Title 23: Division of Medicaid

Part 207: Institutional Long Term Care

Part 207 Chapter 2: Nursing Facility

Rule 2.5: Reimbursement

A. Participating Mississippi nursing facilities must prepare and submit a Medicaid cost report for reimbursement.

1. All cost reports are due by the end of the fifth (5th) calendar month following the reporting period.

2. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars ($50.00) per day and may result in the termination of the provider agreement.

B. The Division of Medicaid uses a prospective method of reimbursement. Effective as of July 1, 2021 all rates and/or fees for items and services will remain the same as those in effect July 1, 2021, with no adjustments except for amended desk reviews or audits affecting the rates calculated effective prior to July 1, 2021.

1. The rates are calculated from cost reports and resident case-mix assessment data.

2. Standard rates are calculated annually with an effective date of January first (1st).

3. Rates are adjusted quarterly based on changes in the case-mix of the facility. Effective after July 1, 2021, rates are not adjusted quarterly without authorization from the state legislature

4. In no case may the reimbursement rate for services exceed an individual nursing facility's customary charges to the general public for such services in the aggregate, except for those public nursing facilities rendering such services free of charge or at a nominal charge.

5. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

6. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or case-mix scores or to correct errors.

a) These revisions may result from amended cost reports, field visit reviews, audits or other corrections.

b) Facilities are notified in writing of amounts due to or from the Division of Medicaid as a result of these adjustments.

c) There is no time limit for requesting settlement of these amounts.

C. The Division of Medicaid conducts periodic cost report financial reviews of selected nursing facilities to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. Adjustments will be made as necessary to the cost reports based on the results of the reviews.

D. Each nursing facility that is participating in the Medicaid program must keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

1. Providers who are required to pay assessments must keep and preserve books and records as necessary to determine the amount of the assessments for which it is liable for no less than five (5) years.

2. Providers must maintain adequate documentation, including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program.

   a) The cost report must be based on the documentation maintained by the nursing facility.

   b) All non-governmental nursing facilities must file cost reports based on the accrual method of accounting.

   c) Governmental nursing facilities have the option to use the cash basis of accounting for reporting.

3. Documentation of financial and statistical data must be maintained in a manner consistent from one (1) period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.

4. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the nursing facility cost report for the purpose of determining compliance with Medicaid rules.

   a) These records must be made available as requested by the Division of Medicaid.

   b) All documentation which substantiates the information included in the nursing facility cost report, including any documentation relating to home office and/or management company costs must be made available to the Division of Medicaid reviewers as requested by the Division of Medicaid.

E. The Division of Medicaid reimburses for the day of admission to a nursing facility.

1. The day of discharge is not reimbursed by the Division of Medicaid unless it is the same day as the date of admission.

2. Nursing facilities cannot bill the resident or responsible party for the day of discharge.

F. The Division of Medicaid reimburses for home/therapeutic and inpatient hospital temporary leave.

1. Home/therapeutic temporary leave is limited to forty-two (42) days per year in addition to holidays listed in Miss. Admin. Code Part 207, Rule 2.8. Reimbursement is limited to fifteen (15) consecutive days per leave period.

2. Inpatient hospital temporary leave days are not limited except for reimbursement of a maximum of fifteen (15) consecutive days per leave period.

3. If the resident has utilized the fifteen (15) consecutive day maximum, the resident must return to the facility for twenty-four (24) consecutive hours before the nursing facility can be reimbursed for a new temporary leave period.

4. If the resident is on inpatient hospital leave and has not been discharged, the nursing facility is responsible for providing transportation for the return to the nursing facility.

G. The Division of Medicaid does not reimburse for the following instances:

1. Nursing facilities which bill the Division of Medicaid for fifteen (15) consecutive days of home/therapeutic or inpatient hospital temporary leave, discharge the resident from the nursing facility, and subsequently refuse to readmit the resident under the nursing facility's resident return policy when a bed is available.

2. Inpatient hospital temporary leave for days when a resident is transferred to a Medicare skilled nursing facility (SNF) or a swing bed after an acute care hospitalization.

3. Medicaid billing of home/therapeutic or inpatient hospital temporary leave for more than fifteen (15) consecutive days.

H. Nursing facilities must bill the appropriate day code as follows:

1. For a resident who has a home/therapeutic temporary leave bill a home/therapeutic leave day code beginning the calendar day the resident:

a) Leaves the facility for eight (8) consecutive hours or more during the day excluding:

1) Dialysis,

2) Chemotherapy,

3) Physical therapy,

4) Speech therapy,

5) Occupational therapy, or

6) Medical treatments that occur two (2) or more days per week,

b) Is out of the facility at twelve midnight (12 a.m.),

c) Is out of the facility for a hospital observation stay of eight (8) or more consecutive hours, or

d) Returns from a therapeutic leave if the resident was out of the facility for eight (8) or more consecutive hours on the return day except for the day of return after a hospital observation stay of eight (8) or more consecutive hours.

2. For a resident who has an inpatient hospital temporary leave, bill an inpatient hospital leave day code beginning the calendar day the resident is admitted to an inpatient hospital for continuous acute care.

3. Bill a room and board day code:

a) If the resident does not meet the criteria for either a home/therapeutic or inpatient hospital temporary leave,

b) If the resident receives:

1) Dialysis,

2) Chemotherapy,

3) Physical therapy,

4) Speech therapy,

5) Occupational therapy, or

6) Medical treatments that occur two (2) or more days per week.

c) The day the resident returns to the nursing facility from an inpatient hospital acute care stay or a hospital observation stay of eight (8) or more consecutive hours, or

d) The day the resident returns to the nursing facility from a home/therapeutic leave if the resident was out of the facility for less than eight (8) consecutive hours. [Refer to Miss. Admin. Code Part 207, Rule 2.5.H.3.c)]

I. Nursing facilities are required to maintain complete and accurate room and board and temporary leave records in order to accurately bill the fiscal intermediary.

J. Nursing facilities must enter the correct temporary leave, regardless of the resident's payment source, in the case-mix web portal to match the billing records as specified in Miss. Admin. Code Part 207, Rule 2.5.H.1. or 2.

1. The deadline for entering temporary leave information for the quarter is the fifth (5^{th}) day of the second (2^{nd}) month following the end of the quarter the leave occurred.

2. The case-mix review process includes a review and reconciliation of the facility's official home/therapeutic and inpatient hospital temporary leave records.

Source: 42 C.F.R. Part 447, Subparts B and C; Miss. Code Ann. §§ 43-13-117, 43-13-121, 43-13-145.

History: Revised eff. 05/01/2022; Revised eff 07/01/2021; Revised eff. 11/01/2019; Revised eff. 08/01/2018 except for Miss Admin Code Part 207, Rule 2.5.F.1. revised to correspond with SPA 18-0005 (eff. 07/01/2018) eff. 08/01/2018.

Rule 2.6: Per Diem

A. The nursing facility must provide and pay for all items and services required to meet the needs of a resident.

B. Items and services covered by Medicare or any other third party must be billed to Medicare or the other third party and are considered non-allowable on the cost report. Applicable crossover claims must also be filed with the Division of Medicaid.

C. The following items and services are included in the Medicaid per diem rates and cannot be billed separately to the Division of Medicaid or charged to a resident:

1. Room/bed maintenance services,

2. Nursing services,

3. Respiratory therapy (RT) services,

4. Dietary services, including nutritional supplements,

5. Activity services,

6. Medically-related social services,

7. Laundry services including the residents' personal laundry,

8. Over-the-counter (OTC) drugs,

9. Legend drugs not covered by Medicaid drug program, Medicare, private, Veterans Affairs (VA), or any other payor source,

10. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the nursing facility. [Refer to Miss. Admin. Code Part 207, Rule 2.6.D. for medical supplies which must be billed outside the per diem rate.]

    a) Enteral supplies,

    b) Diabetic supplies,

    c) Incontinence garments, and

    d) Oxygen administration supplies.

