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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 Medicare 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 for per diem rates through September 30, 2009, and in cases of error or omission, as determined by the Division. (Refer to Appendix I.)

A base rate will be established for hospitals that open or change ownership on or after October 1, 2005. A new owner will be reimbursed at the previous owner's rate until the rate is recalculated based on the new owner's initial cost report using rate-setting procedures in place prior to October 1, 2005. A new hospital will be reimbursed the average rate paid a like-sized Mississippi hospital as of the effective date of the Medicaid provider agreement until the rate is recalculated based on the new hospital's initial cost report using rate-setting procedures in place prior to October 1, 2005. Each rate year the inpatient per diem for each Mississippi hospital is grouped by bed class (as described in Section VII.C.) and an average rate is determined for each class. New Mississippi hospitals will be reimbursed the average for their bed class based on the number of beds. The fiscal year 2005 class ceilings will be trended using the percentage increase of the most recent Medicare Inpatient Hospital PPS Market Basket Update as published in the Federal Register to establish class ceilings for these rates as described in Section VII.

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 most recent Medicare Inpatient Hospital PPS Market Basket Update as published in the Federal Register. 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 annually using the cost reporting methodology employed prior to October 1, 2005.

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.

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D. 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 using the most recently filed cost report have increased by 5% or more as compared to the existing hospital inpatient per diem rate; 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. (Refer to Appendix A.)

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.

I. Records of related organizations as defined by 42 CFR 413.17 must be available upon demand to representatives, employees or contractors of the Division of Medicaid, MS State Department of Audit, GAO, Medicaid Fraud Control Unit, United States Attorney General's Office or HHS.

J. 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 42 CFR 431.17 and in accordance with Mississippi State Law. Access to submitted cost reports will be in conformity with Mississippi statutes and the Division of Medicaid policy.

III. Cost Reporting – For Rate Years Beginning 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).

B. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII. All other provisions of Section II, Parts D-J above also apply.

IV. Audits

A. Background

The Division of Medicaid may periodically audit the financial and statistical records of participating providers. The hospital common audit program was established to reduce the cost of auditing costs reports submitted under Medicare (Title XVIII) and Medicaid (Title XIX) and to avoid duplicating audit effort. The purpose is to have one audit of a participating hospital which will serve the needs of all participating programs reimbursing the hospital for services rendered.

F. The hospital assessment referred to in Section 43-13-145 (4), Mississippi Code of 1972, will be considered allowable costs on the cost report filed by each hospital, in accordance with the Provider Reimbursement Manual, Part I, Section 2122.1.

G. Requests for Rate Change – For rate years prior to October 1, 2005

A hospital may at times offer to the public new or expanded services, purchase equipment, drop such services, or retire equipment which requires Certificate of Need (CON) approval. Within thirty (30) days of implementing a CON approved change, the hospital must submit to the Division an allocation of the approved amount to the Medicaid Program. This amount must be separated as applicable between capital costs, educational costs and operating costs. An estimate of any increase or decrease in operating costs applicable to the Medicaid Program due to the change, as well as the effective date of the change will also be submitted. Such amounts will be subject to desk review and audit by the Division. Allowance for such changes shall be made to the hospital's Medicaid Prospective rate as provided elsewhere in this plan. Failure to submit such required information within thirty (30) days will be a basis for disallowance of all expenses associated with the change. Overpayments as a result of the differences between estimates and actual costs shall be refunded to the Division of Medicaid.

H. Class ceilings and individual provider's reimbursement rates will not include amounts representing growth allowances, profits or efficiency bonuses.

I. Amounts paid to a provider under this plan shall not exceed charges.

J. Payment classes and class ceilings will be established prospectively based on groupings of hospitals by number of total beds available as described in Section VII.C.

K. The prospectively determined individual hospital's rate may be adjusted under certain circumstances, which are:

1. Discovery of administrative errors on the part of the Division or the facilities which may result in erroneous payments, as determined by the Division: These errors most commonly result from: failure to report a death, discharge, or

transfer; system error in patient classification; and miscalculated payments. Overpayments or underpayments resulting from these errors will be corrected when discovered. Overpayments will be recouped by the Division of Medicaid and underpayments will be reimbursed to the facility. Payment adjustments will not be made for administrative error or audit findings prior to notifying the appropriate facility and affording the facility an opportunity to present facts and evidence to dispute the exception.

