DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 8, 2026

Cindy Bradshaw, Executive Director
Division of Medicaid
Mississippi Department of Human Services
550 High Street, Suite 1000
Walters Sillers Building
Jackson, MS 39201-1325

Dear Cindy Bradshaw:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Mississippi's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on July 2, 2025, and a final revised preprint was received on January 30, 2026. The proposal has a control name of MS_Fee_Oth_Renewal_20250701-20260630.

CMS has completed our review of the following Medicaid managed care SDP(s):

- Uniform Dollar Increase for ground emergency ambulance services for the rating period covering July 1, 2025 through June 30, 2026, incorporated in the capitation rates through a separate payment term amount up to $35,786,648

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state must ensure that the state and its managed care plans appropriately support program integrity activities, including prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.6(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.07.08 08:48:33 -04'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2025 - June 30, 2026
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2025
3. Identify the managed care program(s) to which this payment arrangement will apply:
   MississippiCAN
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $35,786,648
   a. Identify the estimated federal share of this state directed payment: $27,519,932
   b. Identify the estimated non-federal share of this state directed payment: $8,266,716

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

July 1, 2022 - June 30, 2023; July 1, 2023 - June 30, 2024; July 1, 2024-June 30, 2025

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☒ Other; please describe:

Total preprint amount increased based on utilization; Reconciliation pool has decreased from 10% to 4.9%. Additionally, each provider is now defined as its own distinct provider class.

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

See attachment and copied here, "3. SFY 2026 MS TREAT preprint-Questions 8, 19, and 20.pdf".
Managed care plans will make separate, directed payments to in-state licensed 911 and critical care ground emergency ambulance services providers serving Medicaid managed care enrollees. Provider eligibility will be determined annually for each state fiscal year as of July 1. Eligible emergency ambulance service providers must be enrolled as a Mississippi Medicaid provider and licensed in Mississippi as a 911 ground ambulance provider or critical care ground transport provider as of July 1, 2025, and at the time of payment.
This program began in state fiscal year (SFY) 2023, when providers began receiving quarterly interim payments based on historical utilization, with a final reconciliation payment based on actual utilization of services by managed care enrollees during the rating period. The state is continuing this payment arrangement for the SFY 2026 rating period (July 1, 2025 through June 30, 2026). In order to allow for increases in utilization during the reconciliation calculated for the rating period, the state has increased the total amount in Question 4 of the preprint to $35,786,648 to allow for an increase in utilization of approximately five percent (5%). The state will make "interim" payments based on the total amounts included in the Model of $34,124,225, but will not exceed the $35,786,648 once utilization is reconciled during the following year to allow for at least six (6) months of runout for the rating period. Emergency transport services eligible under the program are identified by Healthcare Common Procedure Coding System (HCPCS) codes and include ALS-1 emergency (A0427), BLS- emergency (A0429), ALS 2 (A0433), Specialty care transport (A0434), and mileage codes, limited to mileage for emergency transports, including Ground mileage (A0425), and Advanced life support mileage (A0390). Providers will be monitored in accordance with the quality metric(s) as stated in attachment "5. SFY 2026 MS TREAT-Evaluation Findings Template".

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/

The related documents from the above link are included for reference in the attached file entitled, " 4. SFY 2026 MS TREAT-Managed Care Authority Documents.zip".

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☒ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

See attachment and copied here, "3. SFY 2026 MS TREAT preprint-Questions 8, 19, and 20.pdf". DOM is proposing a uniform dollar increase specific to each providers' average commercial rate per eligible procedure code. Each provider-level dif

