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.

A. Bed Hold Days Payment

A facility will be paid its per diem rate for the allowed bed hold days. For assessments through September 30, 2025, 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. Assessments on or after October 1, 2025 will be classified as 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.

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.

The Division of Medicaid uses the Centers for Medicare and Medicaid (CMS) resident case mix classification system to compute nursing facility rates.

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). MDS RUG IV will be used for rate periods through December 31, 2025, and for base rates utilized during the phase in period of the Patient Driven Payment Model (PDPM), effective January 1, 2026. For rate periods on or after January 1, 2026, the blend of PDPM components as described in this state plan shall be utilized for the adjustable component in the Medicaid rate to cover the cost of service for the facility specific case mix or residents. Should the PDPM methodology be discontinued, its successor will be utilized for rate setting. 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.

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 Reconsiderations, Appeals, and Sanctions

A. Reconsideration and 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 appeal to the Division of Medicaid within thirty (30) calendar days after receipt of the notification of the final reconsideration letter. The appeal will be governed by 23 Mississippi Administrative Code, Part 300, Chapter 3. 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 appeal request will be considered.

Notification of any adjustment(s) to the provider’s allowable costs and notification of a reconsideration decision 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.

B. Reconsideration and Appeal Procedures – Minimum Data Set

Long-term care providers who disagree with an adjustment made by either a desk review or onsite visit to the Minimum Data Set (MDS) that changes the classification of the resident to a different MDS classification than 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 appeal to the Division of Medicaid. within thirty (30) calendar days after the provider was notified of the final reconsideration letter. The appeal will be governed by 23 Mississippi Administrative Code, Part 300, Chapter 3. 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 appeal request will be considered.

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The action of the Division of Medicaid under review shall be stayed until all administrative proceedings have been exhausted.

C. 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.

D. Sanctions

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.

Within thirty (30) calendar days after the provider receives notice of the sanctions, a provider may appeal pursuant to 23 Mississippi Administrative Code, Part 300, Chapter 3. The imposition of sanctions shall be stayed until all administrative proceedings have been exhausted unless the Executive Director of Medicaid determines, in writing and in his or her sole discretion, that it is in the best interest of Medicaid beneficiaries that the imposition of sanctions not be stayed.

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 to Medicaid only beneficiaries are allowable. Physical, Occupational and Speech Language Pathology therapy expenses will be included in the per diem rate for all long-term care providers for rates starting January 1, 2026. Respiratory therapy expenses will be included in the direct care and care related per diem rate for all long-term care facilities.

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. For assessments through September 30, 2025, bed hold days, which are therapeutic leave and hospital leave days, will be calculated

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 resident's MDS RUG or PDPM classification with assigned case mix index (CMI) for all days within the reporting period. Bed hold days are reflected on the roster reports. The facility's weighted average index, or score, is also reported. The quarterly rosters that closely coincide with the provider's cost reporting period will be used to determine the case mix index used in setting the annual base per diem rates each January 1. Quarterly Roster Reports are also used in setting the direct care per diem rate for each quarter. In accordance with the provision of this plan, the direct care and care related quarterly case mix adjustment will be made using the provider's final roster score from the second preceding 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 are required to submit the MDS resident assessments via the Quality Improvement and Evaluation System (QIES). MDS resident assessments which are due and not completed, transmitted, and accepted by the end of the period, on the 93rd day will result in an inactive assessment or expired assessment period. 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.

For all RUG assessments, 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.

For all PDPM assessments, the days following an inactive or expired assessment (starting the 93rd day) will be assigned the delinquent PDPM classification of BC1, Inactive Category, with a CMI of 0.751, or equivalent to the lowest case mix category blend, until the next assessment is received.

3-3 Resident Classification System for assessments through September 30, 2025

The Division of Medicaid uses the M D S RUG IV classification model, for all assessments through September 30, 2025, 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.)

