to employee pension plans; and deferred compensation. The allowable portion of deferred compensation is limited to the dollar amount that an employer contributes during a cost reporting period. The deferred compensation expense must represent a clearly enumerated liability of the employer to individual employees.

16. Start-Up Costs. In the period prior to admission of patients, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they are subject to the reasonableness test and must be capitalized as deferred charges and amortized over a sixty (60) month period beginning with the month in which the first patient is admitted to the facility.

Start up costs include, for example, administrative and nursing salaries, utilities, taxes, insurance, mortgage and other interest, employee training costs, repairs and

maintenance, housekeeping, and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as organization costs, or which may be capitalized as construction costs, must be appropriately classified as such and excluded from start-up costs.

Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratably over a period of sixty (60) consecutive months beginning with the month in which the first patient is admitted to the facility. Where a provider prepares portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time.

17. Supplies and Materials. This includes, but is not limited to, medical supplies, office, dietary, housekeeping, and laundry supplies; food and dietary

supplements; materials and supplies for the operation, maintenance and repair of buildings, grounds and equipment; linens and laundry alternatives; and postage. Medical supplies necessary for the provision of care in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care are allowable costs. Any supplies or equipment ordered by a resident's attending physician must be provided by the facility and will be an allowable cost.

18. Therapy Expenses. Costs attributable to the administering of therapy services are allowable. Physical, Occupational and Speech Language Pathology therapy expenses will be included in the per diem rate for NFSD, PRTF and ICF/IID providers. Physical, Occupational and Speech Language Pathology therapy expenses for Small Nursing Facilities and Large Nursing Facilities will be reimbursed on a fee for service basis. Respiratory therapy expenses will be included in the per diem rate for all long-term care facilities.

19. Travel. Travel expenses incurred for facility business that is related to patient care are allowable costs. Travel must be documented as to the person traveling, dates of the trip, destination, purpose of the trip, expense description, and the cost. Travel incurred by employees not related to the owner for "in-town travel" (travel within the town of the facility) does not need to be itemized if the expenditure is less than $50.00.

20. Utilities. This includes electricity, natural gas, fuel oil, water, waste water, garbage collection, hazardous waste collection, telephone and communications and cable television charges.

21. Medicaid Assessment. The monthly nursing facility, ICF/IID and PRTF bed assessments based on bed occupancy, will be considered allowable costs on the cost report filed by each long-term care facility, in accordance with the CMS Provider Reimbursement Manual, Part 1, Section 2122.1.

22. Training Costs. Training costs, other than nurse aide training, are an allowable cost where the fees paid are (a) to maintain current license/certifications, (b) or directly applicable to your current position, and therefore related to patient care, or (c) for training on software updates. The costs are allowable in the cost report period incurred.

23. Educational costs to attain a college or technical degree resulting in the attainment of an increase in license level (e.g. CNA receiving an LPN, or RN degree or certification) - Costs of education of employees at accredited and technical institutions to acquire an undergraduate or graduate degree are allowable in accordance with the Provider Reimbursement Manual (PRM) 15-1 section 416.3 as modified by the following;

    The costs should not be claimed until the cost report period after the employee has attained their degree/certification. The costs should amortized over a similar number of periods for which tuition was paid or the continued employment agreement period (between the employee and the facility) whichever is longer. i.e. If 4 semesters of tuition were paid, then the expense should be spread over 2 years of a cost report period.

B. Non-Allowable Costs

Certain expenses are considered non-allowable for Medicaid purposes because they are not normally incurred in providing patient care. These non- allowable costs include, but are not limited to, the following types of expenses.

1. Advertising Expense Non-Allowable. Costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.

Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable.

Costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered reductions in the proceeds from the sale and, therefore, are not allowable.

Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the Division of Medicaid or its contractor of the advertising copy and its distribution may then be necessary to determine the specific objective.

2. Bad Debts. Bad debts are not an allowable cost for Medicaid reimbursement purposes.

3. Barber and Beauty Expense. The cost of a barber and beauty shop located in the facility must be excluded from allowable costs if the residents are charged for these services. Costs to exclude include salaries and fringe benefits of barber and beauty shop staff, utilities, supplies and capital costs related to the square footage used for this purpose. If the facility does not submit a cost finding with the cost report, the revenue for barber and beauty services will be deducted from allowable costs. The cost of barber and beauty services provided to residents for which no charge is made should be included in care relatedcosts in the allowable cost section of the cost report.

4. Contributions. Contributions are not an allowable cost. This includes political contributions and donations to religious, charitable, and civic organizations.

5. Feeding Assistant Training. Feeding Assistant training is a non-allowable cost. Reimbursement for feeding assistant training is made to the provider through direct billing.

6. Income Taxes - State and Federal. State and federal income taxes paid are not allowable costs for Medicaid reimbursement purposes.

7. Other Medicaid assessments

   a) Any portion of Medicaid Hospital assessments and IGTs, will be considered non-allowable costs on the cost report filed by each long-term care facility.

   b) Medicaid Assessments other than the monthly Medicaid LTC bed assessments based on occupancy, will be considered non-allowable costs on the cost report filed by each long-term care facility.

7. Life Insurance - Officers, Owners and Key Employees. In general, the cost of life insurance on the officer(s), owner(s), key employee(s) where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured individual, the insurance proceeds are payable directly to the provider. A provider is an indirect beneficiary when another party receives the proceeds of a policy through an assignment by the provider to the party or other legal mechanism but the provider benefits from the payment of the proceeds to the third party.

An exception to these requirements is permitted where (1) a provider as a requirement of a lending institution must purchase insurance on the life of an officer(s), owner(s), or key employee(s) to guarantee the outstanding loan balance, (2) the lending institution must be designated as the beneficiary of the insurance policy, and (3) upon the death of the insured, the proceeds will be used to pay off the balance of the loan. The insurance premiums allowable are limited to premiums

equivalent to that of a decreasing term life insurance policy needed to pay off the outstanding loan balance. In addition, the loan must be related to patient care and be considered an allowable debt as described elsewhere in this plan.

8. Non-Nursing Facility Costs. Facilities which have a portion of the facility that is not certified for Medicaid should allocate the costs associated with that portion of the facility as non-allowable costs. These costs should be allocated based on square footage for fixed costs (i.e. utilities, depreciation, interest), actual salaries and fringe benefits of employees working in the non-certified area, and based on patient days for non-direct costs (i.e. administrative costs, dietary costs), or other methods which are acceptable by Medicare per CMS PRM 15-1 guidelines.

9. Nurse Aide Testing and Training. Nurse aide training and testing is a non-allowable cost. Reimbursement for nurse aide training and testing is made to the provider through direct billing.

10. Other Non-Allowable Costs. The cost of any services provided for which residents are charged a fee is a non-allowable cost. In addition, the amount paid for any item subject to direct reimbursement by the Division of Medicaid is a non-allowable cost.

11. Penalties and Sanctions. All penalties and sanctions assessed to the facility are considered non-allowable costs. These include, but are not limited to, delinquent cost report penalties, Internal Revenue Service penalties, civil money penalties, delinquent bed assessment penalties, late payment fees and insufficient check charges.

12. Television. The cost of providing television service to residents is a non-allowable cost if residents are charged a fee for this service.

13. Vending Machines. The cost of providing vending machines is a non-allowable cost. If a cost finding is not submitted with the cost report, the vending machine revenues will be offset against allowable costs.

2-2 Nurse Aide Training and Competency Testing

Reasonable costs of training and competency testing of nursing assistants in order to meet the requirements necessary for the nursing assistants to be certified in accordance with the Omnibus Budget Reconciliation Act of 1987 are to be billed directly to the Division of Medicaid. The nursing facility will be directly reimbursed by the Division of Medicaid following policies stated in the Mississippi Medicaid Nursing Facility Manual. Payments made by Medicaid will be based on the facility's Medicaid utilization percentage which will be calculated for each state fiscal year. Each facility's percentage will be calculated once for each fiscal year, no more than forty-five (45) days in advance of the start of the state fiscal year and will be based upon data from the most recent cost report available. Facilities which change ownership will use the old owner's percentage for the remainder of the fiscal year. A facility's interim percentage will be eighty percent (80%) if no cost report data is available. The percentage will be adjusted to actual upon receipt of a cost report; the adjustment will not be retroactive. The training costs must be incurred for an employee of a Medicaid participating nursing facility who attends a program approved by the Mississippi State Department of Health. Nursing facilities must account for and request for reimbursement for training and competency testing costs in accordance with policies and procedures adopted in the Mississippi Medicaid Nursing Facility Manual. All costs billed to the Division of Medicaid are subject to verification of the expense prior to being processed for payment. The Division of Medicaid shall claim these expenses as administrative costs on the CMS-64 Quarterly Statement of Expenditures.

The costs of in-service training of certified nursing assistants are a nursing facility cost and are an allowable cost to be included on the nursing facility's cost report.

2-3 Related Party Transactions

A. Allowability of Costs

Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership of 5% or more equity, control, interlocking directorates, or officers are allowable at the cost to the related organization. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. These requirements apply to the sale, transfer, lease-back or rental of the property, plant or equipment or purchase of services of the related organization.

Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in the Provider's Reimbursement Manual, CMS Publication 15-1, Chapter 10 and Section 2150.3.

B. Determination of Common Ownership or Control

In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other.

C. Exception

An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the fiscal agent and/or the Division of Medicaid:

1. That the supplying organization is a bona fide separate organization.

2. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization.

3. That the services, facilities, or supplies are those which are commonly obtained by nursing facilities from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by nursing facilities.
4. That the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

Where all of the conditions of this exception are met, the charges by the supplier to the provider for such services or supplies are allowable as costs.

D. Hospital Based Costs Allocation

1. For costs allocated from hospitals, the costs must be reasonable and necessary in the provision of patient care at the long-term care facility (LTC) providers. All cost allocation determinations must be in accordance with Chapters 21, 22 and 23 of PRM Publication 15-1.
2. Allocation of these costs must be in a manner that is auditable and that is supported by documentation that verifies the allocation of expense is applicable to the LTC facility for which services were rendered.
3. For LTC facilities that are not contiguous to the hospital, square footage or number of personnel is not an acceptable allocation statistic. Documented provision of service must be maintained related to the allocation of any cost center other than Administrative and General (A&G), which should be allocated on the accumulated cost basis. This documentation includes, but is not limited to, time or assignment schedules documenting the provision of service to the affected LTC facility.
4. As part of the allocation of the A&G cost center, only costs of those areas, included in the A&G center, that provided service to the attached LTC facility should be allocated to them.
5. Hospital providers are not mandated to componentize their A&G or other cost centers; but, should the hospital provider choose not to do so, any expenses allocated to the LTC facility contrary to the instructions in items 1-4 above should be calculated and removed before inclusion in the Medicaid Long Term Cost Report forms.

E. Definitions

1. Reasonable - The consideration given for goods or services is the amount that would be acceptable to an independent buyer and seller in the same transaction.
2. Necessary - The purchase is required for normal, efficient, and continuing operation of the business.

3. Costs related to patient care - Include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others.
4. Costs not related to patient care - Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees, cost of drugs sold to other than patients, cost of operation of a gift shop, and similar items.
5. Related to provider - The provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. The existence of an

immediate family relationship will create an irrefutable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests are met. The following persons are considered immediate family for these purposes: (1) husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) step-parent, step-child, step-sister, and step-brother; (5) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law; (7) grandparent and grandchild.

6. Common ownership - Common ownership exists when an individual or individuals possess ownership to the extent that significant control can be exercised.

2-4 Private Room Charge

The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room due to medical necessity prescribed and ordered by a physician. No extra charge will be made to the resident, his/her family, or the Medicaid program.

When a resident is in a private room, by resident or family choice, a resident may be charged the difference between the private room charge and the semi-private room charge if the provider informs the

resident at the time of his/her admission of the amount of the charge. Semi-private room accommodations are covered by the Medicaid reimbursement rate.

2-5 Reserved Bed Days Payments – Refer to Attachment 4.19-C

A. Hospital Leave – Refer to Attachment 4.19-C

B. Home/Therapeutic Leave – Refer to Attachment 4.19-C

C. Bed Hold Days Payment – Refer to Attachment 4.19-C

2-6 Feeding Assistant Training

Reasonable costs of training feeding assistants in order to meet the requirements necessary to certify feeding assistants in accordance with 42 CFR, Section 483.35 (4)(2) are to be billed directly to the Division of Medicaid. Nursing facilities must account for and request reimbursement of training costs in accordance with policies and procedures adopted in the Mississippi Medicaid Nursing Facility Manual. The nursing facility will be directly reimbursed by the Division of Medicaid. The expenses will be subject to verification prior to processing the payment. Payments made by Medicaid will be based on the facility's Medicaid utilization percentage used for nurse aide training and testing reimbursement. The Division of Medicaid shall claim these expenses as administrative costs on the CMS-64 Quarterly Statement of Expenditures report.

CHAPTER 3

RATE COMPUTATION - NURSING FACILITIES

3-1 Rate Computation - Nursing Facilities - General Principles

It is the intent of the Division of Medicaid to reimburse nursing facilities a rate that is adequate for an efficiently and economically operated facility. An efficiently and economically operated facility is defined as one with direct care and care related costs greater than 90% of the median and less than the maximum rate, therapy costs of NFSD less than the maximum rate, administrative and operating costs of less than the maximum rate, and an occupancy rate of 80% or more.

3-2 Resident Assessments

All nursing facilities shall complete a Minimum Data Set assessment on all residents, in accordance with the policies adopted by the Division of Medicaid and CMS.

A. Submission of MDS Forms and Bed Hold Days Information.

Assessments of all residents must be submitted electronically in accordance with CMS requirements. Bed hold day information must be submitted electronically to the Division of Medicaid’s designee.

Data processing on all assessments and bed hold days started within a calendar quarter will be closed on the fifth (5th) day of the second (2nd) month following the quarter, e.g., the MDS's with start

dates between July 1, 1996 and September 30, 1996 will be closed out for the final calculations on November 5, 1996. This allows a full month for the submission and correction of all MDS's begun in a calendar quarter and the submission of bed hold day information. Assessments and bed hold day information for a specific quarter which are received after the file has been closed will not be entered for previous quarterly calculations except as a result of a Division of Medicaid case mix review. If the quarter close date is on a weekend, a state of Mississippi holiday, or a Federal holiday, the data must be submitted on or before the first business day following such weekend or holiday. Final Roster Reports upon the close of the quarter are not subject to an informal reconsideration or an appeal.

The submission schedule may be extended as deemed necessary by the Division of Medicaid for extenuating circumstances.

B. Assessments Used to Compute a Facility's Average Case Mix Score.

All resident assessments completed per a calendar quarter will be used to compute the quarterly case mix average for a facility. These will include the last assessment from the previous calendar quarter. Bed Hold days, which are therapeutic leave and hospital leave days, will be calculated

at the lower of the case mix weight as computed for the resident on leave using the assessment being utilized for payment at the point in time the resident starts the leave, or a case mix score of 1.000. Assessments used will affect the case mix computation using the start date of the assessment except for new admissions and reentries. The computation of the facility's case mix score will use the date of admission for new admissions or residents that are reentered after a discharge from the facility. In computing a facility's average case mix, the dates of admission or reentry will be counted and the dates of discharge will not be counted in the computation.

C. Medicaid Reviews of the MDS. The accuracy of the MDS will be verified by Registered Nurses. At least ten percent (10%) of the total facilitybeds will be selected for the sample. The sample should include at least one resident from each major classification group. Residents may be added to the minimum sample as deemed appropriate by the review nurse(s) and/or other case mix staff. The sample will not be limited to Title XIX beneficiaries since the total case mix of the facility will be used in computing the per diem rate. If twenty-five percent (25%) or greater of the sample assessments are found to have errors which change the classification of the resident, the sample will be expanded.

Policies adopted by the Division of Medicaid will be used as a basis for changes in reviews of the MDS, the sample selection process, and the acceptable error rate. If MDS data is not available, the Division may temporarily cease performing reviews.

D. Roster Reports. Roster reports are used for reporting each beneficiary's MDS RUG classification with assigned case mix index (CMI) for all days within the report period. Bed hold days are reflected on the roster reports. The facility's weighted average index, or score, is also reported. Roster reports are run for each calendar quarter (quarterlies) and for each cost report period (annuals). The annual rosters are used to set base per diem rates each January 1. The quarterlies are used in setting the direct care per diem rate each quarter. Roster reports are made available to all facilities electronically. Interim roster reports should be checked by the facilities to confirm assessments completed by the facility have been submitted to the QIES ASAP System used by the Division of Medicaid case mix database and to confirm discharge assessments are reflected on the report. Facilities should also use the interim roster reports and bed hold reports to confirm all hospital and home/therapeutic leave has been properly reported. Missing assessments, discharge assessments, and bed hold day information should be submitted electronically prior to the close of the quarter. If the quarter close date is on a weekend, a state of Mississippi holiday, or a Federal holiday, the data should be submitted on or before the first business day following such weekend or holiday. Final Roster Reports upon the close of the quarter are not subject to an informal reconsideration or an appeal.