2. Corrections by a hospital to a previously submitted cost report for rate years prior to October 1, 2005: Such corrections must be submitted prior to the end of the current rate period. If an increase or decrease in a rate results, any adjustment shall be made retroactive to the effective date of the original rate.

3. Intentional misrepresentation of cost report information: Such 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 hospital from the Mississippi Medicaid program until such time as an administrative hearing is held, if requested by the hospital.

4. Appeal decisions are made to the Division of Medicaid as provided by Section VI of this plan.

5. Disproportionate Share Hospitals

Refer to Appendix G.

L. Legal costs and fees resulting from suits against federal and state agencies administering the Medicaid program are not allowable costs.

M. Notwithstanding any other subparagraph, depreciation and interest expense shall not exceed the limitations set forth in Appendix F.

N. Inpatient hospital services provided under the Early Periodic Screening Diagnostic and Testing (EPSDT) program will be reimbursed at the hospital's Medicaid prospective rate.

O. Out-of-state hospitals in contiguous states are reimbursed at the lower of (1) the average rate paid a like-sized hospital in Mississippi or (2) the inpatient rate established by the Medicaid agency of the domicile state. The fiscal agent is responsible for verifying the rate with the Medicaid agency in the domicile state. Verification should be made annually.

Out-of-state hospitals in states other than contiguous states are reimbursed at the average rate paid a like-sized hospital in Mississippi.

Out-of-state hospitals providing services not otherwise available within the state of Mississippi to Mississippi children under the age of twenty-one (21) be paid an amount not to exceed the cost of their services.

P. The State has in place a public process which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act.

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Q. Durational Limit Prohibition

In compliance with Section 6404 of the Omnibus Budget Reconciliation Act of 1990, no durational limit will be imposed for medically necessary inpatient services 1) provided in disproportionate share hospitals to children under the age of 19 years, or 2) provided in any hospital to an individual under the age of 1 year.

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Capital Cost Component, the Medicaid Prospective Educational Cost Component, and the Medicaid Prospective Operating Cost Component. Amount allowed by appeals or adjustments will be added to or subtracted from this total. This rate shall be referred to as the Medicaid Prospective Rate.

VIII. Upper Payment Limit

Refer to Appendix H.

IX. Plan Implementation

A. Payments under this plan will be effective for services rendered July 1, 1981 and thereafter.

B. The Division of Medicaid will provide an opportunity for interested members of the public to review and comment on the rate methodology before it is implemented. This will be accomplished by publishing in newspapers of widest circulation in each city in Mississippi with a population of 50,000 or more prior to implementing the rate methodology. A period of thirty (30) days will be allowed for comment. The Division of Medicaid will notify the administrator of each hospital of the prospective rate for their hospital.

C. The Division of Medicaid shall maintain any comments received on the plan, subsequent changes to the plan, or rates for a period of five (5) years from the date of receipt.

X. Application of Sanctions

A. Sanctions may be imposed by the Division of Medicaid against a provider for any one of the following reasons:

1. Failure to disclose or make available to the Division of Medicaid, or its authorized agent, any records of services provided to Medicaid recipients and records of payment made therefore.

2. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as determined by the Division of Medicaid (DOM), the Mississippi State Department of Health or the Mississippi Foundation for Medical Care.

3. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid Claim form.

4. Documented practice of charging recipients for services over and above that paid by the DOM.

5. Failure to correct deficiencies in provider operations after receiving written notice of the deficiencies from the Director of the Mississippi State Department of Health, PSRO, or DOM.

6. Failure to meet standards required by State or Federal law for participation.

7. Submission of a false or fraudulent application for provider status.

8. Failure to keep and maintain auditable records as prescribed by the DOM.

9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

10. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid Program.

11. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.

12. Presenting, or causing to be presented, for payment any false or fraudulent claims for services or merchandise.

13. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation to which the provider is legally entitled (including charges in excess of the fee schedule as prescribed by the DOM or usual and customary charges as allowed under DOM regulations).

14. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

15. Exclusion from Medicare because of fraudulent or abusive practices.

16. Conviction of a criminal offense relating to performance of a provider agreement with the state, or for the negligent practice resulting in death or injury to patients.

