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

Inpatient Hospital Services

Prior authorization (PA) by the Utilization Management and Quality Improvement Organization (UM/QIO) is required on all hospital admissions except newborns at birth. Upon approval of a hospital admission, a treatment authorization number (TAN) is issued for an inpatient stay up to nineteen (19) consecutive days. If a beneficiary is discharged during these nineteen (19) days and requires another inpatient stay, a new PA request must be submitted to the UM/QIO for a new TAN.

Continued stay authorizations by the UM/QIO are required when the beneficiary remains hospitalized more than nineteen (19) days.

All hospital admissions for deliveries must be reported to the UM/QIO to receive an automatic TAN for an inpatient stay up to nineteen (19) consecutive days.

Newborns do not require a PA for admission at birth. Well or sick newborns hospitalized more than five (5) days from the date of delivery require a PA with the begin date of the hospital stay as the newborn's date of birth. If a newborn is discharged and requires another inpatient stay, a PA by the UM/QIO must be obtained on admission.

The Division of Medicaid covers all medically necessary services for EPSDT-eligible beneficiaries without regard to service limitations and with prior authorization.

State of Mississippi
Title XIX Inpatient Hospital Reimbursement Plan

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Introduction

This plan is for use by providers, their accountants, the Division of Medicaid, and its fiscal agent in determining the allowable and reasonable costs of and reimbursement for hospital inpatient services furnished to Medicaid recipients. The plan contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Division of Medicaid. The inpatient payment to hospital providers except for Choctaw Indian Health Services will be under an All Patient Refined Diagnosis Related Group (APR-DRG) reimbursement system. Choctaw Indian Health Services will be reimbursed on a per diem basis in accordance with Miss. Code Ann. § 43-13-121; Sec. 1911 [42 U.S.C. 1396j] (a)(b)(c)(d); Section 1905(b).

The program herein adopted is in accordance with Federal Statute, Sec. 1396 [42 U.S.C. 1396a]. The applicable Federal Regulations are 42 CFR 430; 42 CFR 440.10; 42 CFR 440.160; 42 CFR 440.230; 42 CFR 441.12; 42 CFR 441, Subpart D; 42 CFR 447, Subparts A, B, C and E; 42 CFR 455, Subparts A, B, C and D; 42 CFR 456, Subpart B; 42 CFR 482; and 42 CFR 489 Subparts A, B, C, D and E. Each hospital that has contractually agreed to participate in the Title XIX Medical Assistance Program will adopt the procedures set forth in this plan; each must file the required cost report and will be paid for the services rendered on an APR-DRG basis. The objective of this plan is to reimburse providers at a rate that is reasonable and adequate for efficiently and economically operated hospitals that comply with all requirements of participation in the Medicaid program.

State of Mississippi
Title XIX Inpatient Hospital Reimbursement Plan

As changes to this plan are made and approved by the Centers for Medicare and Medicaid Services (CMS), the plan document will be updated on the Medicaid website at http://www.medicaid.ms.gov.

Questions related to this reimbursement plan or to the interpretation of any of the provisions included herein should be addressed to:

Office of the Governor
Division of Medicaid
Suite 1000, Walter Sillers Building
550 High Street
Jackson, Mississippi 39201

CHAPTER 1
PRINCIPLES AND PROCEDURES

1-1 Plan Implementation

A. Payments under this plan will be effective for services with admission dates October 1, 2012 and thereafter. The reimbursement period will run from October 1 through September 30 of each year.

B. The Division of Medicaid will provide an opportunity for interested members of the public to review and comment on the reimbursement 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 reimbursement methodology. A period of thirty (30) days will be allowed for comment. The Division of Medicaid will notify the administrator of each hospital of their inpatient Medicaid DRG base rate and inpatient cost-to-charge ratio used to pay cost outlier payments.

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

1-2 Plan Evaluation

Documentation will be maintained to effectively monitor and evaluate experience during administration of the plan.

1-3 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.

1-4 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 hospitals in the program so that eligible persons 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.

1-5 Payments to Providers

A. Assurance of Payments

The State will pay each hospital which furnishes the services in accordance with the requirements of the State Plan the amount determined for services furnished by the hospital according to the standards and methods set forth in the Mississippi Title XIX Inpatient Hospital Reimbursement Plan.

In all circumstances where third party payment is involved, Medicaid will be the payer of last resort.

B. Acceptance of Payments

Participation in the program shall be limited to hospitals who accept, as payment in full for services rendered to Medicaid recipients, the amount paid in accordance with this State Plan.

C. Overpayments – An overpayment is an amount which is paid by the Division of Medicaid to a provider in excess of the amount that is computed with the provisions of this plan. All overpayments must be reported and returned by the later of either (1) the date which is 60 days after the date on which the overpayment was identified, or (2) the date any corresponding cost report is due, if applicable. Any overpayment retained by a provider after the deadline for reporting and returning the overpayment is an obligation as defined in Section 3729 (b)(3) of Title 31, United States Code. Failure to repay an overpayment to the Division of Medicaid may result in sanctions.