11. Durable medical equipment (DME), and/or medical appliances, except for DME and/or medical appliances listed in Miss. Admin. Code Part 207, Rule 2.6.D. The Division of Medicaid defines DME and/or medical appliances as an item that (1) can withstand repeated use, (2) primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the nursing facility.

12. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:

    a) Hair hygiene supplies,

    b) Comb and brush,

    c) Bath soap,

    d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,

    e) Razor and shaving cream,

    f) Toothbrush and toothpaste,

    g) Denture adhesive and denture cleaner,

h) Dental floss,

i) Moisturizing lotion,

j) Tissues, cotton balls, and cotton swabs,

k) Deodorant,

l) Incontinence supplies,

m) Sanitary napkins and related supplies,

n) Towels and washcloths,

o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part of routine grooming care, and

p) Bathing.

13. Private room coverage as medically necessary:

    a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.

    b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.

14. Ventilators. [Refer to Miss. Admin. Code Part 207, Rule 2.15.]

15. The nursing facility must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.

16. The nursing facility cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Nursing facilities may use NET providers that also provide NET services for the NET Broker if:

    a) The nursing facility arranges the transportation, and

    b) Pays the NET provider directly.

D. The following items and services are not included in the Medicaid per diem rates, are considered non-allowable costs on the nursing facility's cost report, and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the nursing facility:

1. Laboratory services,

2. X-ray services,

3. Drugs covered by the Medicaid drug program, Medicare, Veteran's Affairs (VA), or any other payor source,

4. Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services,

5. Ostomy supplies,

6. Continuous Positive Airway Pressure (CPAP) Devices effective January 2, 2015,

7. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015.

8. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 2.18 for definition and coverage criteria.]

9. Emergency transportation described in Miss. Admin. Code Part 201.

E. Prior authorization from a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity is required for the following:

1. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident, and

2. PT, OT and SLP services, and

3. All other DME and/or medical appliances identified in Part 209 requiring prior authorization.

F. Prior authorization from the Division of Medicaid or UM/QIO is required for ventilators except for those in a Nursing Facility for the Severely Disabled (NFSD).

G. All nursing facilities must prominently display the below information in the nursing facility, and provide to applicants for admission and residents the below information in both oral and written form:

1. How to apply for and use Medicare and Medicaid benefits, and

2. How to receive refunds for previous payments covered by such benefits.

H. The nursing facility must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid of:

a) The items and services that are included in the nursing facility services under the State Plan and for which the resident may not be charged, and

b) Those other items and services that the nursing facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 2.6.G.1.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

I. The nursing facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for items and services consistent with the notice stated in Miss. Admin. Code Part 207, Rule 2.6.G.

1. The nursing facility's non-Medicaid per diem rate may be set above the Medicaid per diem rate but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.

2. Items and services available in the nursing facility not covered under Title XVIII or the nursing facility's Medicaid per diem rate must be available and priced identically for all residents in the facility.

J. A nursing facility cannot require a deposit before admitting a Medicaid beneficiary.

Source: 42 C.F.R. §§ 483.10, 483.65; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 05/01/2022; Revised eff. 09/01/19; Added Miss. Admin. Code Part 207, Rule 2.6.C.15 and D.9 eff. 09/01/2018; Revised to correspond to SPA 18-0001 (eff. 01/01/2018) eff. 8/01/2018. Revised eff. 08/01/2017; Removed Miss. Admin. Code Part

207, Rule 2.6.D.6 (retroactively eff. 01/02/2015) eff. 11/01/2016; Revised eff. 01/02/2015.

Rule 2.9: Resident Assessment Instrument (RAI)

A. Nursing facilities must complete the Minimum Data Set (MDS) 3.0, including Section S, which is the Resident Assessment Instrument (RAI) specified by the Division of Medicaid and approved by the Centers of Medicare and Medicaid Services (CMS), on all residents regardless of source of payment.

B. Section S identifies beneficiaries residing in an Alzheimer's/dementia care unit of a nursing facility which must be completed on all residents during the specified time period of each of the following MDS assessments including, but not limited to:

1. Comprehensive (NC) which includes:

   a) Admission,

   b) Annual,

   c) Significant Change in Status Assessment (SCSA), and

   d) Significant Correction to Prior Comprehensive Assessment (SCPA),

2. Prospective Payment System (PPS),

3. Quarterly (NQ),

4. Significant Correction to Prior Quarterly Assessment (SCQA),

5. Entry Tracking Record (NT),

6. Death in Facility Tracking Record (NT),

7. Discharge Assessment – Return not anticipated (ND), and

8. Discharge Assessment – Return Anticipated (ND).

C. Nursing facilities cannot indicate in Section S that a resident has received care in an Alzheimer's/dementia care unit if the nursing facility does not have a designated Alzheimer's/dementia care unit. The fourteen (14) day look-back period cannot include:

1. A resident's hospital stay in a geriatric psychiatric unit, or

2. An Alzheimer's/dementia care unit stay in another nursing facility.

D. The RAI must be completed in accordance with the most current CMS Long-Term Care Facility Resident Assessment Instrument User's Manual and the Division of Medicaid's requirements as follows:

1. An Admission Assessment, which is a comprehensive assessment, must be completed by the fourteenth (14^{th}) calendar day of the resident's admission.

2. An Annual Assessment, which is a comprehensive assessment, must be completed within three hundred sixty-six (366) calendar days of the previous assessment reference date for an OBRA comprehensive and ninety-two (92) calendar days of the previous assessment reference date for an OBRA Quarterly assessment.

3. A Significant Change in Status Assessment, which is a comprehensive assessment, must be completed by the fourteenth (14^{th}) calendar day following the determination that a significant change has occurred.

4. A Quarterly Assessment, which is a non-comprehensive assessment, must be completed no less than eighty (80) calendar days and no more than ninety-two (92) calendar days from the previous assessment reference date.

5. A Significant Correction to Prior Comprehensive Assessment must be completed no later than the fourteenth (14^{th}) calendar day following the determination that a significant error in a prior comprehensive assessment has occurred.

6. A Significant Correction to Prior Quarterly Assessment, which is a non-comprehensive assessment, must be completed no later than fourteen (14) days following the determination that a significant error in a prior quarterly assessment has occurred.

Source: 42 U.S.C. §§ 1395i-3, 1396r; 42 C.F.R. §§ 483.20, 483.315; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 05/01/2022; Revised eff. 08/01/2017; Revised to correspond to MS SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.11: Resident Funds

A. Basic Requirements

1. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.

2. Resident fund accounts are reviewed to assist facilities in developing acceptable systems

of accounting for resident funds.

3. Penalties may be assessed on any licensed nursing facility that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with the provisions of federal law and of the requirements contained in this section.

B. Statement Provided at Time of Admission - The facility must provide each resident and responsible party with a written statement at the time of admission that states the following:

1. All services provided by the facility must be distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.

2. There is no obligation for the resident to deposit funds with the facility.

3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:

   a) The resident's right to receive, retain and manage his/her personal funds or to have this done by a legal guardian, if any,

   b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,

   c) The resident's right to designate, in writing, another person to act for the purpose of managing his/her personal funds, and

   d) The resident's right to require the facility to hold, safeguard, and account for such personal funds under a system established and maintained by the facility, if requested by the resident.

4. Any charge for this service is included in the facility's basic rate.

5. The facility is permitted to accept a resident's funds to hold, safeguard, and account for, only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.

6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.

7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.

C. Individual Records - The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which the facility has been given for holding, safeguarding, and accounting. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. GAAP means that the facility, for example, employs proper bookkeeping techniques by which it can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of individual resident funds. Resident fund records must:

1. Include the resident's name.

2. Identify the resident's representative, if any.

3. Include the resident's admission date.

4. Show the actual transaction date and amount of each deposit and withdrawal.

5. Reflect the actual date of an adjusting or correcting entry.

6. State the name of the person who accepted the withdrawn funds.

7. Show the balance after each transaction.

8. Provide the appropriate signatures for all disbursements of funds, such as:

   a) Resident's signature,

   b) Resident's mark, or "x" with two witnesses' signatures,

   c) Power of attorney's signature,

   d) Resident's responsible party when the amount disbursed is supported by appropriate documentation, or

   e) Two signatures of facility personnel when the amount disbursed is supported by appropriate documentation.