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E. Failure to Submit MDS Forms. Nursing facilities that do not submit the MDS for residents for which an assessment was due and completed, transmitted electronically and accepted, the period beginning day 93 is considered an inactive assessment or expired assessment period. The days following an expired assessment (starting the 93rd day) will be assigned the delinquent RUG classification of BC1, Inactive Category, with a CMI of 0.450, equivalent to the lowest case mix category until the next assessment is received. Delinquent assessments will result in the calculation of delinquent days at the Inactive classification of BC1. Delinquent assessments are defined as those assessments not completed according to the schedule required by CMS and the Division of Medicaid.

3-3 Resident Classification System

The Division of Medicaid uses the MDS RUG IV classification model to classify nursing facility residents so a facility case mix average may be computed. This classification system utilizes specific items from the MDS to assign residents to categories which reflect the resident's functional status as well as resource utilization to meet resident care needs. The RUG IV model contains forty-eight (48) total groups and is based on index maximizing; ranging from the most resource intense to the least resource intense. (The graphic depiction of the classification hierarchy included at the end of this section provides a visual representation of this narrative.)

The seven (7) major categories in which a resident may be classified are as follows:

Extensive Services
Rehabilitation
Special Care High
Special Care Low
Clinically Complex
Behavioral Symptoms and Cognitive Performance
Reduced Physical Functioning

These seven (7) major categories split into additional groupings based on specific criteria; namely the Activities of Daily Living (ADL) Score, Depression Severity Score, and Restorative Nursing Programs, each of which is described below.

The Inactive Category is defined in 3-2, E. as for delinquent or expired assessments.

ADL Score

The ADL Score is a composite score for assessing the ability of a resident to perform in four of the Activities of Daily Living - bed mobility, toilet use, transfer, and eating, as defined in the RAI User's Manual. The ADL score is **NOT** a total of the actual ADL codes on the MDS. A score is assigned to show how a resident functions in Self Performance and Support Provided in the following manner:

For **Bed Mobility, Toilet Use, and Transfer**, residents who are coded as:

- Independent or needing Supervision receive a score of 0
- Needing Limited Assistance receive a score of 1
- Requiring Extensive Assistance with no physical assist, setup assist or 1 person physical assist receive a score of 2
- Requiring Total Dependence with no physical assist, setup help or 1 person physical assist receive a score of 3
- Requiring Extensive Assistance or Total Dependence with 2+ person physical assist receive a score of 4

For **Eating**, residents who are coded as:

- Independent, needing Supervision or Limited Assistance with or without setup help only receive a score of 0
- Independent, needing Supervision or Limited Assistance with 1 or 2+ person physical assist receive a score of 2
- Requiring Extensive Assistance or Total Dependence with no setup help or physical help from staff or setup help only receive a score of 2
- Requiring Extensive Assistance with 1 or 2+ person physical assist receive a score of 3
- Requiring Total Dependence with 1 or 2+ physical assist receive a score of 4

The ADL Score may range from a low of zero (0) to a high of sixteen (16). The following example illustrates how an ADL Score is computed. Assume a resident is independent in bed mobility, requires extensive assistance with one-person assist in toilet use, requires limited assistance with transferring and is independent in eating. This resident's ADL Score would be computed as follows:

-Bed mobility (independent)	= 0
-Toilet use (extensive assistance with 1-person assist)	= 2
-Transfer (limited assistance) 11	= 1
-Eating (independent)	= 0
ADL Score	**3**

An ADL score is calculated for all assessments. The ADL score determines which group the assessment is under for its specific category. The only exception is the category of Extensive Services.

Depression Groups

The major categories of Special Care High, Special Care Low and Clinically Complex have splits which indicate whether or not a resident meets specific indicators of depression. In order to be classified in one of the depression groups, the following criteria must be present based on the MDS: The presence and frequency of symptoms of depression are determined by a standardized severity score greater than or equal to 10. The Total Severity Score is derived from responses to items contained in the PHQ-9© Resident interview or the **PHQ-9-OV©** Staff Assessment of Mood. Copyright © Pfizer Inc. All rights reserved.

Restorative Nursing Groups

Three of the major categories have splits which indicate the receipt of restorative nursing programs. The major categories for which this split applies are Rehabilitation, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. In order to be computed as receiving Restorative Nursing, a resident must receive two (2) restorative nursing programs, each for at least six (6) days a week and a minimum of fifteen (15) minutes a day. Restorative Nursing includes the techniques/practices specified in the MDS.

In an index maximized classification system, assessments are sorted from those having the highest acuity/resource utilization to those with the least acuity/resource utilization. Once the criteria for placement in one of the seven major categories is met, the ADL score, Depression Severity Score and/or Restorative Nursing Program is determined, and the final group classification is made.

An additional group classification is included to allow placement of assessments that become delinquent or inactive. This group classification (BCl,) is given the same weight as the lowest group classification.

The classification will be calculated electronically at the Division of Medicaid or its designee using the MDS assessment and the MDS RUG IV classification model. Submission requirements are addressed in section 3-2(A).

Each of the forty-eight (48) resident group classifications as well as the inactive/expired classifications have been assigned case mix weights. The base weights for all classification groups are listed in the following table for residents in regular units as well as residents with Alzheimer's or related dementia in licensed Alzheimer's Special Care Units.

CMS MEDICAID PAYMENT INDEX
MDS RUG IV, SET F01, NURSING ONLY
48 Group Classification Model

EXTENSIVE SERVICE CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
ES3 Extensive Services	2-16	3.000	
ES2 Extensive Services	2-16	2.230	
ES1 Extensive Services	2-16	2.220	

REHABILITATION CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
RAE Rehabilitation	15-16	1.650	
RAD Rehabilitation	11-14	1.580	
RAC Rehabilitation	6-10	1.360	
RAB Rehabilitation	2-5	1.100	
RAA Rehabilitation	0-1	0.820	

SPECIAL CARE HIGH CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
HE2 Special Care High with Depression	15-16	1.880	
HE1 Special Care High	15-16	1.470	
HD2 Special Care High with Depression	11-14	1.690	
HD1 Special Care High	11-14	1.330	
HC2 Special Care High with Depression	6-10	1.570	
HC1 Special Care High	6-10	1.230	
HB2 Special Care High with Depression	2-5	1.550	
HB1 Special Care High	2-5	1.220	

SPECIAL CARE LOW CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
LE2 Special Care Low with Depression	15-16	1.610	
LE1 Special Care	15-16	1.260	
LD2 Special Care Low with Depression	11-14	1.540	
LD1 Special Care Low	11-14	1.210	
LC2 Special Care Low with Depression	6-10	1.300	
LC1 Special Care Low	6-10	1.020	
LB2 Special Care Low with Depression	2-5	1.210	
LB1 Special Care Low	2-5	0.950	

CLINICALLY COMPLEX CATEGORIES

GROUP DESCRIPTION	ADL SCORE	MISSISSIPPI WEIGHT	
		REGULAR	ALZHEIMER'S
		UNIT	UNIT
CE2 Clinically Complex with Depression	15-16	1.390	1.779
CE1 Clinically Complex	15-16	1.250	1.600
CD2 Clinically Complex with Depression	11-14	1.290	1.651
CD1 Clinically Complex	11-14	1.150	1.472
CC2 Clinically Complex with Depression	6-10	1.080	1.382
CC1 Clinically Complex	6-10	0.960	1.229
CB2 Clinically Complex with Depression	2-5	0.950	1.216
CB1 Clinically Complex	2-5	0.850	1.088
CA2 Clinically Complex with Depression	0-1	0.730	0.934
CA1 Clinically Complex	0-1	0.650	0.832

BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE CATEGORIES

GROUP DESCRIPTION	ADL SCORE	CMI	
		REGULAR	ALZHEIMER'S
		UNIT	UNIT
BB2 Behavioral Symptoms and Cognitive Performance with Restorative Nursing	2-5	0.810	1.393
BB1 Behavioral Symptoms and Cognitive Performance	2-5	0.750	1.290
BA2 Behavioral Symptoms and Cognitive Performance with Restorative Nursing	0-1	0.580	0.998
BA1 Behavioral Symptoms and Cognitive Performance	0-1	0.530	0.912

REDUCED PHYSICAL FUNCTION CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
PE2 Reduced Physical Function with Restorative Nursing	15-16	1.250	1.600
PE1 Reduced Physical Function	15-16	1.170	1.498
PD2 Reduced Physical Function with Restorative Nursing	11-14	1.150	1.472
PD1 Reduced Physical Function	11-14	1.060	1.357
PC2 Reduced Physical Function with Restorative	6-10	0.910	1.165
PC1 Reduced Physical Function	6-10	0.850	1.088
PB2 Reduced Physical Function with Restorative	2-5	0.700	0.896
PB1 Reduced Physical Function	2-5	0.650	0.832
PA2 Reduced Physical Function with Restorative	0-1	0.490	0.627
PA1 Reduced Physical Function	0-1	0.450	0.576

INACTIVE CATEGORY

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
BC1 Inactive Group*	Not Applicable	0.450	0.450

***RESIDENT ASSESSMENTS THAT CONTAIN ERRORS IN FIELDS WHICH PROHIBIT CLASSIFICATION WILL AUTOMATICALLY BE PLACED INTO THIS CATEGORY BY DEFAULT.**

3-4 Computation of Standard Per Diem Rate for Nursing Facilities

A standard per diem base rate will be established annually, unless this plan requires a rate being calculated at another time, for the period January 1 through December 31. A case mix adjustment will be made quarterly based on the MDS forms submitted by each facility in accordance with other provisions of this plan. Cost

reports used to calculate the base rate will be the cost report filed for the period ending in the second calendar year prior to the beginning of the calendar rate year. For example, the base rates effective January 1, 2015 will be determined from cost reports filed for the year ended June 30, 2013 for state owned facilities, for the year ended September 30, 2013 for county owned facilities and for the year ended December 31, 2013 (or other approved year-end) for all other facilities, unless a short period cost report and rate calculation are required by other provisions of this plan.

A description of the calculation of the per diem rate is as follows:

A. Direct Care Base Rate and Care Related Rate Determination

Direct care costs include salaries and fringe benefits for registered nurses (RN's),(excluding the Director of Nursing, the Assistant Director of Nursing and the Resident Assessment Instrument (RAI) Coordinator); licensed practical nurses (LPN's); nurse aides; respiratory therapists; feeding assistants; contract RN's, contract LPN's, and contract nurse aides; contract respiratory therapists; contract feeding assistants; medical supplies and other direct care supplies; medical waste disposal; and allowable drugs.

Care related costs include salaries and fringe benefits for activities, the Director of Nursing, the Assistant Director of Nursing, RAI Coordinator, pharmacy and social services. It also includes barber and beauty expenses for which the residents are not charged, raw food and food supplements, consultants for activities, nursing, pharmacy, social services and therapies, the Medical Director, and supplies used in the provision of care related services.

1. Calculate the average case mix score for each facility during the facility's cost report period. [Divide the case mix adjusted patient days (the sum of the patient days multiplied by case mix weights) by total period patient days.]
2. Determine the per diem direct care cost for each facility during the cost report period. (Divide direct care cost by total period patient days.)
3. Divide each facility's per diem direct care cost by its case mix score as determined in 1, above. The result is the facility's case mix adjusted direct care per diem cost. This adjustment expresses each facility's direct care costs as if the facility had a case mix of 1.000.
4. Add the per diem care related cost for each facility to the case mix adjusted direct care per diem cost calculated in 3, above.
5. Trend forward each facility's case mix adjusted direct care and care related cost per diem to the middle of the rate year using the trend factor. This is done by multiplying the trend factor by a mid-point factor. The mid-point factor allows costs to be trended forward from the mid-point of the cost report period to the mid-point of the payment period.

6. Determine the ceiling for direct care and care related costs together for small and large nursing facilities and separately for NFSD’s as follows:

   A. Prepare an array of the small and large nursing facilities; their associated trended direct care and care related costs, summed; and their annualized total patient days. Prepare a separate array of the NFSD’s.

   B. Arrange the data in order from lowest to highest cost for each array.

   C. Add to each array the cumulative annualized total patient days by adding in succession the days listed for each facility.

   D. Determine the median patient days by multiplying the total cumulative patient days by fifty percent (50%) and locate the median patient days on each array.

   E. Determine the median costs by matching the median patient days to the cost associated with the median patient day for each array. This may require interpolation.

   F. The ceiling for direct care and care related costs is determined by multiplying the median cost for each array by one hundred twenty percent (120%).

7. Determine the rate for each facility for direct care and care related costs. If the facility's case mix adjusted cost is above the ceiling, its base rate is the ceiling. If the adjusted cost falls below the ceiling, then its base rate is its case mix adjusted cost.
8. Allocate each facility's base rate between direct care costs and care related costs. This is done by using the percentage of case mix adjusted direct care costs and care related costs to the total of these costs used in 4, above, for each facility. This will result in the

Case Mix Adjusted Direct Care Base Rate and the Care Related Per Diem Rate.

9. The Case Mix Adjusted Direct Care Base Rate of each facility will be multiplied by the facility's average case mix score as described in Section B, below, on a quarterly basis.

B. Case Mix Adjusted Per Diem Rate

A per diem rate will be calculated for each nursing facility on a quarterly basis. Each nursing facility's direct care base rate will be multiplied by its average case mix for the period two calendar quarters prior to the start date of the rate being calculated. For example, the January 1, 2015 rate will be determined by multiplying the direct care base rate by the average case mix for the quarter July 1, 2014~~3~~ through September 30, 2014. This will result in the case mix adjusted direct care per diem rate. This is added to the care related per diem rate, the therapy per diem rate for NFSD's only, the administrative and operating per diem rate, the per diem fair rental payment, and the per diem return on equity capital to compute the facility's total standard per diem rate for the calendar quarter. The direct care per diem base rate, the care related per diem rate, the therapy per diem for NFSD's only, the administrative and operating per diem rate, the per diem fair rental payment, and the per diem return on equity capital are computed annually and are effective for the period January 1 through December 31. The case mix

adjustment is made quarterly to determine the total rate for the periods January 1 through March 31, April 1 through June 30, July 1 through September 30, and October 1 through December 31.

C. Therapy Rate for Nursing Facilities for the Severely Disabled

Therapy costs include salaries and fringe benefits or contract costs of therapists and other direct costs incurred for therapeutic services.

1. Determine the per diem therapy cost for each Nursing Facility for the Severely Disabled during the cost report period. (Divide therapy cost by total period patient days.)

2. Trend each facility's therapy per diem cost to the middle of the rate year using the trend factor as defined in Chapter 7. This is done by multiplying the trend factor by a mid-point factor. The mid-point factor allows costs to be trended forward from the mid-point of the cost report period to the mid-point of the payment period.

3. Determine the ceiling for therapy costs as follows:
   a. Prepare an array for the classification, including the facility names, the associated trended therapy costs, and the annualized total patient days.
   b. Arrange the data from lowest to highest cost.
   c. Add to each array the cumulative annualized total patient days by adding in succession the days listed for each facility.
   d. Determine the median patient day by multiplying the total cumulative patient days by fifty percent (50%) and locate the median patient day on each array.
   e. Determine the median cost by matching the median patient day to the associated costs. This may require interpolation.
   f. Multiply the cost at the median patient day by 105% to determine the ceiling.
4. Determine the therapy per diem rate for each facility. If the facility's therapy cost is above the ceiling, its therapy rate is the ceiling. If the facility's cost falls below the ceiling, then its therapy rate is its trended cost.

D. Administrative and Operating Rate. Administrative and operating costs include salaries and fringe benefits for the administrator, assistant administrator, dietary, housekeeping, laundry, maintenance, medical records, owners and other administrative staff. These costs also include contract costs for dietary, housekeeping, laundry and maintenance, dietary and medical records consultants, accounting

fees, non-capital amortization, bank charges, board of directors fees, dietary supplies, depreciation expense for vehicles and for assets purchased that are less than the equivalent of a new bed value, dues, educational seminars, housekeeping supplies, professional liability insurance, non-capital interest expense, laundry supplies, legal fees, linens and laundry alternatives, management fees and home office costs, office supplies, postage, repairs and maintenance, taxes other than property taxes, telephone and communications, travel and utilities.

1. Determine the per diem administrative and operating cost for each facility during the cost report period. (Divide administrative and operating cost by total period patient days. Patient days will be increased, if less than 80% occupancy, to 80% occupancy.)
2. Trend each facility's administrative and operating per diem cost to the middle of the rate year using the trend factor. This is done by multiplying the trend factor by a mid-point factor. The mid- point factor allows costs to be trended forward from the mid-point of the cost report period to the mid-point of the payment period.
3. Determine the ceiling for administrative and operating costs for each classification as follows:

    a. Prepare an array for each nursing facility classification. Each array should include the facility names, their associated trended administrative and operating costs, and their annualized total patient days.

    b. Arrange the data in each array from lowest to highest cost.

c. Add to each array the cumulative annualized total patient days by adding in succession the days listed for each facility.

d. Determine the median patient days by multiplying the total cumulative patient days by fifty percent (50%) and locate the median patient days on each array.

e. Determine the median costs by matching the median patient days to the associated costs. This may require interpolation.

f. The cost at the median patient day is multiplied by 109% to determine the ceiling for each classification.

