FILED
JAN 26 2010
MISSISSIPPI
SECRETARY OF STATE

NOTICE OF PROPOSED RULE ADOPTION

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

Miss. Division of Medicaid
c/o Ginnie McCardle, Spec. Proj. Officer
Walter Sillers Building
550 High St.
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Reference to Rules repealed, amended or suspended by the Proposed Rule :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 4.19-B, Page 21

Explanation of the Purpose of the Proposed Rule and the reason(s) for proposing the rule:
SPA2010-001 This State Plan Amendment is being filed in order for the Division of Medicaid to comply with Miss. Code Ann. §43-13-117 (39). This requires "From on and after July 1, 2009, the Division shall reimburse crossover claims for inpatient hospital services and crossover claims covered under Medicare Part B in the same manner that was in effect on January 1, 2008, unless specifically authorized by the Legislature to change this method." In addition, the SPA is updated to define how the agency is reimbursing all other crossover claims. This filing is compliant with the filing time-line requirement in accordance to Miss Code 25.43.3113.

This rule is proposed as a ☒Final Rule, and/or a ☒ Temporary Rule (Check one or both boxers as applicable.)

Persons may present their views on the proposed rule by addressing written comments to the agency at the above address. Persons making comments should include their name and address, as well as other contact information, and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

Oral Proceeding: Check one box below:

☐An oral proceeding is scheduled on this rule on Date: Time:
Place:

If you wish to be heard and present evidence at the oral proceeding you must make a written request to the agency at the above address at least _____ day(s) prior to the proceeding to be placed on the agenda. The request should include your name, address, telephone number as well as other contact information; and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

☒ An oral proceeding is not scheduled on this rule. Where an oral proceeding is not scheduled, an oral proceeding will be held if a written request for an oral proceeding is submitted by a political subdivision, an agency or ten (10) persons. The written request should be submitted to the agency contact person at the above address within twenty (20) days after the filing of this notice of proposed rule adoption and should include the name, address and telephone number of the person(s) making the request; and if you are an agent or attorney, the name, address and telephone number of the party or parties you represent.

Economic Impact Statement: Check one box below:

☐The agency has determined that an economic impact statement is not required for this rule, or

☒The concise summary of the economic impact statement required is attached.

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

Date Rule Proposed: January 26, 2010

Proposed Effective Date of Rule: July 1, 2009

Executive Director
Signature and Title of Person Submitting Rule for Filing

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Mississippi

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

Item 1. Payment of Title XVIII Part A and Part B Deductible/ Coinsurance

The Medicaid agency uses the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/ QMB Individual	Medicare-QMB Individual
Part A Deductible Inpatient Hospital	___ limited to State Plan rates _X_ full amount	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount
Part A Coinsurance Inpatient Hospital	___ limited to State plan rates _X_ full amount	___limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount
Part A Deductible Nursing Facility Hospice Home Health	_X_ limited to State plan rates* ___ full amount	_X_ limited to State plan rates ___ full amount	_X_ limited to State plan rates ___ full amount
Part A Coinsurance Nursing Facility Hospice Home Health	_X_ limited to State plan rates* __ full amount	_X_ limited to State plan rates ___ full amount	_X_ limited to State plan rates ___ full amount
Part B Deductible	__ limited to State plan rates _X_ full amount	__ limited to State plan rates _X_ full amount	__ limited to State plan rates _X_ full amount
Part B Coinsurance	__ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount

*The Medicaid agency will not reimburse for services that are not covered under the Medicaid State Plan.