# PUBLIC NOTICE

January 31, 2023

Pursuant to 42 C.F.R. Section 447.205, public notice is hereby given for the submission of a Medicaid State Plan Amendment (SPA) 23-0003 Home Health Services. The Division of Medicaid, in the Office of the Governor, will submit this proposed SPA to the Centers for Medicare and Medicaid Services (CMS) effective February 1, 2023, contingent upon approval from CMS, our Transmittal #23-0003.

1. Mississippi Medicaid State Plan Amendment (SPA) 23-0003 Home Health Services is being submitted to remove rate freeze language and allow reimbursement to be updated annually based on cost reports.

2. The expected increase in federal annual aggregate expenditures is $1,618,459 for Federal Fiscal Year 2023 (FFY23) and $2,055,558 for FFY24. The expected increase in state annual aggregate expenditures for FFY23 is $367,076 and $591,822 for FFY24.

3. The changes made in this State Plan Amendment are to comply with Miss. Code § 43-13-117, as amended by MS House Bill 657, effective July 1, 2022. Additional authority: Miss. Code § 43-13- 121.

4. A copy of the proposed SPA will be available in each county health department office and in the Department of Human Services office in Issaquena County for review. A hard copy can be downloaded and printed from www.medicaid.ms.gov, or requested at 601-359-3984 or by emailing at DOMPolicy@medicaid.ms.gov.

5. Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or DOMPolicy@medicaid.ms.gov for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at www.medicaid.ms.gov.

6. A public hearing on this SPA will not be held.

**State of Mississippi**

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

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, set on a federal fiscal year (October 1-September 30) basis, and 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 l 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 (HIS) 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 thetime difference between the midpoint of the cost report period and the midpoint of the rate period;

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(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;

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(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 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);

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(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);

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**V. New Providers**

1. Changes of Ownership

**State of Mississippi**

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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. ~~Effective July 1, 2021 t~~The prospective rates will be determined from cost reports, ~~from 2019 and will be~~ set on ~~October 1, 2020~~a federal fiscal year~~ly~~ (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 l~~, 2021~~ 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/#.

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