4. Determine the per diem rate for each facility for administrative and operating costs. If the facility's administrative and operating cost is above the ceiling, its administrative and operating rate is the ceiling. If the facility's cost falls below the ceiling, then its administrative and operating rate is its trended cost plus seventy-five percent (75%) of the difference between the greater of the trended cost or the median and the ceiling. For NFSDs, the ceiling for Administrative and Operating Costs will be the facility's allowable costs.

E. Property Payment.

1. The property payment includes the fair rental per diem and the property taxes and insurance per diem. The fair rental per diem is a rental payment based on the age of each facility. The property taxes and insurance per diem is based on actual facility costs.

The fair rental system establishes a facility's value based on its age. The newer the facility is aged, the greater its value. The facility specific value and fair rental per diem are determined using the following parameters:

State of Mississippi

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

a. State-wide new bed value
b. Medicaid certified beds at the start of the rate period
c. Facility average age, not to exceed 28.5714 years
d. Accumulated depreciation, accumulating at a rate of 1.75% annually, not to exceed 50%
e. Rental factor of 5.35% with an added risk factor of 2%
f. Annualized patient days, at no less than 80% occupancy

The new bed value minus the accumulated depreciation multiplied by total beds determines the facility value. The value times the rental factor divided by days equals the fair rental per diem. The parameters and calculations are further described below.

2. Each year a state-wide new bed value is determined. The new bed value for 2015 is $91,200. Therefore, a new facility constructed during 2015 will have a per bed value of $91,200 for the 2015 rental payment. The value of new construction will be indexed each year using the RS Means Construction Cost Index estimate for Jackson, MS. The new bed value will be indexed each year to January 1 of the payment year. For example, in computing the rates for the year January 1, 2016 through December 31, 2016, the 2015 new bed value will be adjusted to the January 1, 2016 value using the estimated index. For licensed Alzheimer's units, new beds constructed on January 1, 2015 are assumed to have an additional value of $33,926.40, which is 37.20% of the nursing facility bed value. Each year, the January 1 new bed value adjustment for beds in licensed Alzheimer's units will be determined by multiplying the nursing facility new bed value by 37.20%, to account for the additional construction costs required to be licensed as an Alzheimer's unit. For NFSDs, a new facility constructed on January 1, 2015 is assumed to have a per bed value of $159,600, which is 175 percent of the nursing facility bed value. Each year, the January 1 new bed value for the NFSD class will be determined by multiplying the nursing facility new bed value by 175%.

   The new bed value for Mississippi has been rebased effective January 1, 2015. The previous new bed values apply for rate setting periods prior to January 1, 2015. For transition purposes, $91,200 will be used for determining if 2013 and 2014 capitalized assets and renovation costs will be converted into new beds. The list of historical new bed value indices is included in 9.

3. The Medicaid certified beds at the start of the annual rate period will be used for the property rate calculation. An increase or decrease in the number of certified beds that does not result in a change of classification will be reflected in the facility rate for the next quarter after the Division of Medicaid is notified of the change in the number of certified beds if the Division of Medicaid receives the notification from the certifying agency on or before the first day of the month preceding the effective date of the quarterly rate change. For example, a facility increases its number of Medicaid beds from 100 to 110 effective August 1, 1993. The rate of the facility would reflect 100 beds for the period July 1, 1993 through September 30, 1993. The rate would reflect 110 beds for the period October 1, 1993 through December 31, 1993. If the change in the number of beds had been effective September 1, 1993 and the Division of Medicaid did not receive notification until September 15, 1993, the increase would be reflected in the rate effective January 1, 1994.

4. Each facility's average age is a weighted average of each certified bed within the facility. The beds are aged using their construction date and adjustments for additions, replacements, and renovations and major improvements as defined by this plan. Additions, replacements, and renovations and major improvements will be recognized by lowering the age of the facility and, thus, increasing the facility's value. The facility average age will not exceed 28.5714 years for purposes of the fair rental calculations. Beds constructed during the rate setting year will be considered to have a zero (0) age. All beds will be aged by one (1) year at each December 31. Beds will not be aged beyond thirty (30) years for calculating new bed equivalents.

a. The addition of beds is typically accomplished through construction or the conversion of personal care or hospital beds. Newly constructed beds are aged in the year placed in service. Converted beds will be assigned the average age of the Medicaid-certified beds calculated for the 1992 start-up of the fair rental system. If the converted beds were aged for start-up, however, the related computation will be used. The cost of renovations and major improvements after start-up and before conversion will be considered in aging the beds if the facility provides proper documentation at the time of the conversion.

b. The replacement of existing beds differs from the addition of beds in that a certain number of beds replace those that were previously aged. Unless the replaced beds can be specifically identified on the property rate sheet, it is assumed that the oldest beds are the ones replaced.

c. Renovations and major improvements reduce the average age of the facility by bringing a calculated number of beds' aging to the year of renovation or major improvement. Renovation and major improvement costs include all capitalized assets greater than or equal to $5,000, excluding vehicles. The costs must be documented through cost reports, depreciation schedules, construction receipts, or other means. Costs must be capitalized in order to be considered a renovation or major improvement. Costs capitalized by a facility lessor are considered. In facilities with distinct parts, renovation and/or major improvement costs are limited to the portion of capitalized assets allocated directly and indirectly to the classification being considered. The indirect allocation for assets shared between the certified beds and the other beds in the facility are based on the number of beds in the classification being considered to total facility beds at year end.

In establishing the age of a facility, renovations/improvements are converted into bed replacements when the renovations/improvements in the aggregate exceed the new bed value. The conversion is made by dividing the total cost by the average accumulated depreciation per bed at January 1st of the renovation year.

d. The start-up age of each facility bed will not exceed thirty (30) years.

5. Accumulated Depreciation. Facilities, one year or older, will be valued at the new construction bed value less depreciation of 1.75% per year according to the age of the facility. The average accumulated depreciation per bed is calculated by multiplying the new bed value by the average age of the facility and by the 1.75% depreciation rate. Facilities will not be depreciated to an amount less than fifty percent (50%) of the new bed value. For sales of assets closed on or after July 1, 1993, there will be no recapture of depreciation.
6. Facility Value. The average per bed value is the difference between the new bed value and the accumulated depreciation. The average per bed value will be multiplied by the number of beds to estimate the facility's total current value.
7. A rental factor is applied to the facility's total current value to estimate its annual fair rental value. The rental factor is determined by using the Treasury Securities Constant Maturities (10 year) as published in the Federal Reserve Statistical Release using the average for the second calendar year preceding the beginning of the rate period with an imposed lower limit of 5.35% per annum and an imposed upper limit of ten percent (10%) per annum plus a risk premium. A risk premium in the amount of two percent (2%) is added to the index value. The rental factor is multiplied by the facility's total current value to determine the annual fair rental value.
8. The annual fair rental value is divided by annualized total patient days to calculate the fair rental per diem. Annualized patient days will equal the total patient days for Medicaid certified beds reported for the cost report period used to set the rate. An adjustment to annualize the days will be made if the cost report period is not equal to twelve months. Annualized total patient days will be adjusted to reflect any increase or decrease in the number of certified beds by applying to the increase or decrease the occupancy rate reported on the cost report being used to set rates. Patient days will be adjusted to at least 80% occupancy, if the facility reported an occupancy rate lower than 80%.

9

NEW CONSTRUCTION VALUE PER BED FOR NURSING FACILITIES USING THE RS MEANS CONSTRUCTION COST INDEX FOR JACKSON, MS

CALENDAR YEAR		NEW CONSTRUCTION VALUE PER BED
1992		$25,908
1993		$26,300
1994		$26,750
1995		$27,604
1996		$28,233
1997		$28,818
1998		$29,858
1999		$30,663
2000		$31,016
2001		$31,315
2002		$31,911
2003		$32,210
2004		$32,475
2005		$36,617
2006		$38,174
2007		$40,759
2008		$47,552
2009		$52,622
2010		$50,999
2011		$50,700
2012		$52,954
2013	For Renovations only	$91,200
2014	For Renovations only	$91,200
2015	Rebased	$91,200

MS PROPERTY REIMBURSEMENT - FAIR RENTAL SYSTEM EXAMPLE

Per Bed Value of New Nursing Facility

$91,200 (including building, land and equipment) on January 1, 2015.

Per Bed Value of Specific Facility (Based on Annual Depreciation for age of Facility)

Depreciation of new bed value at 1.75% per year based on year of construction or bed replacement, not to exceed 50% of the new bed value. Individual beds will not be aged beyond 30 years and the facility average age will not exceed 28.5714 years.

Example: Facility Constructed in 2010 has depreciated 5 years.
Depreciation: 1.75% x 5 = 8.75%.
Depreciated bed value: $91,200 x 91.25% (100%-8.75%) = $83,220.

Facility's Total Current Value

Per Bed Value x Number of Beds

Example: 120 Bed Facility Value = $83,220 x 120 = $9,986,400

Rental Factor

Federal Reserve Treasury Securities Constant Maturities (10yr) + Risk Premium

Example: Rental Factor = 5.35% + 2.0% = 7.35%

Annual Fair Rental Value

Facility Value x Rental Factor

Example: Rental Value = $9,986,400 x 7.35% = $734,000

Fair Rental Per Diem

Rental Value/Annualized Total Patient Days

Example: Rental Payment = $734,000/41610 = $17.64

Property Taxes and Insurance Per diem

Pass Through Based on Annualized Reported Costs/Annualized Total Patient Days

Example: Property Taxes	$0.65	($27,050/41,610)
Cost report Form 6, line 5-05		
Prop. Insurance	0.60	($24,970/41,610)
Cost report Form 6, Line 5-04		
Total	$1.25	

Per Diem Property Payment

Rental Payment + Taxes & Insurance
Example: Per Diem Property Payment = $17.64 + $1.25 = $18.89

F. Return on Equity Payment

The facility's average net working capital for the reporting period maintained for necessary and proper operation of patient care activities will be multiplied by the return on equity (ROE) factor to determine the return on equity payment. The return on equity payment will be divided by

annualized patient days during the cost report period used to set the rate to calculate the per diem return on equity payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if less than 80% occupancy, to 80% occupancy. The facility's net working capital will be limited to two (2) months of the facility's allowable costs, including property-related costs. The return on equity factor is five and seventy-five hundredths percent (5.75%).

In effect, net working capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicaid program) **excluding** net property, plant, and equipment, and liabilities associated therewith, and those assets and liabilities which are not related to the provision of patient care. Providers that are members of chain operations must also include in their working capital a share of the equity capital of the home office.

The average of the net working capital computed for the beginning and ending of the reporting period will be used for purposes of determining the net working capital eligible for a return on investment. The following are examples of items not included in the computation for net working capital:

1. Property, plant, and equipment, excluding vehicles;
2. Debt related to property, plant, and equipment, excluding vehicles;
3. Liabilities related to property, plant, and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance;
4. Notes and loans receivable from owners or related organizations;
5. Goodwill;
6. Unpaid capital surplus;
7. Treasury Stock;
8. Unrealized capital appreciation surplus;

9. Cash surrender value of life insurance policies;
10. Prepaid premiums on life insurance policies;
11. Assets acquired in anticipation of expansion and not used in the provider's operations or in the maintenance of patient care activities during the rate period;
12. Inter-company accounts;
13. Funded depreciation;
14. Cash investments that are long term (more than six months);
15. Deferred tax liability attributed to non-allowable tax expense;
16. Any other assets not directly related to or necessary for the provision of patient care;
17. Net capitalized loan/financing costs;
18. Resident fund accounts held on behalf of the resident which were included on the facility's balance sheet;
19. Workers' Compensation self-insurance fund.

Return on Non-Property Equity Per Diem

*Average Non-Property Equity x ROE Factor / Annualized Total Patient Days

Example:

Avg. Non-Property Equity=$156,500 x 5.75% (ROE factor)/41,610 = $.22

*Subject to limitation of two (2) months of reported allowable costs

G. Total Standard Per Diem Rate. The annual standard per diem rate is the sum of the direct care per diem rate, the care related per diem rate, the administrative and operating per diem rate, the per diem property payment, and the per diem return on equity payment. The annual rate for NFSD's also includes the therapy per diem rate.

H. Calculation of the Rate for One Provider. In years when the rate is calculated for only one NFSD, 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. The property payment and the return on equity payment will be calculated for the facility as described in Sections 3-4 F and G.

3-5 Ventilator Dependent Care (VDC) Per Diem Rate

A ventilator dependent care (VDC) per diem rate of $178.34 is established for beneficiaries receiving VDC services in large and small nursing facilities. The VDC per diem rate will be reviewed for adjustment every fifth year.

3-6 Occupancy Allowance

The per diem rates for fixed administrative and operating costs, care related costs and property costs wi11 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. This minimum occupancy level will not be applied to the computation of patient days used to calculated the direct care and therapy rates, or the variable portion of the administrative and operating and care related rates.

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. 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 (20,000/70%)

X 80%) to equal a minimum of eighty percent (80%) occupancy. Reserved bed days will be counted as an occupied bed for this computation. Facilities having an occupancy rate of less than eighty percent (80%) should complete Form 14 when submitting their cost report.

3-7 State Owned NF's

NF's that are owned by the State of Mississippi will be included in the rate setting process described above in order to calculate a prospective rate for each facility. However, state owned facilities will be paid based on 100% of allowable costs, subject to the Medicare upper limit. A state owned NF may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned NF's file their cost report, the per diem rate for each cost report period will be adjusted to the actual allowable cost for that period, subject to the Medicare upper limit.

3-8 Adjustments to the Rate for Changes in Law or Regulation

Adjustments may be made to the rate as necessary to comply with changes in state or federal law or regulation.

3-9 Upper Payment Limit (UPL)

Non-state government owned or operated NF's will be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each facility, the amount that Medicare would have paid for the previous year will be calculated and compared to payments actually made by Medicaid during that same time period. The calculation will be made as follows: MDS data is run for a sample population of each facility to group patient days into one of the Medicare RUGs. An estimated amount that Medicare would have paid on average by facility is calculated by multiplying each adjusted RUG rate by the number of days for that RUG. The sum is then divided by the total days for the estimated average per diem by facility that Medicare would have paid. From this amount, the Medicaid average per diem for the time period is subtracted to determine the UPL balance as a per diem. The per diem is then multiplied by the Medicaid days for the period to calculate the available UPL balance amount for each facility. This calculation will then be used to make payment for the current year to nursing facilities eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. 100 percent of the calculated UPL will be paid to non-state government-owned or operated facilities, in accordance with applicable state and federal laws and regulations, including any provisions specified in appropriations by the Mississippi Legislature.

State government owned or operated NF's will be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each facility, the amount that Medicare would have paid for the previous year will be calculated and compared to payments actually made by Medicaid during that same time period. The calculation will be made as follows: For each State provider, total Medicaid allowed amounts and total covered days including bed hold are obtained from the provider's most current Medicaid cost report after desk review. In addition total Medicaid bed hold patient days will be obtained from the MMIS. For each provider the allowed amount per day is calculated by dividing the Medicaid allowed amounts per cost report by the total covered days per cost report less bed hold days. The allowed amount per day is multiplied by paid Medicaid days less bed hold days per the MMIS to determine the upper payment limit on Medicaid payments. The upper payment limit on Medicaid payments is then compared to the actual Medicaid payments made during that same time period to calculate the available UPL balance for each facility. This calculation will then be used to make payment for the current period to nursing facilities eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. 100 percent of the calculated UPL will be paid to State government owned or operated facilities, in accordance with applicable state and federal laws and regulations, including any provisions specified in appropriations by the Mississippi Legislature.

CHAPTER 4

RATE COMPUTATION - ICF/IID'S

4-1 Rate Computation - ICF/IID's - General Principles

It is the intent of the Division of Medicaid to reimburse Intermediate Care Facilities for Individuals with Intellectual Disabilities a rate that is adequate for an efficiently and economically operated facility. An efficiently and economically operated facility is defined as one with direct care costs, therapy costs, care related costs, and administrative and operating costs less than 110% of the median and an occupancy rate of 80% or more.

4-2 Computation of Rate for Intermediate Care Facilities for Individuals with Intellectual Disabilities

A per diem rate will be established annually for the period January 1 through December 31, unless this plan requires a rate being calculated at another time. Cost reports used to calculate the rate will be the cost report filed for the period ending in the second calendar year prior to the beginning of the next calendar rate year, unless this plan requires a short period cost report to be used to compute the facility rate. For example, the rates effective January 1, 2015 will be determined from cost reports filed for the cost report year ended in 2013 unless a short period cost report and rate calculation is required by other provisions of this plan. Costs used in the rate calculations may be adjusted by the amount of anticipated increase in costs or decrease in costs due to federal or state laws or regulations.

A description of the calculation of the rate is as follows:

A. Direct Care, Therapies, Care Related, and Administrative and Operating Rate Determination

1. Determine the per diem cost for direct care costs, therapies, care related costs, and administrative and operating costs for each facility during the cost report period. This is done by adding the total allowable costs for these cost centers and dividing the result by the total patient days.

2. Trend each facility's per diem cost as determined in 1, above, to the middle of the rate year using the ICF/IID and PRTF Trend Factor. This is done by multiplying the ICF/IID and PRTF Trend Factor in order to trend costs forward from the

the cost report period to the mid-point of the payment period.

