Submission - Summary

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 01/01/2018
Superseded SPA ID

Executive Summary

Summary Description Including Goals and Objectives State Plan Amendment (SPA) 18-0003 Medicaid Administration is being submitted to allow the Mississippi Division of Medicaid (DOM), the single state agency, to update the organizational structure and administration of the Medicaid program effective January 1, 2018.
Superseded Pages:

	COMPLETE PAGES SUPERSEDED:	PARTIAL PAGES SUPERSEDED:
Designation and Authority	Section 1.1 (page 1), TN 92-02 Section 1.1 (page 2), TN 84-35 Section 1.1 (pages 3), TN 76-16	
Attachment 1.1-A Attorney General certification	Attachment 1.1-A, TN 84-35	
Intergovernmental Cooperation Act Waivers	Section 1.1 (page 4), TN 76-16	
Eligibility Determinations and Fair Hearings	Section 1.1 (page 5), TN 76-16	
Organization and Administration	Section 1.2 (page 7), TN 84-35 Attachment 1.2-B (pages 1-52), TN 2000-09 Attachment 1.2-C, TN 84-35 Attachment 1.2-D (pages 1-5), TN 90-24	
Attachment 1.2-A Organizational chart	Attachment 1.2-A (page 1), TN 84-35 Attachment 1.2-A (pages 2-3), TN 90-24	
Single State Agency Assurances	Section 1.1 (page 6), TN 76-16 Section 1.3 (page 8), TN 74-7 Section 5.1 (page 80), TN 77-13 Section 5.3 (page 82, TN 78-2	Only Section 1.4 (page 9), TN17-0004
Financial Eligibility Requirements for Non-MAGI Groups	NEW	

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	$0
Second	2019	$0

Federal Statute / Regulation Citation

42 C.F.R. §§ 431.10, 431.11, 431.12, 431.50 and 430.12(b)

Medicaid State Plan Administration

Organization

Designation and Authority

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Superseded SPA ID	84-35		
	User-Entered		

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 18-0003 Medicaid Administration Attorney General Certification	3/28/2018 10:59 AM EDT	

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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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)

8/3/2017
DATE

Jim Hood
Signature

Attorney General
Title

Medicaid State Plan Administration

Organization

Intergovernmental Cooperation Act Waivers

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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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B. Additional information (optional)

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

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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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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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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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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	

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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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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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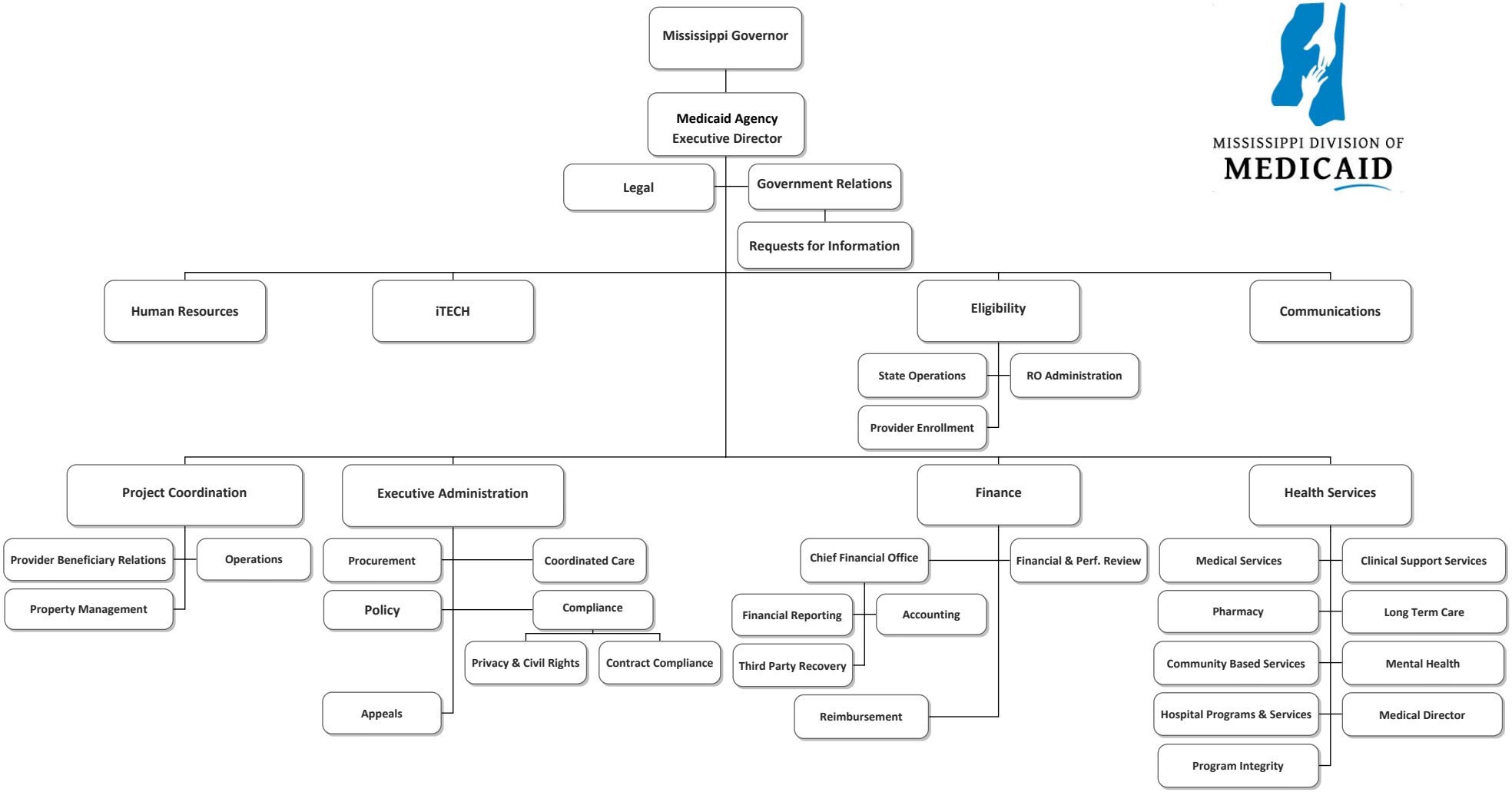
F. Additional information (optional)

State of Mississippi – Organizational Chart



Medicaid State Plan Administration

Organization

Single State Agency Assurances

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

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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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 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)

Medicaid State Plan Administration

General Administration

Reporting

Package Header

Package ID	MS2024MS0002O	**SPA ID**	MS-24-0004
Submission Type	Official	**Initial Submission Date**	12/4/2024
Approval Date	12/13/2024	**Effective Date**	12/1/2024
Superseded SPA ID	NEW		
	User-Entered		

A. General Reporting

The agency submits all reports in the form and with the content required by the Secretary and complies with any provisions that the Secretary finds necessary to verify and assure the correctness of all reports.

☐ 1. The agency assures that all requirements of 42 CFR 431.16 are met.

B. Annual Reporting on the Child and Adult Core Sets

☐ 1. The agency assures that all requirements of 42 CFR 437.10 through 437.15 are met.

☐ 2. The agency reports annually, by December 31, on:

a. All measures on the Child Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

b. All behavioral health measures on the Adult Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

C. Additional Information (optional)

State of Mississippi

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 Health Director, Deputy Health Director and Chief Financial Officer.

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

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	NEW		
	User-Entered		

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~~

Superseded by SPA 19-0018 but language unchanged

~~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.