9. Document transaction with receipts indicating the purpose for which any withdrawn funds were spent. This restriction is applicable to all parties, except the residents and their power of attorney, who have written authorization to withdraw funds from a resident's trust fund account. Applicable parties include, but are not limited to, responsible parties, facility personnel, representative payees, etc. The facility must reimburse the resident's account for any undocumented transactions.

10. For powers of attorney, the provider must maintain a copy of the power of attorney in the

resident's file, and before the provider can allow withdrawals of funds based upon the power, the provider must ensure that the power contains language sufficient to allow the holder to withdraw funds and expend them.

11. Reflect the resident's earned interest, if any.

12. Be reconcilable, at all times, with the current bank statement and/or petty cash.

13. Not include as an outstanding item any check written on a resident's account that has not been cashed within one year of check date. Any check held as outstanding for 12 months or more should be reissued to the appropriate party or voided and credited to the appropriate resident's account. If the check was a refund for a discharged or deceased resident, the funds may be sent to the State Treasurer as unclaimed funds. For further information on Accounting Upon Death or Discharge of Resident refer to the Title 23 Administrative Code Part 207, Chapter 3 Rule 3.7 M., and

14. Be kept for at least five years after the resident's discharge or death.

D. Limitation on Charges to Resident Funds

1. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation, as specified in under the heading "Individual Records" of this section is provided. The facility must notify the resident and/or responsible party, in advance, that there will be a charge for non-Medicaid covered items and services, such as:

   a) Personal communication/entertainment items and services, like a telephone, television, radio, and computer,

   b) Personal comfort items, including tobacco, novelties, and candy,

   c) Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services,

   d) Personal clothing,

   e) Personal reading material,

   f) Gifts purchased on behalf of the resident,

   g) Flowers and plants for the resident's room,

   h) Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate,

i) Private sitters or aides,

j) Private room provided that a private room is not medically necessary, such as isolation for infection control,

k) Specially prepared or alternative food requested instead of or in addition to the food generally prepared by the facility, and

l) Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.

2. Unacceptable charges to resident funds include the following categories and examples:

a) Any charge not authorized and documented.

b) Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.

c) Medically necessary items and services are reimbursed as part of the Medicaid per diem rate. However, any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services, must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity. Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.

d) Transportation.

e) Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by a nursing facility for nursing facility costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.

f) Loans or collateral for loans to anyone, including the facility and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.

g) Transfers or gifts of money not authorized by the resident, such as when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.

h) Any item or service as a condition of admission or continued stay.

E. Resident's Access to Financial Records and Quarterly Statements - The facility must provide each resident, responsible party, or legal representative of each resident, reasonable access to the resident's financial records. In addition, the facility must provide a written statement, at

least quarterly, to each resident, responsible party, or legal representative. The quarterly statement must reflect any resident funds which the facility has deposited in an interest bearing or a non-interest bearing account, as well as any resident funds held by the facility in a petty cash account.

F. Commingling of Residents' Funds - The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds and from the funds of any person other than another resident in that facility. The facility may not open any additional accounts within the trust fund account, such as donation accounts, miscellaneous accounts, or the like. Only funds of the facility's residents may be maintained as part of the resident trust fund account.

G. Deposit of Resident Funds into an Interest or Non-Interest Bearing Account

1. The facility must deposit any resident's personal funds in excess of fifty dollars ($50.00) in an interest bearing account(s) that is separate from any of the facility's operating accounts. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:

   a) Prorated to each resident's account on an actual interest-earned basis; or

   b) Prorated to each resident's account on the basis of its end-of-quarter balance.

2. The facility must maintain a resident's personal funds that do not exceed fifty dollars ($50.00) in a non-interest bearing account, an interest-bearing account, or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars ($50.00) or less in a pooled account with all other residents' funds, interest is accumulated based on the total amount of funds in the trust fund account; therefore, all residents must be allocated interest proportionately in that instance.

3. The facility may neither limit nor restrict any resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars ($50.00). A facility may not establish policy that conflicts with this absolute right of the residents for the facility to hold, safeguard, manage, and account for all residents' funds deposited with the facility.

H. Access to Funds

1. Funds held in the facility - The residents must have access to funds daily during normal business hours and for some reasonable time of at least two (2) hours on Saturdays and Sundays. The facility must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, the legal guardian or the representative payee all funds remaining that the facility has received for holding, safeguarding and accounting and that are maintained in a petty cash fund.

2. Funds held outside the facility - For a resident's personal funds that the facility has received and that are deposited in an account outside the facility, the facility, upon request, must,

within five (5) business days, return to the resident, the legal guardian, or the representative payee, all or any part of those funds.

I. Accounting on Change of Ownership

1. Duties of new owner - Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written accounting of all resident funds being transferred and obtain a written receipt for those funds from the new owner.

2. Duties to resident - The facility must give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.

3. Rights of resident - In the event of a disagreement with the accounting provided by the facility, the resident retains all rights and remedies provided under state law.

4. Sponsor signatures for fiscal responsibility - A nursing facility cannot require a family member or other individual to sign a financial responsibility statement for a Medicaid resident. In instances where Medicaid beneficiaries have no family member or individual available for such signatures, it is clearly discriminatory for a Medicaid provider to refuse admission to the resident.

J. Accounting Upon Death or Discharge of Resident

1. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. If the deceased resident's estate has no executor or administrator, the facility must convey the resident's funds and provide a final accounting to the:

   a) Resident's next of kin,

   b) Resident's representative, or

   c) Clerk of the probate court of the county in which the resident died.

2. Disposition of Funds for Deceased Resident Who Dies Intestate Within a Long-Term Care Facility

   a) Any Medicaid beneficiary receiving medical assistance for services provided in a long-term care facility who dies intestate and leaves no known heirs shall have deemed, through acceptance of such medical assistance, the Division of Medicaid as the beneficiary of funds in his/her possession at the time of death, in an amount not to exceed two hundred fifty dollars ($250.00). The Division of Medicaid is the beneficiary of these funds regardless of whether a claim is later made to the beneficiary's property in accordance with Miss. Code Ann. § 43-13-120(3) and (4).

b) The long-term care facility shall make a report to the State Treasurer of all funds, including any accrued interest, in the possession of the Medicaid beneficiary at the time of death. The report of such funds shall be on a form prescribed or approved by the State Treasurer and shall include the name of the deceased Medicaid beneficiary and his/her last known address prior to entering the facility, the name and last known address of each person who may possess an interest in such funds, and any other information which the State Treasurer prescribes by regulation . This report must be filed with the State Treasurer, with a copy to the Division of Medicaid, prior to November 1 of the year in which the facility provided services to the Medicaid beneficiary having funds to which this section applies.

c) Within one hundred twenty (120) days from November 1 of each year in which a report is made, the State Treasurer shall cause notice to be published in the newspaper in accordance with Miss. Code Ann. § 43-13-120(3). The Division of Medicaid shall pay the cost of publishing the notice.

d) The long-term care facility that makes a report of funds of a deceased Medicaid beneficiary shall pay over and deliver such funds, including any accrued interest, to the State Treasurer not later than ten (10) days after notice of such funds has been published by the State Treasurer.

e) If within ninety (90) days of the State Treasurer's publication no claims are made to the funds in excess of the two hundred fifty dollars ($250.00) the Division of Medicaid has already received pursuant to 2.a) above, the State Treasurer shall place those funds in a special account in the State Treasury to the credit of the Division of Medicaid.

3. Disposition of Funds for Deceased Resident Who Dies Intestate in a State Institution

a) Miss. Admin. Code Part 207, Rule 2.11.J.2. shall not be applicable for residents of any state institution.

b) The funds of any resident in a state institution who dies intestate and without any known heirs may be deposited in the facility's operational account, after a period of one (1) year from the date of death.