3. Array the trended costs from the lowest cost to the highest cost.

4. Determine the ceiling for direct care costs, therapies, care related costs, and administrative and operating costs. The ceiling is based on 110% of the cost associated with the median patient day. The median is determined by accumulating the annualized total patient days for each facility in the array described in 3, above. The trended cost that is associated with the mid-point of the total patient days is determined by multiplying the total patient days by fifty percent (50%) and interpolating to determine the median cost. The cost at the median is multiplied by 110% to determine the ceiling.

5. Determine the per diem rate for each facility for direct care costs, therapies, care related costs and administrative and operating costs. If the facility's cost is above the ceiling, its rate is the ceiling. If the facility falls below the

ceiling, then its rate is its trended cost plus fifty percent (50%) of the difference between the trended cost or the median, whichever is greater, and the ceiling.

B. Property Payment. A per diem payment will be made for property costs based on a fair rental system. The amount of the payment is determined as follows:

1. A new facility constructed on January 1, 2015 is assumed to have a per bed value of $109,440, which is 120 percent of the nursing facility bed value. Each year, the January 1 new bed value for the ICF/IID class will be determined by multiplying the nursing facility new bed value by 120%.

2. Existing facilities, one year or older, will be valued at the new bed value less depreciation of 1.75% per year according to the average age of the facility. Facilities will not be depreciated to an amount less than 50% of the new bed value. Additions, replacements and renovations and major improvements will be aged and converted to new beds as described for nursing facilities in Chapter 3.

3. The per bed value is multiplied by the number of certified beds to estimate the facility's total current value.

4. A rental factor will be applied to the facility's total current value to estimate its annual fair rental value. The rental factor is determined by using the Treasury Securities Constant Maturities (10-year) as published in the Federal Reserve Statistical Release using the average for the second calendar year preceding the beginning of the rate period with an imposed lower limit of five and thirty-five hundredths percent (5.35%) per annum and an imposed upper limit of ten percent (10%) per annum plus a risk premium. A risk premium in the amount of two percent (2%) will be added to the index value. The rental factor is multiplied by the facility's total value, as determined in 3, above, to determine the annual fair rental value.

5. The annual fair rental value will be divided by the facility's annualized total patient days during the cost report period to determine the fair rental per diem payment. Annualized total patient days will be adjusted to reflect changes in the number of certified beds by applying to the increase or decrease the occupancy rate reported on the cost report used to set rates. Patient days will be adjusted, if less than 80% occupancy, to 80% occupancy.
6. Property taxes and property insurance will be annualized and divided by annualized total patient days to determine a per diem amount for these costs and will be passed through as an addition to the fair rental per diem payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if less than 80% occupancy, to 80% occupancy.
7. The total of the fair rental per diem payment and the per diem property taxes and insurance is the per diem property payment.

C. Return on Equity Payment

The facility's average net working capital for the reporting period maintained for necessary and proper operation of patient care activities will be multiplied by the return on equity (ROE) factor to determine the return on equity payment. The return on equity payment will be divided by annualized patient days during the cost report period used to set the rate to calculate the per diem return on equity payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if less than 80% occupancy, to 80% occupancy. The facility's net working capital will be limited to two (2) months of the facility's allowable costs, including property-related costs. The return on equity factor is five and seventy-five hundredths percent (5.75%). In effect, net working capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicaid program) **excluding** net property, plant, and equipment, and liabilities associated there with, and those assets and liabilities

which are not related to the provision of patient care. Providers that are members of chain operations must also include in their working capital a share of the equity capital of the home office.

The average of the net working capital computed for the beginning and ending of the reporting period will be used for purposes of determining the net working capital eligible for a return on investment. The following are examples of items not included in the computation for net working capital:

1. Property, plant, and equipment, excluding vehicles;
2. Debt related to property, plant, and equipment, excluding vehicles;
3. Liabilities related to property, plant, and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance;
4. Notes and loans receivable from owners or related organizations;
5. Goodwill;
6. Unpaid capital surplus;
7. Treasury Stock;

8. Unrealized capital appreciation surplus;
9. Cash surrender value of life insurance policies;
10. Prepaid premiums on life insurance policies;
11. Assets acquired in anticipation of expansion and not used in the provider's operations or in the maintenance of patient care activities during the rate period;
12. Inter-company accounts;
13. Funded depreciation;
14. Cash investments that are long term (six months or longer);
15. Deferred tax liability attributed to non-allowable tax expense;
16. Any other assets not directly related to or necessary for the provision of patient care;
17. Net capitalized loan/financing costs;
18. Resident fund accounts held on behalf of the resident which were included on the facility's balance sheet;
19. Workmen's Compensation self insurance fund.

D. Total Rate

The annual rate is the sum of the per diem rate for direct care costs, therapies, care related costs and

administrative and operating costs, the per diem property payment, and the per diem return on equity payment.

E. State Owned ICF/IID's

ICF/IID's that are owned by the State of Mississippi will be included in the rate setting process described above in order to calculate a prospective rate for each facility. However, state owned facilities will be paid based on 100% of allowable costs, subject to the Medicare upper limit. A state owned ICF/IID may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned ICF/IID's file their cost report, the per diem rate for each cost report period will be adjusted to the actual allowable cost for that period.

F. Adjustments to the Rate for changes in Law or Regulation Adjustments may be made to the rate as necessary to comply with changes in state or federal law or regulation.

CHAPTER 5
RATE COMPUTATION - PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

5-1 Rate Computation-Psychiatric Residential Treatment Facilities (PRTF's) - General Principles

It is the intent of the Division of Medicaid to reimburse Psychiatric Residential Treatment Facilities (PRTF's) a rate that is adequate for an efficiently and economically operated facility. An efficiently and economically operated facility is defined as one with direct care costs, therapy costs, care related costs, and administrative and operating costs less than 110% of the median, and an occupancy rate of 80% or more.

5-2 Rate Computation for PRTF's

A per diem rate will be established annually, unless this plan requires a rate being calculated at another time, for the period January 1 through December 31, unless this plan requires a rate being calculated at another time. Cost reports used to calculate the rate will be the cost report filed for the period ending in the second calendar year prior to the beginning of the calendar rate year, unless this plan requires a short period cost report to be used to compute

the facility rate. For example, the rates effective January 1, 2001 will be determined from cost reports filed for the cost report year ended in 1999 unless a short period cost report and rate calculation is required by other provisions of this plan. Costs used in the rate calculations may be adjusted by the amount of anticipated increase in costs or decrease in costs due to federal or state laws or regulations.

However, the PRTF rates effective January 1, 2010, will continue to be effective through June 30, 2012, for facilities in operation as of August 25, 2010. For facilities initially Medicaid certified between August 25, 2010 and June 30, 2012, the per diem base rate effective the first day of certification, computed in accordance with this plan subject to January 1, 2010 ceilings, will be used as the base rate through June 30, 2012. No adjustments to the rate, otherwise required by this plan, will be used to determine PRTF rates after January 1, 2010 and before July 1, 2012, except that rates will be adjusted to incorporate facility cost changes related to the provider tax limit increase effective October 1, 2011.

A description of the calculation of the rate is as follows:

A. Direct Care, Therapies, Care Related, and Administrative and Operating Rate Determination

1. Determine the per diem cost for direct care costs, therapies, care related costs, and administrative and operating costs for each facility during the cost report period. This is done by adding the total allowable costs for these cost centers and dividing the result by the total patient days.

2. Trend each facility's per diem cost as determined in 1, above, to the middle of the rate year using the ICF/IID and PRTF Trend Factor. This is done by multiplying the ICF/IID and PRTF Trend Factor in order to trend costs forward from the mid-point of the cost report period to the mid-point of the payment period.

3. Array the trended costs from the lowest cost to the highest cost.

4. Determine the ceiling for direct care costs, therapies, care related costs, and administrative and operating costs. The ceiling is based on 110% of the cost associated with the median patient day. The median is determined by accumulating the annualized total patient days for each facility in the array described in 3, above. The trended cost that is associated with the mid-point of the total patient days is determined by multiplying the total patient days by fifty percent (50%) and interpolating to determine the median cost. The cost at the median is multiplied by 110% to determine the ceiling.

5. Determine the per diem rate for each facility for direct care costs, therapies, care related costs and administrative and operating costs. If the facility's cost is above the ceiling, its rate is the ceiling. If the facility falls below the

ceiling, then its rate is its trended cost plus fifty percent (50%) of the difference between the trended cost or the median, whichever is greater, and the ceiling.

B. Property Payment. A per diem payment will be made for property costs based on a fair rental system. The amount of the payment is determined as follows:

1. A new facility constructed on January 1, 2015 is assumed to have a per bed value of $109,440 which is 120 percent of the per bed value of a nursing facility. Each year, the January 1 new bed value of the PRTF class will be determined by multiplying the nursing facility new bed value by 120%.

2. Existing facilities, one year or older, will be valued at the new bed value less depreciation of 1.75% per year according to the average age of the facility. Facilities will not be depreciated to an amount less than 50% of the new construction bed value. Additions, replacements, and renovations and major improvements will be aged and converted to new beds as described for nursing facilities in Chapter 3.

3. The per bed value will be multiplied by the number of beds in the facility to estimate the facility's total current value.

4. A rental factor will be applied to the facility's total current value to estimate its annual fair rental value. The rental factor is determined by using the Treasury Securities Constant Maturities (10-year) as published in the Federal Reserve Statistical Release using the average for the second calendar year preceding the beginning of the rate period with an imposed lower limit of five and thirty-five hundredths (5.35%).

per annum and an imposed upper limit of ten percent (10%) per annum plus a risk premium. A risk premium in the amount of 2% will be added to the index value. The rental factor is multiplied by the facility's total value as determined in 3, above, to determine the annual fair rental value.

5. The annual fair rental value will be divided by the facility's annualized total patient days during the cost report period to determine the fair rental per diem payment. Annualized total patient days will be adjusted to reflect changes in the number of certified beds by applying to the increase or decrease the occupancy rate reported on the cost report used to set rates. Patient days will be adjusted, if less than 80% occupancy, to 80% occupancy.

6. Property taxes and property insurance will be annualized and divided by annualized total patient days to determine a per diem amount for these costs. These costs will be passed through as an addition to the fair rental per diem payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if less than 80% occupancy, to 80% occupancy.

7. The total of the fair rental per diem payment and the per diem property taxes and insurance is the per diem property payment.

C. Return on Equity Payment

The facility's average net working capital for the reporting period maintained for necessary and proper operation of patient care activities will be multiplied by the return on equity (ROE) factor to determine the return on equity payment. The return on equity payment will be divided by annualized patient days during the cost report period used to set the rate to calculate the per diem return on equity payment. Patient days will be adjusted to reflect changes in the number of certified beds, and if less than 80% occupancy, to 80% occupancy. The facility's net working capital will be limited to two (2) months of the facility's allowable costs, including property-related costs. The return on equity factor is five and seventy-five hundredths percent (5.75%). In effect, net working capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicaid program) **excluding** net property, plant, and equipment, and liabilities associated therewith,

and those assets and liabilities which are not related to the provision of patient care. Providers that are members of chain operations must also include in their working capital a share of the equity capital of the home office.

The average of the net working capital computed for the beginning and ending of the reporting period will be used for purposes of determining the net working capital eligible for a return on investment. The following are examples of items not included in the computation for net working capital:

1. Property, plant, and equipment, excluding vehicles;

2. Debt related to property, plant, and equipment, excluding vehicles;

3. Liabilities related to property, plant, and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance;

4. Notes and loans receivable from owners or related organizations;

5. Goodwill;

6. Unpaid capital surplus;

7. Treasury Stock;

8. Unrealized capital appreciation surplus;

9. Cash surrender value of life insurance policies;

10. Prepaid premiums on life insurance policies;

11. Assets acquired in anticipation of expansion and not used in the provider's operations or in the maintenance of patient care activities during the rate period;

12. Inter-company accounts;

13. Funded depreciation;

14. Cash investments that are long term (six months or longer);

15. Deferred tax liability attributed to non- allowable tax expense;

16. Any other assets not directly related to or necessary for the provision of patient care;

17. Net capitalized loan/financing costs;

18. Resident fund accounts held on behalf of the resident which were included on the facility's balance sheet;

19. Workmen's Compensation self insurance fund.

D. Total Rate

The annual rate is the sum of the per diem rate for direct care costs, therapies, care related costs and administrative and operating costs, the per diem property payment, and the per diem return on equity payment.

E. State Owned PRTF[1]s

PRTF[1]s that are owned by the State of Mississippi will be included in the rate setting process described above in order to calculate a prospective rate for each facility. However, state owned facilities will be paid based on 100% of allowable costs, subject to the Medicare upper limit. A state owned PRTF may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned PRTF[1]s file their cost report, the per diem rate for each cost report period will be adjusted to the actual allowable cost for that period.

F. Adjustments to the Rate for Changes in Law or Regulation

Adjustments may be made to the rate as necessary to comply with changes in state or federal law or regulation.

CHAPTER 6

TREND FACTORS

6-1 Trend Factor - General Principles

The trend factor is a statistical measure of the change in the costs of goods and services purchased by long term care facilities during the course of one year. The intent of the trend factor is to provide the Division of Medicaid with insight into the amount and nature of change of health care costs experienced by long-term care providers.

6-2 Trend Factor Computation

A trend factor will be computed each year for long-term care facilities and will be used in the calculation of the base rates effective for the rate year, January 1 through December 31. A separate trend factor will be calculated for direct care costs and care related costs, for therapy costs, and for administrative and operating costs. These trend factors will be computed as described below.

A. Cost Reports Used in the Calculation of the Trend Factors

Cost reports used in the computation of the trend factors are as described below.

1. Facilities which have at least eighty percent (80%) occupancy.

2. Facilities which are in operation a full twelve (12) months. Facilities which have undergone a change of ownership will be used if the facility was open at least twelve (12) months under both the buyer's and seller's periods of operations combined. The costs from all cost reports in the standard reporting year will be used in the computation.

3. Nursing facilities which either certify additional beds or decertify beds that results in a change in classification (either Small Nursing Facility to Large Nursing Facility or vice versa) as long as the facility was in operation at least twelve (12) months under both classifications combined. The costs from all cost reports in the standard reporting year will be used in the computation.

4. Facilities which use the cost report line(s) for allocated costs will not be used.

B. Computation of the Trend Factors

The following steps will be taken to compute the trend factors for direct care costs, therapies, care related costs and administrative and operating costs.

1. Separate the costs into the following cost categories as defined in the cost report form:
   a. Direct Care Expenses (Form 6, Section 1)
   b. Therapies (Form 6, Section 2)
   c. Care Related Expenses (Form 6, Section 3)
   d. Administrative and Operating Costs(Form 6, Section 4)

2. Determine the relative weight of each of the line items in each category. A trend factor will not be developed for property costs because the value of each nursing facility bed will be indexed using the RS Means Construction Index for use in the fair rental reimbursement computation.

3. Obtain the market basket of economic indicators. An example of this market basket follows Section 6-6 of this plan.

4. The economic indicators for each line item of cost will be multiplied by the relative weight of the Form 6 line items in order to determine the trend factor for each line item. An example of the computation of the trend factors, using weighted

averages, is shown in Section 6-7 of this plan.

5. Add the line item trend factors determined in (4) above for each cost category. The result will be the trend factor for each of the cost categories.

6. The forecasted trend factor for each of the cost centers may be adjusted due to the following:

   a. Known increases or decreases in costs due to federal or state laws or regulations, or
   b. Other factors that can be reasonably forecasted to have a material effect on costs in the prospective year.

6-3 Trend Factors - Nursing Facilities

Trend factors will be used in computing the base rates for nursing facilities. A direct care and care related costs trend factor will be determined by combining the trend factors determined for each of these cost centers as determined in Section 6-2. The total Direct Care and Care Related Trend Factor will be computed by weighting the total allowable costs in each of the cost centers to the total costs for the two (2) cost centers. The percent of each cost center to total costs will be multiplied by the individual trend factors to determine an adjusted trend factor. The total of the two adjusted trend factors will be the direct care and care related costs trend factor.

NURSING FACILITY TREND FACTORS - 2004

COST CENTER	ALLOWABLE COSTS	TREND FACTOR	% OF TOTAL COSTS	ADJUSTED TREND FACTOR
Direct Care	$216,911,547	6.13%	77.93%	4.78%
Care Related	61,417,034	4.15%	22.07%	0.92%
DC/CR Trend Factor	$278,328,581		100.00%	**5.70%**
Therapy				
Trend Factor	**$ 17,048,995**	**6.32%**	**100.00%**	**6.32%**
Administrative and Operating Trend Factor	$188,448,481	8.75%	100.00%	**8.75%**

For example: The trend factor for direct care costs was determined to be 6.13% and the trend factor for care related costs was determined to be 4.15% in the trend factor computation example shown in Section 6-7, computed in accordance with Section 6-2. The total allowable costs for these cost centers was $216,911,547 for direct care costs and $61,417,034 for care related costs for a total of $278,328,581. Direct care costs made up 77.93% and care related costs amounted to 22.07% of the total for these two cost centers. Accordingly, the trend factor for direct care costs was multiplied by 77.93% and the trend factor for care related costs was multiplied by 22.07% in order to compute the Direct Care and Care Related Costs Trend Factor. The result in the example is (6.13% X

77.93%) + (4.15% X 22.07%) = 5.70% direct care and care related trend factor. The therapy trend factor in the example is 6.32%. The administrative and operating trend factor in the example is 8.75%.

