NOTICE OF RULE ADOPTION—FINAL RULE

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

FILED
NOV 26 2008
MISSISSIPPI
SECRETARY OF STATE

Miss. Division of Medicaid
c/o Ginnie McCardle, Staff Officer
Walter Sillers Building
550 High Street
Suite 1000
Jackson, MS 39201-1399
(601) 359-6310
http://www.dom.state.ms.us

Specific Legal Authority Authorizing the promulgation of Rule: Miss Code Ann. §43-13-121(1972), as amended

Reference to Rules repealed, amended or suspended by the Proposed Rule :
MS State Plan Attachment 4.18-A, Page 1

Date Rule Proposed: October 6, 2008

Explanation of the Purpose of the Proposed Rule and the reason(s) for proposing the rule:
SPA2008-010 This amendment adds a co-payment amount of $3.00 per day for services provided in an Ambulatory Surgical Center. Section 43-13-117 (49) of the Mississippi Code Ann. (1972 as amended) authorizes the Division to establish co-payments for all Medicaid services for which co-payments are allowable under federal law or regulations; and, set the amount of the co-payment for each of those services at the maximum amount allowable under federal law or regulation.

The Agency Rule Making Record for this rule including any written comments received during the comment period and the record of any oral proceeding is available for public inspection by contacting the Agency at the above address.

☐ An oral proceeding was held on this rule:

Date:
Time:
Place:

☒ An oral proceeding was not held on this rule.

The Agency has considered the written comments and the presentations made in any oral proceedings, and

☒ This rule as adopted is without variance from the proposed rule.

☐ This rule as adopted differs from the proposed rule as there are minor editorial changes which affect the form rather than the substance of the rule.

☐ The rule as adopted differs from the proposed rule. The differences however are:
Within the scope of the matters in the Notice of Proposed Rule Adoption, the logical outgrowth of the contents of the Notice of Proposed Rule Adoption and the comments submitted in response thereto, and
The Notice of Proposed Rule Adoption provided fair warning that the outcome of the proposed rule adoption could be the rule in question.

The entire text of the Proposed Rule including the text of any rule being amended or changed is attached.

Effective Date of Rule: October 1, 2008

Executive Director
Signature and Title of Person Submitting Rule for Filing

STATE PLAN UNDER TITLE X1X OF THE SOCIAL SECURITY ACT
State: MISSISSIPPI

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905 (a) (1) through (5) and (7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Ambulance			X	$3.00 per trip
Ambulatory Surgical Center			X	$3.00 per vist
Dental Visits			X	$3.00 per visit
Durable Medical Equipment, orthotics, and prosthetics (excludes medical supplies)			X	Up to $3.00 per item (varies per State payment for each item)
Eyeglasses			X	$3.00 per pair
Home Health visits			X	$3.00 per visit
Hospital Inpatient Days			X	$10.00 per day up to one-half the hospital=s first day per diem per admission.
Hospital Outpatient visits			X	$3.00 per hospital outpatient visit
Physician Visits: office, home, emergency room, ophthalmological			X	$3.00 per visit
Prescription drugs			X	$3.00 per prescription, including refills
Rural Health Clinic visits, FQHC visits, and MSDH clinic visits			X	$3.00 per visit

When the average or typical State payments for the above services are taken into consideration, all copayments are computed at a level to maximize the effectiveness without causing undue hardship on the recipients, assuring that they do not exceed the maximum permitted under 42 CFR 447.54

The basis for determining the charge of each co-payment for all services except in-patient hospital was the standard co-payment amount described in 42 CFR Section 447.55. The maximum co-payment amount in 42 CFR Section 447.54 was applied to the agency's average or typical payment for the particular service. For in-patient hospital services, the amount was calculated so as not to exceed one-half the first day's per diem for each hospital per admission.

Providers are required by the agency's provider agreements and policy manuals to assume the responsibility for collecting the co-payment amounts from those beneficiaries who are required to pay co-payments. Providers are required to make the determination as to whether or not a Medicaid beneficiary is able to pay required co-payment amounts Providers are prohibited by the agency's provider agreements and policy manuals from denying services to Medicaid beneficiaries because of inability to pay the co-payment, in compliance with 42 CFR Section 447.15.

Providers are prohibited by the agency's provider agreements and policy manuals from charging co-payment amounts for those services and beneficiaries found in 42 CFR Section 447.53(b). Beneficiaries are educated regarding co-payment amounts and regarding those services and beneficiaries that are exempt from co-payments. The agency's claims payment system contains an edit that prohibits the reduction of the co-payment amount from an excluded service or beneficiary category.