K. Surety Bond

1. The facility must purchase a surety bond or otherwise provide assurance as to the security of all personal funds of residents deposited with the facility. A surety bond is an agreement between the principal (the facility), the surety (the insurance company), and the obligee (the residents of the trust fund), wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages and for which the facility accounts. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring for any failure by the facility to hold, safeguard, manage, and account for the residents' funds; that is, losses occurring as

a result of acts or errors of negligence, incompetence or dishonesty.

2. Unlike other types of insurance, the surety bond protects the obligee (the residents of the trust fund), not the principal, from loss. The surety bond differs from a fidelity bond, also called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.

3. The surety bond is the commitment of the facility to meet the standard of conduct. The facility assumes the responsibility to compensate the obligee (the residents of the trust fund), for the amount of the loss up to the entire amount of the surety bond. Therefore, the surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident funds held on deposit. A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at the facility and available for inspection.

4. Reasonable alternatives to a surety bond must:

   a) Designate the obligee, (the resident, individually, or in aggregate), who can collect in case of a loss,

   b) Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and

   c) Be managed by a third party unrelated in any way to the facility or its management.

5. The facility cannot be named as an obligee. Self-insurance is not an acceptable alternative to a surety bond. Likewise, funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.

6. If a corporation has a surety bond that covers all of its facilities, the corporation's surety bond must be sufficient to ensure that all of the residents in the corporation's facilities are covered against any losses due to acts or errors by the corporation, its agents, or any of its facilities. The intent of focus is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.

L. Resident Incapable of Managing Funds

1. If a resident is incapable of managing personal funds and has no representative, the facility must refer the resident to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.

2. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA office and the actual appointment of a guardian or representative payee, the facility must serve as temporary

representative payee for the resident.

3. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source, like a Social Security check, cannot be commingled with facility funds prior to those funds being transferred to the trust fund account.

M. Notice of Resource Limits, Medicaid or SSI

1. The facility must notify each resident receiving medical assistance under Title XIX, Medicaid, when the amount in the resident's account reaches two hundred dollars ($200) less than the SSI resource limit and five hundred dollars ($500), less than the Medicaid resource limit, to remain eligible for Medicaid long term care benefits. The notice must include the fact that if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the applicable resource limits, the resident may lose eligibility for Medicaid or SSI.

2. The facility must issue written notification to the Medicaid regional office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the applicable resource limit.

N. Glossary and Explanation of Common Terms Used in the Performance of Resident Trust Fund Reviews

1. Basic Rate - Also referred to as the standard or per diem rate. This is the rate that Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in writing at the time of admission, of the items and services provided by the facility, as well as the items and services not included in the basic rate, and the amount of such charges that may be charged to the resident.

2. Book Balance - The total balance of all resident trust funds and petty cash held according to the accounting ledger.

3. Census - The total number of residents in a facility.

4. Compliance - The Omnibus Budget Reconciliation Act of 1987, Paragraph 17, 399, Section 1919(6)(A) requires a facility to establish and maintain a system that fully and completely accounts for the resident's funds managed by the provider. A facility that does this is issued an opinion by the Division of Medicaid that "the facility generally complies with Section 1919(6)(A)." A facility may be found to be in compliance and still have minor errors in its resident fund system; however, for a facility that lacks an accounting system, lacks several parts of an accounting system, or has a sufficient number of exceptions that would indicate a breakdown of the system of accounting, an opinion may be issued that

"the facility does not comply with Section 1919(6)(A)."

5. DOM - Division of Medicaid.

6. Fiduciary - A fiduciary has rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting in this capacity.

7. Fiscal Agent - The agency, under contract with the Division of Medicaid, for the purpose of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.

8. GAAP - Generally Accepted Accounting Principles. GAAP for resident trust funds means that the facility employs proper bookkeeping techniques by which it can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident and the amount of each individual resident's fund balance. Proper bookkeeping techniques may, include a computer software package for the accounting of resident trust funds, an individual ledger card, ledger sheet or equivalent established for each resident on which only those transactions involving the resident's personal funds are recorded and maintained.

9. Intestate - Without a valid will at the time of death.

10. Legal Guardian - A legal guardian, or conservator, is a person or persons appointed by the court of jurisdiction to manage the resident's income and assets in the best interest of the resident. The court may require a court order prior to disbursements of the resident's funds, and/or a periodic accounting to the court to document income and disbursements. A legal guardian or conservator must supply documentation to the facility for disbursements from the resident fund, just as any other responsible party for any other resident.

11. Medicaid Income - The Medicaid income is the dollar amount shown on a resident's form DOM-317. It is the maximum liability that the resident owes to the facility each month for room and board.

12. Medically Necessary Items and Services - Those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary, and therefore justifiable as an expenditure of the resident's personal funds.

13. Obligee - The party to whom the facility is legally or morally bound, i.e. "the residents of the trust fund". The obligee is the beneficiary of funds collected in the event of the failure of the facility to hold, safeguard, manage, and account for the resident's funds.

14. Per Diem Rate - Refer to "Basic Rate."

15. Personal Needs Allowance (PNA) - The amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.

16. Plan of Correction - An acceptable plan of correction must address each exception noted in the findings letter and include the following:

    a) Documentation that the exception has been corrected,

    b) The measures that have been put in place to ensure that the exception will not be repeated, and

    c) The measures that have been put in place to monitor the continued effectiveness of the changes.

17. Reconciliation - At all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits, or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.

18. Representative Payee - A resident may have someone designated to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is available to represent the resident.

19. Resident's Personal Funds - All of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.

20. Resource Limit - The maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two (2) resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.

21. Responsible Party - For resident trust fund purposes, may be known as sponsor or residents representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization form, to assist the resident in managing the personal funds

of the resident that are maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation (e.g., receipts or invoice).

22. State Institution - These are facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeth Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.

23. Testate - Having a valid will at the time of death.

24. Trial Balance - A listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.

25. Written Authorization - Authorization to establish a resident trust fund for a resident must be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific transaction of funds for the resident must be in writing and/or documented with a receipt of purchase.

Source: 42 U.S.C. § 1396r; 42 C.F.R. §§ 431.53, 447.15, 483.420; Miss. Code Ann. §§ 43-13-120, 43-13-121.

History: Revised eff. 05/01/2022; Revised eff. 09/01/2018; Revised eff. 12/1/2017.

Part 207 Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Rule 3.5: Per Diem

A. The intermediate care facility for individuals with intellectual disabilities (ICF/IID) must provide for all items and services required to meet the needs of a resident according to the comprehensive functional assessment and the individual program plan (IPP).

B. Items and services covered by Medicare or any other third party must be billed to Medicare or the other third party and are considered non-allowable on the cost report. Applicable crossover claims must also be filed with the Division of Medicaid.

C. The following items and services are included in the Medicaid per diem rates and cannot be billed separately to the Division of Medicaid or charged to a resident:

1. Room/bed maintenance services.

2. Nursing services.

3. Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services.

4. Dietary services, including nutritional supplements.

5. Activity services.

6. Medically-related social services.

7. Laundry services including the residents' personal laundry.

8. Over-the-counter (OTC) drugs.

9. Legend drugs not covered by the Medicaid program, Medicare, private, Veteran's Administration (VA) or any other payor source.

10. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for medical supplies which must be billed outside the per diem rate.]

    a) Enteral supplies,

    b) Diabetic supplies,

    c) Incontinence garments and

    d) Oxygen administration supplies.

11. Durable medical equipment (DME), except for DME listed in Miss. Admin. Code Part 207, Rule 3.4.D. The Division of Medicaid defines DME as an item that (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for DME which must be billed outside the per diem rate.]

12. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:

    a) Hair hygiene supplies,

    b) Comb and brush,

    c) Bath soap,

d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,

e) Razor and shaving cream,

f) Toothbrush and toothpaste,

g) Denture adhesive and denture cleaner,

h) Dental floss,

i) Moisturizing lotion,

j) Tissues, cotton balls, and cotton swabs,

k) Deodorant,

l) Incontinence supplies,

m) Sanitary napkins and related supplies,

n) Towels and washcloths,

o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part of routine grooming care, and

p) Bathing.