D. Underpayments – An underpayment occurs when an amount which is paid by the Division of Medicaid to a provider is less than the amount that is computed in accordance with the provisions of this plan. Underpayments, likewise determined, will be reimbursable to the provider.

E. Credit Balances – A credit balance, or negative balance, on a provider's account is an amount which is due to the Division of Medicaid. The credit balance is treated as an overpayment by the Division of Medicaid and is subject to the rules described above for overpayments.

1-6 Hospital Classes

A. Bed Class of Facilities

The following statewide bed class of facilities shall be used as a basis for evaluating adequate access to care and reasonableness of payments in Mississippi and other reasons as outlined in the Plan. General hospitals will be classified based on the number of beds available per the annual cost report. This number is determined as follows: Total hospital beds less nursery beds, NICU beds and beds for provider components paid at a different rate or not participating in the Medicaid program. Free-standing psychiatric hospitals are a separate class of hospitals with all bed sizes combined. Services provided in long-term acute care hospitals, (freestanding Medicare-certified hospitals with an average length of inpatient stay greater than twenty-five (25) days and primarily engaged in providing chronic or long-term medical care), are only reimbursable for Medicaid beneficiaries under the age of twenty-one (21). A separate bed class is set up for these hospitals providing services as to Medicaid beneficiaries under twenty-one (21) years of age.

CLASS OF FACILITIES

1. General Hospitals with 0 - 50 Beds
2. General Hospitals with 51 - 100 Beds
3. General Hospitals with 101 - 150 Beds
4. General Hospitals with 151 - 200 Beds
5. General Hospitals with 201 or more Beds
6. Free-Standing Psychiatric Hospitals
7. Long-term Acute Care Hospital Pediatric Services

B. Calculation of Average Cost-to-Charge Ratio of Bed Classes

The setting of the average inpatient cost-to-charge ratio for each bed class of facilities is determined by using the inpatient cost-to-charge ratio computed for each hospital using the Medicare cost report FORM CMS-2552-96, or its successor, and the desk review procedures outlined in Section 2-1.H.

CHAPTER 2
COST REPORTING AND COST FINDING

2-1 Cost Reporting

A. Reporting Period

Each Mississippi hospital participating in the Mississippi Medicaid Hospital program will submit a Uniform Cost Report using the appropriate Medicare FORM CMS- 2552-96, or its successor. All references to the cost report in this document refer to CMS-2552-96, or its successor. A hospital which voluntarily or involuntarily ceases to participate in the Mississippi Medicaid Program or experiences a change of ownership must file a cost report. Short period cost reports may also be required for changes in status such as a change from a general acute care hospital to a critical access hospital. In cases where there is a change in fiscal year end, the most recent filed cost report will be used to perform the desk review. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII.

B. When to File

Each facility must submit a completed cost report postmarked no later than five (5) calendar months after the close of its cost reporting year. Should the due date fall on a weekend, a State of Mississippi holiday or a federal holiday, the due date shall be the first business day following such weekend or holiday.

C. Failure to File a Cost Report

A hospital which does not file a cost report within six (6) calendar months after the close of its reporting period may be subject to cancellation of its Provider Agreement at the discretion of the Division of Medicaid, Office of the Governor.

D. Extensions for Filing

No routine extensions will be granted. Extensions of time to file may be granted due to unusual situations or to match a Medicare filing. Extraordinary circumstances will be considered on a case-by-case basis. Extensions may only be granted by the Executive Director of the Division of Medicaid. All other filing requirements shall be the same as those for Title XVIII. If the granted cost report due date extension causes a delay in the calculation of the Medicaid inpatient cost-to-charge ratio (CCR), the current inpatient CCR on file prior to October 1 of each year will be used to pay cost outlier payments. The Division of Medicaid will perform a desk review on the late filed cost report(s) upon receipt. After the desk review is completed and the thirty (30) day appeal option has been exhausted, the new inpatient CCR is entered into the Mississippi Medicaid Management Information System and is in effect through the end of the current reimbursement period. No retroactive adjustments will be made.

E. Delinquent Cost Reports

Cost reports that are submitted after the due date will be assessed a penalty in the

amount of $50.00 per day the cost report is delinquent. This penalty may only be waived by the Executive Director of the Division of Medicaid for good cause. Good cause is defined as a substantial reason that affords a legal excuse for a delay or an intervening action beyond the provider's control, e.g. flood, fire, natural disaster or other equivalent occurrence. Good cause does not include ignorance of the law, hardship, inconvenience or a cost report preparer engaged in other work.

