Mississippi Title XIX Inpatient Hospital
Reimbursement Plan

Payment Methodology for Rate Years Beginning August 6, 2008

A. Notwithstanding any other provision of this section, the Division of Medicaid shall recalculate hospital inpatient per diem rates for all providers, except for state owned and operated and Medicare designated critical access hospitals. Existing hospital inpatient per diem base rates shall be multiplied by an adjustment factor specified in subsection B of this section.

B. Effective August 1, 2008, the adjustment factor for all providers, except state owned and operated and Medicare designated critical access hospitals, shall be .665.

C. 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 rebasing of inpatient per diem rates described above. These facilities will be paid based on 100% of allowable costs. State hospitals and CAHs may request that the per diem 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, the per diem rate for each cost report period will be adjusted to the actual allowable cost for that period.

I. Payment Methodology for Rate Years Beginning October 1, 2005

A. Prospective Rate

The Division of Medicaid will set hospital inpatient reimbursement rates prospectively on an annual (October 1 – September 30) basis. For the rate year beginning October 1, 2005, the rate shall be based upon the greater of (1) the facility's most recent inpatient per diem rate for FFY 2005, or (2) the average of the facility's most recent inpatient per diem rates for FFY 2004 and 2005. The resulting base amount will then be increased by the percentage increase of the most recent Inpatient Hospital PPS Market Basket Update as published in the Federal Register. The base rate will not be recalculated for any subsequent changes that occur in the FFY 2004 or 2005 inpatient per diem rates, except for adjustments made to include or exclude the low DSH component, as appropriate, based on changes in low DSH eligibility.

A base rate will be established for hospitals that open or change ownership on or after October 1, 2005. The base rate will be set using the hospital's initial cost report and rate setting procedures in place prior to October 1, 2005. The fiscal year 2005 class ceilings will be trended using the percentage increase of the most recent Inpatient Hospital PPS Market Basket Update as published in the Federal Register to establish class ceilings for these rates.

For rate years beginning October 1, 2006, and thereafter, the prospective rate for the immediately preceding rate year will be increased by the percentage increase of the then most recently published Inpatient Hospital PPS Market Basket Update. Facility per diems shall be trended forward in this manner annually until such time as a new methodology is adopted by the Division or for five rate years beginning October 1, 2005, whichever comes first. If no new methodology has been adopted by the end of the fifth rate year of trending, hospital inpatient reimbursement rates will be rebased using the cost reporting methodology employed prior to October 1, 2005, and every five years thereafter.

B. Subsequent Adjustment

The base year payments effective October 1, 2005 will not be adjusted when fiscal year 2004 and fiscal year 2005 rates are amended due to final settlement cost reports. Rates determined under this methodology will be subject to subsequent adjustment only in cases of error or omission, as determined by the Division, affecting the base year(s) or for adjustments made to include or exclude the low DSH component, as appropriate, based on changes in low DSH eligibility.

C. Class of Facilities

The statewide classes of facilities shall be the same as specified in Section VII, Paragraph C of this Attachment 4.19-A.

D. Upper Payment Limit

In addition to the Medicaid prospective rate described above, hospitals located within Mississippi may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit, as described in Section VIII of this Attachment 4.19-A.

E. Requests for Rate Change

A hospital may appeal its prospective reimbursement rate to the Division of Medicaid whenever there is a significant, documented change in the overall cost of providing services. Requests for changes in the prospective rates will be reviewed when a provider can demonstrate that allowable Medicaid expenses per patient day have increased by 5% or more as compared to allowable Medicaid expenses per patient day reported in the most recently filed cost report; however, requests which do not result in a rate change of at least 5% more than the current rate will not be granted. The request must be submitted in writing to the Division of Medicaid, clearly identifying the grounds of the appeal and the dollar amount in question. Copies of documenting support for the appeal must be included. Facilities should make every effort possible to ensure that requests which do not meet the criteria are not submitted.

II. Cost Findings and Cost Reporting – For Rate Years Prior to October 1, 2005

A. Each Mississippi hospital participating in the Mississippi Medicaid Hospital program will submit a Uniform Cost Report using the appropriate Medicare/Medicaid forms postmarked no later than five (5) calendar months after the close of its cost reporting year. No routine extensions will be granted. All other filing requirements shall be the same as those for Title XVIII. Extraordinary circumstances will be considered on a case-by-case basis. One (1) complete copy of the cost report shall be submitted to the Division of Medicaid (DOM). The cost reports for periods ending in the prior calendar year will be used to calculate the per diem rates for the following October 1 – September 30 fiscal year. For example, the cost report of a hospital with a June 30, 1996 year end would be used to set the rate effective October 1, 1997 through September 30, 1998.

B. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII.

C. Cost reports used to initiate this plan will be for reporting periods beginning April 1, 1980, or earlier.

D. All hospitals are required to detail their cost reports for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals must adhere to all requirements of Section 25, Provider Policy Manual.

Notice of Proposed Rule Adoption

State of Mississippi
Office of the Governor
Division of Medicaid

Economic Impact Statement
For
Hospital Inpatient 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 existing hospital inpatient per diem rates 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
$ 19,247,545.29	$ 5,981,901.94	$ 95,670,063.89	$ 30,477,172.25

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.