6-4 Trend Factor - PRTF's and ICF/IID's

One (1) trend factor will be used in computing the rates for PRTF's and ICF/IID's. A trend factor will be determined by combining the trend factors determined for each cost center, as determined in Section 7-2. The PRTF and ICF/IID trend factor will be computed by weighting the total allowable costs in each of the four (4) cost centers to the total costs of the four (4) cost centers. The percent of each cost center to total costs will be multiplied by the individual trend factors to determine an adjusted trend factor. The total of the adjusted trend factors will be the PRTF and ICF/IID trend factor. For example:

PRTF and ICF/IID TREND FACTORS - 2004

Cost Center	Allowable Costs	Trend Factor	% of Total Costs	Adjusted Trend Factor
Direct Care	$216,911,547	6.13%	44.83%	2.75%
Therapies	17,048,995	6.32%	3.52%	0.22%
Care Related	61,417,034	4.15%	12.70%	0.53%
Admin./Oper.	188,448,481	8.75%	38.95%	3.41%
Total	$483,826,057		100.00%	6.91%

In this example the PRTF and ICF/IID Trend Factor is 6.91%.

6-5 Mid-Point Factor

A mid-point factor is applied separately for each facility to allow costs to be trended forward from the mid-point of the cost report period to the mid-point of the payment period. The applicable mid-point factor is multiplied by each trend factor the adjusted trend factor is then used to determine each facility's trended costs. The mid-point factor is calculated by counting the number of months from the mid-point of the cost report period to the mid-point of the payment period. This number of months is divided by twelve (12). The product is the mid-point factor. The mid-point factor for a calendar year cost report being used to set rates for the second following calendar year is 2.0. For example, the mid-point factor is 2.0 when the cost report for January 1, 2002 through December 31, 2002 is used to set rates for the payment period January 1, 2004 through December 31, 2004. This is calculated by first determining the mid-points of both the cost report period and the payment period, July 1, 2002 and July 1, 2004, respectively. The number of months between the two mid-points in this example is twenty-four (24). Twenty-four (24) divided by twelve (12) equals 2.0.

The mid-point factor is multiplied by each applicable trend factor for a facility. Using the trend factors in Sections 6-3 and 6-4, the

Cost Center(s)	**Trend Factor**	**Mid-Point Adjusted Factor**	**Mid-Point Adjusted Trend Factor**
Direct Care/ Therapy	6.32%	2.0	.126400
Administrative and Operating	8.75%	2.0	.175000
Direct Care, Therapies, Care Related,			

6-6 Market Basket of Economic Indicators Example

CPI						
SERIES ID	ITEM	EXPENSE DESCRIPTION	COST REPORT LINE(S)	2001	2002	01-02
SAM2	Medical Care Services	Group Health Insurance	1-06, 2-06, 3-08, 4-11	278.8	292.9	5.1%
SAA	Apparel	Uniform Allowance	1-09, 2-09, 3-11, 4-14	127.3	124	-2.6%
SAM1	Medical Care Commodities	Drugs	1-14	247.6	256.4	3.6%
		Medical Supplies	1-15			
SEHG02	Garbage and Trash Collection	Medical Waste Disposal	1-16	275.5	283	2.7%
SEGC01	Haircuts and Other Personal Care Services	Barber & Beauty Expense	3-13	112.5	114.9	2.1%
SEMC04	Services by Other Medical Professionals	Consultant Fees - Activities	3-14	167.3	171.8	2.7%
		Consultant Fees - Nursing	3-16			
		Consultant Fees - Pharmacy	3-17			
		Consultant Fees - Social Worker	3-18			
		Consultant Fees - Therapists	3-19			
SEMC01	Physicians' Services	Consultant Fees - Medical Director	3-15	253.6	260.6	2.8%
SAF	Food and Beverages	Food - Raw and Supplements	3-20, 3-21	173.6	176.8	1.8%
SEHP	Household Operations	Contract - Dietary	4-16	115.6	119	2.9%
		Contract - Housekeeping	4-17			
		Contract - Maintenance	4-19			
		Repairs and Maintenance	4-42			
SEGD03	Laundry and Dry Cleaning Services	Contract - Laundry	4-18	109.9	113.2	3.0%
SEGD	Miscellaneous Personal Services	Consultant Fees - Dietician	4-20	263.1	274.4	4.3%
		Consultant Fees - Medical Records	4-21			
SS68023	Tax Return Preparation and Other Accounting Fees	Accounting Fees	4-22	121.2	127.5	5.2%
SETA	New and Used Motor Vehicles	Auto Lease	4-24	101.3	99.2	-2.1%
SS68021	Checking Account and Other Bank Services	Bank Service Charges	4-25	113.7	116.9	2.8%
SAS	Services	Board of Directors Fees	4-26	203.4	209.8	3.1%
SEHN	Housekeeping Supplies	Dietary Supplies	4-27	158.4	159.8	0.9%
		Housekeeping Supplies	4-31			
		Laundry Supplies	4-34			
SAH3	Household Furnishings and Operations	Depreciation	4-28	129.1	128.3	-0.6%
SEGD01	Legal Services	Legal Fees	4-35	199.5	211.1	5.8%
SEHH03	Other Linens	Linen and Laundry Alternatives	4-36	96	93.2	-2.9%
SAT	Transportation	Non-Emergency Transportation	4-39	154.3	152.9	-0.9%

CPI						
SERIES ID	ITEM	EXPENSE DESCRIPTION	COST REPORT LINE(S)	2001	2002	01-02
SEEC	Postage and Delivery Services	Postage	4-41	107.3	113.7	6.0%
SEED	Telephone Services	Telephone & Communications	4-44	99.3	99.7	0.4%
SA0	All Items	Travel	4-45	177.1	179.9	1.6%
SAH2	Fuels and Utilities	Utilities	4-46	150.2	143.6	-4.4%
SA0L1E	All Items Less Food and Energy	Other Supplies - Direct Care	1-17	186.1	190.5	2.4%
		Therapy Supplies	2-15			
		Supplies - Care Related	3-21			
		Amortization Expense	4-23			
		Dues	4-29			
		Educational Seminars & Training	4-30			
		Interest Expense	4-33			
		Miscellaneous Expense	4-37			
		Management Fees/ Home Office	4-38			
		Office Supplies and Subscriptions	4-40			
		Taxes - Other	4-43			
OTHER INDICES		EXPENSE DESCRIPTION	COST REPORT LINE(S)	2001	2002	01-02
	MESC Average Weekly Wage on covered employment (NAICS 6231)	Salaries	1-01, 1-02, 1-03, 1-04, 2-01, 2-02, 2-03, 2-04, 3-01, 3-02, 3-03, 3-04, 3-05, 3-06, 4-01, 4-02, 4-03, 4-04, 4-05, 4-06, 4-07,4-08, 4-09	198.3	210.9	6.4%
		Contract - Aides	1-10			
		Contract - LPN's	1-11			
		Contract - RN's	1-12			
		Contract - OT	2-11			
		Contract - PT	2-12			
		Contract - ST	2-13			
		Contract - Other Therapists	2-14			
	FICA rates change with wage index	FICA	1-05, 2-05, 3-07, 4-10	222.5	236.7	6.4%
	PERS rate change with wage index	Pensions	1-07, 2-07, 3-09, 4-12	211.1	224.5	6.4%
	Worker's compensation and employer's liability. Classification code 8829 used with wage index	Worker's Compensation	1-10, 2-10, 3-12, 4-15	136.8	145.5	6.4%
	Wage Index	Unemployment Tax	1-08, 2-08, 3-10, 4-13	198.3	210.9	6.4%
	MHCISC or Other Available Study	Professional Liability Insurance	4-32	750	1300	73.3%

6-7 Trend Factor Computation Example

Line No.	COST CENTER	Line Cost Item	Percentage of Cost Center	Trend Factor	Weighted Trend Factor
1	**DIRECT CARE COSTS**				
1-01	Salaries-Aides	89,848,420	41.42%	6.40%	2.65%
1-02	Salaries-LPN's	49,940,472	23.02%	6.40%	1.47%
1-03	Salaries-RN's (exclude DON & RAI Coord.)	21,223,437	9.78%	6.40%	0.63%
1-04	Salaries-Feeding Assistants	1,833,641	0.85%	6.40%	0.05%
1-05	FICA-Direct Care	12,576,700	5.80%	6.40%	0.37%
1-06	Group Insurance-Direct Care	10,377,862	4.78%	5.01%	0.24%
1-07	Pensions-Direct Care	598,697	0.28%	6.40%	0.02%
1-08	Unemployment Taxes-Direct Care	1,011,299	0.47%	6.40%	0.03%
1-09	Uniform Allowance-Direct Care	413,085	0.19%	-2.60%	0.00%
1-10	Workmen's Comp-Direct Care	6,206,719	2.86%	6.40%	0.18%
1-11	Contract-Aides	6,437,412	2.97%	6.40%	0.19%
1-12	Contract-LPN's	1,520,643	0.70%	6.40%	0.04%
1-13	Contract-RN's	1,777,912	0.82%	6.40%	0.05%
1-14	Drugs - Over-the-Counter and Legend-VDC	4,005,160	1.85%	3.60%	0.07%
1-15	Medical Supplies	6,658,105	3.07%	3.60%	0.11%
1-16	Medical Waste Disposal	511,655	0.23%	2.70%	0.01%
1-17	Other Supplies-Direct Care	1,970,328	0.91%	2.40%	0.02%
1-18	Allocated Costs-Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
Total Direct Care Costs		$216,911,547	100.00%		6.13%
2	**THERAPY COSTS**				
2-01	Salaries-Occupational Therapists	306,165	1.80%	6.40%	0.12%
2-02	Salaries-Physical Therapists	431,249	2.53%	6.40%	0.16%
2-03	Salaries-Speech Therapists	261,529	1.53%	6.40%	0.10%
2-04	Salaries-Other Therapists	1,936,608	11.36%	6.40%	0.73%
2-05	FICA Taxes - Therapies	240,304	1.41%	6.40%	0.09%
2-06	Group Insurance-Therpapists	268,452	1.57%	5.01%	0.08%
2-07	Pensions-Therapists	66,130	0.39%	6.40%	0.02%
2-08	Unemployment Taxes-Therapists	21,455	0.13%	6.40%	0.01%
2-09	Uniform Allowance-Therapists	6,266	0.03%	-2.60%	0.00%
2-10	Workmen's Comp-Therapists	62,182	0.36%	6.40%	0.02%
2-11	Contract-Occupational Therapists	3,542,127	20.78%	6.40%	1.33%
2-12	Contract-Physical Therapists	4,386,198	25.73%	6.40%	1.65%
2-13	Contract-Speech Therapists	1,846,379	10.83%	6.40%	0.69%
2-14	Contract-Other Therapists	3,433,903	20.14%	6.40%	1.29%
2-15	Therapy Supplies	240,048	1.41%	2.40%	0.03%
2-16	Allocated Costs-Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
Total Therapy Costs		$17,048,995	100.00%		6.32%

6-7 Trend Factor Computation Example

Line No.	COST CENTER	Line Cost Item	Percentage of Cost Center	Trend Factor	Weighted Trend Factor
3	**CARE RELATED COSTS**				
3-01	Salaries-Activities	5,136,257	8.36%	6.40%	0.54%
3-02	Salaries-Assistant Director of Nursing	3,123,663	5.09%	6.40%	0.33%
3-03	Salaries- Director of Nursing	7,777,076	12.66%	6.40%	0.81%
3-04	Salaries-MDS Coordinator	4,013,640	6.54%	6.40%	0.42%
3-05	Salaries-Pharmacy	45,378	0.07%	6.40%	0.00%
3-06	Salaries-Social Services	4,687,317	7.63%	6.40%	0.49%
3-07	FICA Taxes-Care Related	2,061,706	3.36%	6.40%	0.22%
3-08	Group Insurance-Care Related	1,824,792	2.97%	5.01%	0.15%
3-09	Pension Plan-Care Related	376,240	0.61%	6.40%	0.04%
3-10	Unemployment Taxes-Care Related	155,099	0.25%	6.40%	0.02%
3-11	Uniforms-Care Related	112,715	0.18%	-2.60%	0.00%
3-12	Workmen's Comp-Care Related	922,489	1.50%	6.40%	0.10%
3-13	Barber & Beauty Expense-Allowable	345,793	0.56%	2.10%	0.01%
3-14	Consultant Fees-Activities	75,920	0.12%	2.70%	0.00%
3-15	Consultant Fees-Medical Director	1,725,043	2.81%	2.80%	0.08%
3-16	Consultant Fees-Nursing	1,477,260	2.41%	2.70%	0.07%
3-17	Consultant Fees-Pharmacy	646,320	1.05%	2.70%	0.03%
3-18	Consultant Fees-Social Worker	113,825	0.19%	2.70%	0.01%
3-19	Consultant Fees-Therapists	42,012	0.07%	2.70%	0.00%
3-20	Food	22,033,612	35.88%	1.80%	0.65%
3-21	Supplies-Care Related	4,720,877	7.69%	2.40%	0.18%
3-22	Allocated Costs-Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
3-18	**Total- Care Related Expenses**	$61,417,034	100.00%		4.15%

Line No.	COST CENTER	Line Cost Item	Percentage of Cost Center	Trend Factor	Weighted Trend Factor
4	**ADMINISTRATIVE AND OPERATING**				
4-01	Salaries-Administrator	8,700,745	4.62%	6.40%	0.30%
4-02	Salaries-Assistant Administrator	577,088	0.31%	6.40%	0.02%
4-03	Salaries-Dietary	20,847,337	11.06%	6.40%	0.71%
4-04	Salaries-Housekeeping	10,928,029	5.80%	6.40%	0.37%
4-05	Salaries-Laundry	4,989,169	2.65%	6.40%	0.17%
4-06	Salaries-Maintenance	5,154,790	2.74%	6.40%	0.18%
4-07	Salaries-Medical Records	3,126,640	1.66%	6.40%	0.11%
4-08	Salaries-Other Administrative	13,928,346	7.39%	6.40%	0.47%
4-09	Salaries-Owner	1,135,719	0.60%	6.40%	0.04%
4-10	FOCA Taxes-Admin & Operating	5,331,387	2.83%	6.40%	0.18%
4-11	Group Health-Administrative	5,188,213	2.75%	5.01%	0.14%

COST CENTER	LINE ITEM COST	PERCENTAGE OF COST CENTER	TREND FACTOR	WEIGHTED TREND FACTOR
Administrative and Operating Costs, Cont.				
Line 4-12, Pension Plan-Administrative	575,803	0.31%	6.40%	0.02%
Line 4-13, Unemployment Taxes-Admin.	397,391	0.21%	6.40%	0.01%
Line 4-14, Uniforms-Administrative	207,546	0.11%	-2.60%	0.00%
Line 4-15, Workmen's Comp-Administrative	2,264,173	1.20%	6.40%	0.08%
Line 4-16, Contract-Dietary	433,573	0.23%	2.90%	0.01%
Line 4-17, Contract-Housekeeping	3,245,623	1.72%	2.90%	0.05%
Line 4-18, Contract-Laundry	2,309,604	1.23%	3.00%	0.04%
Line 4-19, Contract-Maintenance	971,411	0.52%	2.90%	0.02%
Line 4-20, Consultant Fees-Dietician	701,924	0.37%	4.30%	0.02%
Line 4-21, Consultant Fees-Medical Records	126,834	0.07%	4.30%	0.00%
Line 4-22, Accounting Fees	1,849,501	0.98%	5.20%	0.05%
Line 4-23, Amortization Expense - Non-Capital	91,710	0.04%	2.40%	0.00%
Line 4-24, Auto Lease	373,062	0.20%	-2.10%	0.00%
Line 4-25, Bank Service Charges	108,425	0.06%	2.80%	0.00%
Line 4-26, Board of Directors Fees	580,127	0.31%	3.10%	0.01%
Line 4-27, Dietary Supplies	2,032,753	1.08%	0.90%	0.01%
Line 4-28, Depreciation Expense	1,019,382	0.54%	-0.60%	0.00%
Line 4-29, Dues	704,978	0.37%	2.40%	0.01%
Line 4-30, Educational Seminars & Training	540,840	0.29%	2.40%	0.01%
Line 4-31, Housekeeping Supplies	2,406,546	1.28%	0.90%	0.01%
Line 4-32, Insurance-Professional Liability	13,651,905	7.24%	73.30%	5.31%
Line 4-33, Interest Expense-Non-Capital & Vehicle	805,570	0.42%	2.40%	0.01%
Line 4-34, Laundry Supplies	819,401	0.42%	0.90%	0.00%
Line 4-35, Legal Fees	1,216,909	0.65%	5.80%	0.04%
Line 4-36, Linen & Laundry Alternatives	2,662,787	1.41%	-2.90%	-0.04%
Line 4-37, Miscellaneous	1,010,396	0.54%	2.40%	0.01%
Line 4-38, Management Fees & Home Office	26,635,205	14.13%	2.40%	0.34%
Line 4-39, Non-Emergency Medical Transportation	573,025	0.30%	-0.90%	0.00%
Line 4-40, Office Supplies & Subscriptions	2,543,119	1.35%	2.40%	0.03%
Line 4-41, Postage	443,070	0.24%	6.00%	0.01%
Line 4-42, Repairs & Maintenance	6,595,366	3.50%	2.90%	0.10%
Line 4-43, Taxes, Other	14,280,784	7.58%	2.40%	0.18%
Line 4-44, Telephone & Communications	2,509,632	1.33%	0.40%	0.01%
Line 4-45, Travel	914,315	0.49%	1.60%	0.01%
Line 4-46, Utilities	12,938,328	6.87%	-4.40%	-0.30%
Line 4-47, Allocated Costs, Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
Total Administrative & Operating Costs	$188,448,481	100.00%		8.7500%

CHAPTER 7

DEFINITIONS

Annualized Total Patient Days - The total patient days reported on the cost report adjusted for any cost report period less than one year and for changes in the number of Medicaid-certified beds. This is done to estimate what the total patient days would be for a full year for a facility. For example, a nursing facility files a cost report for three (3) months with total patient days of 10,000. The annualized total patient days would be (10,000 / 3) X 12 = 40,000. In this example, it is estimated that the total patient days for this facility would be 40,000.

