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.