STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: MISSISSIPPI

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

Outpatient Hospital Services –Prior to October 1, 2008

Outpatient hospital services shall be reimbursed at a percentage of billed charges unless specified differently elsewhere in this Plan. The percentage paid is the lower of 75% of charges or the cost to charge ratio, as computed by Medicaid using the hospital's cost report. The cost to charge ratio shall be computed each year for use in the following rate year's payments. Adjustments to outpatient services claims may be made if the cost to charge ratio is adjusted as a result of an amended cost report, audit, or Medicare settlement. The cost to charge ratio for outpatient services will be computed under Title XVIII (Medicare) methodology, excluding bad debts and other services paid by Medicaid under a different rate methodology (i.e., Rural Health Clinic services and Federally Qualified Health Center services). Out-of-state hospitals shall be reimbursed at the lower of 75% of charges or the average cost to charge ratio of hospitals located in Mississippi for their classification, as computed by Medicaid.

Outpatient Hospital Services –Effective Beginning October 1, 2008

Outpatient hospital services shall be reimbursed on a prospective basis at a percentage of billed charges unless specified differently elsewhere in this Plan. The percentage paid is equal to the Medicaid cost to charge ratio, as computed by Medicaid, based on the hospital's Medicare cost report, using the attached protocol. The percentage paid will be computed annually, unless this plan requires a rate being calculated at another time, for the period October 1 through September 30. Cost reports used to calculate the percentage will be the cost report filed by the provider for a cost reporting period ending in the preceding calendar year. For example, the percentage effective October 1, 2008, will be based on the most recent cost report filed with a reporting year end as of or prior to December 31, 2007, unless a short period cost report is required for a new provider.

Percentages for new providers, including changes of ownership, will be set at the average outpatient percentage of hospitals located in Mississippi, as determined by the Division. The outpatient percentage computed based on the hospital's initial Medicare cost report, using the attached protocol, will be effective retroactive to the effective date of enrollment.

Out-of-state hospitals shall be reimbursed at the average outpatient reimbursement rate of hospitals located in Mississippi, as determined by the Division.

Laboratory and Radiology Services

All outpatient laboratory services shall be reimbursed on a fee-for-service basis.
All outpatient radiology services shall be reimbursed on a fee-for-service basis.

Hospital-Based Clinics

Hospital-based clinics may not bill facility fees on the UB-92 unless they are a teaching hospital with a resident-to-bed ratio of .25 or greater.

Medicaid Upper Payment Limit

In addition to the reimbursement methodology described above, hospitals located within Mississippi may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each specified class of hospital (State government-owned or operated facilities, non-State government-owned or operated facilities, and privately owned and operated facilities), the amount that Medicare would have paid for the previous year will be calculated and compared to the payments actually made by Medicaid during that same time period. This calculation may then be used to make payments for the current year to hospitals eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. Up to 100 percent of the difference between Medicaid payments and what Medicare would have paid may be paid to State government-owned or operated facilities, non-State government-owned or operated facilities, and privately owned and operated facilities, in accordance with applicable State and Federal laws and regulations, including any provision specified in appropriations by the Mississippi Legislature. This provision will sunset as of December 31, 2007.

5% Reduction

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. Effective August 6, 2008, the Division of Medicaid shall reduce the rate of reimbursement to all hospital providers, with the exception of state owned and operated and Medicare designated critical access hospitals, for any service by an additional thirty-three and one-half percent (33.5%) of the allowed amount for that service. Hospitals that are owned and operated by the State of Mississippi (State hospitals) and hospitals designated as critical access hospitals (CAHs) by Medicare will not be subject to the reimbursement reductions described above. These facilities will be paid based on 100% of allowable costs. State hospitals and CAHs may request that the outpatient rate be adjusted during the year based on changes in their costs. After the State hospital and CAH files their cost report during the rate year, total outpatient payments for each cost report period will be adjusted to the actual allowable cost for that period.

Notice of Proposed Rule Adoption

State of Mississippi
Office of the Governor
Division of Medicaid

Economic Impact Statement
For
Hospital Outpatient Providers

The Executive Director of Medicaid is required by law to recommend expenditure containments when expenditures are expected to exceed funds available for any fiscal year. Medicaid is facing a $90,000,000 shortfall in state revenues for FY2009; therefore, certain cost containment measures have been identified as necessary to balance Medicaid's budget. These measures include reducing payments for hospital outpatient services by 33.5%.

It is estimated that it will cost the Division of Medicaid approximately $5,000 to enforce the increased reduction in payments to providers. This includes system changes and staff time.

An estimate of the total economic impact for hospital providers, including small business providers, is noted in the chart below. The total economic impact for providers in State FY 2009 is equal to the sum of federal and state savings noted in the chart below. The Division of Medicaid estimated the impact utilizing the actual and estimated expenditures for the same services for FY2008.

FFY2008 Federal Savings	FFY2008 State Share Savings	FFY2009 Federal Savings	FFY2009 State Share Savings
$ 8,653,905.70	$ 2,689,528.17	$ 43,014,301.26	$ 13,702,868.12

The Division of Medicaid is facing a $90,000,000 shortfall in state revenues for FY2009. If this cost containment measure is not enacted, there will not be sufficient revenues to reimburse providers for the entire year.

State law limits the cost containment measures that may be taken and precludes the Governor from changing eligibility or benefits; therefore, the only option to reduce expenditures is to reduce payment.