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.**

Resident Classification System for rate setting periods beginning 1/1/2026

Effective for rate periods on or after January 1, 2026, the Division of Medicaid (DOM) uses the Patient-Driven Payment Model (PDPM) classification to classify nursing facility residents for the facility case mix average computation. 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 PDPM methodology will be implemented beginning with the assessments that correspond to the base cost reporting period ending 2024 and onward. A blended approach to determining the Case-Mix Index (CMI) will be used. This approach involves applying the CMI weights as listed in the final Skilled Nursing Facility (SNF) Prospective Payment System (PPS) payment rule for FY 2025 (CMS-1802-F):

a. Physical Therapy: 15 percent;

b. Occupational Therapy: 15 percent;
c. Speech Language Pathology 8 percent;
d. Non-Therapy Ancillary: 12 percent; and
e. Nursing: 50 percent.

The base weights for all nursing only PDPM 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 PDPM NURSING ONLY

PDPM Category	Nursing HIPPS Code	Regular Unit	Alzheimer's Unit
ES3	A	3.84	
ES2	B	2.9	
ES1	C	2.77	
HDE2	D	2.27	
HDE1	E	1.88	
HBC2	F	2.12	
HBC1	G	1.76	
LDE2	H	1.97	
LDE1	I	1.64	
LBC2	J	1.63	
LBC1	K	1.35	
CDE2	L	1.77	2.266
CDE1	M	1.53	1.958
CBC2	N	1.47	1.882
CA2	O	1.03	1.318
CBC1	P	1.27	1.626
CA1	Q	0.89	1.139
BAB2	R	0.98	1.686
BAB1	S	0.94	1.617
PDE2	T	1.48	1.894
PDE1	U	1.39	1.779
PBC2	V	1.15	1.472
PA2	W	0.67	0.858
PBC1	X	1.07	1.37
PA1	Y	0.62	0.794

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

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, 2024 rate will be determined by multiplying the direct care base rate by the average case mix for the quarter July 1, 2023 - through September 30, 2023. 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 (applicable for rate periods effective on or after January 1, 2026), 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 (applicable for rate periods effective on or after January 1, 2026), 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 Nursing Facilities for the Severely Disabled, the therapy per diem is as follows:

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.

For all other Nursing Facilities for rates effective on or after January 1, 2026, the therapy per diem is determined as follows:

Therapy costs include salaries and fringe benefits or contract costs of therapists and other direct costs incurred for therapeutic services. Respiratory therapy costs are considered direct care and are not included in the therapy per diem.

1. Determine the Medicaid-only per diem therapy cost for each Nursing Facility during the cost report period. (Multiply the Medicaid Only therapy charges by the total payor cost to charge ratio as determined in the cost report, then divide this amount by Medicaid patient days for the period.)
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.

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 **l** of the payment year. For example, in computing the rates for the year January l, 2016 through December 31, 2016, the 2015 new bed value will be adjusted to the January l, 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 l, 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 l, 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.

x 80%) to equal a minimum of eighty percent (80&) occupancy. Reserved bed days wi11 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 NFs and PSNFs

NFs and PSNFs that are owned by the State of Mississippi will be included in the rate setting process described above 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 and PSNF may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned NFs and PSNFs 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

Non-state government owned or operated NFs 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 Lime period. The calculation will be made as follows: Effective State Fiscal Years Ending on or after June 30, 2026, MDS data is run for a sample population of each facility to group patient days into the PDPM grouper. An estimated amount that Medicare would have paid on average by facíl1ity is calculated by multiplying each adjusted PDPM, or successor, rate by the number of days for that PDPM group. 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 co 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.

3-10 PDPM Transition Rate Adjustment

Effective for rate periods beginning January 1, 2026, through December 31, 2026, each applicable nursing facility provider will receive an additional pass-through rate adjustment to allow for a phase-in of the PDPM resident classification system used for determining case-mix indices. The nursing facility provider pass-through rate adjustment will be calculated and applied as follows.

