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State/Territory Name: Mississippi

State Plan Amendment (SPA) #: 21-0031

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

August 24, 2021

Mr. Drew Snyder, Executive Director
Mississippi Division of Medicaid
Attention: Margaret Wilson
550 High Street, Suite 1000
Jackson, MS 39201-1399

RE: Mississippi State Plan Amendment (SPA) Transmittal Number 21-0031

Dear Mr. Snyder:

We have reviewed the proposed Mississippi State Plan Amendment (SPA), which was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 30, 2021. This plan amendment will allow the Division of Medicaid (DOM) to 1) set the fees for home health services in effect as of October 1, 2020, 2) set the fees for durable medical equipment and medical supplies in effect as of July 1, 2020, and 3) remove the five percent (5%) reimbursement reduction effective July 1, 2021.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2021. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Moe Wolf at 410-786-9291 or Moshe.Wolf@CMS.HHS.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **21-0031**

2. STATE: **MS**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: **REGIONAL ADMINISTRATOR**
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 C.F.R. § 447.201

7. FEDERAL BUDGET IMPACT:
FFY 2021: $344,406
FFY 2022: $1,307,721

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Exhibit A, Page 6 - 12

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Exhibit A, Page 6 - 12

10. SUBJECT OF AMENDMENT:
State Plan Amendment (SPA) 21-0031 is being submitted to allow the Division of Medicaid (DOM) to 1) set the fees for home health services in effect as of October 1, 2020, 2) set the fees for durable medical equipment and medical supplies in effect as of July 1, 2020, and 2) remove the five percent (5%) reimbursement reduction effective July 1, 2021.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: **Drew L. Snyder**

14. TITLE: **Executive Director**

15. DATE SUBMITTED: JUN 3 0 2021

16. RETURN TO:
Drew L. Snyder
Miss. Division of Medicaid
Attn: Margaret Wilson
550 High Street, Suite 1000
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 30, 2021

18. DATE APPROVED: August 24, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Todd McMillion

22. TITLE:
Director, Division of Reimbursement Review

23. REMARKS:

State of Mississippi

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

A. The Division of Medicaid will utilize a prospective rate of reimbursement and will not make retroactive adjustments except as specified in the State Plan. Effective July 1, 2021 the prospective rates will be determined from cost reports from 2019 and will be set on October 1, 2020 and will be applicable to all facilities with a valid provider agreement. Total payments per month for each home health beneficiary may not exceed the average Medicaid nursing facility rate per month as determined based on the nursing facility rates computed July l, 2021. The average Medicaid Nursing Facility rates are posted on the Mississippi Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

Providers will be paid the lower of their prospective rate as computed in accordance with the State Plan or their usual and customary charge.

B. Payments of medical supplies which are directly identifiable supplies furnished to individual beneficiaries and for which a separate charge is made will be reimbursed as described in Section IV. D. 5., of this plan. Payments of durable medical equipment, appliances and supplies are reimbursed as described In Section VIII, of the State Plan.

Prospective rates and ceilings will be established for the home health visits.

C. Trend Factor

Effective July 1, 2021, the rates will remain the same as those effective on October 1, 2020.

In order to adjust costs for anticipated increases or decreases due to changes in the economy, a trend factor is computed using the Centers for Medicare and Medicaid Services (CMS) Home Health Market Baskets that are published in the Integrated Healthcare Strategies (HIS) Economic Healthcare Cost Review, or its successor, in the fourth (4^{th} quarter of the previous calendar year, prior to the start of the rate period. The moving averages for the following market basket components are used: Wages and Salaries, Benefits, Utilities, Malpractice Insurance, Administrative Support, Financial Services, Medical Supplies, Rubber Products, Telephone, Postage, Other Services, Other Products, Transportation, Fixed Capital, and Movable Capital. Relative weights are obtained from the same period National Market Basket Price Proxies-Home Health Agency Operating Costs.

D. Rate Setting

Effective July 1, 2021, the rates will remain the same as those effective on October 1, 2020.

