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.

   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.

   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.

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 to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; 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 2.10: Case Mix Reimbursement and Case Mix Review

A. The Division of Medicaid utilizes a resource utilization grouper-version 4 (RUG-IV) forty-eight (48) group model for case mix calculation for reimbursement.

1. Each of the forty-eight (48) resident classifications as well as the default classification is assigned case mix weights.

2. The classifications are calculated electronically using the minimum data set (MDS) assessment data and the RUG-IV calculation program.

B. Clinical documentation must be maintained in the clinical record which supports the MDS 3.0 assessment and substantiates the resources and services needed to provide care to the resident.

1. Review results are based only on the supporting original clinical documentation available and presented during the review.

2. No additional original clinical documentation will be accepted after the exit conference.

C. Documentation for case mix reimbursement must adhere to the Division of Medicaid's Supportive Documentation Requirements.

D. In addition to the clinical documentation review, the case mix review process includes a review of the facilities' official bed hold record which includes therapeutic and hospital leave records.

Source: 42 C.F.R. § 483.75; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; Revised eff. 07/01/2021; Revised eff. 04/01/2017. Revised to correspond to SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.15: Ventilator Dependent Care

A. The Division of Medicaid defines ventilator dependent care (VDC) as mechanical ventilation for life support designed to replace and/or support normal ventilatory lung function.

B. Effective January 1, 2015, the Division of Medicaid provides an established reimbursement per diem rate in addition to the standard per diem rate to Mississippi nursing facilities, excluding out-of-state nursing facilities and Nursing Facilities for the Severely Disabled (NF-SD), for residents requiring VDC services. Effective January 1, 2015, Mississippi nursing facilities will receive the following reimbursement for a ventilator dependent resident:

    1. A standard per diem, and

    2. A ventilator per diem.

C. Mississippi nursing facilities providing VDC services must file a VDC Addendum to its current provider agreement and it must be approved by the Division of Medicaid.

    1. The VDC Addendum must include required attestations regarding the nursing facility requirements consistent with Miss. Admin. Code Part 207, Rule 2.15 including, but not limited to:

        a) Number of beds designated to serve ventilator dependent residents,

        b) Required equipment,

        c) Staffing ratios for the VDC resident(s), and

        d) Documentation of a formal relationship between the nursing facility and a local hospital for the emergency care of all ventilator dependent residents.

    2. The Division of Medicaid reserves the right to approve VDC Addendums at its discretion based on:

        a) Geographic coverage,

        b) Market saturation, and/or

        c) The ability of the nursing facility to demonstrate compliance with certification requirements.

    3. The approval of the VDC Addendum is dependent upon:

        a) Successful completion of the VDC Addendum and submission of required documents,

        b) Establishment of policies to support the operations of VDC services,

c) Successful completion of an on-site visit by Mississippi State Department of Health (MSDH), Health Facilities Licensure and Certification (HFLC), and

d) The nursing facility's completion of all other required documents applicable to providing VDC services as requested by HFLC or the Division of Medicaid.

4. The Division of Medicaid will close a VDC Addendum if the provider fails to submit any requested information or documentation within thirty (30) days of a request by the Division of Medicaid. Once closed, a provider is not eligible to re-apply for three (3) months.

D. The Division of Medicaid reserves the right to terminate a nursing facility's provider agreement, including the VDC Addendum, based on failure to comply with Administrative Code requirements and/or state licensure and federal requirements.

1. Upon receipt of a termination notice, the nursing facility has ten (10) days to submit a transfer plan for each resident which fully addresses their medical, social, and safety support needs in anticipation of and throughout the transfer process.

2. Upon the Division of Medicaid's approval of the transfer plan, all transfers resulting from the termination of the provider agreement must be completed within thirty (30) days from the date of the termination notice.

3. Providers notified of termination may appeal this decision pursuant to Miss. Admin. Code Part 300.

4. The Division of Medicaid reserves the right to enforce an immediate transfer of ventilator dependent residents if the nursing facility's compliance failure is so egregious in nature that a resident's safety is threatened.