13. Private room coverage as medically necessary.

a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.

b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.

14. The ICF/IID must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.

15. The ICF/IID cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. ICF/IIDs may use NET providers that also provide NET services for the NET Broker if:

    a) The ICF/IID arranges the transportation, and

    b) Pays the NET provider directly.

D. The following items and services are not included in the Medicaid per diem rates, are considered non-allowable costs on the ICF/IID's cost report and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the ICF/IID:

    1. Laboratory services,

    2. X-ray services,

    3. Drugs covered by the Medicaid drug program,

    4. Ostomy supplies,

    5. Continuous Positive Airway Pressure (CPAP) Devices effective January 2, 2015,

    6. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015, and/or

    7. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident when prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity effective January 2, 2015.

    8. Emergency transportation described in Miss. Admin. Code Part 201.

E. All ICF/IID's must prominently display the below information in the ICF/IID, and provide to applicants for admission and residents the below information in both oral and written form:

    1. How to apply for and use Medicare and Medicaid benefits, and

    2. How to receive refunds for previous payments covered by such benefits.

F. The ICF/IID must:

    1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the ICF/IID or when the resident becomes eligible for Medicaid of:

        a) The items and services that are included in the ICF/IID services under the State Plan and for which the resident may not be charged, and

b) Those other items and services that the ICF/IID offers and for which the resident may be charged and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 3.4.F.1.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the ICF/IID and of charges for those services, including any charges for services not covered under Medicare or by the ICF/IID's per diem rate.

G. The ICF/IID may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for items and services, consistent with the notice stated in Miss. Admin. Code Part 207, Rule 3.4.F.

1. The ICF/IID's non-Medicaid per diem rate may be set above the Medicaid per diem rate, but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.

2. Items and services available in the ICF/IID not covered under Title XVIII or the ICF/IID's Medicaid per diem rate must be available and priced identically for all residents in the ICF/IID.

H. An ICF/IID cannot require a deposit before admitting a Medicaid beneficiary.

I. Refer to Miss. Admin. Code Part 224, Rule 1.4 for coverage of immunizations.

Source: 42 C.F.R. §§ 483.12, 483.440; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 05/01/2022; Revised eff. 09/01/19; Added Miss. Admin. Code Part 207, Rule 3.4.C.15 and D.8 eff. 09/01/2018; Revised eff. 08/01/2017; Removed Miss. Admin. Code Part 207, Rule 3.4.D.5 (retroactively eff. 01/02/2015), eff. 11/01/2016; Added Miss. Admin. Code Part 207, Rule 3.4.F.4.-6., eff. 04/01/2016; Revised eff. 01/02/2015.

Rule 3.7: Temporary Leave Payment

A. The Division of Medicaid defines temporary leave as a temporary absence for one (1) or more calendar days the resident is out of the intermediate care facility for individuals with intellectual disabilities (ICF/IID) for:

1. A home/therapeutic temporary leave.

a) The temporary leave is defined as:

1) Eight (8) consecutive hours or more during the day excluding dialysis,

chemotherapy or medical treatments that occur two (2) or more days per week,

2) An absence at twelve midnight (12 a.m.), or

3) A hospital observation stay.

b) The first (1st) day of a temporary leave begins the calendar day the resident left the ICF/IID.

c) The end of the home/therapeutic temporary leave is the calendar day:

1) The resident returns to the ICF/IID,

2) After the resident returns if the resident was out of the ICF/IID for eight (8) or more hours as of midnight (12 a.m.) on the day the resident returned to the ICF/IID.

3) The resident is admitted to an inpatient hospital acute care stay from an observation stay, or

2. An inpatient hospital temporary leave.

a) The temporary leave is defined as an admission to the inpatient hospital for continuous acute care.

b) The first (1st) day of a temporary leave begins the calendar day the resident is admitted to the inpatient hospital for continuous acute care.

c) The end of the temporary leave is the calendar day the resident returns to the ICF/IID.

B. Before the resident departs on home/therapeutic or inpatient hospital temporary leave, the ICF/IID must provide a written notice to the resident and/or family member or legal representative explaining the ICF/IID's temporary leave, bed-hold and resident return policies.

1. The written notice must define the period of time during which the resident is permitted to return and resume residence in the ICF/IID.

2. The written notice must also state that if the resident's absence exceeds the Division of Medicaid's bed-hold limit the resident will be readmitted to the ICF/IID upon the first availability of a semi-private bed if the resident still requires the services provided by the ICF/IID.

C. The Division of Medicaid covers up to fifteen (15) consecutive days of home/therapeutic temporary leave per one (1) absence for up to a total of sixty-three (63) days per state fiscal year, which begins July 1 and ends June 30 of the following calendar year, in addition to certain holidays.

1. The holidays included in home/therapeutic temporary leave are:

    a) Christmas Day,

    b) The day before Christmas Day,

    c) The day after Christmas Day,

    d) Thanksgiving Day,

    e) The day before Thanksgiving Day, and

    f) The day after Thanksgiving Day.

2. All home/therapeutic temporary leave days must be approved by the attending physician.

3. Home/therapeutic temporary leave includes the resident's absence for:

    a) Eight (8) or more consecutive hours during the day or at midnight (12 a.m.),

    b) A hospital observation stay when the resident is not admitted for an inpatient hospital acute care stay, or

    c) Outpatient treatments except for dialysis, chemotherapy and medical treatments that occur two (2) or more days per week.

4. The ICF/IID must reserve the resident's bed in anticipation of the resident's return and cannot fill the resident's bed with another resident during the covered period of home/therapeutic temporary leave.

5. ICF/IIDs cannot refuse to readmit a resident from home/therapeutic temporary leave if the facility has billed for home/therapeutic leave days and the resident still requires the services provided by the ICF/IID.

6. After a fifteen (15) day home/therapeutic temporary leave period has been exhausted, a new leave of absence for home/therapeutic temporary leave does not begin until the resident has returned to the ICF/IID for twenty-four (24) consecutive hours or longer.

D. The Division of Medicaid covers fifteen (15) consecutive days of inpatient hospital temporary leave per each absence for continuous acute care during an inpatient hospital stay.

1. The period of leave is determined by counting the first (1^{st}) day of leave as the calendar day the resident was admitted to an inpatient hospital for continuous acute care after leaving the ICF/IID.

2. There is no maximum number of inpatient hospital temporary leave days per each state

fiscal year.

3. Inpatient hospital temporary leave applies to acute care hospital stays in a licensed hospital including geriatric psychiatric units.

4. Inpatient hospital temporary leave does not apply if the resident is admitted for:

   a) Hospital observation stays,

   b) Medicare-only skilled nursing facility (SNF) stays, or

   c) Swing-bed stays.

5. After a fifteen (15) day inpatient hospital temporary leave period has been exhausted, a new leave of absence for acute hospitalization does not begin until the resident has returned to the ICF/IID for a period of twenty-four (24) consecutive hours or longer.

6. ICF/IIDs cannot refuse to readmit a resident from inpatient hospital temporary leave if the facility has billed for inpatient hospital leave days and the resident still requires the services provided by the ICF/IID.

7. The ICF/IID must reserve the resident's bed in anticipation of the resident's return and cannot fill the resident's bed with another resident during the covered period of inpatient hospital temporary leave.

8. If the resident is on inpatient hospital leave and has not been discharged, the ICF/IID is responsible for providing transportation for the return to the ICF/IID.

Source: 42 C.F.R. § 447.40; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised 05/01/2022; Revised eff. 08/01/2018 except for Miss Admin Code Part 207, Rule 3.7.C. revised to correspond with SPA 18-0005 (eff. 07/01/2018) eff. 08/01/2018. Revised eff. 08/01/2017.

Rule 3.8: Resident Personal Funds

A. The intermediate care facility for individuals with intellectual disabilities (ICF/IID) must, upon written authorization by the resident, and/or guardian or legal representative accept responsibility for holding, safeguarding and accounting for the resident's personal funds.