F. What to Submit

One (1) copy of the following information is considered a completed cost report:

1. Hard copy of the cost report with original signature;
2. Electronic copy of the cost report (printable text file or adobe acrobat format on a CD). The signatures obtained for the electronic version can be submitted by scanning the signed signature page as an attachment to the file on the CD or by submitting the signed signature page in its original format;
3. Working trial balance;
4. Depreciation expense schedule;
5. Supporting workpapers for:
    a. Worksheet A-6;
    b. Worksheet A-8;
    c. Worksheet A-8-1;
6. Worksheet C, Part I total charges workpaper;

7. Medicare Title XVIII information for the Worksheet D series:
    a. Worksheet D, Parts V & VI. Define what types of services are included on line 76 OP Psych Therapy, IOP, PHP, etc. and what revenue codes are included. Distinguish what part of these costs and charges are related to geriatric patients. The MS Division of Medicaid does not reimburse for partial hospitalization programs or day treatment programs and geriatric psychiatric services;
    b. Worksheet D-1, Parts I, II & III;
    c. Worksheet D-3;
8. Medicaid Title XIX information for the Worksheet D series:
    a. Worksheet D, Parts V & VI. Define what types of services are included on line 76 OP Psych Therapy, IOP, PHP, etc. and what revenue codes are included. Distinguish what part of these costs and charges are related to geriatric patients. The MS Division of Medicaid does not reimburse for partial hospitalization programs or day treatment programs and geriatric psychiatric services;
    b. Worksheet D-1, Parts I, II & III;
    c. Worksheet D-3;
9. Medicaid Worksheet E-3, Part VII, specifically lines 8 and 9.

G. Where to File

The cost report and related information should be mailed to:

Office of the Governor
Division of Medicaid
Reimbursement Division
Suite 1000, Walter Sillers Building
550 High Street
Jackson, MS 39201

H. Desk Reviews

The Division of Medicaid will conduct cost report reviews prior to the reimbursement period. The objective of the desk reviews is to evaluate the necessity and reasonableness of facility costs in order to determine the allowable costs used in the calculation of the inpatient cost-to-charge ratio used to pay cost outlier payments. Desk reviews will be performed using desk review programs developed by the Division of Medicaid. Providers will be notified, in writing, of all adjustments made to allowable costs. Facilities have the right of appeal as described in Section 3-1 of this plan.

The desk review procedures will consist of the following:

1. The latest cost report available to Medicaid in each calendar year for each hospital will be reviewed for completeness, accuracy, consistency and compliance with the Mississippi Medicaid State Plan, Medicare Principles of Reimbursement as described in the Medicare Provider Reimbursement Manual, 15-1, and

the Mississippi Administrative Code, Title 23 Medicaid, Part 200 General Provider Information, Chapter 2 Benefits, Rule 2.2 Non-Covered Services and Part 202 Hospital Services, Chapter 1 Inpatient Services, Rule 1.5 Non-Covered Services, regarding non-covered services.

2. The provider must submit a complete cost report. When it is determined that a cost report has been submitted that is not complete enough to perform a desk review, the provider will be notified. Providers will be allowed a specified amount of time to submit the requested information. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information will be made. The provider will be given five (5) working days from the date of the provider's receipt of the second request for information. Information that is requested that is not submitted following either the first or the second request may not be submitted for reimbursement purposes. Providers will not be allowed to: submit the information at a later date; submit the information at the time of audit; or amend the cost report in order to submit the additional information. An appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including cost findings, is omitted.

For cost reports submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If there is no response to the request, an additional five (5) working days will be allowed for submission of the requested information. Providers will not be allowed to: submit the information at a later date; submit the information at the time of audit; or amend the cost report in order to submit the additional information. An appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including cost findings, is omitted;

3. Once all the information required for the desk review is received, the cost report will be reviewed and adjusted:
   a. to reflect the results of desk review and/or field audits;
   b. to adjust for excessive costs;
   c. to determine if the hospital's general routine operating costs are in accordance with 42 CFR 413.53. For hospitals having excessive general routine operating costs, appropriate adjustments shall be made.
   d. to remove the costs of non-covered services.
4. Total cost allocated to the Medicaid Program on the appropriate cost reporting forms for the purposes of the inpatient cost-to-charge ratio used to pay outlier payments shall include capital costs and operating costs. Capital costs are defined

by this plan to include those costs reported for Medicare reimbursement purposes such as depreciation, non-employee related insurance, interest, rent, and property taxes (real and personal). Operating costs are defined as total Medicaid costs less capital costs apportioned to the Medicaid Program. Medical education costs will not be included in the calculation of the inpatient cost-to-charge ratio used to pay outlier payments because these costs will be paid outside the APR-DRG payments as noted in section 4-1.O. of this plan. Those Mississippi hospitals that file a cost report with no Medicaid activity will be assigned the average inpatient cost-to-charge ratio for the bed class in which the hospital falls.

5. All desk review findings will be sent to the provider.
6. Desk reviews amended after the inpatient cost-to-charge ratio (CCR) is determined due to an amended cost report will be used only to adjust the CCR from the date the amended CCR is calculated and input into the MMIS, through the end of the current reimbursement period. No retroactive adjustments to cost outlier payments will be made as a result of the change to the inpatient CCR.