5. Once terminated, the provider may not reapply to provide VDC services for one (1) year from the date of termination.

E. Nursing facilities providing services to ventilator dependent residents must:

1. Meet all federal and state regulations governing nursing facilities.

2. Provide residents in need of VDC services with the following licensed staff which cannot be included as part of the HFLC nursing facility state minimum staffing requirements:

a) One (1) registered nurse (RN) assigned the primary responsibility for the VDC services and ventilator dependent residents twenty-four (24) hours a day seven (7) days a week in addition to:

1) One (1) RN for every ten (10) ventilator dependent residents (1:10),

2) One (1) RN and one (1) licensed practical nurse (LPN) for every eleven (11) to fourteen (14) ventilator dependent residents, and

3) Two (2) RNs for every fifteen (15) to twenty (20) ventilator dependent residents.

b) One (1) in-house licensed respiratory therapist (RT) twenty-four (24) hours a day seven (7) days a week with a ratio of one (1) RT for every ten (10) ventilator dependent residents (1:10).

3. Must maintain separate staffing records for the nursing staff and respiratory staff responsible for the ventilator dependent residents.

4. Ensure physician visits are conducted in accordance with the federal and state regulations for nursing facilities.

5. Must provide adequate equipment and supplies for the provision of VDC services including, but not limited to:

a) Primary ventilators,

b) Back up ventilators,

c) Emergency batteries,

d) Oxygen tanks,

e) Suction machines,

f) Nebulizers,

g) Manual resuscitator,

h) Pulse oximetry monitoring equipment,

i) Nutrient infusion pumps, and

j) Any medically necessary durable medical equipment (DME) and supplies.

6. Must have an audible, redundant external alarm system located outside the resident's room to alert of ventilator failure.

7. Must have written policies and procedures for ventilator dependent residents including, but not limited to:

a) Ventilator monitoring expectations,

b) Routine maintenance of ventilator equipment,

c) Specific staff training related to ventilator care and operation,

d) Staffing requirements,

e) Infection control program for:

1) Ventilator dependent residents, to include:

(a) Actions to investigate, control, and prevent infections,

(b) Isolation procedures,

(c) Standard precautions,

2) Maintenance and care requirements of equipment and disposal of supplies.

8. Place individuals admitted with any contagious diagnoses related to a respiratory illness in isolation according to the Centers for Disease Control (CDC) and requirements under 42 C.F.R. § 483.65.

9. Provide staff education and in-service training to direct and indirect care staff.

a) Required training must be completed prior to the provision of care, including infection control procedures and addressing the needs of a ventilator dependent resident.

b) Required training must be conducted annually to all staff provided by a:

1) Licensed RT, or

2) Board certified pulmonologist.

c) Additional training of nursing staff is required to be conducted by a full-time RN who has completed documented training in the care of ventilator dependent individuals by an RT or a board certified pulmonologist. This RN will be responsible for:

1) Quarterly and on-going training to all VDC nursing staff as evidenced by documentation.

2) Providing initial in-service training for ten (10) work days to all direct care and indirect care staff assuring they are competent to care for VDC residents.

10. Ensure the nursing facility's Emergency Plan includes:

a) Provisions for continuous operation of ventilator equipment during power outages and/or ventilator equipment failure, and

b) A revised Emergency Operations Plan approved by the MSDH Office of Emergency Planning and Response which includes the VDC services.

11. Execute a written agreement with a local acute care hospital:

a) Located within twenty (20) miles or thirty (30) minutes of an Emergency Department with the capability to treat emergencies for beneficiaries with ventilator dependency.

b) With provisions for twenty-four (24) hour access to VDC services.

c) Documenting a formal relationship between the nursing facility and a local acute care hospital that confirms the ability and willingness of the hospital to serve the acute care needs of residents requiring mechanical ventilation:

1) On an as-needed basis, and

2) In emergency situations when the entire VDC population of the unit/ventilator dependent residents must be temporarily transferred to the hospital.

3) The agreement should outline transfer logistics and financial responsibilities.

F. Residents in a nursing facility receiving VDC services must:

1. Have long-term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.

2. Be dependent on mechanical ventilation via a tracheostomy for at least fifty percent (50%) of each day or continuous mechanical ventilation via a tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process.