Base Rate - A direct care per diem rate established for nursing facilities that is set at least annually and is the equivalent of a case mix score of 1.0.

Care Related Costs - These costs include salaries and fringe benefits for activities, Director of Nurses, pharmacy, social services; food; Medical Director; consultants for activities, nursing, pharmacy, social services and therapies; related supplies; and personal hygiene supplies.

Direct Care Costs-Expenses incurred by nursing facilities for the hands on care of the residents. These costs include salaries and fringe benefits for Registered Nurses (RN's), (excluding the Director of Nursing, the Assistant Director of Nursing and the Resident Assessment Instrument (RAI) Coordinator; Licensed Practical Nurses (LPN's); nurse aides; feeding assistants; contract RN's, LPN's, Respiratory Therapist (RTs) and nurse aides; medical supplies and other direct care supplies; medical waste disposal; and allowable drugs.

Fair Rental System-The gross rental system as modified by the Mississippi Case Mix Advisory Committee and described in this plan.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)-A classification of long-term care facilities that provides services only for individuals with intellectual disabilities in accordance with 42 CFR Part 483, Subpart I.

Minimum Data Set (MDS)-The resident assessment instrument approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), for use by all Medicaid and Medicare certified nursing facilities in Mississippi including section S, as applicable.

Mississippi Alzheimer's Unit Weights-A calculation, based on actual time and salary information of the care givers, of the relationship of each RUG IV group to the average for residents in licensed Alzheimer's Units.

Resource Utilization Grouper IV (RUG IV)– The Centers for Medicare and Medicaid Services Medicaid 48-grouper classification system adopted for use in setting per diem rates for nursing facilities. This classification system is based on assessments of residents and the time and cost associated with the care of the different types of residents.

Large Nursing Facility- A classification of long-term care facilities that provides nursing facility care in accordance with 42 CFR Part 483, Subpart B and which has 61 or more beds certified for Title XIX.

Nursing Facility- Psychiatric - A classification of facilities now called Psychiatric Residential Treatment Facilities (PRTF).

Patient Days- The number of days of care charged to a beneficiary, including bed hold and leave days, for patient long-term care is always counted in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method must be used in reporting the days of care for beneficiaries, even if the facility uses a different definition for statistical or other purposes. The day of admission counts as a full day. However, the day of discharge

is not counted as a day. If both admission and discharge occur on the same day, the day is considered a day of admission and counts as one patient day.

Psychiatric Residential Treatment Facilities- A classification of facilities that provides long-term psychiatric care for children under age 22, in accordance with 42 CFR, Part 441, Subpart D. Services must be provided under the direction of a physician who is at least board eligible and has experience in child/adolescent psychiatry. The psychiatric services must also be provided in accordance with an individual comprehensive services plan.

Small Nursing Facility- A classification of long-term care facilities that provides nursing facility care in accordance with 42 CFR Part 483, Subpart B and which has 1-60 beds certified for Title XIX.

Nursing Facility for the Severely Disabled- A classification of long-term care facilities that provides specialized nursing facility care to severely disabled residents, including, but not limited to, those with spinal cord injuries, closed head injuries, and ventilator-dependence, in accordance with 42 CFR, Part 483, Subpart B and MS Code 43-13-117 (44).

State Mississippi

DEFINITION OF A CLAIM

- For hospital outpatient, physician, dental, prescribed drugs, home health services, and clinics, a claim is a line item with an associated charge to be adjudicated.

- For hospital inpatient services, a claim is a separate hospital billing issued for all or a portion of the inpatient hospital stay. When a single hospital billing is comprised of more than one document, the billing should be counted as a single claim.

- A nursing home claim is defined as one claim per month per recipient stay. Recipient stay is defined as consecutive days in a nursing home at the same level of care.

- EPSDT claim is defined as one claim per line item.

- Cross-over claims are defined as the cross-over billing item.

TN No. 87-11 DATE/RECEIPT 6/1/87
SUPERSEDES DATE/APPROVED 6/23/87
TN No. 79-19 DATE/EFFECTIVE 4/1/87

State of Mississippi

REQUIREMENTS FOR THIRD PARTY LIABLILITY IDENTIFYING LIABLE RESOURCES

42 C.F.R. § 433.138(f)

The designated state agency, Department of Human Services (DHS), performs the required data exchanges specified in Section 433.138(d)(l) during application period and at least on a quarterly basis. The exception to this time frame is the institutionalized individuals for which exchanges of data are conducted as specified in Sec. 435.948(d).

Data exchange agreements have been executed with Workers' Compensation Commission and the Department of Public Safety.

The Medicaid Management Information System (MMIS) identifies on a weekly basis those paid claims that contain diagnosis codes 800-999 (ICD10CM) for the purpose of identifying the legal liabilities of third parties.

42 C.F.R. §§ 433.138(e), 433.138(g)(l)(i), 433.138(g)(l)(ii) and (2)(ii)

The Division of Medicaid receives health insurance information from DHS who performs the State wage information collection agency (SWICA) and Social Security Administration (SSA) wage and earnings files data exchanges. DHS maintains a copy of the information in the eligibility file and the information to the Division of Medicaid. The Division of Medicaid completes any necessary research, enters the data into the MMIS Third Party Liability (TPL) files within forty-five (45) days.

The Division of Medicaid receives insurance information from the Department of Human Services (DHS), the SSA, and the Medicaid Regional Offices from application and redetermination procedures for Medicaid eligibility. The sources of eligibility maintain the third party information in the eligibility case file and send the information to the Division of Medicaid as part of the agreement with DHS. This information is uploaded into the MMIS TPL files.

42 C.F.R. § 433.138(q)(2)(i)

The required data exchange takes place weekly with the Mississippi Workers' Compensation Commission. In order to incorporate TPL data within sixty (60) days as specified in section 433.139(g)(2)(i), prior to producing the final report of "hits," the MMIS cross references the data received back from worker's compensation with the trauma code claims which appeared on the Trauma Code edit reports to avoid duplication of effort. Inquiries containing Medicaid's subrogation rights to insurance companies, employers or attorneys are generated by the MMIS. Upon receipt of response, a TPL recovery case is established.

State of Mississippi

REQUIREMENTS FOR THIRD PARTY LIABLILITY IDENTIFYING LIABLE RESOURCES

42 C.F.R. § 433.138(g) (3) (i) and (iii)

A required data exchange takes place with the Department of Public Safety (DPS) annually. A questionnaire will be sent to the beneficiaries found in data match. Upon receipt of a response indicating a liable third party, a recovery case is established.

42 C.F.R. § 433.138(g)(4)(i) through (iii)

The MMIS identifies on a weekly basis those paid claims that contain diagnosis codes 800-999 (ICD-10-CM.) An accident questionnaire is system generated and mailed to each recipient whose accumulated monthly paid amount equals or exceeds $250. Responses received by the Division of Medicaid that identify a liable third party, attorney, or insurance carrier require a notice and inquiry to that party advising of Medicaid's subrogation statute (section 43-13-125 of the Mississippi Code of 1972, annotated as amended) within 30 days. In order to incorporate third party information within 50 days, the sources of eligibility are notified to include third party information in the eligibility case record. The Division of Medicaid will make any necessary updates to the MMIS files and maintain related hard copy files. A detailed amount of the state's subrogation claim is provided to the third party upon request and updated immediately prior to settlement. Should Medicaid's potential recovery be less than the total subrogation interest, the case is referred to the staff attorney for a comprise determination (Section 43-l3-125(2)(b), Mississippi Code of 1972, annotated amended). Additionally, the right of subrogation by the state to the recipient's right to recovery shall be subject to ordinary and reasonable attorney fees (Section 43-13-125(2)(a), Mississippi Code of 1972, annotated as amended).

42 C.F.R. § 433.138(e)

Priority for follow-up will be given to the trauma codes, which yield the highest recovery as evidenced by the quarterly report produced by the DOM TPL Unit in-house computer program.

State of Mississippi

REQUIREMENTS FOR THIRD PARTY LIABILITY PAYMENT OF CLAIMS

(1) Providers are required to file a claim with the third party prior to filing with the Division of Medicaid except in the following circumstances:

a) Claims for preventive pediatric services (including EPSDT services), and
b) Claims for covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

(2) If a provider submits a claim to a third party and does not receive a response within thirty (30) days, the provider must submit a written inquiry to the third party. If the third party has not responded after sixty (60) days from the date of the original claim submission, the provider may submit a "Third Party Liability (TPL) Edit Override Attachment: No Response Form". The Division of Medicaid will pay the claim according to policies related to that service. The Division of Medicaid's Third Party Recovery vendor will include these claims in future recoveries.

Section 53102(a)(1) of the Bipartisan Budget Act of 2018 amended section 1902(a)(25)(E) of the Act to require a state to use standard coordination of benefits cost avoidance when processing claims for prenatal services which now included labor and delivery and postpartum care claims. Therefore, if DOM has determined that a third party is likely liable for a prenatal claim, the claim will be denied-and be returned to the provider noting the third party that Medicaid believes to be legally responsible for payment. If, after the provider bills the liable third party and a balance remains or the claim is denied payment for a substantive reason, the provider can submit a claim to DOM for payment of the balance, up to the maximum Medicaid payment amount established for the service in the State Plan.

Section 53102(a)(1) of the Bipartisan Budget Act of 2018 amended section 1902(a)(25)(E) of the Act, to require a state to make payments without regard to third party liability for pediatric preventive services unless DOM has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.

Section 7 of the Medicaid Services Investment and Accountability Act of 2019 (Pub. L. 116-16) amended section 202(a)(2) of the Bipartisan Budget Act of 2013. Therefore, DOM will allow 100 days instead of 90 days to pay claims related to medical support enforcement pursuant to section 1902(a)(25)(F)(i) of the Act.

(3) A threshold amount of $100 is used to determine whether to seek recovery from a liable third party except for trauma-related claims in which case a threshold amount of $ 250 is used.

REQUIREMENTS FOR THIRD PARTY LIABILITY PAYMENT OF CLAIMS

(4) Third party recovery will be pursued when the accumulated monthly trauma code paid claims amount for each beneficiary equals or exceeds a $250 threshold.

The MMIS will generate monthly invoices of preventive pediatrics and Title IV-D related claims when the accumulated paid claims for each beneficiary with a third party indicator in the claims payment system and no third party amount listed on the claim, equals or exceeds a $100 threshold.

The Medicaid provider may not refuse covered services to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability. The provider may not seek to collect from the Medicaid eligible individual (or any financially responsible relative or representative of that individual) if the total amount of the third party liability is equal to or greater than the amount payable under the State Plan (which includes, when applicable, approved cost-sharing payments.) When the total third party payment is less than the amount payable under the State Plan (which includes, when applicable, approved cost-sharing payments), the provider may collect from the individual (or any financially responsible relative or representative) an amount the lesser of any approved cost-sharing amount or the difference between the amount payable under the State Plan and the total third party payment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

I. The State of Mississippi will use two (2) methods to determine the likely cost effectiveness of a group health plan:

(1) Cost Effectiveness Based on Average Expenditure Projection

The likely cost effectiveness of a health insurance policy to Medicaid may be determined by comparing the annualized premium, deductible, and copayments, plus the administrative cost of analysis and processing by the State against the average Medicaid expenditure for a recipient in the recipient's eligibility classification for types of service(s) covered under the policy. The premium shall be paid even if the policy covers other non-Medicaid person(s).

(2) Cost Effectiveness Based on Actual Expenditures

The likely cost effectiveness of health insurance may be established by documentation of actual expenditure (Explanation of Benefits) from the insurer which, based on a recipient's existing condition, are likely to continue and that exceed the annualized cost of the policy as described in item (1) above.

II. Policies with Coverage Limitations

Health insurance policies which are not considered to be cost effective, based upon the limited nature of their coverage, are accident, indemnity, Medicare supplemental and surgical policies. These policies, therefore, will not be evaluated. Dread disease and cancer policies may be cost effective if documented by insurance benefits which can be expected to be ongoing and when determined to be cost effective as described in item I.

State of Mississippi
Income and Eligibility Verification System Procedures

Matching Agency	General Description and Frequency
Social Security Administration (SSA)	Non-MAGI applicants are submitted through daily file transmissions and on-demand requests for standard SVES responses to verify an applicant's SSN, U.S. citizenship (if not previously verified) and title II and title XVI data. Upcoming non-MAGI renewals are submitted once per month to verify title II and title XVI data. Renewal files are processed in the month prior to the scheduled review due date. MAGI applicants are submitted through the Federal Data Services Hub to verify SSN, title II and U.S. citizenship (if not previously verified). The FDSH also verifies wages through TALX and alien status through the Department of Homeland Security as part of the same submission and not as a separate match by the agency.
MS Department of Employment Security (MDES)	Applicants are submitted weekly to verify wage and unemployment benefits. Renewals are submitted once per month for the same data. Renewal files are processed in the month prior to the scheduled review due date.
Public Employees Retirement System (PERS)	Age appropriate applicants are sent monthly to verify state retirement benefits. All known State retirees are submitted annually to verify current State retirement benefits.
Internal Revenue Service (IRS)	Temporarily discontinued. Discussions are being held with IRS to develop an acceptable secure matching process.
Public Assistance Reporting Information System (PARIS)	Quarterly file transmissions of Medicaid recipients active in the previous quarter are submitted for matching purposes with applicable federal databases to identify benefit information on matching Federal civilian employees and military members, both active and retired, and to identify duplicate participation across state lines.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

To be determined on an individual basis. Policy written to cover this. (I.E., recipient may request card to be sent to Medicaid's State Office or a Regional Office. If request is made, then recipient may get the card at the specified designation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLAN FOR MEDICAL ASSISTANCE

The material that follows in Supplement 1 to Attachment 4.34-A, pages 1 - 10, is contained in pamphlet form and is distributed by the applicable providers at the time specified in paragraph 4.13 to those individuals under their care. The pamphlet contains the essential elements of State law on advance directives and prescribes implementing forms that comply with the requirements of the law.

INTRODUCTION

In general, you have the right to make health care decisions, including decisions as to nursing home care, for yourself. Under the law, a patient must consent to any treatment or care received. Generally, if you are a competent adult, you can give this consent for yourself. In order for you to give this consent, you should be told what the recommended procedure is, why it is recommended, what risks are involved with the procedure, and what the alternatives are.

If you are not able to make your own health care decisions, your advance directives can be used. An "advanced directive" can be a Living Will, a Durable Power of Attorney for Health Care, or other evidence of your wishes concerning health care decisions.

A Living Will is a directive to be allowed to die naturally. The Living Will comes into play only when your attending physician, along with 2 other physicians, believes that you will not regain consciousness or a state of health that is meaningful to you and but for the use of life-sustaining mechanisms, you would soon die. The Living Will must be in substantially the form set forth in the back of this pamphlet.

A "Durable Power of Attorney for Health Care" ("DPAHC") is a document where you designate someone as your agent to make health care decisions for you if you are unable to make such a decision. The DPAHC comes into play when you cannot make a health care decision either because of a permanent or temporary illness or injury. The DPAHC must specifically authorize your attorney in fact to make health care decisons for you and must contain the standard language set out in the law. This language is included in the of DPAHC form at the back of this pamphlet. Otherwise, the DPAHC can contain any instructions which you wish.

If you are unable to make decisions and have not left a Living Will or DPAHC, members of your family may make decisons for you. Family members, however, may disagree among themselves or with the physician. In these instances, a Living Will or DPAHC may help to clarify the decisons and who can make them.

The law on making health care decisions and advance directives is discussed in this pamphlet in detail in wording that we hope makes it easy for you to read. Please read the entire pamphlet.

