

State of Mississippi

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

b. Optometrists' services.

Provided: No limitations With limitations*

Not Provided

c. Chiropractor's services.

Provided: No limitations With limitations

Not provided.

d. Other practitioners' services.

Provided: Identified on attached sheet with description of limitations, if any.

Not provided.

7. Home health services.

- a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: No limitations With limitations*

- b. Home health aide services provided by a home health agency.

Provided: No limitations With limitations*

- c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities except when the facility is not required to provide the home health service, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Provided: No limitations With limitations*

*Description provided on attachment.

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- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided: No limitations With limitations*

Not provided.

8. Private duty nursing services.

Provided: No limitations With limitations*

Not provided.

*Description provided on attachment.

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Home Health Services

The Division of Medicaid covers the following home health services, limited to a combined total of twenty-five (25) visits per state fiscal year:

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 home health aide 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 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

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applicable state and federal laws and requirements.

The Division of Medicaid covers medical supplies, equipment, and appliances prescribed by a physician and prior authorized as specified by the Division of Medicaid. Medical supplies, equipment, and appliances may be provided regardless of whether a beneficiary is receiving services from a home health agency.

For the initial ordering of certain medical equipment the prescribing physician or allowed non-physician practitioner must document that a face-to-face encounter occurred no more than six (6) months prior to the start of services. The face-to-face encounter must be related to the primary reason the beneficiary requires the medical equipment. An allowed non-physician practitioner that performs the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

Medical supplies, equipment, and appliances are covered if they:

1. Are relevant to the beneficiary's plan of care,
2. Are medically necessary,
3. Primarily serve a medical purpose,
4. Have therapeutic or diagnostic characteristics enabling a beneficiary to effectively carry out a physician's prescribed treatment for illness, injury, or disease, and
5. Are appropriate for use in the non-institutional setting where the beneficiary's normal life activities take place, other than a hospital; nursing facility; intermediate care facility for individuals with intellectual disabilities (ICF/IID) unless the ICF/IID is not required to provide the home health service; or any setting in which payment is or could be made under Medicaid for inpatient service that include room and board.

The beneficiary's need for medical supplies, equipment and appliances must be reviewed by the beneficiary's physician annually.

Medical equipment and appliances must be provided through qualified DME providers. Medical supplies may be provided through a qualified home health agency or DME provider.

The Division of Medicaid covers all medically necessary services for Early, Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries without regard to service limitation and with prior authorization.

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Home Health Care Services - Payment for home health service's shall be on the basis of cost or charges, whichever is less, as determined under standards and principles applicable to Title XVIII, not to exceed in cost the prevailing cost of skilled nursing home services under Medicaid. Effective July 1, 1981, payment for Home Health Services is in accordance with the Mississippi Title XIX Home Health Agency Reimbursement Plan (see Exhibit "A", pages 1-9); however, under no circumstances will the cost of Home Health Services exceed the cost of skilled nursing home services per month under the Medicaid Program.

Home Health care services for EPSDT recipients, if medically necessary, which exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph and in Exhibit A of Attachment 4.19-B.

Durable Medical Equipment Services - Payment for Durable Medical Equipment (DME) is in accordance with the Mississippi Title XIX Durable Medical Equipment Reimbursement Plan at Exhibit "A", page 10.

Medical Supplies - Payment for medical supplies is in accordance with Mississippi Title XIX Medical Supply Reimbursement at Exhibit "A", page 11.

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MISSISSIPPI TITLE XIX HOME HEALTH AGENCIES REIMBURSEMENT PLAN

I. Cost Finding and Cost Reporting

- A. Each home health agency participating in the Mississippi Medicaid Program will submit a uniform cost report using the appropriate Medicare/Medicaid forms, CMS-1728-94 or CMS-2552-10, postmarked no later than five (5) calendar months after the close of its cost reporting year. Extensions will be granted only if the provider submits documentation of an extension granted by CMS or a waiver granted by the Executive Director of the Division of Medicaid (DOM). The year-end adopted for the purpose of this plan shall be the same as for Title XVIII, if applicable. One (1) completed copy of the cost report, with original signature, must be submitted to the Division of Medicaid.
- B. Cost reports must be submitted by the specified due date, unless a waiver is granted by the Executive Director of the Division of Medicaid, in order to avoid a penalty in the amount of fifty dollars (\$50.00) per day for each day the cost report is delinquent. Cost reports with a due date that falls on a weekend, a State of Mississippi holiday or a federal holiday will be due the following business day.

A home health agency which does not file a cost report within five (5) calendar months after the close of its cost reporting year may be subject to cancellation of its provider agreement at the discretion of the Division of Medicaid.