2-2 Amended Cost Reports

The Division of Medicaid accepts amended cost reports if the cost report is submitted prior to the end of the reimbursement period in which the cost report is used for payment purposes. Amended cost reports must include all information in Section F. above; an explanation for the amendment; and workpapers for all forms that are being amended. Each form and schedule submitted should be clearly marked "Amended" at the top of the

page. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the amended cost report, no retroactive adjustments will be made to cost outlier payments using the amended cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System and will be in effect from the date of entry through the end of the current reimbursement period.

Cost reports may not be amended after an audit has been initiated.

2-3 Cost Finding

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. The cost report must be prepared in accordance with the methods of reimbursement and cost finding in accordance with Title XVIII (Medicare) Principles of Reimbursement, as described in the Medicare Provider Reimbursement Manual, 15-1, or as modified by this plan.

2-4 Allowable Costs

Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.5 - 413.178 (excluding the inpatient routine salary cost differential) and the Mississippi Administrative Code, Title 23 Medicaid, Part 200 General Provider Information, Chapter 2 Benefits, Rule 2.2 Non-Covered Services

and Part 202 Hospital Services, Chapter 1 Inpatient Services, Rule 1.5 Non-Covered Services, regarding non-covered services, or as modified by Title XIX of the Act and this Plan.

A. Title XIX reimbursement will not recognize the above average cost of inpatient routine nursing care furnished to aged, pediatric, and maternity patients. The inpatient routine nursing salary cost differential reimbursed by the Title XVIII program will reduce the reasonable cost for determining Title XIX reimbursement as required in the applicable CMS cost reporting forms;

B. Section 42 CFR 413.35 Limitations on Coverage of Costs: Charges to Beneficiaries if Cost Limits are Applied to Services - This section will not be applicable to inpatient hospital services rendered to Title XIX beneficiaries to prevent a form of supplementation reimbursement. However, Section 42 CFR 413.30 Limitations on Reimbursable Costs will be applied for determining Title XIX reimbursement;

C. All items of expense may be included which hospitals must incur in meeting:

   1. The definition of a hospital contained in 42 CFR 440.10 and 42 CFR 440.140 in order to meet the requirements of Sections 1902(a), (13) and (20) of the Social Security Act;

   2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610; and

   3. Any other requirements for the licensing under state law which are necessary for providing hospital inpatient services.

D. 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 excess costs would not be reimbursable under the plan. Such cost is allowable to the extent that it is related to patient care, is necessary and proper, and is not in excess of what would be incurred by a prudent buyer.

E. The costs of implantable programmable baclofen drug pumps used to treat spasticity implanted on an inpatient basis are allowable costs for Medicaid cost report purposes. The cost of the pumps should not be removed from allowable costs on the cost report.

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 Medicare Provider Reimbursement Manual, 15-1, Section 2122.1.

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

H. Notwithstanding any other subparagraph, depreciation and interest expense shall not exceed the limitations set forth in Section 2-9.

I. Inpatient hospital services provided under the Early Periodic Screening Diagnostic and Testing (EPSDT) program will be reimbursed at the APR-DRG amount.

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

2-5 Cost Report 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.

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 for participation in a common audit program shall provide the Division of Medicaid the results of the field audits of those hospitals located in Mississippi, upon the Division of Medicaid request to the Medicare intermediary. The Division of Medicaid may also request a copy of the final cost report from the provider.

C. Other Hospital Audits - For those hospitals not covered by the common audit agreements with Medicare intermediaries, the Division of Medicaid shall be responsible for performance of the desk reviews, field reviews and field audits in accordance with Title XVIII standards. On-site audits will be made when desk reviews indicate such are needed.

D. Retention - All cost reports received from Medicare intermediaries or issued by

Medicaid will be kept for a period of at least five (5) years following the date all audit findings are resolved.

2-6 Availability of Hospital Records

All hospitals are required to maintain financial and statistical records. All records must be available upon demand to the Division of Medicaid staff, other State and Federal agencies and its contractors, thereof.

2-7 Records of Related Organizations

Records of related organizations as defined by 42 CFR 413.17 must be available upon demand to the Division of Medicaid staff, other State and Federal agencies and its contractors, thereof.

2-8 Record Keeping Requirements

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.

2-9 Change of Ownership

A. Change in Ownership of Depreciable Assets - For purposes of this plan, a change in ownership of assets includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility. 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. In a case in which a change in ownership of a provider's depreciable assets occurs, and if a bona fide sale is established, the Title XIX basis for depreciation will be the lower of:

1. The portion of the purchase price properly allocable to a depreciable asset; or
2. The fair market value of the depreciable asset determined by an independent appraiser who is a member of the society of Real Estate Appraisers; or
3. The allowable cost basis under Title XVIII (Medicare) cost principles to the owner of record on July 18, 1984.