YOUR RIGHT UNDER MISSISSIPPI LAW TO MAKE DECISIONS CONCERNING HEALTH CARE

The Patient Self Determination Act of 1990 (the "PSDA") is a new federal law which imposes on the State and providers of health care -- such as hospitals, nursing homes, hospices, home health agencies, and prepaid health care organizations -- certain

requirements concerning advance directives and an individual's rights under State law to make decisions concerning medical care. This pamphlet will discuss your rights under state law to make health care decisions and set out a description of the Mississippi law on advance directives.

What Are My Rights to Accept or Refuse Treatment or Care?

In general, you have the right to make health care decisions, including decisions as to nursing home care, for yourself, if you are 18 or older and are competent.

What Information Must I Be Told To Give My Consent?

The physician should explain to you the pertinent facts about your illness and the nature of the treatment in nontechnical terms which are understandable to you. The physician also should explain to you why the proposed treatment is recommended.

The physician should inform you of all reasonable risks and material consequences or "side effects" associated with the proposed treatment.

Finally, the physician must tell you about any other types of treatment which you could undergo instead. The nature, purpose, and reasonable risks, and consequences of these treatments should be explained to you.

With this information, you can then make your health care decison.

What If I am Unable to Make These Decisions?

If you cannot make a health care decision because of incapacity, your advance directive, such as a Living Will or Durable Power of Attorney for Health Care, can be used. If you have not signed an advance directive, a family member may make the decison, or a court may have to make the decison for you.

A. LIVING WILLS

What is a Living Will?

A Living Will is a directive to be allowed to die naturally. Through the Living Will, you authorize your physician to withdraw life-sustaining mechanisms under certain circumstances. The Living Will comes into play only when you suffer a terminal physical condition which causes you severe distress or unconsciousness and but

for the use of life-sustaining mechanisms, you would soon die.

What Must the Living Will Say?

The Living Will must be in substantially the form set forth in the Mississippi Code and properly witnessed. A copy of this form is included in the Form section in the back of this pamphlet.

Must the Living Will be Filed?

The Living Will must be filed, along with $10, with the Division of Public Health Statistics of the Mississippi State Department of Health.

How Can a Living Will be Revoked?

The Living Will, once filed, is valid until revoked. You may revoke a Living Will by signing a revocation in substantially the form set forth in the statute. The revocation must be signed by witnesses and filed with the Division of Public Health Statistics of the Mississippi State Department of Health. No filing fee is charged for the filing of a revocation of a Living Will. A copy of the revocation form is included in the back of this pamphlet.

What If I am Unable to Follow This Procedure?

If you wish to revoke a Living Will but are unable to sign a form, a clear expression by you, oral or otherwise, of your wish to revoke the Living Will is effective.

What Happens When it is Time to Use the Living Will?

Your attending physician, along with 2 other physicians, must believe that you will not regain consciousness or a state of health that is meaningful to you and but for the use of life-sustaining mechanisms, you would soon die. Then the physician in charge must get a copy of your Living Will and make sure it has not been revoked. Once this has been done, the life-sustaining mechanisms will be withdrawn.

Will My Living Will Be Followed?

Your Living Will is to be honored by your family and physician as the final expression of your desires concerning the manner in which you die.

A physician, hospital, nursing home, or other provider, however, has the right to refuse to follow your Living Will. But a provider not honoring your Living Will must cooperate in your transfer to another provider that will follow your Living Will.

Upon admission, you should receive a copy of the facility's policies concerning advance directives. You should review these policies and determine whether or not the facility will follow your Living Will.

Should I Give My Physician a Copy of My Living Will?

Yes. A copy also should be given to any other provider, such as a hospital, home health agency, or nursing home, from which you are receiving care.

B. DURABLE POWERS OF ATTORNEY FOR HEALTH CARE

What is a Durable Power of Attorney for Healthcare?

You may designate an individual as your agent (or "Attorney In Fact") to make health care decisions for you if you are unable to make such a decison because of a permanent or temporary illness or injury. The document authorizing this action is the Durable Power of Attorney for Health Care ("DPAHC").

What Must the DPAHC Contain?

The DPAHC must be properly witnessed, must specifically authorize your Attorney In Fact to make health care decisions for you, and must contain the standard language set out in the law. This language is included in the DPAHC form at the back of this pamphlet. Otherwise, the DPAHC can contain any instructions which you wish.

What Should I Do With the DPAHC?

The DPAHC does not need to be filed. You should keep the DPAHC for yourself and give a copy to the Attorney In Fact you named in the DPAHC. A copy should also be given to your physician to make a part of your medical records. You should also give a copy to any other provider from which you are receiving care, such as a nursing home, hospital, or a home health agency. You may also want to provide a copy to your clergy, family members and friends who are not named in the documents.

Who Will Decide if I Cannot Act and My Attorney In Fact Should Act for Me?

You can name a physican in the DPAHC to make this determination. You also can specify how incapacity and mental status is to be determined if the need should arise. If no instructions are provided, then "generally accepted standards" will normally apply.

Who Can Act As My Attorney In Fact?

Neither a treating health care provider nor an employee of a treating health care provider may be named as your Attorney In Fact. Otherwise, any person, such as a family member or a friend, may act as the Attorney In Fact. The Attorney In Fact does not need to be a lawyer.

What are the Powers of My Attorney In Fact?

Your Attorney In Fact has whatever power you give in the DPAHC to make health care decisons for you. "Making health care decisions" means consenting, refusing to consent or withdrawing consent to any care, treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. This includes decisions as to nursing home care as well as decisions as to medical treatment.

Are There Limitations on the Power of My Attorney In Fact?

Your Attorney In Fact has a duty to act according to what you put in the DPAHC or as you otherwise have made known to him or her. If your desires are unknown, he or she must act in your best interest. Your Attorney In Fact cannot make a particular health care decision for you if you are able to make that decision.

What if Someone Other Than the Attorney In Fact Wants to Make Health Care Decisons for Me?

Unless the DPAHC says otherwise, your Attorney In Fact has priority over any other person to act for you.

Will a Health Care Provider Recognize My Attorney In Fact's Authority?

In general, yes. Special rules, however, may apply when life-sustaining treatment is at issue.

Upon admission, you should receive a copy of the facility's policies on advance directives. You should review these policies and determine whether or not the facility will follow your DPAHC.

Can My DPAHC be Changed?

You can change your Attorney In Fact by telling him or her of the change, or you can revoke the authority to make decisions by notifying the health care provider in writing. In order to make either of these changes, you must be of sound mind.

C. GENERAL

What If I Have a Living Will or DPAHC I Signed When Living in Another State?

To be binding, these documents must meet Mississippi law. Many out-of-state documents will not meet these requirements. The safest route is to execute new documents following the Mississippi statute.

Do I Need Both a Living Will and DPAHC?

A Living Will and a DPAHC are distinct documents. They serve different purposes.

A Living Will applies only if you are about to die. It instructs your physician to discontinue life support if your condition is terminal and you have become incompetent.

A DPAHC allows you to pick another person to make your health care decisons for you whenever you are unable to make those decisions yourself.

You should discuss with your lawyer the advisability of having either or both documents in place.

What Other Documents Should Be Considered?

The Living Will and DPAHC are the only documents recognized in Mississippi by statue. However, depending upon particular circumstances, the state may recognize other health care directives or indications of your desires concerning health care. You also should discuss these options with your lawyer.

Can I Let My Family Make These Decisions?

Members of your family may make decisions for you if you are unable to do so and have not left a Living Will or DPAHC. Family members, however, may disagree among themselves or with the physician. In these instances, a Living Will or DPAHC may help to clarify the decisions and who can make them.

When Will a Court Make This Decision?

As a final resort, if someone authorized to consent for you has refused or declined to do so and there is no other person known to be available who is authorized to consent, a court may order treatment for you if you are not able to do so.

LIVING WILL FORM

Declaration

I, _____ being of sound mind, declare that if at any time I should suffer a terminal physical condition which causes me severe distress or unconciousness, and my physician, with the concurrence of two (2) other physicians, believes that there is no expectation of my regaining consciousness or a state of health that is meaningful to me and but for the use of life-sustaining mechanisms my death would be imminent, I desire that the mechanisms be withdrawn so that I may die naturally. However, if I have been diagnosed as pregnant and that diagnosis is known to my physician, this Declaration shall have no force or effect during the course of my pregnancy. I further declare that this Declaration shall be honored by my family and my physician as the final expression of my desires concerning the manner in which I die.

Signature _____ *Date* _____

Name _____ *Social Security Number* _____

Address _____

Next of kin _____

Address _____

Witness

I hereby witness this Declaration and attest that:

1. I personally know the Declarant and believe the Declarant to be of sound mind.
2. To the best of my knowledge, at the time of the execution of this Declaration, I:
   a. Am not related to the Declarant by blood or marriage,
   b. Do not have any claim on the estate of the Declarant,
   c. Am not entitled to any portion of the Declarant's estate by any will or by operation of law,
   d. Am not a physician attending the Declarant or a person employed by a physician attending the Declarant.

Signature _____ *Signature* _____

Name _____ *Name* _____

Address _____ *Address* _____

_____ _____

Social Security Number _____ *Social Security Number* _____

LIVING WILL REVOCATION

Revocation

On _____ (date), I _____ (person's name), of _____ _____ (address), _____ (Social Security Number), being of sound mind, revoke the Declaration made on _____ (date Declaration made) regarding the manner in which I die.

Signed _____

Witness

I hereby witness this Revocation and attest that:

1. I personally know the maker of this Revocation and believe the maker of this Revocation to be of sound mind.
2. To the best of my knowledge, at the time of the execution of this Revocation, I:
   a. Am not related to the maker of the Revocation by blood or marriage,
   b. Do not have any claim on the estate of the maker of this Revocation,
   c. Am not entitled to any portion of the maker of this Revocation's estate by any will or operation of law, and
   d. Am not a physician attending the maker of this Revocation or a person employed by a physician attending the maker of this Revocation.

Signature _____	*Signature* _____
Name _____	*Name* _____
Address _____	*Address* _____
Social Security Number _____	*Social Security Number* _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____ hereby appoint:

_____
Name

_____
Home Address

_____
Work Telephone Number Home Telephone Number

my attorney-in-fact to make health care decisions for me if I become unable to make my own health care decisions.

Subject to my special instructions below, this gives my attorney-in-fact the full power to make health care decisons for me, before or after my death, to the same extent I could make decisons for myself and to the full extent permitted by law, including making a dispositon under the state's anatomical gift act, authorizing an autopsy, and directing the disposition of remains. My attorney-in-fact also has the authority to talk to health care personnel, get information and sign forms necessary to carry out these decisions.

Special instructions: _____

_____

_____

_____

_____

If the person named as my attorney-in-fact is not available or is unable to act as my attorney-in-fact, I appoint the following person to serve in his or her place:

_____
Name

_____
Home Address

_____
Work Telephone Number Home Telephone Number

By my signature I do hereby indicate that I understand the purpose and effect of this document.

_____
SIGNATURE

DATE: _____

The law requires that this document be either (1) signed by two persons who witnessed your signature, or (2) acknowledged by a Notary Public in Mississippi. Therefore, one of the sections below must be completed.

SECTION 1. WITNESSES

I declare under penalty of perjury under the laws of Mississippi that the principal is personally known to me, that the principal signed or acknowledged this Durable Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

FIRST WITNESS	SECOND WITNESS
Signature _____	Signature _____
Print Name _____	Print Name _____
Date _____	Date _____

At least one of the witnesses listed above shall also sign the following declaration:

I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____
SIGNATURE

SECTION 2. NOTARY PUBLIC

State of Mississippi

County of _____

On this the _____ day of _____, in the year _____, before me _____ personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
NOTARY PUBLIC

My Commission Expires:

_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at 42 CFR 488.404 (b) (1):

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at Section 1919 (h) (2) (A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at Section 1919 (h) (2) (A)) for applying the remedy.

_X_ Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at Section 1919 (h) (2) (A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at Section 1919 (h) (2) (A)) for applying the remedy.

X Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at Section 1919 (h) (2) (A)) for applying the remedy.

X Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at Section 1919 (h) (2) (A)) for applying the remedy.

_X_ Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at Section 1919 (h) (2) (A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

Ban on Admissions - A ban on all admissions will be imposed for facilities with substandard quality of care. This remedy will be categorized as a Category 2 remedy.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The following information which is contained in the nurse aid registry in addition to the requirements of 42 CFR 483.156 (c)(1)(iii) and (iv) shall be disclosed upon request:

- the individual's last known address,
- the individual's date of birth,
- the employment status of the individual including: place of employment and full time or part time,
- the social security number of the individual,
- if the individual is included on the registry by successfully completing the examination, by reciprocating from another state or by receiving deemed status,
- the state assigned registration number,
- the training code number for program completed and the date of completion of training program,
- the date the individual passed the competency evaluation,
- the individual's last known employer including name/location and date of hire
- a special code or identifier to indicate, if applicable, confirmed findings by the state survey agency of abuse, neglect, or misappropriation of resident property by the individual, and
- a special code or identifier to indicate, if applicable, that an administrative hearing is pending regarding alleged abuse, neglect, or misappropriation of property.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

In addition to the requirements of 42 CFR 483.156(c) the nurse aide registry shall contain all the information listed on attachment 4.38, page 1.

State of Mississippi

DEFINITION OF SPECIALIZED SERVICES

Specialized services for mental illness are the services which, combined with services provided by the nursing facility (NF), result in the continuous and aggressive implementation of an individualized plan of care that is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professionals. The plan of care prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning level that permits· reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time. These services are defined as medication monitoring by a psychiatrist, life-threatening crisis intervention, intensive individual, family or group psychotherapy, and intensive psychosocial rehabilitation skills.

Specialized serves for intellectual and developmental disabilities are the services which, combined with services provided by the NF or other service providers, result in treatment which meets the requirements of 42 C.F.R. § 483.440(a)(1).

State of Mississippi

False Claims Act

1. The Division of Medicaid, the Mississippi single state agency, will incorporate into the provider enrollment agreement and other contractors, the responsibilities of the affected entities in implementing Section 6032 of the Deficit Reduction Act of 2005, the "Employee Education about False Claims Recovery."
2. The Division of Medicaid will determine affected entities based upon federal law, regulations, and guidance from the Centers for Medicare and Medicaid Services.
3. The Division of Medicaid will conduct an audit of the affected entities written policies/procedures including all relevant affected employee education policies and any provisions described in the entity's employee handbook. A written response of approval and/or suggestions will be provided to the affected entity. Policies and procedures will include explanation of the false claims act; the entity's policies and procedures for detecting and preventing waste, fraud and abuse; the rights of the employee to be protected as whistle blowers and telephone numbers and/or addresses for reporting fraud and abuse.
4. Thereafter, the Division will contact affected entities on a yearly basis for any update or change to its written policies. The Division will accomplish this verification by survey.
5. New affected entities identified each year will be required to submit their policies and dissemination plan and will be handled per #2, 3, and 4.
6. The Division of Medicaid has a range of sanctions contained in its administrative regulation for non-compliance with Medicaid policies. These sanctions range from requiring a plan of correction to termination from the Medicaid program. These sanctions will be applied to non-compliance with the "Employee Education about False Claim Recovery."

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 7.2-A

State Mississippi

NONDISCRIMINATION

Currently approved methods of administration under the Civil Rights requirements are on file in the Regional Office for Civil Rights.

Rec'd [illegible] # 73-10 Date: [illegible]

[illegible] 12/18/73

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Mississippi

METHODS OF ADMINISTRATION REGARDING COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

I. Assignment of Responsibility -- Responsible for overall coordination of Title VI activities.

Medicaid Program Administrator (0019) - Assigned the specific duties of implementing policies and procedures approved by the Department of Health & Human Services, Office for Civil Rights (OCR), for monitoring all providers of Title XIX services to insure their compliance with Federal nondiscriminatory regulations. The Medicaid Program Administrator will delegate responsibilities to a Medicaid Program Development Specialist to perform tasks pertinent to the administration of this program.

For services based on the Title XVIII certification, this Agency accepts all Title VI certifications made by the Office for Civil Rights. After initial certification by OCR, compliance determinations for both the single State agency and Region IV OCR will be completed in keeping with approved procedures.

II. Dissemination of Information

Orientation sessions are conducted periodically for all new agency employees. These sessions are designed to acquaint the employee with all general areas of the Medicaid Program, including Title VI requirements. Those with more specific responsibilities in the area of Title VI are given more detailed instructions. Joint training has been done with staff of the Regional Office for Civil Rights.

All brochures, leaflets and other informational material for dissemination to the public contain appropriate statements relating to provisions of Title VI and instructions as to how and where complaints may be filed.

Vendors are advised of Title VI requirements through individual provider manuals, participation agreements, statements on claim forms, personal contact by agency staff in the routine performance of duty, and, in the case of nursing homes, through special regional meetings arranged through the nursing home professional associations.

METHODS OF ADMINISTRATION REGARDING COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

III. Maintaining and Assuring Compliance

Region IV OCR has approved the attached written procedures as acceptable for monitoring the compliance of Title XIX providers. These procedures were developed for their appropriateness to implementation in this specific State Agency and were developed with the guidance and assistance of Region IV OCR staff. Written procedures for handling complaints of discriminatory nature are also included in the approved procedures (see attached Exhibit "A").

The attached written procedures are currently being utilized by the appropriate Mississippi Medicaid staff in the on-going monitoring of State Title XIX providers.

