Title 23: Division of Medicaid

Part 207: Institutional Long-Term Care

Chapter 2: Nursing Facility

Rule 2.1: General

A. The Division of Medicaid will execute a provider agreement with a nursing facility (NF) only when the Mississippi Department of Health (MSDH) or Centers for Medicare and Medicaid Services (CMS) has certified the NF has met all participation requirements in accordance with federal and state law.

B. The Division of Medicaid does not make payments to any NF prior to the date of certification and execution of a valid Medicaid provider agreement.

C. If the Division of Medicaid has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility. A provider agreement is not valid, even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 C.F.R. Parts 80, 84 and 90.

Source: 45 C.F.R. Parts 80, 84, 90; 42 C.F.R. §§ 442.10, 442.12, 483.1; Miss. Code Ann. §§ 43-11-1, 43-13-117, 43-13-121.

History: Revised eff. 04/01/2020.

Rule 2.3: Remedies and Termination of Agreements

A. The Division of Medicaid will use one (1) or more of the following remedies when deemed appropriate by the Centers for Medicare and Medicaid Services (CMS) or the Division of Medicaid based on results of surveys conducted by the Mississippi State Department of Health, Bureau of Health Facilities Licensure and Certification (MSDH HFLC):

1. Temporary Management,

2. Denial of payment for new admissions,

3. Civil money penalties,

4. Transfer of residents,

5. Closure of the facility and transfer of residents, and/or

6. State monitoring.

B. Remedies will be applied in accordance with federal and state requirements.

C. The Division of Medicaid and/or CMS may terminate any Medicaid participating nursing facility's (NF's) provider agreement if an NF nursing facility:

1. Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present,

2. Fails to submit an acceptable plan of correction within the timeframe specified by CMS and/or the Division of Medicaid, or

3. Fails to relinquish control to the temporary manager, if that remedy is imposed by CMS and/or the Division of Medicaid.

D. Notice of Termination: Before terminating a provider agreement, CMS and/or the Division of Medicaid will provide written notification to the NF and public notification via local and/or general newspaper publication as follows:

1. At least two (2) calendar days before the effective date of the termination for an NF with immediate jeopardy deficiencies, and

2. At least fifteen (15) calendar days before the effective date of termination for an NF with non-immediate jeopardy deficiencies that constitute noncompliance.

E. Reimbursement: When a provider agreement is terminated, federal regulations provide that payments may continue for no more than thirty (30) days from the date the provider agreement is terminated if it is determined that:

1. Reasonable efforts are being made to transfer the residents to another NF, community care, or other alternate care, and

2. Additional time is needed to facilitate an orderly transfer of the residents.

F. Discharge and Relocation of Residents

1. When CMS or the Division of Medicaid terminates a nursing facility's (NF) provider agreement, the Division of Medicaid will arrange for the safe and orderly transfer of all Medicare and Medicaid residents to another NF. The NF must send written notification to each Medicaid resident, legal representative and/or responsible party, and attending physician, advising of the impending closure.

2. The resident or the resident's legal representative and/or responsible party must be given an opportunity to designate a preference for a specific NF or other alternative arrangements. A resident's rights/freedom of choice in selecting an NF or alternative to NF placement must be respected. An NF chosen for the relocation of a Medicaid beneficiary must be:

a) Title XIX certified and in good standing under its provider agreement, and

b) Able to meet the needs of the resident.

G. Resident Trust Fund Accounts maintained by the closing facility must be properly inventoried and receipts obtained for audit purposes by the Division of Medicaid. All documentation required to perform an audit of the residents' trust fund account must be maintained and available for review. This includes, but is not limited to, residents' trial balances, residents' transactions histories, bank statements, vouchers, and receipts of purchases. In addition, the NF must maintain a current surety bond to cover the total amount of funds in the trust fund account.

H. Reinstatement After Termination

1. When a provider agreement has been terminated by the Office of Inspector General (OIG), CMS and/or the Division of Medicaid under 42 C.F.R. § 489.53, a new agreement with that provider will not be accepted unless it is found that:

   a) The reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur, and

   b) The provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

2. To be considered for re-instatement the Division of Medicaid must receive:

   a) A notification of re-instatement from the appropriate entity,

   b) An application for re-instatement to participate in the Medicaid program, and

   c) The Division of Medicaid has the sole discretion to determine the final retro-eligibility effective date.

Source: 42 C.F.R. Part 488, Subpart F; 42 C.F.R. §§ 483.10; 483.75; 489.53; 489.55; Miss. Admin. Code Title 15, Part 16, Subpart 1, Chapter 45; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 04/01/2020.