If the basis of a provider's depreciable assets is limited to 3 above, then the estimated useful life of the assets as used by the seller must be used by the buyer.

B. Interest Expense – Where interest expense is incurred to finance the purchase of a hospital of a depreciable asset used therein and the purchase price exceeds the allowable cost basis, interest expense on that portion of the debt or other interest

bearing instrument used to finance the excess of the purchase price over the allowable cost basis is not considered reasonably related to patient care and is not allowable.

C. Loss on Sale of a Hospital – The sale of depreciable assets, or a substantial portion thereof, at a price less than the Title XIX cost basis of the property as reduced by accumulated depreciation calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement indicates a loss on the sale of the assets. Such losses are not reimbursable under this plan.

A Mississippi facility which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the sale. The seller must file a final cost report with the Division of Medicaid from the date of the last cost report to the effective date of the sale. The filing of a final cost report may be waived by the Division of Medicaid, if the cost report will not be needed for reimbursement purposes. The new owner must file a cost report from the date of the change of ownership through the end of the Medicare cost report year end. The new owner must submit provider enrollment information required under Division of Medicaid policy.

The inpatient cost-to-charge ratio of the old owner is used to pay cost outlier payments for the new owner. The new owner's inpatient cost-to-charge ratio used to pay cost outlier payments is calculated for the first rate year beginning October 1, for which the

new owner's cost report is available. There are no retroactive adjustments to a new owner's inpatient cost-to-charge ratio used to pay cost outlier payments.

2-10 New Providers – Mississippi hospitals beginning operations during a reporting year will file an initial cost report from the date of certification to the end of the cost report year end. Each rate year the inpatient cost-to-charge ratio used to pay outlier payments for each Mississippi hospital is grouped by bed class (as described in Section 1-6) and an average inpatient cost-to-charge ratio is determined for each class. The initial inpatient cost-to-charge ratio used to pay cost outlier payments to a new hospital will be the average inpatient cost-to-charge ratio used for the bed class of a Mississippi hospital as of the effective date of the Medicaid provider agreement until the inpatient cost-to-charge ratio is recalculated based on the new hospital's initial cost report. There will be no retroactive adjustments to a new hospital's inpatient cost-to-charge ratio used to pay cost outlier payments. After the desk review is completed for the new provider's cost report and the thirty (30) day appeal option has been exhausted, the new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System and will be in effect through the end of the current reimbursement period.

2-11 Out-of-State Hospitals

A. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each

out-of-state hospital are set annually using the Federal Register that applies to the federal fiscal year beginning October 1 of each year, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

B. Payment for transplant services is made under the Mississippi APR-DRG payment methodology including a policy adjustor. (Refer to Appendix A.) If access to quality services is unavailable under the Mississippi APR-DRG payment methodology, a case rate may be set.

1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the most current *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion.*
2. The *Milliman* categories comprising the sum of billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) discharge. Outpatient immune-suppressants and other prescriptions are not included in the case rate. (Refer to Appendix B Table 1.)
3. For beneficiaries enrolled in a Coordinated Care Organization (CCO), the CCO is responsible for reimbursement of outpatient services received thirty (30) days pre-transplant and one-hundred eighty (180) days post (transplant) discharge. These

billed charges are not included in the case rate. (Refer to Appendix B Table 2.)

4. If the transplant stay exceeds the hospital length of stay published by *Milliman,* an outlier per-diem payment will be made for each day that exceeds the hospital length of stay as indicated below:

   a. Beneficiaries Not Enrolled in a Coordinated Care Organization (CCO)

   The outlier per-diem payment is calculated by taking the difference between the sum of *Milliman's* total average billed charges including thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) discharge and the case rate, divided by the maximum outlier days. The outlier per-diem is added to the case rate for each day that exceeds the hospital length of stay. (Refer to Appendix B Table 1.)

   b. Beneficiaries Enrolled in a Coordinated Care Organization (CCO)

   The outlier per-diem payment is calculated by taking the difference between the sum of *Milliman's* total average billed charges including procurement, hospital transplant inpatient admission, and physician services during transplant and the case rate, divided by the maximum outlier days. The outlier per-diem is added to the case rate for each day that exceeds the hospital length of stay. (Refer to Appendix B Table 2.)

5. Total reimbursement of transplant services cannot exceed one-hundred percent (100%) of the sum of average billed charges for the categories listed in B.2. and B.3. above.

6. Contracts for transplant services negotiated prior to October 1, 2012, are honored through the term of the contract.

7. For transplant services not available in Mississippi and not listed in the most current *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion*, the Division of Medicaid will make payment using the Mississippi APR-DRG payment methodology. If Mississippi APR-DRG payment impacts access to care, the Division will reimburse what the domicile state pays for the service. The Division of Medicaid is responsible for payment of transplant services listed in B.2. above, with the CCO responsible for payment of transplant services listed in B.3. above for beneficiaries enrolled in a CCO.