   1. The ICF/IID may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this rule remains with the ICF/IID.

   2. The ICF/IID must include any charges for this service in the ICF/IID's basic daily rate and cannot charge the resident.

B. Penalties may be assessed on any ICF/IID that fails to maintain an auditable system of accounting for residents' personal funds or has had repeated instances of noncompliance with federal regulations.

C. The ICF/IID must provide each resident and/or guardian or legal representative with a written statement at the time of admission that states the following:

1. All services provided by the ICF/IID, distinguishing between services are included in the ICF/IID's basic rate and those services that are not. The written statement must include the services that may be charged to the resident's personal funds and the amount of such charges.

2. There is no obligation for the resident to deposit funds with the ICF/IID.

3. The resident has the right to select how personal funds will be handled including the following rights to:

   a) Receive, retain, and manage his/her personal funds or have this done by a guardian or legal representative, if any,

   b) Apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,

   c) Designate, in writing, another person to act for the purpose of managing his or her personal funds except when the resident does not deposit funds with the ICF/IID, and

   d) Require the ICF/IID to hold, safeguard and account for resident personal funds under a system established and maintained by the ICF/IID requested by the resident.

4. Any charge for this service is included in the ICF/IID's basic rate.

5. The ICF/IID may only accept a resident's personal funds to hold, safeguard and account when:

   a) Provided with written authorization by the resident and/or guardian or legal representative, or

   b) The ICF/IID is appointed as the resident's representative payee.

6. The ICF/IID is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a guardian or legal representative.

7. The ICF/IID must maintain a complete copy of its resident's personal funds policies and procedures and must make them accessible and available for review.

D. The ICF/IID must maintain current, written, individual records of all financial transactions involving the resident's personal funds which have been given for holding, safeguarding, and accounting.

1. The ICF/IID must act as fiduciary of the resident's personal funds and account for these funds in an auditable manner.

2. The ICF/IID must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. The Division of Medicaid requires the ICF/IID to employ proper bookkeeping techniques by which it can determine upon request all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of each resident's personal funds.

3. Resident fund records must:

a) Include the resident's name.

b) Identify the resident's representative, if any.

c) Include the resident's admission date.

d) Show the actual transaction date and amount of each deposit and withdrawal.

e) Reflect the actual date of an adjusting or correcting entry.

f) State the name of the person who accepted the withdrawn funds.

g) Show the balance after each transaction (i.e., maintain a running balance).

h) Provide the appropriate signatures for all disbursements of funds, such as:

(1) Resident's signature,

(2) Resident's mark, or "x" with two witnesses' signatures,

(3) Power of attorney's signature,

(4) Resident's responsible party when the amount disbursed is supported by appropriate documentation, or

(5) Two signatures of facility personnel when the amount disbursed is supported by appropriate documentation.

i) Document transaction with receipts indicating the purpose for which any withdrawn funds were spent. This restriction is applicable to all parties, other than the residents

and their powers of attorney, who have written authorization to withdraw funds from a resident's trust fund account. Applicable parties include, but are not limited to, responsible parties, facility personnel, representative payees, etc. The facility must reimburse the resident's account for any undocumented transactions.

j) For powers of attorney, the provider must maintain a copy of the power of attorney in the resident's file, and before the provider can allow withdrawals of funds based upon the power, the provider must ensure that the power contains language sufficient to allow the holder to withdraw funds and expend them. This power is normally designated as a "General Power of Attorney" and not as a "Limited or Special" power.

k) Reflect the resident's earned interest, if any.

l) Be reconcilable, at all times, with the current bank statement and/or petty cash.

m) Not include as an outstanding item any check written on a resident's account that has not been cashed within one year of check date. Any check held as outstanding for 12 months or more should be reissued to the appropriate party or voided and credited to the appropriate resident's account. If the check was a refund for a discharged or deceased resident, the funds may be sent to the State Treasurer as unclaimed funds. For further information on Accounting Upon Death or Discharge of Resident refer to the Title 23 Administrative Code Part 207, Chapter 3 Rule 3.7 M., and

n) Be kept for at least five years after the resident's discharge or death.

E. Acceptable charges to resident personal funds include, but are not limited to, the following general categories and examples, if properly authorized and documented as specified in Miss. Admin. Code Rule 3.8.D. is provided. The ICF/IID must notify the resident in advance of charges for non-Medicaid covered items and services, including, but not limited to:

1. Personal communication/entertainment items and services, including, but not limited to, telephone, television, radio, and computer.

2. Personal comfort items, including, but not limited to, tobacco, novelties, and candy.

3. Items and services in excess of those included in the Medicaid per diem rate, including, but not limited to, grooming or cosmetic items requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services.

4. Personal clothing.

5. Personal reading material.

6. Gifts purchased on behalf of the resident.

7. Flowers and plants for the resident's room.

8. Entertainment and social events included in the Medicaid per diem rate.

9. Private sitters or aides.

10. Private room, unless the private room is medically necessary including, but not limited to, isolation for infection control.

11. Specially prepared or alternative food requested instead of, or in addition to, the food generally prepared by the ICF/IID.

12. Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.

F. Unacceptable charges to resident's personal funds include, but are not limited to:

1. Any charge not:

a) Authorized by the resident and/or guardian or legal representative, or

b) Documented.

2. Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.

3. Medically necessary items and services reimbursed as part of the Medicaid per diem rate.

a) Any properly made charge for equipment or services including, but not limited to, geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services must be supported by a written statement from the resident's physician that documents the item or service was not medically necessary.

b) Failure to maintain the physician's denial of medical necessity statement may result in the ICF/IID's reimbursement of charges to a resident's account.

4. Transportation.

5. Any item or service requiring a waiver of the resident's personal needs allowance, including, but not limited to, repayment of a debt owed to the ICF/IID. The personal needs allowance may be used by an ICF/IID for ICF/IID costs only upon the written authorization of the resident and/or guardian or legal representative with the understanding that this action is voluntary and is not a requirement.

6. Loans or collateral for loans to anyone, including the ICF/IID, and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.

7. Transfers or gifts of money not authorized by the resident and/or guardian or legal representative including, but not limited to, the resident's guardian or legal representative transferring funds without documentation that the funds were used for the benefit of the resident.

8. Any item or service as a condition of admission or continued stay.

G. The ICF/IID must provide each resident and/or guardian or legal representative reasonable access to his/her own financial records.

1. The ICF/IID must provide a written financial statement, at least quarterly, to each resident and/or guardian or legal representative.

2. The quarterly financial statement must reflect any resident's personal funds which the ICF/IID has deposited in an interest bearing or a non-interest bearing account, as well as any resident personal funds held by the ICF/IID in a petty cash account.

H. The ICF/IID must keep any funds received from a resident for holding, safeguarding and accounting separate from the ICF/IID's funds and from the funds of any person other than another resident in that ICF/IID.

1. The ICF/IID cannot open any additional accounts within the trust fund account, including donation accounts or miscellaneous accounts.

2. Only funds of the ICF/IID's residents may be maintained as part of the resident's personal funds account.

I. The ICF/IID must deposit any resident's personal funds in excess of fifty ($50.00) dollars into an interest-bearing account(s) separate from any of the ICF/IID's operating accounts.

1. The ICF/IID must credit all interest earned on such separate account(s) in one of the following ways, at the election of the ICF/IID:

a) Prorated to each resident's personal funds account on an actual interest-earned basis, or

b) Prorated to each resident's personal funds account on the basis of its end-of-quarter balance.

2. The ICF/IID must maintain a resident's personal funds that do not exceed fifty dollars ($50.00) in a non-interest bearing account, an interest bearing account or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars ($50.00) or less in a pooled account with all other resident's personal funds, and interest is accumulated based on the total amount of funds in the trust fund account, all residents must be allocated interest proportionately.

3. The ICF/IID must neither limit nor restrict any resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars ($50.00). An ICF/IID must not establish policy that conflicts with the absolute right of residents for the ICF/IID to hold, safeguard, manage, and account for all residents' funds deposited with the ICF/IID.