In order for cost reports to be considered complete, the following information must be submitted:

1. Cost report with original signature (1 copy),
2. Working trial balance including assets and liabilities (1 copy),
3. Depreciation schedule (1 copy),
4. Home office cost report and other related party support, i.e., a detailed statement of total costs with adjustments for non-allowable costs and a description of the basis used to allocate the costs, along with a narrative description or a copy of contracts of management services provided by the related party or home office (1 copy),
5. Medicaid cost reporting schedules, i.e., Medicaid costs and visits by discipline and a schedule to reflect the lower of reasonable costs or customary charges as applicable to Medicaid (1 copy),
6. Medicare provider questionnaire and related exhibits (1 copy),
7. Supporting work papers for the Medicare cost report worksheets for reclassifications, adjustments, and related party expenses (1 copy),
8. A narrative description of purchased management services or a copy of contracts for managed services (1 copy), and
9. Verification of the Medicare and Medicaid surety bond premiums included in the cost report (1 copy).

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If all required information is not submitted with the original cost report by the due date, the provider will be notified via fax or email to the provider's designee on file with the Division of Medicaid. The notification will contain the specific items missing. The provider will have ten (10) business days from the date of the notification to submit the requested information. If the information has not been received by the tenth (10th) business day, a second request will be faxed or emailed to the provider's designee on file with the Division of Medicaid. The provider will have five (5) business days from the date of the second notification to submit the requested information. Failure to submit the requested information by the fifth (5th) business day after the second notification will result in the related costs being disallowed. The provider will not be allowed to submit the information at a later date, amend the cost report in order to submit the requested information, or appeal the desk review and/or audit as a result of the omission of the requested information.

- C. All home health agencies are required to maintain financial and statistical records. For purposes of this plan, statistical records shall include beneficiaries' medical records. All records must be available upon demand to representatives, employees or contractors of the Division of Medicaid, Mississippi Office of the State Auditor, General Accounting Office (GAO) or the United States Department of Health & Human Services (HHS).
- D. Records of related organizations as defined by 42 C.F.R. § 413.17 must be available upon demand to representatives, employees or contractors of the Division of Medicaid, Mississippi Office of the State Auditor, GAO, or HHS.
- E. The Division of Medicaid shall retain all uniform cost reports submitted for a period of at least five (5) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 45 C.F.R. § 205.60 and Mississippi state law. Access to submitted cost reports will be in conformity with the Mississippi Public Records Act.

II. Audits

A Background

Medicaid (Title XIX) requires that home health agencies be reimbursed on a reasonable cost related basis. Medicare (Title XVIII) is reimbursed based on a prospective payment system. To assure that payment of reasonable cost is being achieved, a comprehensive audit program has been established.

The common audit program has been established to reduce the cost of auditing submitted cost reports under the above programs and to avoid duplicate auditing efforts. The purpose then is to have one audit which will serve the needs of participating programs reimbursing home health agencies for services rendered.

B. Common Audit Program

The Division of Medicaid has entered into agreements with Medicare intermediaries for participation in a common audit program of Titles XVIII and XIX. Under this agreement, the intermediaries shall provide the Division of Medicaid the results of desk reviews and field audits of those agencies located in Mississippi.

C. Other Audits

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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. Desk Review Appeals

A provider may appeal the results of their original desk review. The appeal must be made in writing to the Division of Medicaid within thirty (30) calendar days of the date of the original desk review. 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 appeal should include the provider's name, provider number, cost reporting period, and a detailed description of the adjustment(s) being appealed. Work papers and legal references supporting the basis of the appeal may also be submitted.

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

If the provider is not satisfied with the results of the appeal, within thirty (30) calendar days of the date of the Division of Medicaid's original response to the appeal, the provider may request a formal hearing as described in Miss. Admin. Code Part 300.

Unless a timely and proper request for a formal 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. The 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

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intermediary. Once appealed adjustments have been resolved by the Medicare intermediary, the provider's rates will be adjusted if necessary, based on the amended final cost report.

III. Allowable Costs

Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement and the guidelines in the Provider Reimbursement Manual except as modified by Title XIX of the Act, the State Plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Mississippi Medicaid Program.