B. The following sanctions may be invoked against providers based on the grounds specified herein above:

1. Suspension, reduction, or withholding of payments to a provider;

2. Suspension of participation in the Medicaid Program and/or

3. Disqualification from participation in the Medicaid Program.

Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to recipients or their families.

C. Within thirty (30) days after notice from the Executive Director of DOM of the intent to sanction, the provider may request a formal hearing. Such request must be in writing and must contain a statement and be accompanied by supporting documents setting forthwith particularly the facts which the provider contends places him in compliance with the DOMs regulations or his defenses thereto.

Suspension or withholding of payments may continue until such time as a final determination is made regarding the appropriateness of the claims or amounts in question.

APPENDIX A – Rate Setting Procedures in Place Prior to October 1, 2005

Rate Setting Example

The following example shows the step by step process which shall be used to set the Medicaid Prospective Rate for each hospital for the reimbursement period beginning October 1, 19x3. The cost reports for the periods ended in the prior calendar year will be used to set the per diem rate.

Hospital A (60 Bed, Rural Facility)

Y/E September 30, 19x2
Information contained in Cost Report:

Total available days	21,900
Total inpatient days	15,330
Medicaid inpatient days	2,000
Total costs allocated to Medicaid Program	$1,000,000
Total capital costs	$683,000
Total education costs	$100,000

It is assumed for this example that the above data has already been reviewed and adjusted to reflect results of desk reviews, etc.

1. Total cost allocated to the Medicaid Program is to be separated into capital costs, education costs, and operating costs.

   Capital costs allocated to the Medicaid Program: (Based on the ratio of Medicaid inpatient days to total inpatient days) 2,000/15,330 x $683,000 = $89,106. Education costs allocated to the Medicaid Program: 2,000/15,330 x $100,000 - $13,046. Operating cost allocated to the Medicaid Program: $1,000,000 - (89,106 + 13,046) = $897,848.

2. Capital Cost Component

   a. Divide capital cost allocated to Medicaid by the Medicaid inpatient days

   $89,106
   ÷
   2,000
   $44.55

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APPENDIX B – Rate Setting Procedures in Place Prior to October 1, 2005

Maximum Operating Cost Component

Procedures for determining the maximum operating cost component of reimbursement to hospitals are as follows:

(1) Facilities will be grouped according to the bed-size classification as established in the State Plan.

(2) The following procedures will be used separately for each classification of facilities.

(a) Operating cost per diems as described at V.D. and illustrated at Appendix A, 3., will be arrayed from low to high.

(b) The percentile range will be computed by dividing the individual provider array location number for the scheduled operating cost per diems by the total number of providers in the array.

(c) The selected percentile as specified by this plan will then be determined.

The following is an example of the determination of the maximum operating cost per diem at the 80th percentile.

PROVIDER ARRAY LOCATION NUMBER	OPERATING COST PER DIEM	PERCENTILE
01	$50.00	9.09
02	$57.10	18.18
03	$58.20	27.27
04	$58.25	36.36
05	$59.10	45.45
06	$62.90	54.55
07	$76.80	63.64
08	$80.01	72.73*
09	$81.00	81.82*
10	$92.00	90.91
11	$93.00	100.00

*The 80th percentile falls between the operating cost per diems for provider numbers 08 and 09. The 80th percentile is then computed by interpolation and in this example would be $80.80.

APPENDIX C – Rate Setting Procedures in Place Prior to October 1, 2005

Inflation Factor and Industry Trend Factor

An input price index will be used to compute the reimbursable change in the prices of goods and services purchased by hospitals. The input price index will consist of a market basket classification of goods and services purchased by hospitals, a corresponding set of market basket weights for purchased goods and services, and a related series of price indicators. Weights corresponding to market basket categories are for hospitals in the East South Central region of the United States and are specified in this appendix.

After the close of each calendar year, the input price index will be calculated to account for actual changes in the price indicators based on the market basket weights.

The index will be made available to Mississippi Medicaid by the Mississippi Research and Development Center. This factor will be called the inflation factor and shall be used for the purpose of adjusting costs for all providers to a common year-end. This factor will be applied for the number of months between the mid-point of each provider's reporting period and the mid-point of the most recently ended calendar year. The inflation factor is based on historical data and is not subject to redetermination at a later time.

The Mississippi Research and Development Center will also provide a trend factor to project the inflation rate for the next reimbursement period. Both the inflation factor and the trend factor will use the same market basket, market basket weights, and proxy price variables.