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

See attachment and copied here, "3. SFY 2026 MS TREAT preprint-Questions 8, 19, and 20.pdf".
Interim TREAT payments for the statewide class of providers will be calculated using units of service and payments from the state fiscal year 2024 (July 1, 2023 through June 30, 2024), based on paid date.
This data represents the best information on utilization available to the state at the time the payment calculations need to be performed. Once approved, these interim payments will be distributed in equal quarterly installments by the MCOs with the fourth installment to be issued by June 30, 2026. Once funds are issued to MCOs, payments are made to providers within five (5) business days. The actual utilization will be reconciled based on encounters for the rating period, July 1, 2025 - June 30, 2026 (based on service date). Encounter data used as the source for units of service and payments for reconciliation purposes will contain a minimum of six months of run-out. By June 2027, any underpayments will be paid via a lump-sum payment and any overpayment will be recouped. If necessary, any provider recoupments may extend beyond the June 2027 timeframe. Providers that have closed or filed bankruptcy will not be considered in the reconciliation, and the amounts paid under the interim arrangement will be considered final. For ambulance providers that experience material service changes, DOM may estimate the impact on the managed care volume to adjust interim payments.
Prior to each installment and the annual reconciliation, DOM will collect the necessary non-federal share of funds through the TREAT provider tax. Then, matching federal funds will be drawn and funds will be distributed to each MCO based on service utilization. The MCOs will be directed to make the pre-determined payments to each provider based on the quarterly estimates. A reconciliation will be calculated by June 2027. The same procedures will be followed for collection of required additional funds. Reconciliations will be performed for each MCO, and MCOs will be directed to issue or recoup reconciling amounts from each provider.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

See attachment and copied here, "3. SFY 2026 MS TREAT preprint-Questions 8, 19, and 20.pdf".
Ground emergency ambulance services providers reported five (5), and no less than three (3), commercial rates for each of the covered procedure codes (A0425, A0427, A0429, A0433, and A0434). These were used to calculate an average commercial rate (ACR) for each provider and procedure code. The provider specific ACRs were then used to calculate statewide ACRs. Statewide ACRs were used for a code if the provider reported less than three commercial rates for the code.
Historical state fiscal year (SFY) 2024 (based on service date) managed care encounters, the most recent data available when the calculation needed to be made, provided the managed care payments and average rates per unit of service for each procedure code. The difference between the ACR and the historical average managed care payment rate per service type determines the estimated TREAT payment rates for each provider. Using this approach for each provider the payment rate per unit of service on average will equal, but not exceed, the average commercial payer rate for services provided. The TREAT add-on payment rates will be adjusted to use actual managed care payment rates for SFY 2026 services to replace historical rates. The adjusted rates will be used to calculate the SFY 2026 year-end reconciliation.
TREAT payment rates are multiplied by managed care units of service to calculate payments. SFY 2024 historical managed care utilization of services from encounter data is being used for the estimated increases, to be paid quarterly, and will be replaced with actual utilization for the payment period for final reconciliation payments. Encounter data for the rating period, July 1, 2025 – June 30, 2026 (based on service date) used as the source for units of service and payments for reconciliation purposes will contain a minimum of six months of run-out.
MCOs are required to report the date and amount of payments made to providers. The state will use these reports to ensure all payments are made as directed. Any discrepancies will be addressed with the MCO and corrected.
This uniform increase approach was developed to ensure critically needed funding is directed to Mississippi ground emergency ambulance services providers. See attachment "1. SFY 2026 MS TREAT Model-Preprint Submission.xlsx" for the increase calculations and Table 2 reflecting the reasonableness of payment amounts.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☒ Other: Ground emergency ambulance services

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

20b See attachment and copied here, "3. SFY 2026 MS TREAT preprint-Questions 8, 19, and 20.pdf".
Ground emergency ambulance services providers are each assigned to a separate class. All eligible ground emergency ambulance services providers are included in the program. Eligible emergency ground ambulance service providers are those that are enrolled as a Mississippi Medicaid provider and licensed in Mississippi as a 911 ground ambulance provider or critical care ground transport provider as of July 1, 2025. Ambulance providers must also be an eligible ground ambulance provider enrolled with the Mississippi Division of Medicaid at the time of payment.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Providers eligible for this program are defined in "4. SFY 2026 MS TREAT-Managed Care Authority Documents". The links are located here:

https://medicaid.ms.gov/wp-content/uploads/2023/05/Pages-from-MS-23-0004-APPROVED.pdf
https://medicaid.ms.gov/wp-content/uploads/2023/04/Pages-from-MS-23-0023.pdf

Also see attachments: "8. Page 24a.1 from MS SPA 22 0023".pdf and "9. Page 24a from MS SPA 23 0004".pdf.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

