PUBLIC NOTICE

April 30, 2025

Pursuant to 42 C.F.R. Section 447.205, public notice is hereby given for the submission of a Medicaid State Plan Amendment (SPA) 25-0011 Out-of-State Psychiatric Residential Treatment Facility (PRTF). 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 May 1, 2025, contingent upon approval from CMS, our Transmittal #25-0011.

1. State Plan Amendment (SPA) 25-0011 Out-of-State Psychiatric Residential Treatment Facility (PRTF). This SPA will allow DOM to set the out-of-state rate for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and PRTFs the same as the Medicaid rate of the domicile state for the facility, effective May 1, 2025.

2. The expected annual impact is $351,536. The federal annual aggregate expenditure is $112,638 for Federal Fiscal Year (FFY25) and $270,332 for FFY26. The expected increase in state annual aggregate expenditure is $33,836 for FFY 25 and $81,204 for FFY26.

3. The Division of Medicaid is submitting this proposed SPA in compliance with 42 C.F.R. §§ 440.160 and 447.201.

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.

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, t~~The ~~negotiated~~ rate for ICF/IIDs and PRTFs will be ~~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 nursing facility 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 nursing facility rate will be based on submitted property information from the provider or a thirty year age in the absence of provider information.

P. 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,

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