The trend factor is to be applied for the number of months between the mid-point of the most recently ended calendar year and the mid-point of the reimbursement period.

APPENDIX E

Rate Adjustment for Serving A Disproportionate Number of Medicaid Patients

Appendix G, Section A.(4), of the Plan provides for the adjustment of a hospital's Medicaid prospective rate if it serves a disproportionate number of Medicaid patients.

Following is the computation of the increased rate using Hospital A in Appendix A as the example.

	DSH/OUTLIER ADJ.
Operating Component without Cap	$496.20
Operating Component with Cap	436.56
Amount of Increase	59.64
Adjusted Operating Component	496.20
Educational Component	8.09
Capital Component	44.55
New Rate Adjusted for DSH	548.84

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APPENDIX G

Disproportionate Share Hospitals - All hospitals satisfying the minimum federal DSH eligibility requirements (Section 1923(d) of the Social Security Act) shall, subject to OBRA 1993 payment limitations, receive a DSH payment. This DSH payment shall expend the balance of the federal DSH allotment and associated state share not utilized in DSH payments to state-owned institutions for treatment of mental diseases.

A. A hospital will qualify as a disproportionate share hospital if the criteria listed below are met.

(1) Except as provided in (i) and (ii) below, no hospital may qualify as a disproportionate share hospital for Medicaid unless the hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid under an approved State Plan. In the case of a hospital located in a rural area (an area located outside of a Metropolitan Statistical Area, or MSA, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

Paragraph (1), above, shall not apply to a hospital

(i) the inpatients of which are predominantly individuals under eighteen (18) years of age; or

(ii) which did not offer non-emergency obstetric services as of December 22, 1987.

and;

(2) (a) The hospital's Medicaid inpatient utilization rate must be not less than 1%. For purposes of this paragraph, the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under an approved Medicaid State Plan in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere, or

(b) The hospital's low-income utilization rate exceeds twenty-five percent (25%). For purposes of this paragraph, the term "low-income utilization rate" means, for a hospital, the sum of:

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(i) a fraction (expressed as a percentage) the numerator of which is the sum (for a period) of the total revenues paid the hospital for patient services under an approved Medicaid State Plan and the amount of the cash subsidies for patient services received directly from State and local governments, and the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(ii) a fraction (expressed as a percentage) the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies for patient services received directly from State and local governments. The total charges attributable to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan); and the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

(3) No hospital may qualify as a disproportionate share hospital under this State Plan unless it is domiciled within the State of Mississippi.

(4) Any hospital which is deemed eligible for a disproportionate share payment adjustment and is adversely affected by serving infants who have not attained the age of one (1) year and children who have not attained the age of twenty-one (21) years may request an outlier payment adjustment to the established rate for those individuals. Adversely affected is defined as exceeding the operating cap of the class of the facility, trended forward as applicable. The outlier adjustment is only for claims filed for Medicaid recipients under twenty-one (21) years of age and is the difference between the rate subject to the operating cap and the calculation of the rate without applying the operating cap. The provider should submit their request for an adjustment to the rate for these outlier payments prior to the provision of such services. The adjusted rate is subject to the provisions in Section I. A separate provider number will be assigned to the provider for the related claims payment and these payments will be included for the computation of DSH. Refer to Appendix E.

B. Computation of Disproportionate Share Payments

1) Disproportionate share payments to hospitals that qualify for disproportionate share may not exceed one hundred percent (100%) of the costs of furnishing hospital services by the hospital to residents who either are eligible for medical assistance under this State Plan or have no health insurance (or other source of third party coverage) for services provided during the year less any payments made by Medicaid, other than for disproportionate share payments, and less any payments made by uninsured patients. For purposes of this section, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

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2) The payment to each hospital shall be calculated by applying a uniform percentage required to allocate 100% of the MS DSH allotment to all DSH eligible hospitals for the rate year to the uncompensated care cost of each eligible hospital, excluding state-owned institutions for treatment of mental diseases; however, that percentage for a state-owned teaching hospital located in Hinds County shall be multiplied by a factor of two (2).