MCOs will be required to issue directed payments through uniform dollar increases to each class, where each class is comprised of a single ground emergency ambulance services provider, based on average commercial payer rates for emergency transport services, including procedure codes A0380, A0390, A0425, A0427, A0429, A0433, and A0434.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☒

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. See attachment "TREAT Provider-Level Calculations" Columns L-N and Addendum A.					
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: Average Commercial Rate

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Percentage comparisons are based on base MCO payments, state directed payments and the combined total Medicaid MCO payments, respectively, divided by total payments at average commercial rates (ACR), calculated using estimated volume of services provided for MCO enrollees. The data sources include historical MCO volume and payment encounter data, along with the top 3 to 5 commercial payer rates by provider and procedure code, averaged, or the statewide ACR by procedure code if a provider reported less than 3 commercial payers for a code. ACRs were calculated at the procedure code level and applied to Medicaid encounter volume to estimate total ACR payments by provider and in total program-wide. See attached methodology and calculations for analysis provided in Table 2, titled, "1. SFY 2026 MS TREAT Model-Preprint Submission.xlsx".

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

Table 2 includes all payments the State expects MCOs to make to ground emergency ambulance services providers for the rating period. In the aggregate, base rates plus rates paid for Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) payments exceed Medicare rate levels. However, payment is designed such that base MCO payments combined with TREAT payments reach but do not exceed each provider's average commercial payment levels based on reported commercial payer rates for each procedure code. Considering the substantial challenges facing ground emergency ambulance services providers in the distressed communities of Mississippi, the state determined that the directed payment is appropriate and reasonable as proposed. Ground emergency ambulance services coverage in Mississippi is sparse, and financial support is needed to help ensure the current level of coverage is continued or improved. This program will supply urgently needed financial resources to help ensure access for critical services to Medicaid MCO enrollees.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

MCR-MS-MSCAN-20250701-20260630-CERTIFICATION-20250530

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Sec. 11.2.3, page 12

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. MCR-MS-MSCAN-20250701-20260630-CERTIFICATION-20250530	06/27/2025	Yes	Page 36
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

Quarterly payment by separate payment terms allows for state and MCO administrative efficiency in reviewing and tracking payments. It also ensures that the application of the uniform dollar increases are applied correctly and distributed uniformly among participating providers. The authorizing legislation in Miss Code Ann. §43-13-117 requires the funding to be used "to preserve and improve access to ambulance transportation provider services". The use of a separate payment term ensures the state is in compliance with the legislative directive and that all of the funding is used to support ambulance transportation provider services.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ☐ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☒ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. MS TREAT See Attachment "6. SFY 2026 MS TREAT-Provider Taxes.xlsx"	Emergency ground ambulance services	Yes	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://medicaid.ms.gov/wp-content/uploads/2024/12/MS-DOM-Comprehensive-Quality-Strategy-2024
- **b.** The effective date of quality strategy. December 31, 2024

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Promote Effective Prevention & Treatment of Chronic Disease	Ensure timely and proximate access to primary and specialty care	Page 6
b.		
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

This payment arrangement is expected to advance the Goal and Objective listed in Table 7 by ensuring access for Medicaid managed care beneficiaries to ground emergency ambulance services throughout the state of Mississippi. As a very rural state, it is imperative that Mississippi Medicaid managed care beneficiaries have ground emergency ambulance services in all counties. This payment arrangement will promote the effectiveness of ground emergency ambulance services care provided to Mississippi Medicaid managed care beneficiaries by identifying and promoting quality measures to be required and monitored among all participating ground emergency ambulance services providers.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Ground emergency ambulance services provider in each county	SFY 2022	100%	The state will monitor access to ground emergency ambulance services throughout the state and will assess at the end of each state fiscal year that each county within the state has a ground emergency ambulance services provider.	
ii. Managed Care utilization of ground emergency ambulance services	CY 2021	4.90%	The state will monitor access to ground emergency ambulance services for managed care beneficiaries by a PMPM calculation with a goal of increasing the utilization rate by 1% in the measurement year.	
iii. Improve Trauma Pain Scale Assessment	CY 2023	84.0%	The state will improve the Trauma Pain Scale Assessment rate for EMS Transports originating from a 911 request for patients with injury who were assessed for pain. The Baseline Measure for Mississippi for CY 2023 is 84.0%. The state will work to improve that percentage by 5% during the measurement year.	
iv. Improve Participation in CARES (Cardiac Arrest Registry to Enhance Survival)	October 2023	60.0%	The state will improve participation in the CARES program. The Baseline Measure for Mississippi is 60.0% with 49 counties of 82 currently submitting data as of October 2023. The state will work to improve that number of counties submitting data by 5% during the measurement year.	