C. For specialized services not available in Mississippi, the Division of Medicaid will make payment based on Mississippi APR-DRG payment methodology. If Mississippi APR-DRG payment affects access to care, the Division will reimburse what the domicile state pays for the service or a comparable payment other states reimburse under APR-DRG.

CHAPTER 3
APPEALS AND SANCTIONS

3-1 Appeals and Sanctions

A. Appeal Procedures – Desk Reviews and Field Audits

Mississippi inpatient hospital providers who disagree with an adjustment to their allowable cost or a calculation in the inpatient cost-to-charge ratio used to pay outlier payments may file an appeal to the Division of Medicaid. The following reasons would be grounds to file an appeal with the Division of Medicaid:

1. The addition of new and necessary services not requiring Certificate of Need (CON) approval. Notification must be made in writing to the Division of Medicaid within thirty (30) days of implementing the services. The submitted cost figures must be allocated between capital costs, education costs, and operating costs.
2. The cost of capital improvements receiving CON approval after inpatient cost-to-charge ratios were set if those costs were not considered in the calculation. Notification must be made in writing to the Division of Medicaid within thirty (30) days of implementing the services. The submitted cost figures must be allocated between capital costs, education costs, and operating costs.
3. Cost of improvements incurred because of certification or licensing requirements established after inpatient cost-to-charge ratios used to pay cost outlier payments were set if those costs were not considered in the calculation. The appeal must be

submitted within thirty (30) days of the change in certification or licensing and must be sent to the Division of Medicaid in writing.

4. Incorrect data were used or an error was made in the inpatient cost-to-charge ratio calculation.
5. Extraordinary circumstances which may include but are not limited to riot, strike, civil insurrection, earthquakes or flood.

The appeal must be in writing, must include the reason for the appeal, and must be made within thirty (30) calendar days after the Division of Medicaid notified the provider of the adjustment. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the appeal. The request for an appeal adjustment must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The burden of proof shall be on the hospital to demonstrate that costs for which the additional reimbursement is being requested are necessary, proper and consistent with efficient and economical delivery of covered patient services.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, by hand delivery, or e-mail, and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, (b) if by hand delivery, on the date delivered, or (c) if by

e-mail, on the date an e-mail delivery receipt is received. The hospital will be notified of Medicaid's decision in writing within thirty (30) days of receipt of the hospital's written request, or within thirty (30) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the thirty (30) day period shall be grounds for denial of the request. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the appeal, no retroactive adjustments will be made to cost outlier payments using the amended cost-to-charge ratio. The new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System immediately after the appeal decision is rendered and will be in effect through the end of the current reimbursement period.

B. Application of Sanctions

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

   a. 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.

   b. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by the Mississippi Division of Medicaid, the Mississippi State Department of Health, or

the Information Quality Healthcare.

c. 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.

d. Documented practice of charging recipients for services over and above that paid by the Division of Medicaid.

e. Failure to correct deficiencies in provider operations after receiving written notice of the deficiencies from the Director of the Mississippi State Department of Health, Peer Review Organization, or the Division of Medicaid.

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

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

h. Failure to keep and maintain auditable records as prescribed by the Division of Medicaid.

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

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

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

l. Presenting, or causing to be presented, for payment any false or fraudulent

claims for services or merchandise.

m. 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 Division of Medicaid or usual and customary charges as allowed under the Division of Medicaid regulations).

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

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

p. 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.

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

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

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

   c. 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.

3. Within thirty (30) calendar days after notice from the Executive Director of the Division of Medicaid 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 Division of Medicaid 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. Unless a timely and proper request for a 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 and Fair Hearings as adopted by the Mississippi Division of Medicaid.

C. Appeals – APR-DRG Parameters

Providers cannot appeal the APR-DRG base price or any other APR-DRG parameters established by the Division of Medicaid described herein.

CHAPTER 4
REIMBURSEMENT

4-1 Payment Methodology Effective October 1, 2012

A. Applicability

Except as specified in this paragraph, the inpatient prospective payment method applies to all inpatient stays in all acute care general, rehabilitation and mental health (psychiatric/substance abuse treatment) hospitals. It does not apply to stays where Medicare is the primary payer or to "swing bed" stays. It also does not apply to Indian Health Services hospitals, where payment is made on a per-diem basis per federal law.

B. Primacy of Medicaid Policy

Many features of the Medicaid inpatient prospective payment method are patterned after the similar method used by the Medicare program. When specific details of the payment method differ between Medicaid and Medicare the Medicaid reimbursement methodology described here-in prevails.

C. APR-DRG Reimbursement

For admissions dated October 1, 2012 and after, the Division of Medicaid will reimburse all hospitals a per stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs). APR-DRGs classify each case based on information contained

on the inpatient Medicaid claim: diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG determines the reimbursement when the APR-DRG relative weight is multiplied by the APR-DRG base price.

