Table of Contents

State/Territory Name: Mississippi

State Plan Amendment (SPA) MS: 23-0003

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

April 11, 2023

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 23-0003

Dear Mr. Snyder:

We have reviewed the proposed Mississippi State Plan Amendment (SPA) 23-0003, which was submitted to the Centers for Medicare & Medicaid Services (CMS) March 30, 2023. Mississippi Medicaid State Plan Amendment (SPA) 23-0003 Home Health Services was submitted to remove rate freeze language and allow reimbursement to be updated annually based on cost reports.

Based upon the information provided by the State, we have approved the amendment with an effective date of February 1, 2023. 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 Monica Neiman via email at monica.neiman@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0003

2. STATE: MS

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. § 440.70 1905(a)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 23 $ 1,618,459
b. FFY 24 $ 2,055,558

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B, Exhibit A, Page 6 - 8
MS SPA 21-0031

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B, Exhibit A, Page 6 - 8

Superseding SPA: TN# 21-0031

9. SUBJECT OF AMENDMENT
Mississippi Medicaid State Plan Amendment (SPA) 23-0003 Home Health Services is being submitted to remove rate freeze language and allow reimbursement to be updated annually based on cost reports.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Drew L. Snyder

13. TITLE
Executive Director

14. DATE SUBMITTED
MAR 30 2023

15. RETURN TO
Drew L. Snyder
Miss. Division of Medicaid
Attn: Robin Bradshaw
550 High Street, Suite 1000
Jackson, MS 39201-1399

FOR CMS USE ONLY

16. DATE RECEIVED
March 30, 2023

17. DATE APPROVED
April 11, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
February 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Pen and Ink change approved by the State and processed by CMS on the following fields:
179 Form:
Box 5: Added: CFR: 1905(a)
Box 8: Added: Superseding SPA: TN# 21-0031

Instructions on Back

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. The prospective rates will be determined from cost reports, set on a federal fiscal year (October 1-September 30) basis, and 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 of each year. 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

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

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 thetime difference between the midpoint of the cost report period and the midpoint of the rate period;

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

(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:

(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);

(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:

(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