For each rate period during the transition period, the nursing facility provider's direct care and care related rate component will be calculated using the PDPM resident classification system to determine the nursing facility cost report period case mix index and nursing facility-wide average case mix index values.

For use in calculating a differential, the nursing facility provider's January 1, 2026 direct care and care related rate component will also be calculated using the RUG-IV resident classification system to determine the nursing facility cost report period case mix index and nursing facility-wide average case mix index values.

For each rate period during the transition period, the direct care and care related rate differential will be determined by subtracting the direct care and care related rate calculated for January 1, 2026 using the RUG-IV resident classification system from the direct care and care related rate calculated using the PDPM resident classification system for determining the case-mix indices.

If the calculated rate differential exceeds a positive or negative $5, then a pass-through rate adjustment will be applied to the nursing facility provider's reimbursement rate. The pass-through rate will be applied in an amount equal to the difference between the rate differential total and the ±$5 threshold. This will be done in order to ensure the nursing facility provider's rate is not increased or decreased more than $5 as a result of the change to the PDPM resident classification system for determining the case-mix indices.

Should the nursing facility provider, for the aforementioned rate periods used in calculating the rate differential, receive an adjusted nursing facility-wide average case mix index value due to a nurse review CMI change or other factors, the facility will have its rate differential recalculated using the revised case mix index values. The ±$5 rate change threshold will apply to the recalculated differential and associated case mix index values, not the original differential calculation.

If a nursing facility provider's calculated direct care and care related rate component differential does not exceed the ±$5 rate change threshold, then no pass-through rate adjustment will be applied for the applicable rate period.

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, or the nursing only component of PDPM, 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

Patient Driven Payment Model (PDPM)- The Centers for Medicare and Medicaid Services Medicaid 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.

Pediatric Skilled Nursing Facility (PSNF) - Any building or buildings, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide basic residential services to three (3) or more medically dependent or technologically dependent children , from birth up to twenty-one (21) years of age, who are not related to the owner or operator by blood, marriage or adoption and who require such services. Infants and children considered for admission to a Pediatric Skilled Nursing Facility must be ventilator dependent or otherwise medically dependent pediatric patients who require medical and nursing care or rehabilitative services; thus having complex medical conditions that require continual care. Prerequisites for admission are a prescription from the child's physician and consent from a parent or guardian.

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1-7 Reconsiderations, Appeals, and Sanctions

A. Reconsideration and 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 ~~administrative hearing~~ appeal 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 appeal will be governed by 23 Mississippi Administrative Code, Part 300, Chapter 3. ~~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~~ administrative appeal request will be considered.

Notification of any adjustment(s) to the provider's allowable costs and notification of a reconsideration decision ~~ces 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.

B. Reconsideration and Appeal Procedures – Minimum Data Set

Long-term care providers who disagree with an adjustment made by either a desk review or onsite visit 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~~ classification than 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~~ appeal 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 appeal will be governed by 23 Mississippi Administrative Code, Part 300, Chapter 3. ~~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~~ appeal 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.~~

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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.~~

C~~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.

D~~C~~. Sanctions

~~After all administrative proceedings have been exhausted, the~~ 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.

Within thirty (30) calendar days after the provider receives notice of the sanctions, a provider may appeal pursuant to 23 Mississippi Administrative Code, Part 300, Chapter 3. The imposition of sanctions shall be stayed until all administrative proceedings have been exhausted unless the Executive Director of Medicaid determines, in writing and in his or her sole discretion, that it is in the best interest of Medicaid beneficiaries that the imposition of sanctions not be stayed.

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 to Medicaid only beneficiaries are allowable. Physical, Occupational and Speech Language Pathology therapy expenses will be included in the per diem rate for ~~NFSD, PRTF and ICF/IID~~all long-term care providers for rates starting January 1, 2026. ~~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 direct care and care related per diem rate for all long-term care facilities.