- A. Allowable costs include all expense items that home health agencies incur in meeting:
1. The definition of a home health agency as described in Section 1901(a)(13) of the Social Security Act.
 2. Requirements established by the State Agency responsible for establishing and maintaining health standards.
 3. Any other requirements for licensing under the state law which are necessary for providing home health services.
- B. Implicit in any definition of allowable costs is that those costs should not exceed what a prudent and cost conscious buyer pays for a given service or item. If costs are determined to exceed the level that a prudent buyer would incur, then the excess costs would not be reimbursable under the State Plan.
- C. A proportion of costs incurred by a home health agency for services to an eligible Medicaid beneficiary for whom payments are received from third parties are not reimbursable under the State Plan. Appropriate adjustments shall be made.
- D. Cost reports for years ended within a calendar year will be used to establish the class ceilings and home health agency rates beginning the following October 1. For example cost reports ended during 1996 will be used to compute the rate effective October 1, 1997. If a provider experiences a change of ownership and files two cost reports during the calendar year, the last filed cost report will be used. Providers will be notified of their respective rates by type of visit and rate ceilings by type of visit prior to implementation of the rates. Any provider of home health services under the Medicaid Program may appeal its prospective rates in accordance with Attachment 4.19-B, Exhibit A, Section VI of the State Plan.
- E. The Division of Medicaid shall maintain any responses received on the State Plan, subsequent changes to the State Plan, or rates for a period of five (5) years from the date of receipt. Such comments shall be available to the public upon request.
- F. A home health agency may offer to the public new or expanded services or may drop a service. Within sixty (60) days after such an event, the home health agency may submit a budget which shall take into consideration new and expanded services or dropped services. Such budgets will be subject to desk review and audit by the Division of Medicaid. Upon completion of the desk review, new reimbursement rates will be established. Failure to submit budgets within sixty (60) days shall require disallowance of all expenses, direct and indirect, associated with the service. Overpayments as a result of the differences between budget and

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actual costs shall be refunded to the Division of Medicaid. New reimbursement rates shall not exceed the established class ceilings.

- G. Type of visit ceilings and individual provider's reimbursement rates will not include amounts representing growth allowances.
- H. Payment by type of visit and type of visit ceilings will be established prospectively.
- I. The prospectively determined individual home health agency's rate will be adjusted under the following circumstances:
 - 1. Administrative errors on the part of the Division of Medicaid or the home health agencies that result in erroneous payments. Overpayments or underpayments resulting from errors will be corrected when discovered. Overpayments will be recouped by the Division of Medicaid and underpayments will be paid to the home health agency. In no case will payment adjustments be made for administrative error or audit findings prior to notifying the appropriate agency and affording an opportunity to present facts and evidence to dispute the exception.
 - 2. The amendment of a previously submitted cost report. Such amendments must be submitted within eighteen (18) months following the close of the cost report period that is being amended. If an increase or decrease in the rate is computed as a result of the amended cost report, claims history will be adjusted retroactive to the effective date of the original rate.
 - 3. The information contained in the cost report is found to be intentionally misrepresented. Such an adjustment shall be made retroactive to the date of the original rate. At the discretion of the Division of Medicaid, this shall be grounds to suspend the home health agency from the Mississippi Medicaid Program until such time as an administrative hearing is held, if requested by the home health agency.
 - 4. The home health agency experiences extraordinary circumstances which may include, but are not limited to riot, strike, civil insurrection, earthquakes or flood.
 - 5. Under no circumstances shall such adjustment exceed the class ceiling established for the respective classes.
 - 6. The receipt of the final or amended final cost report from the Medicare intermediary.
 - 7. Resolution by the Medicare intermediary of a provider appealed adjustment on a previous year final cost report that was applied to an original desk review. The rates for all years affected by the appealed adjustment for which the final cost report has not been received will be recalculated and claims history adjusted retroactive to the effective date of the original rate.
- J. Costs incurred for the acquisition of durable medical equipment, appliances and supplies related to the use of durable medical equipment are non-allowable costs since they are reimbursed outside of the home health agency visit rate.

IV. Rate Methodology

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- A. The Division of Medicaid will utilize a prospective rate of reimbursement and will not make retroactive adjustments except as specified in the State Plan. The prospective rates will be determined from cost reports and will be set on a yearly (October 1 -September 30) basis and will be applicable to all facilities with a valid provider agreement. Total payments per month for each home health beneficiary may not exceed the average Medicaid nursing facility rate per month as determined based on the nursing facility rates computed July 1 of each year. The average Medicaid Nursing Facility rates are posted on the Mississippi Division of Medicaid's website at <https://medicaid.ms.gov/providers/fee-schedules-and-rates/#>.

Providers will be paid the lower of their prospective rate as computed in accordance with the State Plan or their usual and customary charge.

- B. Payments of medical supplies which are directly identifiable supplies furnished to individual beneficiaries and for which a separate charge is made will be reimbursed as described in Section IV. D. 5., of this plan. Payments of durable medical equipment, appliances and supplies are reimbursed as described In Section VIII, of the State Plan.

Prospective rates and ceilings will be established for the home health visits.

- C. Trend Factor

In order to adjust costs for anticipated increases or decreases due to changes in the economy, a trend factor is computed using the Centers for Medicare and Medicaid Services (CMS) Home Health Market Baskets that are published in the Integrated Healthcare Strategies (IHS) Economic Healthcare Cost Review, or its successor, in the fourth (4th) quarter of the previous calendar year, prior to the start of the rate period. The moving averages for the following market basket components are used: Wages and Salaries, Benefits, Utilities, Malpractice Insurance, Administrative Support, Financial Services, Medical Supplies, Rubber Products, Telephone, Postage, Other Services, Other Products, Transportation, Fixed Capital, and Movable Capital. Relative weights are obtained from the same period National Market Basket Price Proxies-Home Health Agency Operating Costs.

