

Table of Contents

State/Territory Name: Mississippi

State Plan Amendment (SPA) #: 19-0005

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303



Atlanta Regional Operations Group

March 26, 2019

Mr. Drew Snyder, Executive Director
Mississippi Division of Medicaid
Attention: Margaret Wilson
550 High Street, Suite 1000
Jackson, MS 39201-1399

Re: Mississippi State Plan Amendment, Transmittal # 19-0005

Dear Mr. Snyder:

We have reviewed the proposed Mississippi State Plan Amendment 19-0005, which was submitted to the Atlanta Regional Office on March 5, 2019. The SPA was submitted to allow the Mississippi Division of Medicaid to increase the number of home health visits from twenty-five (25) to thirty-six (36) visits per state fiscal year and to clarify the provider appeals process to include reconsideration prior to an administrative hearing request.

Based on the information provided, the Medicaid State Plan Amendment MS-19-0005 was approved on March 22, 2019. The effective date of this amendment is July 1, 2019. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Tandra Hodges at 404-562-7409 or by email at Tandra.Hodges@cms.hhs.gov.

Sincerely,

//s//

Shantrina D. Roberts, MSN
Deputy Director
Division of Medicaid Field Operations South

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 19-0005	2. STATE MS
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		4. PROPOSED EFFECTIVE DATE 07/01/2019
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		

5. TYPE OF PLAN MATERIAL (*Check One*):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION: 42 C.F.R. §§ 430.12, 440.70	7. FEDERAL BUDGET IMPACT: FFY 19: \$38,195 FFY 20: \$152,780
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Exhibit 7, Page 1 Attachment 4.19-B, Exhibit A, Page 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 3.1-A, Exhibit 7, Page 1 Attachment 4.19-B, Exhibit A, Page 3

10. SUBJECT OF AMENDMENT:

State Plan Amendment (SPA) 19-0005 Home Health Visit Increase is being submitted to allow the Division of Medicaid to increase the number of home health visits from twenty five (25) visits to thirty-six (36) visits per state fiscal year (SFY) and to clarify the provider appeals process to include reconsideration prior to an administrative hearing request, effective July 1, 2019.

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/	16. RETURN TO: Drew L. Snyder Miss. Division of Medicaid Attn: Margaret Wilson 550 High Street, Suite 1000 Jackson, MS 39201-1399
13. TYPED NAME: Drew L. Snyder	
14. TITLE: Executive Director	
15. DATE SUBMITTED: 3/05/2019	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03/05/19	18. DATE APPROVED: 03/22/19
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/19	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Shantrina D. Roberts	22. TITLE: Deputy Director

23. REMARKS:

State of Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF
MEDICAL CARE AND SERVICES PROVIDED

Home Health Services

The Division of Medicaid covers the following home health services:

1. Skilled Nursing Visit for intermittent or part-time nursing services provided by a registered nurse employed by a home health agency in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards or a registered nurse when no home health agency exists in the area. The registered nurse must be a graduate of an approved school of professional nursing, who is licensed as a registered nurse by the State in which they practice.
2. Home Health Aide Visit for personal care services provided directly by an aide employed by a home health agency and in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards. The home health aide must be an individual who has successfully completed a state-established or other home health aide training program approved by the State. Home Health aide services may be provided without a requirement for skilled nursing services and must be supervised by a registered nurse.

Home Health visits are limited to a combined total of thirty-six (36) visits per state fiscal year.

Home health services must be provided to a beneficiary at the beneficiary's place of residence defined as any setting in which normal life activities take place, other than:

1. A hospital,
2. Nursing facility,
3. Intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provide the home health service; or
4. Any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Home health services must be provided in accordance with the beneficiary's physician's orders as part of a written plan of care, which must be reviewed every sixty (60) days. The beneficiary's attending physician must document that a face-to-face encounter occurred no more than ninety (90) days before or thirty (30) days after the start of home health services. The face-to-face encounter must be related to the primary reason the beneficiary requires the home health service.

The home health agency providing home health services must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and comply with all

State of Mississippi

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

For those home health agencies not covered by the common audits agreement with Medicare intermediaries, the Office of Compliance and Financial Review of the Division of Medicaid shall be responsible for performance of field reviews and field audits. The Office of Reimbursement of the Division of Medicaid will be responsible for performance of desk reviews.

D. Retention

All audit reports received from Medicare intermediaries or issued by the Division of Medicaid will be retained for a period of at least five (5) years.

E. Overpayment

Overpayments as determined by desk review or audit will be reimbursable to the Division of Medicaid. All overpayments shall be reported to HHS as required.

F. Appeal Procedures – Desk Reviews

A provider who disagrees with the results of their original desk review may request a reconsideration. The request for reconsideration must be made in writing to the Division of Medicaid and must include the reason for the request and any supporting documentation, and must be made within thirty (30) calendar days after receipt of the notification of the desk review results. Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received, if by certified mail or overnight mail, on the day the delivery receipt is signed, or if by hand delivery, on the date delivered. The written request for reconsideration should include the provider's name, provider number, cost reporting period, and a detailed description of the adjustment(s) or issues to be reconsidered. If the provider does not request a reconsideration, the Division of Medicaid will consider the provider's nonresponse as acceptance of the final desk review results. Therefore, no administrative hearing request will be considered.

If the reconsideration is submitted on a timely basis and includes all required information, the Division of Medicaid will review the reconsideration request and respond to the provider within thirty (30) calendar days of the date of receipt of all the required information.

If the provider disagrees with the results of the reconsideration, the provider may request an administrative hearing by the Division of Medicaid as described in Miss. Admin. Code Part 300, within thirty (30) calendar days of the receipt date of the final reconsideration letter.

Unless a timely and proper request for an administrative hearing is received by the Division of Medicaid from the provider, the findings of the Division of Medicaid shall be considered a final and binding administrative determination. Any administrative hearing will be conducted in accordance with the procedures for administrative hearings as adopted by the Division of Medicaid.

G. Final Cost Reports

The final cost reports received from Medicare intermediaries will be used as received from the intermediary to adjust rates. Providers may not appeal to the Division of Medicaid regarding the results of final cost reports. Appeals should be made to the Medicare intermediary under the procedures established by the