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. The rate for ICF/IIDs and PRTFs will be the Medicaid rate of the domicile state. 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 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.

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,

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