1. Home health agencies are reimbursed for skilled nursing visits at the lower of the following:

   (a) trended cost, plus a profit incentive, but not greater than 105% of the median, which is computed as follows:

      (1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;

      (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;

(3) array the trended costs from the lowest to the highest with the total number of skilled nursing visits and determine the cost associated with the median visit (interpolate, if necessary);

(4) multiply the median visit trended cost by 105% to determine the ceiling;

(5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;

(6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above; or,

(b) the sum of the following:

(1) the ceiling for direct care and care related costs for nursing facilities at a case mix score of 1.000 as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period; and

(2) the ceiling for administrative and operating costs for Large Nursing Facilities as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period.

(c) plus the medical supply add-on as computed in Section IV. D. 5.

2. Physical therapy visits for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries are reimbursed on a fee-for-service basis at an all-inclusive, per visit rate of $65.00 plus the medical supply add-on as computed in Section IV. D. 5.

3. Speech therapy visits for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries are reimbursed on a fee-for-service basis at an all-inclusive, per visit rate of $65.00 plus the medical supply add-on as computed in Section IV. D. 5.

4. Home health agencies are reimbursed for home health aide visits based on the following methodology:

Effective July 1, 2021, the rates will remain the same as those effective on October 1, 2020.

(a) trended cost, plus a profit incentive, but not greater than 105% of the median, plus the medical supply add-on, which is computed as follows:

(1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;

(2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;

(3) array the trended costs from the lowest to the highest with the total number of home health aide visits and determine the cost associated with the median visit (interpolate, if necessary);

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

(4) multiply the median visit trended cost by 105% to determine the ceiling;

(5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;

(6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above, plus the medical supply add-on as computed In Section IV. D. 5.

5. The Medical Supply payment amount that will be added on to each discipline will be reimbursed at the lower of the following:

Effective July 1, 2021, the rates will remain the same as those effective on October 1, 2020.

(a) trended medical supply cost per visit computed as follows:

(1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk. review; divide this number by total Medicaid visits);

(2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period; or

(b) 105% of the median medical supply trended cost, which is computed as follows:

(1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk review; divide this number by total Medicaid visits);

(2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;

(3) array the trended costs from the lowest to the highest with the total number of Medicaid visits per the desk review and determine the cost associated with the median visit (interpolate, if necessary);

(4) multiply the median visit trended cost by 105% to determine the ceiling.

V. New Providers

1. Changes of Ownership

State of Mississippi

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

For purposes of this plan, a change of ownership of a home health agency includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash, transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the agency. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship.

A home health agency which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the change of ownership. The new owner will be assigned the previous owner's rate. The Division of Medicaid will update the provider's information in the Medicaid Management Information System (MMIS).

The new owner, upon consummation of the transaction affecting the change of ownership, shall as a condition of participation, assume liability, jointly and severally, with the prior owner for any and all amounts that may be due or become due to the Medicaid Program, and such amounts may be withheld from the payment of claims submitted when determined. However, the new owner shall not be construed as relieving the prior owner of his liability to the Division of Medicaid.

2. New Home Health Agencies

When new providers are established that are not changes of ownership, the provider shall be reimbursed at the maximum rate for each type of home health visit pending the receipt of the initial cost report. After receipt of the initial cost report, a rate will be determined that is retroactive to the date of the establishment of the provider.

VI. Provider Participation

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of home health agencies in the program, so that eligible beneficiaries can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public. Providers must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and meet all applicable state laws and requirements.

VII. Payment in Full

Participation in the program shall be limited to home health agencies who accept, as payment in full, the amount paid in accordance with the State Plan.

VIII. Durable Medical Equipment

A. The payment for the purchase of new Durable Medical Equipment (DME) is the lesser of the provider's usual and customary charge or a fee from statewide uniform fee schedule effective as of July 1, 2020 and effective for services provided on or after July 1, 2020. The Mississippi statewide uniform fee schedule will be calculated using eighty percent (80%) of the Medicare rural rate, if available, or the non-rural rate if there is no rural rate, on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1, 2020.