IV. Recruitment and Training Programs

The policies, rules, and procedures governing personnel and position management with this agency are under the authority of the Mississippi Code of 1972, as Amended, Section 25-9-101, et seq., as approved by the Mississippi State Personnel Board, effective February 1, 1981.

All vacancies are filled through approved State Personnel Board procedures and this agency has a standing request that State Personnel Board advertisements of vacancies be made in such a way as to reach all segments of the community. Applicants certified by the State Personnel Board are considered on the basis of education, experience and personal interview with the single objective of filling vacancies with the best qualified persons. Race, sex and age are not determining factors, nor is a physical handicap if it does not impair the person's ability to do the work required. The make-up of our staff attests to the effectiveness of the policies as stated.

In-service training is provided all employees on an on-going basis through supervisory personnel and additional training outside the agency is made available to all employees with the only condition being relevance to the employees' duties with the agency.

Approved 9/24/82 effective 7/1/82

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

METHODS OF ADMINISTRATION

FOR

RECIPIENTS OF FEDERAL FINANCIAL ASSISTANCE
TITLE VI - CIVIL RIGHTS COMPLIANCE

Transmittal #2001-14
Supersedes TN No. 87-19

Effective Date: JUL 01 2001
Approval Date: JUL 20 2001

DIVISION OF MEDICAID

METHOD OF ADMINISTRATION

TITLE VI - CIVIL RIGHTS COMPLIANCE

INDEX

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Transmittal #2001-14
Supersedes TN No. 87-19

Effective Date: JUL 01 2001
Approval Date: JUL 20 2001

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
METHODS OF ADMINISTRATION
FOR
RECIPIENTS OF FEDERAL FINANCIAL ASSISTANCE
TITLE VI - CIVIL RIGHTS COMPLIANCE

A. PURPOSE

The purpose of this Methods of Administration is to provide a step-by-step guideline for Division of Medicaid personnel to monitor the Civil Rights and Section 504 compliance of the Program's providers of service. There procedures will help to implement an effective mechanism to reasonably insure that providers/vendors comply with the non-discriminatory requirements and guidelines of the Civil Rights Act and the Rehabilitation Act.

The revised document reestablishes written policy, procedure and guidance relative to non-discrimination by the Office of the Governor, Division of Medicaid in the administration of its federal financial assistance programs.

B. AUTHORITY

Title VI of the Civil Rights Act of 1964 prohibits federally assisted programs from discriminating on the basis of race, color or national origin (including persons with limited English proficiency). Pursuant to this Act: "No person in the United States shall, on the ground of race, color, or national origin (including persons with limited English proficiency) be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies."

Additionally, Title VI Regulations requires that State Agencies, receiving funds from Department of Health and Human Services (DHHS), develop and maintain Methods Of Administration (MOA).

**** *Reference Title VI of the Civil Rights Act of 1964*
(45 Code of Federal Regulations (CFR) Part 80).

As part of the Rehabilitation Act of 1973 (Public Law 93-112) Congress enacted Section 504, which provides that, "No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance (including persons with HIV/AIDS)."

****Reference Section 504 of the Rehabilitation Act of 1973*
(45 Code of Federal Regulations (CFR) Part 84)

Both of these regulations cover the provisions of services and employment practices.

C. POLICY

The Division of Medicaid is committed to assuring that all program benefits are made available to all persons and provided to all eligible individuals, without regard to age, religion, disability, political affiliation, veteran status, sex, race, color or national origin (including persons with limited English proficiency).

PART I
Assignment of Responsibility for Implementation of Title VI and Section 504

Division of Medicaid has assigned the responsibility of the Civil Rights and Section 504 Compliance to the Beneficiary Relations Bureau. The related duties of this assignment shall be:

a. Responding to complaints of discrimination through investigation and written documented replies;

b. Preparation of Compliance Reports and participation data for submission to the Office for Civil Rights upon request;

c. Conducting compliance reviews of providers and providers' facilities;

d. Acting as a liaison between the Division of Medicaid and the Office of Civil Rights;

e. Acting as a liaison between the Division of Medicaid and minority and disability groups or other community groups concerned with the delivery of services;

f. Monitoring essential records and files relative to civil rights and the civil rights program under the Division of Medicaid.

PART II
Title VI and Section 504 Compliance by Other Participants in Division of Medicaid Programs

Division of Medicaid shall recognize that its obligations for compliance extends to providers and their contractors of services and other providers of services, financial aid and other benefits under the Division of Medicaid program. Division of Medicaid will provide assurance that such participants in its programs comply with the Title VI and Section 504 regulations by:

a. Furnishing all providers and other participants with a clear written explanation of their responsibilities under the Title VI and Section 504 regulations;

b. Requiring all providers and other participants to execute, in writing, an assurance that they will comply with Title VI, Section 504, and the implementation of related regulations (such assurances may take the form of a statement printed on the vouchers submitted by the vendor for reimbursement by Division of Medicaid);

c. Recognizing that assurance of compliance serves primarily as notice to participants of the program that they must comply with Title VI and Section 504, and does not automatically indicate actual compliance with Title VI, Section 504, and the implementation of related regulations;

d. Conducting periodic Title VI and Section 504 compliance reviews of designated providers and other participants at least yearly is recommended, and more frequently in those cases where discrimination is alleged or suspected.

PART III
Dissemination of information to Beneficiaries and the General Public

Division of Medicaid will take steps to inform all beneficiaries, potential beneficiaries and the general public of the fact that services, financial aid and other benefits are provided on a non-discriminatory basis as required by Title VI and Section 504. In addition, such persons shall be notified of their rights to file a complaint if they believe they have been discriminated against on the basis of race, color or national origin (including persons with limited English proficiency), physical or mental disability. Such persons will be informed that they have the right to file a complaint with Division of Medicaid or the Office of Civil Rights, Atlanta, Georgia. This may be accomplished by:

a. Including the Division of Medicaid Title VI and Section 504 non-discrimination policy in all brochures, pamphlets, communications radio and TV announcements, etc. which are designed to acquaint potential beneficiaries and members of the general public with the Division of Medicaid programs and services;

b. Printing such communications, as described above, in languages other than English for those in service areas which have a significant representation of persons whose dominant language is other than English.

c. Notifying all customary referral sources of the Division of Medicaid that services and benefits are provided in a non-discriminatory manner; and

d. Displaying in prominent places in all its offices, and in its provider facilities, posters indicating the Division of Medicaid non-discriminatory policy under Title VI and Section 504.

PART IV
COMPLAINT POLICY AND PROCEDURE

Division of Medicaid has established a complaint policy and procedure which provides that :

a. Any person who believes that he or she, or any specific class of persons, is subjected to discrimination on the basis of race, color, national origin (including persons with limited English proficiency), physical or mental disability may or by a representative, file a written complaint;

b. The time period for filing a complaint is no more than 180 days from the date of the alleged discriminatory act (s);

c. The Civil Rights/Section 504 Coordinator may extend the time for filing a discrimination complaint;

d. No person, who has filed a complaint, testified, assisted or participated in any manner in the investigation of a complaint, shall be intimidated, threatened, coerced or discriminated against;

e. Complaints will be brought to the attention of the Executive Director of the Division of Medicaid;

f. Division of Medicaid will conduct a prompt and thorough investigation of complaint;

g. The Civil Rights/Section 504 Coordinator will, based on the complaint investigation, determine whether or not discrimination did, in fact, occur;

h. If discrimination has occurred, Division of Medicaid will take all necessary action to correct the discriminatory practice(s);

i. The complainant will be advised, in a timely fashion of the findings of Division of Medicaid regarding his or her complaint and advised of the right to appeal to the Office of Civil Rights if not satisfied with Division of Medicaid decision;

j. Records will be maintained, which show the nature of the complaint, the details of the investigation, and the actions taken by Division of Medicaid; and

k. In those cases where the complaint is initially filed with the Office of Civil Rights, the latter office may proceed to investigate the complaint utilizing its own resources or it may request Division of Medicaid to conduct the investigation.

PART V
WRITTEN NON-DISCRIMINATION POLICY

Division of Medicaid will have a written non-discrimination policy which effectively communicates that the services, financial assistance and other benefits of its program(s) are provided in a manner that does not discriminate on the basis of race, color, national origin (including persons with limited English proficiency) or disability.

PART VI
CONTINUING COMPLIANCE

Division of Medicaid will have procedures for monitoring all aspects of the providers operation to assure that no policy or practice is, or has the effect of, discriminating against beneficiaries or other participants on the basis of race, color, national origin (including persons with limited English proficiency) or disability.

The monitoring procedures of Division of Medicaid shall include a review of the following providers in the stated manner:

Hospitals	Shall be reviewed once every two years
Long-term Care Facilities	Shall be reviewed once every two years
Physicians and Dentists	Shall be reviewed annually through a random selection ratio of 10% of participating providers

Providers who have completed their compliance with the Medicare Program will be requested to submit copies of their current Medicare certification approval letter and shall not be required to complete the prescribed Medicaid compliance review forms. Medicare compliance mirrors the Medicaid compliance review requirements, as both programs are recipients of federal financial assistance and are monitored by the Office of Civil Rights for non-discrimination.

PART VII
CORRECTIVE REQUIREMENTS

Division of Medicaid will take affirmative action to overcome the effects of prior discrimination in instances where the agency or the participants in its programs have previously discriminated against persons on the grounds of race, color, national origin (including persons with limited English proficiency) or disability.

Even in the absence of such prior discrimination, Division of Medicaid may, on its own motion, take affirmative action to overcome the effects of conditions which result in limiting participation of persons of a particular race, color, national origin (including persons with limited English proficiency) or disability.

PART VIII
COMPLIANCE RECORDS

Division of Medicaid will collect, review, analyze and maintain racial, ethnic and disability data and information on its operation, which will show the extent to which minorities and persons with disabilities are participating in all aspects of its programs. Such data will also include the number of persons served, having Limited English Proficiency. Division of Medicaid will require such data and information from providers and other participants of its programs.

Division of Medicaid will make available to the Office of Civil Rights all data and information necessary to determine its compliance with Title VI and Section 504 and the respective implementing regulations as it pertains to the compliance status of its providers and other participating service providers.

Long Term Care Facilities Compliance Reviews

A. General Procedure Description

Once every two (2) years each long term care provider of Medicaid services will receive a desk compliance review. Each Long Term Care Facility will be requested to submit to this office information necessary to determine provider compliance. This information shall include: 1. a current one-day resident bed census, 2. copies of the facility's current written Title VI policies, 3. copies of the facility's advertisement to the general public of the facility's non-discriminatory policies.

All information submitted will receive a desk review by appropriate Mississippi Division of Medicaid personnel. Certain practices and submitted information could require an explanation from the provider facility because discrimination may be involved. These specific indications will be "spelled out" in writing to each provider and an explanation will be requested of that same provider. Suggestions by the Mississippi Division of Medicaid personnel to correct possible discrimination practices will also be included. If significant problems exist, Mississippi Medicaid personnel may find it necesssary to conduct on-the-site reviews in the provider facilities. These on-site reviews will consist primarily of the same information requested in the desk review with, additionally, administrative and employee interviews.

In order to insure facility commitment toward change, follow-up reviews will be conducted with each provider where problems exist. These reviews will be either desk or on-site reviews and will be initiated within six (6) months from the date of the review where significant problems were identified.

B. Specific Procedure

1. Each month requests for information will be sent to individual Long Term Care provider. (Tickler file will show which provider should be sent information requests

during which month.) This request will include a cover letter and blank census forms.

2. This compliance information should be returned to the Mississippi Division of Medicaid office in a timely and complete manner. Information should be returned within a 30-day time frame. Authorization for such compliance information and this office's access to that same information are clearly outlined in Part 80.6 of the Civil Rights Act.

3. Upon receipt of this information, Mississippi Division of Medicaid Title VI personnel will review its content to determine if the Long Term Care provider practices any procedures which might suggest the presence of discrimination.

4. The requested census data should indicate to Title VI personnel if discriminatory practices are existent at the long term care facility. Specific attention should be directed to total percentage of minority residents (compared to the percentage of minority in the service area) and percentage of minority residents living in biracial accommodations. Residents must also be assigned to wards, floors, sections, buildings, or other areas without regard to race, color, or national origin.

5. Written policy statements should be compared with the Office of Civil Rights guidelines to insure compatibility. Once copies of written policy statements have been secured and placed in Mississippi Division of Medicaid files, future request for written policies will only be necessary if there has been a change in provider written Title VI policy.

Specific written Long Term Care policies should address: a. room assignments, b. admissions, c. patient records, d. staff privileges, e. patient services, f. referrals, g. notification of services available, and h. courtesy titles.

6. Once the material has been reviewed, the long term care provider will be notified in writing of the review findings. The responsible Mississippi Division of Medicaid staff should also make suggestions to the Long Term Care Facility concerning the action necessary to correct the alleged discrimination. It is not necessary for the provider to

accept the Mississippi Division of Medicaid suggestions; however, it is necessary that the Long Term Care Facility submit an acceptable plan of correction to the Mississippi Division of Medicaid within thirty (30) days after receipt of the written review findings.

7. When the office receives the provider's plan of correction, the Title VI staff members should review it and make a determination as to whether it meets Civil Rights' guidelines and expectations. If the worker has some concerns about the acceptability or feasibility of the plan, he should direct them to the specific provider in writing.

8. If significant problems exist between Title VI guidelines and provider practices, an on-site visit will be scheduled. The problem areas will be discussed with the responsible administrative personnel and actual Civil Rights' regulations will be clearly outlined and explained to the responsible staff. Employees should also be interviewed in efforts to determine discrimination either in client or employee practices.

A brief narrative regarding this on-site review will be placed in the provider's record along with the other compliance information and correspondence.

9. When the review of each provider has been completed, summary form will be filled out and placed in the appropriate section (Title VI) of that provider file.

10. Where problems of possible discrimination practices are cited, follow-up reviews will be conducted within six (6) months following the conclusion of the primary review. These reviews may be either desk or announced on-site and will address the provider's plan of correction and that plan's implementation into provider practices. A record of that review will be placed in the provider's compliance file.

11. Each provider will be notified in writing of his current compliance status.

with Section 80.8 of the Civil Rights Act and could suspend, terminate, or refuse to grant Federal Financial Assistance to the provider pending referral to the Division's legal services. However, every effort to persuade the provider to comply with Civil Rights Regulations will be undertaken.

Federal Regulation

§ 80.8 Procedure for effecting compliance.

(a) *General.* If there appears to be a failure or threatened failure to comply with this regulation, and if the noncompliance or threatened noncompliance cannot be corrected by informal means, compliance with this part may be effected by the suspension or termination of or refusal to grant or to continue Federal financial assistance or by any other means authorized by law. Such other means may include, but are not limited to, (1) a reference to the Department of Justice with a recommendation that appropriate proceedings be brought to enforce any rights of the United States under any law of the United States (including other titles of the Act), or any assurance or other contractual undertaking, and (2) any applicable proceeding under State or local law.

(b) *Noncompliance with § 80.4.* If an applicant fails or refuses to furnish an assurance required under § 80.4 or otherwise fails or refuses to comply with a requirement imposed by or pursuant to that section Federal financial assistance may be refused in accordance with the procedures of paragraph (c) of this section. The Department shall not be required to provide assistance in such a case during the pendency of the administrative proceedings under such paragraph except that the Department shall continue assistance during the pendency of such proceedings where such assistance is due and payable pursuant to an application therefor approved prior to the effective date of this part.

(c) *Termination of or refusal to grant or to continue Federal financial assistance.* No order suspending, terminating or refusing to grant or continue Federal financial assistance shall become effective until (1) the responsible Department official has advised the applicant or recipient of his failure to comply and has determined that compliance cannot be secured by voluntary means, (2) there has been an express finding on the record, after opportunity for hearing, of a failure by the applicant or recipient to comply with a requirement imposed by or pursuant to this part, (3) the expiration of 30 days after the Secretary has filed with the committee of the House and the committee of the Senate having legislative jurisdiction over the program involved, a full written report of the circumstances and the grounds for such action. Any action to suspend or terminate or to refuse to grant or to continue Federal financial assistance shall be limited to the particular political entity, or part thereof, or other applicant or recipient as to whom such a finding has been made and shall be limited in its effect to the particular program, or part thereof, in which such noncompliance has been so found.

(d) *Other means authorized by law.* No action to effect compliance by any other means authorized by law shall be taken until (1) the responsible Department official has determined that compliance cannot be secured by voluntary means, (2) the recipient or other person has been notified of its failure to comply and of the action to be taken to effect compliance, and (3) the expiration of at least 10 days from the mailing of such notice to the recipient or other person. During this period of at least 10 days additional efforts shall be made to persuade the recipient or other person to comply with the regulation and to take such corrective action as may be appropriate.

(Sec. 601, 602, Civil Rights Act of 1964; 78 Stat. 252; 42 U.S.C. 2000d, 2000d-1. Sec. 182, 80 Stat. 1299; 42 U.S.C. 2000d-8) [29 FR 16298, Dec. 4, 1964, as amended at 32 FR 14556, Oct. 19, 1967; 38 FR 17982, July 5, 1973]

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