J. The residents must have access to funds daily during normal business hours and for some reasonable time of at least two (2) hours on Saturday and Sunday. The ICF/IID must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, guardian, or legal representative all funds remaining that the ICF/IID has received for holding, safeguarding, and accounting in a petty cash fund.

K. For a resident's personal funds that the ICF/IID has received and are deposited in an account outside the ICF/IID, the ICF/IID, upon request, must within five (5) business days return to the resident, guardian, or legal representative, any or all of those funds.

L. Upon sale of the ICF/IID or other transfer of ownership, the ICF/IID must provide the new owner with a written account, prepared by a certified public accountant in accordance with the American Institute of Certified Public Accountants' Generally Accepted Accounting Principles, of all resident personal funds being transferred and obtain a written receipt for those funds from the new owner.

1. The ICF/IID must give each resident, guardian, or legal representative a written accounting of any resident's personal funds held by the ICF/IID before any transfer of ownership occurs.

2. In the event of a disagreement with the accounting provided by the ICF/IID, the resident retains all rights and remedies provided under state law.

3. An ICF/IID cannot require a family member or other individual to sign a financial responsibility statement for a Medicaid resident. In instances where a Medicaid beneficiary has no family member or individual available for such signatures, it is clearly discriminatory for a Medicaid provider to refuse admission to the resident.

M. Accounting Upon Death or Discharge of Resident

1. The ICF/IID must, within thirty (30) days of a resident's death or discharge, convey the resident's l funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. If the deceased resident's estate has no executor or administrator, the ICF/IID must convey the resident's funds and provide a final accounting to the:

a) Resident's next of kin,

b) Resident's representative, or

c) Clerk of the probate court of the county in which the resident died.

2. Disposition of Funds for Deceased Resident Who Dies Intestate Within a Long-Term Care Facility

   a) Any Medicaid beneficiary receiving medical assistance for services provided in a long-term care facility who dies intestate and leaves no known heirs shall have deemed, through acceptance of such medical assistance, the Division of Medicaid as the beneficiary of funds in his/her possession at the time of death, in an amount not to exceed two hundred fifty dollars ($250.00). The Division of Medicaid is the beneficiary of these funds regardless of whether a claim is later made to the beneficiary's property in accordance with Miss. Code Ann. § 43-13-120(3) and (4).

   b) The long-term care facility shall make a report to the State Treasurer of all funds, including any accrued interest, in the possession of the Medicaid beneficiary at the time of death. The report of such funds shall be on a form prescribed or approved by the State Treasurer and shall include the name of the deceased Medicaid beneficiary and his/her last known address prior to entering the facility, the name and last known address of each person who may possess an interest in such funds, and any other information which the State Treasurer prescribes by regulation. This report must be filed with the State Treasurer, with a copy to the Division of Medicaid, prior to November 1 of the year in which the facility provided services to the Medicaid beneficiary having funds to which this section applies.

   c) Within one hundred twenty (120) days from November 1 of each year in which a report is made, the State Treasurer shall cause notice to be published in the newspaper in accordance with Miss. Code Ann. § 43-13-120(3). The Division of Medicaid shall pay the cost of publishing the notice.

   d) The long-term care facility that makes a report of funds of a deceased Medicaid beneficiary shall pay over and deliver such funds, including any accrued interest, to the State Treasurer not later than ten (10) days after notice of such funds has been published by the State Treasurer.

   e) If within ninety (90) days of the State Treasurer's publication no claims are made to the funds in excess of the two hundred fifty dollars ($250.00) the Division of Medicaid has already received pursuant to 2.a) above, the State Treasurer shall place those funds in a special account in the State Treasury to the credit of the Division of Medicaid.

3. Disposition of funds for deceased residents who die intestate in a state institution is as follows:

   a) Miss. Admin. Code Part 207, Rule 3.8.M.2., shall not be applicable for residents of any state institution.

   b) The funds of any resident in a state institution who dies intestate and without known

heirs may be deposited in the ICF/IID's operational account, after a period of one (1) year from the date of death.

N. The ICF/IID must purchase a surety bond or otherwise provide assurance as to all personal funds of residents deposited with the ICF/IID.

1. The Division of Medicaid defines a surety bond as an agreement between the principal, which is the ICF/IID, the surety, which is the insurance company, and the obligee, who is the resident(s) or the residents participating in the trust fund, wherein the ICF/IID and the insurance company agree to compensate the resident for any loss of residents' personal funds that the ICF/IID holds, safeguards, manages and for which the ICF/IID accounts. The purpose of the surety bond is to guarantee that the ICF/IID will pay the resident for losses occurring for any failure by the ICF/IID to hold, safeguard, manage, and account for the residents' personal funds, that is, losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.

2. Unlike other types of insurance, the surety bond protects the obligee, or the residents of the trust fund, not the principal, from loss. The surety bond differs from a fidelity bond, sometimes called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.

3. The surety bond is the commitment of the ICF/IID to meet the standard of conduct.

   a) The ICF/IID assumes the responsibility to compensate the obligee, or the residents of the trust fund, for the amount of the loss up to the entire amount of the surety bond.

   b) The surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident personal funds held on deposit.

   c) A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at the ICF/IID and available for inspection.

4. Any reasonable alternative to a surety bond must:

   a) Designate the obligee, or the residents, individually or in aggregate, who can collect in case of a loss,

   b) Specify that the obligee may collect due to any failure by the ICF/IID, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and

   c) Be managed by a third party unrelated in any way to the ICF/IID or its management.

5. The ICF/IID cannot be named as an obligee.

a) Self-insurance is not an acceptable alternative to a surety bond. Funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.

b) If a corporation has a surety bond that covers all of its facilities, the corporation surety bond must be sufficient to ensure that all of the corporation's facilities are covered against any losses due to acts or errors by the corporation, its agents, or any of its facilities. The intent is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.

O. If a resident is incapable of managing personal funds and has no representative, the ICF/IID must refer the patient to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.

1. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA and the actual appointment of a guardian or representative payee, the ICF/IID must serve as temporary representative payee for the resident.

2. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source cannot be commingled with ICF/IID funds prior to those funds being transferred to the trust account.

P. The ICF/IID must maintain a current, written record for each resident that includes written receipt for all personal possessions deposited with the ICF/IID by the resident. The property record must be available to the resident.

Q. The ICF/IID must notify each resident receiving medical assistance under Title XIX, Medicaid, when the amount in the resident's account reaches two hundred dollars ($200.00) less than the supplemental security income (SSI) resource limit and five hundred dollars ($500.00) less than the Medicaid resource limit to remain eligible for Medicaid long-term care benefits.

1. The notice must include the fact that if the amount in the account, in addition to the value of the resident's other non-exempt resources, reaches the applicable resource limits; the resident may lose eligibility for such medical assistance or SSI.

2. The ICF/IID must issue written notification to the Medicaid Regional Office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the applicable resource limit.

R. The Division of Medicaid defines:

1. The basic rate as the standard or per diem rate Medicaid pays the ICF/IID per Medicaid resident per day, as established periodically from cost reports. The basic rate is important in the discussion of resident personal funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in writing at the time of admission, of the items and services provided by the ICF/IID as well as the items and services not included in the basic rate; and the amount of such charges that may be charged to the resident.

2. The book balance as the total balance of all resident personal funds and petty cash held according to the accounting ledger.

3. Census as the total number of residents in an ICF/IID.

4. Compliance with The Omnibus Budget Reconciliation Act (OBRA) of 1987 as requiring an ICF/IID to establish and maintain a system that fully and completely accounts for the resident's personal funds managed by the provider.

5. Exception as any item or area selected for review that does not meet the regulatory standards. Finding and exception are used interchangeably for resident trust fund review purposes.

6. Fiduciary as having rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident personal funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting.

7. Fiscal Agent as the agency under contract with the Division of Medicaid for the purpose of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.

8. Generally Accepted Accounting Principles (GAAP) as guidelines for proper accounting practices codified by the Financial Accounting Standards Board which includes proper bookkeeping techniques by which the ICF/IID can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident and the amount of each individual resident's fund balance.