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. For assessments through September 30, 2025, b~~B~~ed h~~H~~old days, which are therapeutic leave and hospital leave days, will be calculated

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 resident's MDS RUG or PDPM classification with assigned case mix index (CMI) for all days within the reporting 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 quarterly rosters that closely coincide with the provider's cost reporting period will be used to determine the ~~The annual rosters~~ case mix index ~~are~~ used ~~to~~ in setting the annual base per diem rates each January 1. ~~The quarterlies q~~Quarterly Roster Reports are also used in setting the direct care per diem rate for each quarter. In accordance with the provision of this plan, the direct care and care related quarterly case mix adjustment will be made using the provider's final roster score from the second preceding 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.~~ Nursing facilities are required to submit the MDS resident assessments via the Quality Improvement and Evaluation System (QIES). MDS resident assessments which are due and not completed, transmitted, and accepted by the end of the period, on the 93rd day will result in an inactive assessment or expired assessment period. 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.

For all RUG assessments, ~~T~~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.~~

For all PDPM assessments, the days following an inactive or expired assessment (starting the 93rd day) will be assigned the delinquent PDPM classification of BC1, Inactive Category, with a CMI of 0.751, or equivalent to the lowest case mix category blend, until the next assessment is received.

3-3 Resident Classification System for assessments through September 30, 2025

The Division of Medicaid uses the M D S RUG IV classification model, for all assessments through September 30, 2025, 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.)

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.**

~~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~~

Resident Classification System for rate setting periods beginning 1/1/2026

Effective for rate periods on or after January 1, 2026, ~~T~~the Division of Medicaid (DOM) uses the Patient-Driven Payment Model (PDPM) classification to classify nursing facility residents for the facility case mix average computation. 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 PDPM methodology will be implemented beginning with the assessments that correspond to the base cost reporting period ending 2024 and onward. A blended approach to determining the Case-Mix Index (CMI) will be used. This approach involves applying the CMI weights as listed in the final Skilled Nursing Facility (SNF) Prospective Payment System (PPS) payment rule for FY 2025 (CMS-1802-F):

a. Physical Therapy: 15 percent;
b. Occupational Therapy: 15 percent;
c. Speech Language Pathology 8 percent;
d. Non-Therapy Ancillary: 12 percent; and
e. Nursing: 50 percent.

The base weights for all nursing only PDPM 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 PDPM NURSING ONLY

PDPM Category	Nursing HIPPS Code	Regular Unit	Alzheimer's Unit
ES3	A	3.84	
ES2	B	2.9	
ES1	C	2.77	
HDE2	D	2.27	
HDE1	E	1.88	
HBC2	F	2.12	
HBC1	G	1.76	
LDE2	H	1.97	
LDE1	I	1.64	
LBC2	J	1.63	
LBC1	K	1.35	
CDE2	L	1.77	2.266
CDE1	M	1.53	1.958
CBC2	N	1.47	1.882
CA2	O	1.03	1.318
CBC1	P	1.27	1.626
CA1	Q	0.89	1.139
BAB2	R	0.98	1.686
BAB1	S	0.94	1.617
PDE2	T	1.48	1.894
PDE1	U	1.39	1.779
PBC2	V	1.15	1.472
PA2	W	0.67	0.858
PBC1	X	1.07	1.37
PA1	Y	0.62	0.794

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

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, 20~~15~~24 rate will be determined by multiplying the direct care base rate by the average case mix for the quarter July 1, 2023~~14'3~~ - through September 30, 20~~14~~23. 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 (applicable for rate periods effective on or after January 1, 2026) ~~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 (applicable for rate periods effective on or after January 1, 2026) ~~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 Nursing Facilities for the Severely Disabled, the therapy per diem is as follows:

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.

For all other Nursing Facilities for rates effective on or after January 1, 2026, the therapy per diem is determined as follows:

Therapy costs include salaries and fringe benefits or contract costs of therapists and other direct costs incurred for therapeutic services. Respiratory therapy costs are considered direct care and are not included in the therapy per diem.