D. DRG Relative Weights

Each version of the APR-DRG relative weights has a set of DRG-specific relative weights assigned to it. The APR-DRG relative weights are calculated by 3M Health Information Systems from the Nationwide Inpatient Sample (NIS) created by the Agency for Healthcare Research and Quality. Each APR-DRG relative weight reflects the typical resources consumed per case. According to 3M Health Information Systems, V.29 relative weights were calculated as follows:

1. A two-year dataset of NIS records was compiled, representing 15.5 million stays.
2. All stays were grouped using APR-DRG V.29.
3. Stays at extreme ends of the distribution of stays (top and bottom 2% in terms of length of stay) for each APR-DRG were "trimmed," that is, excluded from the dataset used to calculate relative weights.
4. For each APR-DRG, the relative weight was calculated as the average hospital charge for that DRG divided by the average charge for all stays in the dataset.

An evaluation performed by the Division of Medicaid determined that the national relative weights calculated by 3M Health Information Systems corresponded closely

to relative weights calculated from Mississippi Medicaid stays. The Division of Medicaid therefore chose to use the national weights, for two reasons. First, relative weights for low-volume DRGs are more stable when calculated from the large national dataset than from relatively small Mississippi Medicaid dataset. Second, the national weights are available on an annual basis, so it is not necessary for the Division of Medicaid to incur the time and expense to recalibrate relative weights.

It is the intention of the Division of Medicaid to update the relative weights whenever the Division of Medicaid adopts a new version of the APR-DRG algorithm. A state plan amendment will be submitted any time the relative weights are updated.

The relative weight is applied to determine the APR-DRG Base Payment that will be paid for each admit-through-discharge case regardless of the specific services provided or the exact number of days of care. The weights are applied prospectively and no retroactive claims adjustments are made. The APR-DRG weights are posted on the Medicaid website at http://www.medicaid.ms.gov.

E. Policy Adjustors

When the Division of Medicaid determines that adjustments to relative weights for specific DRGs are appropriate to meet Medicaid policy goals, a "policy adjustor"

may be applied to increase or decrease these relative weights. Policy adjustors are typically implemented to ensure that payments are consistent with efficiency and access to quality care. They are typically applied to boost payment for services where Medicaid represents a large part of the market and therefore Medicaid rates can be expected to affect hospitals' decisions to offer specific services and at what level. Policy adjustors may also be needed to ensure access to very specialized services offered by only a few hospitals. By definition, policy adjustors apply to any hospital that provides the affected service. The five policy adjustors are described below and the specific values of each are reflected in Appendix A:

1. Obstetrics, neonates and normal newborns – This adjustor was set so that payments for these care categories (in aggregate) approximate 100% of estimated hospital cost.
2. Mental health pediatric – This adjustor was set so that payments to freestanding psychiatric hospitals would be approximately budget-neutral in aggregate and therefore not impact access to care across the state because Medicaid patients represent a substantial portion of the patient census at freestanding psychiatric hospitals and provided over half of inpatient psychiatric care for pediatric patients in 2009. The pediatric mental health policy adjustor applies to stays at both freestanding and general hospitals.
3. Mental health adult – This adjustor was set to mitigate the impact of the decrease in payment that would occur during the shift from per diem payment to DRG

payment. Under the previous payment method, the same per diem amount was paid for relatively inexpensive services such as mental health as for relatively expensive services such as cardiac surgery. As a result, the pay-to-cost ratio for mental health was relatively high.

4. Rehabilitation – This adjustor was set so that payment for rehabilitation would be approximately 100% of cost. This level of cost was estimated by reference to average cost per stay at the in-state facility that performs only rehabilitation.
5. Transplant – This adjustor was set so that payment for transplants would be approximately budget-neutral compared with the previous payment method. Because of the very small volume of stays, the calculation was done using two years of paid claims data rather than six months.

A state plan amendment will be submitted any time policy adjustors are added or adjusted.

F. DRG Base Price

The same base price is used for all stays in all hospitals. The initial base price (effective October 1, 2012) was set at a budget-neutral amount per stay based on the analysis of 55,568 inpatient stays from the period October 2010 through March 2011. These stays were originally paid under the Division's previous per diem method. A series of data validation steps were undertaken to ensure that the analytical dataset

would be as accurate as possible for purposes of calculating the initial APR-DRG base price. In particular, separate records were created for mothers and normal newborns, who previously had been billed on the same claim but would be billed on separate claims under the APR-DRG payment. All stays were grouped using the APR-DRG V.29 algorithm; policy adjustors as described in Paragraph E were applied; a detailed estimate of the fiscal impact of removing inpatient service limits was made; and a 3.5% decrease adjustment was made to the base price to reflect expected improvements in hospital documentation and coding. Within this payment method structure, the APR-DRG base price then determines the overall payment level. By applying the payment method calculations to the 55,568-stay analytical dataset, the budget-neutral APR-DRG base price of $6,223 was calculated. The Division of Medicaid will not make retroactive payment adjustment.