3) Until July 1, 2011, public hospitals permanently classified in (but not reclassified to) the Gulfport-Biloxi, MS Core-Based Statistical Area (CBSA) for hospital wage index purposes and eligible for Deficit Reduction Act Hurricane Katrina Related Stabilization Grants under Section 6201(a)(4) of the Deficit Reduction Act of 2005 shall qualify for DSH payments as follows: (i) critical access hospitals that were forced to cease operations for more than thirty (30) days as a direct result of Hurricane Katrina shall receive a multiple of two (2) times the DSH amount, and (ii) hospitals with more than four hundred (400) licensed beds and greater than thirty-five percent (35%) of total patient days during 2007 from Medicaid patients shall receive a multiple of one and one-half (1-1/2) times the DSH amount.

4) For state fiscal year 2010, the state shall use uninsured costs from 2008 hospital data. For state fiscal year 2011, the state shall use costs from 2009 hospital data.

5) The division shall implement DSH calculation methodologies that result in the maximization of available federal funds.

C. The determination of a hospital disproportionate share status is made annually and is for the period of the rate year (October 1 – September 30). Once the list of disproportionate share hospitals is determined for a rate fiscal year, no additional hospitals will receive disproportionate share status. A hospital will be deleted from disproportionate share status if the hospital fails to continue providing nonemergency obstetric services during the DSH rate year, if the hospital is required to provide such services for DSH eligibility.

D. The DSH payments shall be paid on or before December 31, March 31, and June 30 of each fiscal year, in increments of one-third (1/3) of the total calculated DSH amounts.

E. Audit of Disproportionate Share Payments

As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Division of Medicaid will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Any funds recouped as a result of audits or other corrections shall be redistributed to other DSH eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit. Funds shall be redistributed to the state hospital with the highest Medicaid Inpatient Utilization Rate (MIUR). Any remaining funds available for redistribution shall be redistributed first to other state hospitals in the order of MIUR from highest to lowest, then to government non-state hospitals in the order of MIUR from highest to lowest, then to private hospitals in the order of MIUR from highest to lowest.

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APPENDIX H

Upper Payment Limit

In addition to the Medicaid prospective rate, hospitals located within Mississippi or a hospital within a county or parish contiguous to the State of Mississippi allowed by Federal legislation to submit intergovernmental transfers (IGTs) to the state of Mississippi and otherwise allowed to participate in the UPL program pursuant to Mississippi law may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each specified class of hospitals, the amount that Medicare would have paid for the previous year will be calculated and compared to what payments were actually made by Medicaid during that same time period. This calculation may then be used to make payments to hospitals for the current year. The calculated available UPL, as approved by CMS in DOM's annual DSH/UPL demonstration, may be paid to hospitals, within each specified class, in accordance with applicable state and federal laws and regulations.

UPL Payments

A. Privately operated and non-state government operated general acute care hospitals, within the meaning of 42 CFR Section 447.272, that have fifty (50) or fewer licensed beds as of January 1, 2009, shall receive a supplemental inpatient UPL payment equal to sixty-five percent (65%) of their fiscal year 2010 hospital specific inpatient UPL gap, before any payments under this subsection.

B. General acute care hospitals licensed within the class of state hospitals shall receive a supplemental inpatient UPL payment equal to twenty-eight percent (28%) of their fiscal year 2007 inpatient payments, excluding DSH and UPL payments.

C. General acute care hospitals licensed within the class of non-state government hospitals shall receive:

(1) For fiscal year 2010, a supplemental inpatient UPL payment equal to fifty-six percent (56%) of their fiscal year 2007 inpatient payments, excluding DSH and UPL payments. (For state fiscal year 2010, the state shall use 2007 inpatient payment data)

(2) For state fiscal year 2011 and after, a supplemental inpatient UPL payment determined by multiplying inpatient payments, excluding DSH and UPL, by the uniform percentage necessary to exhaust the maximum amount of inpatient UPL payments permissible under federal regulations. (For state fiscal year 2011, the state shall use 2008 inpatient payment data. For state fiscal year 2012, the state shall use 2009 inpatient payment data)

D. Free-standing psychiatric hospitals shall receive an additional inpatient UPL payment equal to Seven Hundred Sixty Dollars ($760.00) for fiscal years 2010 and 2011, and Seven Hundred Eighty Dollars ($780.00), for fiscal year 2012 and thereafter, less the hospital's fiscal year 2007 average Medicaid inpatient per diem rate, multiplied by the hospital's fiscal year 2007 Medicaid inpatient days. Residential treatment days and payments shall be excluded from this calculation. The base rate for private free-standing psychiatric hospitals shall be that in use January 1, 2009, which shall not be revised or recalculated so long as the hospital assessment is in effect.