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

This is the third year of a multi-year effort. During this past year, the state has worked on improving data collection for ambulance services by: 1) Finalizing the data dictionary, 2) Testing of the data system in November 2024 to verify the fields and logic work, and 3) Implementation of a new data collection system by the end of calendar year 2023 (NEMSIS 3.5).

The state's evaluation plan for future use for the TREAT program is included in Attachment 5. See attached file entitled, "5. SFY 2026 MS TREAT-Evaluation Findings Template.xlsx". This document includes the two new quality measures identified for reporting purposes during this past year.

TABLE 2.A: Provider Payment Analyses

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Level (after accounting for all SDPs and PTPs)
Data Format	**Free text**	**Percent (#.##%)**	**Percent (#.##%)**	**N/A**	**N/A**	**(#.##%)**
Example:	*Rural Inpatient Hospital Services*	*80.0%*	*20.0%*	*N/A*	*N/A*	*100.0%*
a.	AAA Ambulance Service	25.3%	74.7%			100.0%
b.	Acadian Ambulance Service, Inc.	32.3%	67.7%			100.0%
c.	AmeriPro EMS of Mississippi, LLC	44.8%	55.2%			100.0%
d.	ASAP EMS Corporation	32.6%	67.4%			100.0%
e.	Baptist	11.3%	88.7%			100.0%
f.	Baptist Memorial Hospital - Golden Triangle	42.0%	58.0%			100.0%
g.	Children's Transport UMMC	36.2%	63.8%			100.0%
h.	City of Hernando Ambulance	20.9%	79.1%			100.0%
i.	City of Horn Lake Ambulance Service	57.8%	42.2%			100.0%
j.	Covington County Hospital Ambulance Service	26.1%	73.9%			100.0%
k.	Desoto County EMS	27.0%	73.0%			100.0%
l.	Emserv Ambulance Service	28.3%	71.7%			100.0%
m.	King's Daughters Medical Center	37.0%	63.0%			100.0%
n.	LifeCare EMS	21.0%	79.0%			100.0%
o.	LifeGuard Ambulance Service, LLC (Lamar)	40.7%	59.3%			100.0%
p.	LifeGuard Ambulance Service, LLC (Panola, Marshall)	38.6%	61.4%			100.0%
q.	Magnolia Regional Health Center	31.6%	68.4%			100.0%
r.	MedStat EMS, Inc	45.9%	54.1%			100.0%
s.	Metro Ambulance Service	53.3%	46.7%			100.0%
t.	Metro Ambulance Service (Rural), Inc	33.5%	66.5%			100.0%
u.	Miss-Lou Ambulance Service	30.9%	69.1%			100.0%
v.	Mobile Medic Ambulance Service, Inc	44.5%	55.5%			100.0%
w.	Neshoba County Ambulance Enterprise	47.3%	52.7%			100.0%
x.	North Mississippi Ground Ambulance, LLC	56.4%	43.6%			100.0%
y.	Olive Branch Fire Dept Ambulance	25.1%	74.9%			100.0%
z.	Pafford EMS of Mississippi, Inc.	32.1%	67.9%			100.0%
aa.	Pafford Medical Services of Mississippi, Inc	23.1%	76.9%			100.0%
bb.	Paratech EMS, Inc.	30.1%	69.9%			100.0%
cc.	Rural Rapid Response, Inc.	0.0%	100.0%			100.0%
dd.	Southaven Fire Department Ambulance Service	25.9%	74.1%			100.0%
ee.	Tippah County Hospital	27.4%	72.6%			100.0%
ff.	Vicksburg Fire Dept Amb. Service	44.4%	55.6%			100.0%
gg.	Wayne General Hospital	18.9%	81.1%			100.0%
hh.	Yalobusha General Hospital	39.8%	60.2%			100.0%