3. Require daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.

4. Be medically stable and not require acute care services prior to the transfer to the nursing facility.

5. Be prior authorized by the Division of Medicaid or the Utilization Management/Quality Improvement Organization (UM/QIO) for admission and recertified as required by the Division of Medicaid or UM/QIO to determine if the resident's medical condition warrants VDC services.

a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid or UM/QIO.

b) The resident is considered appropriate for VDC services until the weaning process is completed.

G. The Division of Medicaid does not cover admissions as a VDC resident for those who only require continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP).

H. The Division of Medicaid approves out-of-state nursing facility placements for ventilator dependent beneficiaries when all the following are met:

1. The nursing facility is a Mississippi Medicaid Provider,

2. All efforts for in-state placement are exhausted,

3. The transferring facility provides documentation of denial statements from Mississippi nursing facilities unable to care for the beneficiary or there are no nursing facilities beds available in Mississippi to treat VDC residents.

4. The needs of the ventilator dependent beneficiary cannot be met in the state of Mississippi.

5. The Division of Medicaid must prior authorize for medical necessity and approval must be obtained from the Executive Director,

6. The beneficiary is:

a) Mississippi Medicaid eligible.

b) Eligible for long-term care placement.

c) Ventilator dependent and meets all the following requirements:

1) The Division of Medicaid does not cover admission or recertification as a VDC resident for those who only require CPAP or BiPAP.

2) Medically stable and not require acute care services prior to the transfer to the nursing facility.

3) Has long-term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.

4) Requires daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.

5) Be dependent on mechanical ventilation via a tracheostomy of at least fifty percent (50%) of each day or continuous mechanical ventilation via a tracheostomy for at

least six (6) hours each day while in need of VDC services except during the weaning process.

6) Be prior authorized by the Division of Medicaid for admission and recertified as required by the Division of Medicaid to determine if the resident's medical condition warrants VDC services.

(a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid.

(b) The resident is considered appropriate for VDC services until the weaning process is completed.

7. Completion of an admission assessment as required by federal and state regulations and/or the Division of Medicaid.

I. Beneficiaries admitted to an out-of-state nursing facility receiving reimbursement from Medicare must obtain approval from the Division of Medicaid prior to receiving Medicaid reimbursement.

J. The Division of Medicaid reimburses out-of-state nursing facilities the lesser of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for their classification; however, the rates may be negotiated. The negotiated rate for nursing facilities may not exceed the higher of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for nursing facilities, as case mix adjusted. The out-of-state facility must:

1. Provide an initial and quarterly Minimum Data Set (MDS) assessment for review,

2. Provide a desk audit to determine the category classification using the current calculation for reimbursement, and

3. Complete all required Omnibus Budget Reconciliation Act (OBRA) MDS assessments.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; Revised eff. 07/01/2021; Revised eff. 04/01/2017. Revised to correspond with SPA 15-004 (eff. 01/01/2015) eff. 01/02/2015.

Rule 2.16: Therapy Services

A. All nursing facilities are required to provide rehabilitation services for residents. Requirements include physical, occupational and speech-language pathology therapies. Medicaid, consistent with third party liability rules, is obligated to cover these services.

B. Prior authorization/pre-certification of certain physical, occupation, and speech-language

pathology services is required by the Division of Medicaid. Therapy providers must prior authorize services through the Utilization Management and Quality Improvement Organization (UM/QIO) for Medicaid. Failure to obtain prior authorization will result in denial of payment to billing providers.

C. The UM/QIO will determine medical necessity, the types of therapy services, and the number of visits/treatments reasonably necessary to treat the beneficiary's condition. A complete list of procedure codes that require prior authorization may be obtained through the UM/QIO. All procedures and criteria set forth by the UM/QIO are applicable and are approved by Medicaid.

D. Providers must also adhere to all Medicaid outpatient therapy rules.

E. Nursing Facility for the Severely Disabled - Miss. Admin. Code Part 207, Rule 2.16 is not applicable to a Nursing Facility for the Severely Disabled (NFSD). Therapy services for this provider type are inclusive in the per diem rate and cannot be billed separately.

F. Medicaid-Only Residents - Therapy services for Medicaid-only residents may be provided by state-licensed therapists who have a current Medicaid provider number. Nursing facilities may apply for a group therapy provider number for billing purposes.