1. Determine the Medicaid-only per diem therapy cost for each Nursing Facility during the cost report period. (Multiply the Medicaid Only therapy charges by the total payor cost to charge ratio as determined in the cost report, then divide this amount by Medicaid patient days for the period.)
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.

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 val~~J~~ue 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 determ~~nn~~ined. 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 **l** of the payment year. For example, in computing the rates for the year January l, 2016 through December 31, 2016, the 2015 new bed value will be adjusted to the January l, 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 l, 2015 is assume~~wne~~d 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 l, 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.

x 80%) to equal a minimum of eighty percent (80&) occupancy. Reserved bed days wi11 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 NFs and PSNFs~~'s~~

NFs~~'s~~ and PSNFs that are owned by the State of Mississippi will be included in the rate setting process described above ~~in order to~~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 and PSNF may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned NF~~'s~~s and PSNFs 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

~~N~~Non-state government owned or operated NF~~'s~~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 Lime period. The calculation will be made as follows: Effective State Fiscal Years Ending on or after June 30, 2026, MDS data is run for a sample population of each facility to group patient days into ~~one of the Medicare RUGS~~the PDPM grouper. An estimated amount that Medicare would have paid on average by facílity is calculated by multiplying each adjusted ~~RUG~~ PDPM, or successor, rate by the number of days for that ~~RUG~~PDPM group. 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 co 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.

3-10 PDPM Transition Rate Adjustment

Effective for rate periods beginning January 1, 2026, through December 31, 2026, each applicable nursing facility provider will receive an additional pass-through rate adjustment to allow for a phase-in of the PDPM resident classification system used for determining case-mix indices. The nursing facility provider pass-through rate adjustment will be calculated and applied as follows.

For each rate period during the transition period, the nursing facility provider's direct care and care related rate component will be calculated using the PDPM resident classification system to determine the nursing facility cost report period case mix index and nursing facility-wide average case mix index values.

For use in calculating a differential, the nursing facility provider's January 1, 2026 direct care and care related rate component will also be calculated using the RUG-IV resident classification system to determine the nursing facility cost report period case mix index and nursing facility-wide average case mix index values.

For each rate period during the transition period, the direct care and care related rate differential will be determined by subtracting the direct care and care related rate calculated for January 1, 2026 using the RUG-IV resident classification system from the direct care and care related rate calculated using the PDPM resident classification system for determining the case-mix indices.

If the calculated rate differential exceeds a positive or negative $5, then a pass-through rate adjustment will be applied to the nursing facility provider's reimbursement rate. The pass-through rate will be applied in an amount equal to the difference between the rate differential total and the ±$5 threshold. This will be done in order to ensure the nursing facility provider's rate is not increased or decreased more than $5 as a result of the change to the PDPM resident classification system for determining the case-mix indices.

Should the nursing facility provider, for the aforementioned rate periods used in calculating the rate differential, receive an adjusted nursing facility-wide average case mix index value due to a nurse review CMI change or other factors, the facility will have its rate differential recalculated using the revised case mix index values. The ±$5 rate change threshold will apply to the recalculated differential and associated case mix index values, not the original differential calculation.

If a nursing facility provider's calculated direct care and care related rate component differential does not exceed the ±$5 rate change threshold, then no pass-through rate adjustment will be applied for the applicable rate period.

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, or the nursing only component of PDPM, 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

Patient Driven Payment Model (PDPM)- The Centers for Medicare and Medicaid Services Medicaid 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.

Pediatric Skilled Nursing Facility (PSNF) - Any building or buildings, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide basic residential services to three (3) or more medically dependent or technologically dependent children , from birth up to twenty-one (21) years of age, who are not related to the owner or operator by blood, marriage or adoption and who require such services. Infants and children considered for admission to a Pediatric Skilled Nursing Facility must be ventilator dependent or otherwise medically dependent pediatric patients who require medical and nursing care or rehabilitative services; thus having complex medical conditions that require continual care. Prerequisites for admission are a prescription from the child's physician and consent from a parent or guardian.