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E. In addition to other payments provided above, all hospitals licensed within the class of private hospitals, other than free-standing psychiatric hospitals, shall receive:

1) For fiscal year 2010, an additional inpatient UPL payment equal to forty-nine and forty-five one-hundredths percent (49.45%) of their fiscal year 2007 inpatient payments, excluding DSH and UPL payments, and

2) For state fiscal year 2011 and after, an additional inpatient UPL payment determined by multiplying inpatient payments, excluding DSH and UPL, by the uniform percentage necessary to exhaust the maximum amount of UPL inpatient payments permissible under federal regulations. (For state fiscal year 2011, the state shall use 2008 inpatient payment data. For state fiscal year 2012, the state shall use 2009 inpatient payment data.)

F. The division shall implement UPL calculation methodologies that result in the maximization of available federal funds.

G. The UPL payments shall be paid on or before December 31, March 31, and June 30 of each fiscal year, in increments of one-third (1/3) of the total calculated UPL amounts.

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APPENDIX I – Rate Setting Procedures in Place Beginning October 1, 2005

The following example shows the process for determining the hospital inpatient prospective reimbursement rate for the reimbursement periods beginning October 1, 2005.

1. Determine each provider's most recent inpatient per diem rate in place October 1, 2003 through September 30, 2004.

2. Determine each provider's most recent inpatient per diem rate in place October 1, 2004 through September 30, 2005.

3. Determine each provider's base rate for reimbursement periods beginning October 1, 2005. If the FY 2005 rate is greater than the FY 2004 rate, use the FY 2005 rate as the base rate. If the FY 2005 rate is less than the FY 2004 rate, use the average of the two rates as the base rate.

   NOTE: If the provider qualifies for low disproportionate share (DSH) payments in the reimbursement period beginning October 1, 2005, through September 30, 2006, the low DSH component (6% of the operating component) will be included as a component of the inpatient per diem. For reimbursement periods beginning October 1, 2006, if the provider qualifies for low DSH payments, the low DSH component (6% of the operating component) will not be included in the inpatient per diem rate. Instead, a lump sum payout will be made to the provider based on the estimated number of days during each respective rate year times the low DSH component. Therefore, adjustments will be necessary to remove the low DSH component from the FY 2006 rate before calculating the FY 2007 trended rate.

4. For the reimbursement period beginning October 1, 2005, each provider's base rate will be increased by the most recent Medicare Inpatient Hospital PPS Market Basket Update as published in the Federal Register. For reimbursement periods beginning October 1, 2006, through September 30, 2010, the prospective rate for the immediately preceding rate year will be increased by the most recent Medicare Inpatient Hospital PPS Market Basket Update as published in the Federal Register. If a new payment methodology is not adopted by the Division of Medicaid by October 1, 2010, each provider's rate will be recalculated beginning October 1, 2010, and each subsequent October 1, using the methodology described in Appendix A.

Provider	FY 2004 Rate	FY 2005 Rate	Low DSH Component (6% of op. comp.)	Base Rate	Market Basket Update as of 10/01/06	FY 2006 Trended Rate	Remove trended low DSH component	FY 2006 Trended Rate net of low DSH	Market Basket Update as of 10/01/07	FY 2007 Trended Rate
Hospital A+	$894.38	$1,142.27	$65.17	$1,207.44	3.30%	$1,247.29	($67.32)	$1,179.97	3.40%	$1,220.09
Hospital B@	$934.65	$1,334.87		$1,334.87	3.30%	$1,378.92	($71.73)	$1,307.19	3.40%	$1,351.64
Hospital C^	$1,144.00	$1,039.91		$1,091.96	3.30%	$1,127.99		$1,127.99	3.40%	$1,166.34

+ Hospital A did not qualify for low DSH in FY 2004, FY 2005, and FY 2007, but qualified in FY 2006. The operating component of the FY 2005 rate is $1,086.25. ($1,086.25 X 6% = $65.17.)

@ Hospital B qualified for low DSH in FY 2004, FY 2005, and FY 2006, but did not qualify in FY 2007. The low DSH component of the base rate is $69.44.

^ Hospital C did not qualify for low DSH in any year between FY 2004 and FY 2007.