G. Dually Eligible Residents - Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid dual eligibles. Therapists providing services to dually eligible beneficiaries must bill Medicare as the primary coverage. All therapy providers must meet state and federal requirements.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121, SPA 15-004.

History: Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; Revised eff. 07/01/2021.

Rule 2.17: Feeding Assistant Program

A. Feeding Assistant Reimbursement

1. The Division of Medicaid uses the direct reimbursement method for feeding assistant training expenses incurred by nursing facilities. Reasonable costs of training of feeding assistants in order to meet the requirements necessary for the feeding assistant to be certified and are to be billed directly to Medicaid. The nursing facility will be directly reimbursed by Medicaid for covered services and items as defined on the agency website. In order to receive Medicaid reimbursement, the training program must have approval from the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification.

2. Services and supplies approved for payment will be subject to application of the nursing

facility's percentage of Medicaid utilization. The Medicaid utilization percentages of every facility are redetermined annually and are applicable for one (1) state fiscal year. The Medicaid utilization percentages are taken from the most recent cost report at the time of redetermination. Nursing facilities and training centers are notified in writing of their Medicaid utilization percent. In cases where no cost report data is available, eighty (80) percent will be applied to approved billings until such time that the correct Medicaid utilization percent can be determined. Training centers' Medicaid utilization percentage will be redetermined annually and will be calculated based on the weighted average of Medicaid utilization percentages of associated facilities weighted by bed size.

3. The Division of Medicaid will reimburse the nursing facilities or related training centers for the minimum required services and supplies. A facility or training center will be reimbursed for no more than four (4) training sessions per year. No costs actually incurred by the facility or the training center will be considered for reimbursement, like for electricity, gas, or water. No reimbursements will be made for estimated cost. The cost of manuals approved for use by MSDH will be reimbursed.

4. Training programs refer to the training area set up within a nursing facility or training center. Training programs include, but are not limited to, training areas set up by a nursing facility in a remote location due to space restrictions and training centers where an area has been set up for training that serves more than one (1) facility and is located in an area remote from any of the associated facilities.

5. No reimbursement is available for training costs incurred by individuals or for tuition to outside entities.

B. Billing rules requirements for billing of training can be found on the agency website.

C. Withdrawal of Program Approval

1. The Mississippi State Department of Health (MSDH) will withdraw approval of a program if it is determined that any of the minimum requirements are not met by the program.

2. Upon withdrawal of approval, MSDH will notify the entity in writing and will explain the reason(s) for the withdrawal of the approval. Students who have started a program from which approval has been withdrawn must be allowed to complete the course.

3. MSDH will notify Medicaid in writing when program approval is withdrawn. As a result, reimbursement will be stopped as of the date of withdrawal of program approval. However, Medicaid will reimburse the allowable costs incurred to complete a training session which is in progress on the date of withdrawal of program approval.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; 42 CFR §483.158; 42 CFR § 483.160.

History: Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; Revised eff. 07/01/2021.

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

Rule 3.6: Reimbursement

A. Participating Mississippi intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) must prepare and submit a Long-term Care Medicaid cost report for reimbursement.

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.

1. The rates are calculated from cost report data.

2. The rates are calculated annually with an effective date of January first (1^{st}).

3. In no case may the reimbursement rate for services provided exceed an individual ICF/IID'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.

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

a) These revisions may result from amended cost reports, 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. This is applicable to claims for dates of service since July 1, 1993.

C. The Division of Medicaid conducts periodic cost report financial reviews of selected ICF/IIDs 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 ICF/IID 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 ICF/IID.

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

    c) Governmental ICF/IIDs 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 ICF/IID 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.

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

History: Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; Revised eff. 07/01/2021; 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.

1. The rates are determined from cost report data.

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

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.

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.

1. Effective February 1, 2019, 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:

a) The facility arranges the transportation, and

b) Pays the NET provider directly.

2. Prior to February 1, 2019, the PRTF must:

a) Arrange and pay for non-emergency transportation and place the cost on the cost report, or

b) Utilize the NET Broker to arrange non-emergency transportation for residents.

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 to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; Revised eff. 07/01/2021; Added Miss. Admin. Code Rule 4.6.L. eff. 09/01/2018.