- D. Rate Setting

1. Home health agencies are reimbursed for skilled nursing visits at the lower of the following:

- (a) trended cost, plus a profit incentive, but not greater than 105% of the median, which is computed as follows:

- (1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;
- (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;

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- (3) array the trended costs from the lowest to the highest with the total number of skilled nursing visits and determine the cost associated with the median visit (interpolate, if necessary);
 - (4) multiply the median visit trended cost by 105% to determine the ceiling;
 - (5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;
 - (6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above; or,
- (b) the sum of the following:
- (1) the ceiling for direct care and care related costs for nursing facilities at a case mix score of 1.000 as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period; and
 - (2) the ceiling for administrative and operating costs for Large Nursing Facilities as determined each July 1 prior to the start of the October 1 through September 30 home health agency rate period.
- (c) plus the medical supply add-on as computed in Section IV. D. 5.
2. Physical therapy visits for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries are reimbursed on a fee-for-service basis at an all-inclusive, per visit rate of \$65.00 plus the medical supply add-on as computed in Section IV. D. 5.
 3. Speech therapy visits for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries are reimbursed on a fee-for-service basis at an all-inclusive, per visit rate of \$65.00 plus the medical supply add-on as computed in Section IV. D. 5.
 4. Home health agencies are reimbursed for home health aide visits based on the following methodology:
 - (a) trended cost, plus a profit incentive, but not greater than 105% of the median, plus the medical supply add-on, which is computed as follows:
 - (1) determine the cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30;
 - (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;
 - (3) array the trended costs from the lowest to the highest with the total number of home health aide visits and determine the cost associated with the median visit (interpolate, if necessary);

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- (4) multiply the median visit trended cost by 105% to determine the ceiling;
 - (5) for agencies with trended cost below the 105% of the median amount, compute 50% of the difference between the ceiling and the higher of their trended cost or the median trended cost to determine the profit incentive;
 - (6) sum the lesser of each home health agency's trended cost or the 105% of the median ceiling and the profit incentive determined in (5), above, plus the medical supply add-on as computed In Section IV. D. 5.
5. The Medical Supply payment amount that will be added on to each discipline will be reimbursed at the lower of the following:
- (a) trended medical supply cost per visit computed as follows:
 - (1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk. review; divide this number by total Medicaid visits);
 - (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period; or
 - (b) 105% of the median medical supply trended cost, which is computed as follows:
 - (1) determine the medical supply cost per visit as computed on the desk review of each home health agency cost report for the period ended in the calendar year prior to the start of the standard rate year of October 1 through September 30 (divide total medical supply cost per the desk review by total medical supply charges; multiply this ratio times Medicaid medical supply charges per the desk review; divide this number by total Medicaid visits);
 - (2) trend the costs, using the trend factor determined in paragraph C, above, to account for the time difference between the midpoint of the cost report period and the midpoint of the rate period;
 - (3) array the trended costs from the lowest to the highest with the total number of Medicaid visits per the desk review and determine the cost associated with the median visit (interpolate, if necessary);
 - (4) multiply the median visit trended cost by 105% to determine the ceiling.

V. New Providers

1. Changes of Ownership

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For purposes of this plan, a change of ownership of a home health agency includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash, transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the agency. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship.

A home health agency which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the change of ownership. The new owner will be assigned the previous owner's rate. The Division of Medicaid will update the provider's information in the Medicaid Management Information System (MMIS).

The new owner, upon consummation of the transaction affecting the change of ownership, shall as a condition of participation, assume liability, jointly and severally, with the prior owner for any and all amounts that may be due or become due to the Medicaid Program, and such amounts may be withheld from the payment of claims submitted when determined. However, the new owner shall not be construed as relieving the prior owner of his liability to the Division of Medicaid.

2. New Home Health Agencies

When new providers are established that are not changes of ownership, the provider shall be reimbursed at the maximum rate for each type of home health visit pending the receipt of the initial cost report. After receipt of the initial cost report, a rate will be determined that is retroactive to the date of the establishment of the provider.

Notwithstanding any other provision of this section, the Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service. The federal match will be paid based on the reduced amount.

VI. Provider Participation

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of home health agencies in the program, so that eligible beneficiaries can receive the medical care and services included in the State Plan at least to the extent these services are available to the general public. Providers must be certified to participate as a home health agency under Title XVIII (Medicare) of the Social Security Act, and meet all applicable state laws and requirements.

VII. Payment in Full

Participation in the program shall be limited to home health agencies who accept, as payment in full, the amount paid in accordance with the State Plan.