9. Intestate as without a valid will at the time of death.

10. Legal guardian, legal representative, or conservator as a person(s) appointed by the court of jurisdiction to manage the resident's income and assets in the best interest of the resident. The court may require a court order prior to disbursements of the resident's personal funds, and/or a periodic accounting to the court to document income and disbursements. A legal

guardian, legal representative or conservator must supply documentation to the ICF/IID for disbursements from the resident fund, just as any other responsible party for any other resident.

11. Medicaid income as the maximum liability that the resident owes to the ICF/IID each month for room and board.

12. Medically necessary items and services as those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the ICF/IID's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary and therefore justifiable as an expenditure of the resident's personal funds.

13. Obligee as the residents of the trust fund, the party to whom the ICF/IID is legally or morally bound. The obligee is the beneficiary of funds, collected in the event of the failure of the ICF/IID to hold, safeguard, manage, and account for the residents' personal funds.

14. Per Diem Rate - Refer to Miss. Admin. Code Part 207, Rule 3.8.R.1.

15. Personal needs allowance (PNA) as the amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.

16. Plan of Correction as an acceptable plan that must address each exception noted in the findings letter and include the following:

    a) Documentation that the exception has been corrected,

    b) Measures that have been put in place to ensure that the exception will not be repeated, and

    c) Measures that have been put in place to monitor the continued effectiveness of the changes.

17. Reconciliation as the total of the residents' personal funds held, as noted from the bank's current statement of the balance and any cash held at the ICF/IID, equaling the total of the resident's personal funds as noted from the ICF/IID's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.

18. Representative payee as someone designated by the resident to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. An ICF/IID must be willing to be designated as a temporary representative payee if no guardian or legal representative is available to represent the resident.

19. Resident's personal funds as all of a resident's money on deposit with the facility, including all of the resident's personal funds, regardless of the source.

20. Resource limit as the maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit are the two resource limits to be considered.

21. Trust Fund Authorization as the documentation the resident and/or guardian or legal representative signs appointing an individual to assist the resident in managing his/her personal funds maintained within the resident trust fund account. Any withdrawal of funds by this appointed individual must be for the benefit of the resident, must be signed for, and supported by appropriate documentation such as a receipt or invoice.

22. State institutions as facilities owned and operated by the State.

23. Testate as having a valid will at the time of death.

24. Trial balance as a listing of all residents participating in the resident personal fund account with the balance of each resident's personal fund.

25. Written authorization as authorization to establish a resident personal fund in the form of a written statement signed by the resident and/or guardian or legal representative. In addition, authorization to perform a specific funds transaction for the resident must be in writing and/or documented with a receipt of purchase.

Source: 42 U.S.C. § 1396r; 42 C.F.R. §§ 431.53, 447.15, 483.420; Miss. Code Ann. §§ 43-13-120, 43-13-121.

History: Revised eff. 05/01/2022; Revised eff. 09/01/2018; Revised eff. 12/01/2017; Revised eff. 08/01/2017.

Part 207 Chapter 4: Psychiatric Residential Treatment Facility

Rule 4.6: Reimbursement

A. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities.

1. All cost reports are due by the end of the fifth (5^{th}) calendar month following the reporting period.

2. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars ($50.00) per day and may result in the termination of the provider agreement.

B. The Division of Medicaid uses a prospective method of reimbursement. Effective as of July 1, 2021 all rates and/or fees for items and services will remain the same as those in effect July 1, 2021, with no adjustments except for amended desk reviews or audits affecting the rates calculated effective prior to July 1, 2021.

1. The rates are determined from cost report data.

2. Standard rates are determined annually with an effective date of January first (1st).

3. In no case may the reimbursement rate for services provided exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

4. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations when authorized by the state legislature.

5. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or to correct errors when authorized by the state legislature.

    a) These revisions may result from amended cost reports, field visit reviews, or other corrections.

    b) Facilities are notified in writing of amounts due to or from the Division of Medicaid as a result of these adjustments.

    c) There is no time limit for requesting settlement of these amounts. This is applicable to claims for dates of service since July 1, 1993.

C. The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities, including nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. Adjustments will be made as necessary to the reviewed cost reports based on the results of the reviews.

D. Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

1. Providers must maintain adequate documentation including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid

program.

a) The cost report must be based on the documentation maintained by the facility.

b) All non-governmental facilities must file cost reports based on the accrual method of accounting.

c) Governmental facilities have the option to use the cash basis of accounting for reporting.

2. Documentation of financial and statistical data should be maintained in a consistent manner from one period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.

3. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance.

a) These records must be made available as requested by the Division of Medicaid.

b) All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

E. Services and charges include the following:

1. The facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for the provision of services under the State Medicaid Plan.

2. While the facility may set their basic per diem charge for non-Medicaid residents at any level, the services covered by that charge must be identical to the services provided to Medicaid residents and covered by the Medicaid per diem rate.

3. Any items and services available in the facility that are not covered under Title XVIII or the facility's basic per diem rate or charge must be available and priced identically for all residents in the facility.

F. Medicaid allows payment for the date of admission to the PRTF. Medicaid does not cover the date of discharge from the facility. A Medicaid-eligible beneficiary cannot be charged for the date of discharge. If a beneficiary is discharged on the date of admission, the day is covered as the date of admission.

G. Private room coverage by Medicaid is as follows:

1. The overall average cost per day determined from the cost report includes the cost of

private rooms.

2. The average cost per day is used to compute PRTF reimbursement rates. Therefore, the cost of a private room is included in the reimbursement rate and no extra charge can be made to the beneficiary, his/her family or the Medicaid program.

3. Medicaid reimbursement is considered as payment in full for the beneficiary.

H. The following rules apply to hospital leave:

1. A fifteen (15) day length of stay is allowed in a non-psychiatric unit of a hospital. The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed cannot be filled with another resident during the covered period of hospital leave.

2. A resident must be discharged from the facility if he/she remains in the hospital for over fifteen (15) days. A leave of absence for hospitalization is broken if the resident returns to the facility for twenty-four (24) hours.

3. Facilities cannot refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires PRTF services.

4. If the resident is on inpatient hospital leave and has not been discharged, the PRTF is responsible for providing transportation for the return to the PRTF.

I. If a resident elopes from the facility and remains absent for twenty-four (24) hours or longer, he/she must be discharged from the facility. If further treatment at the same facility is desired after the end of the twenty-four (24) hours, the child/adolescent must go through a readmission process.

J. The following rules apply to therapeutic leave:

1. An absence from the facility for eight (8) hours or more within one calendar day constitutes a leave day.

2. Medicaid coverage of therapeutic leave days per fiscal year, July 1 – June 30, is eighteen (18) days for a PRTF.

3. Each therapeutic leave day taken each month must be reported on the billing mechanism.

4. The attending physician must approve all therapeutic leave days. Documentation must include goals to be achieved during the leave, the duration of leave, who participated in the leave, and the outcome of the leave.

K. Payment during therapeutic leave from the facility is as follows:

1. A temporary absence of a resident from a PRTF does not interrupt the monthly payments

to the facility under the provisions as outlined in Part 207, Chapter 4 Rule 4.6 J.

2. Each facility is required to maintain leave records and indicate periods of therapeutic leave days.

3. Before a resident departs on therapeutic leave, the facility must provide each resident and family member or legal representative written information explaining leave policies. The information must define the period of time the resident is permitted to return and resume residence in the facility.

4. A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

L. The PRTF must provide non-emergency transportation.

The PRTF cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. PRTFs may use NET providers that also provide NET services for the NET Broker if:

1) The facility arranges the transportation, and

2) Pays the NET provider directly.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121, 42 CFR § 447 Subparts B & C, Miss. Code Ann. § 43-13-117, 42 CFR § 447.15.

History: Revised eff. 05/01/2022; Revised eff. 07/01/2021; Added Miss. Admin. Code Rule 4.6.L. eff. 09/01/2018.