B. If there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid based on the lower of the Division of Medicaid's average/established fee or the average of the fees from other states, when available, or determine the fee from cost information from providers and/or manufacturers, survey information from national fee analyzers, or other relevant fee-related information. Effective July 1, 2021, the rates will remain the same as those effective for State Fiscal Year (SFY) 2021.

C. If there is no DMEPOS fee or a fee determined by the Division of Medicaid, the provider will be reimbursed a fee calculated through the following manual pricing:

1. Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%), or

2. If there is no MSRP, then the provider's invoice received from a wholesaler or manufacturer plus twenty percent (20%).

D. The payment for rental of DME is made from a Mississippi statewide uniform fee schedule based on ten percent (10%) of eighty percent (80%) of the Medicare DMEPOS in effect January 1, 2020 or Mississippi Medicaid established fee as described in letter A or B not to exceed ten (10) months. After rental benefits are paid for ten (10) months, the DME becomes the property of the Mississippi Medicaid beneficiary unless otherwise authorized by the Division of Medicaid through specific coverage criteria.

E. The payment for purchase of used DME is made from a Mississippi statewide uniform fee schedule basedon fifty percent (50%) of eighty percent (80%) of the Medicare DMEPOS in effect January 1, 2020 or Mississippi Medicaid established fee as described in letter A or B.

F. The payment for repair of DME is the cost of the repair, not to exceed fifty percent (50%) of eighty percent (80%) of the Medicare DMEPOS in effect January 1, 2020 or Mississippi Medicaid established fee as described in letter A or B.

G. Any durable medical equipment not listed on the fee schedule may be requested for coverage by submitting documentation to the Division of Medicaid's UM/QIO who will determine medical necessity on a case-by-case basis.

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

DME for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) beneficiaries, if medically necessary, which exceed the limitations and scope for Medicaid beneficiaries, as covered in this Plan, are reimbursed according to the methodology in the above paragraphs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of DME. The Division of Medicaid's fee schedule rate was set as of July 1, 2020, and is effective for services provided on or after that date. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.

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

Medical Supplies

A. The payment for the purchase of Medical Supplies is the lesser of the provider's usual and customary charge or a fee from a Mississippi statewide uniform fee schedule updated July 1, 2020 and effective for services provided on or after July 1, 2020. The statewide uniform fee schedule will be calculated using eighty percent (80%) of the rural rate, if available, or the non-rural rate if there is no rural rate, on the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule in effect on January 1, 2020.

B. If there is no DMEPOS fee, the provider will be reimbursed a fee determined by the Division of Medicaid based on the lower of the Division of Medicaid's average/established fee or the average of the fees from other states, when available, or determine the fee from cost information from providers and/or manufacturers, survey information from national fee analyzers, or other relevant fee-related information. Effective July 1, 2021, the rates will remain the same as those effective for State Fiscal Year (SFY) 2021.

C. If there is no DMEPOS fee or a fee determined by the Division of Medicaid, the provider will be reimbursed a fee calculated through the following manual pricing:

1. Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%), or

2. If there is no MSRP, then the provider's invoice received from a wholesaler or manufacturer plus twenty percent (20%).

D. Any medical supplies not listed on the Mississippi Medicaid fee schedule may be requested for coverage by submitting documentation to the Division of Medicaid's UM/QIO who will determine medical necessity on a case-by-case basis.

Medical Supplies for EPSDT beneficiaries, if medically necessary, which exceed the limitations and scope for Medicaid beneficiaries, as covered in this Plan, are reimbursed according to the methodology in the above paragraphs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of medical supplies. The Division of Medicaid's fee schedule rate was set as of July 1, 2020, and is effective for services provided on or after that date. All rates are published at www.medicaid.ms.gov/providers/fee-schedules-and-rates/#.