The base price is reflected in Appendix A.

G. DRG Base Payment

For each stay, the DRG Base Payment equals the DRG Relative Weight multiplied by the DRG Base Price with the application of policy adjustors, as applicable. Additional payments and adjustments are made as described in this section and in Appendix A.

H. Parameters

The parameters of base price, policy adjustors, relative weights, and outliers interact with payment methodology to determine payments. Changes to any of the parameters will be updated through a state plan amendment.

The parameters are prospective and will not be implemented retroactively.

I. Cost Outlier Payments

Extraordinarily costly cases in relation to other cases within the same DRG because of the severity of the illness or complicating conditions may qualify for a cost outlier payment. This is an add-on payment for expenses that are not predictable by the diagnoses, procedures performed, and other statistical data captured by the DRG grouper.

The additional payment for a cost outlier is determined by calculating the hospital's estimated loss. The estimated loss is determined by multiplying the Medicaid covered charges for each claim by the hospital's inpatient cost-to-charge ratio minus the DRG base payment. The hospital's inpatient cost-to-charge ratio is limited to a maximum of 100%. If the estimated loss is greater than the DRG cost outlier threshold established by the Division of Medicaid (see Appendix A), then the cost outlier payment equals the estimated loss minus the DRG cost outlier threshold multiplied by the DRG Marginal Cost Percentage (see Appendix A). For purposes of

this calculation, the DRG base payment is net of any applicable transfer adjustment (see Section J of this chapter).

Stays assigned to mental health DRGs are not eligible for cost outlier payments, but may qualify for a day outlier payment if the mental health stay exceeds the DRG Long Stay Threshold (see Section I of this chapter and Appendix A).

1. Cost-to-Charge Ratio – The inpatient cost-to-charge ratio used to pay inpatient cost outlier payments will be calculated as noted in Section 2-1, H.
2. Requests for Change in Inpatient Cost-to-Charge Ratio
   a. Changes Due to a Certificate of Need (CON) - A hospital may at times offer to the public new or expanded services, purchase equipment, drop such services, or retire equipment which requires (CON) approval. Within thirty (30) calendar days of implementing a CON approved change, the hospital must submit to the Division of Medicaid a budget showing the allocation of the approved amount to the Medicaid Program. This amount must be separated as applicable between capital costs, educational costs and operating costs. The budget must show an estimate of any increase or decrease in operating costs and charges applicable to the Medicaid Program due to the change, as well as the effective date of the change. Such amounts will be subject to desk review and audit by the Division of Medicaid. Allowance for such changes shall be made to the hospital's inpatient cost-to-charge ratio 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. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the CON, no retroactive adjustments will be made to cost outlier payments using the amended inpatient cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System and will be in effect through the end of the current reimbursement period.

b. Significant Change in Overall Costs - A hospital should request a revision to its inpatient cost-to-charge ratio used to pay cost outlier payments to the Division of Medicaid whenever a provider can demonstrate that the allowable Medicaid inpatient cost-to-charge ratio using the most recently filed cost report has changed by 5% or more as compared to the existing cost-to-charge ratio. Requests which do not result in a percentage change of at least 5% more or less than the current cost-to-charge ratio will not be granted. The request must be submitted in writing to the Division of Medicaid, clearly identifying the grounds of the request and the percentage change in question. Copies of documenting support for the request must be included. Such amounts will be subject to desk review and audit by the Division of Medicaid. Facilities should make every effort possible to ensure that requests which do not meet the criteria are not submitted. If the provider's inpatient cost-to-

charge ratio used to pay cost outlier payments is changed, no retroactive adjustments will be made to cost outlier payments using the amended inpatient cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted, the new inpatient cost-to-charge ratio will be input into the Mississippi Medicaid Management Information System and will be in effect through the end of the current reimbursement period.

c. Intentional Misrepresentation and/or Suspected Fraud and/or Abuse of Cost Report Information – Such adjustment shall be made retroactive to the date of the original inpatient cost-to-charge ratio. 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 an administrative hearing is requested by the hospital.

d. Appeals – Appeals are made to the Division of Medicaid as provided in Section 3-1 of this plan.

J. Day Outlier Payments

Inpatient psychiatric hospital services are reimbursed under the APR-DRG methodology. Day outlier payments may be made only to stays assigned to mental health DRGs for mental health long lengths of stay for exceptionally expensive cases.

A stay becomes a day outlier when it exceeds the DRG Long Stay Threshold

determined by the Division of Medicaid (see Appendix A). In addition to the DRG base payment, all days after the threshold are paid per diem at the DRG Day Outlier Statewide Amount.

K. Transfer Payment Adjustments

The transfer payment adjustment applies when a patient is transferred to another acute care hospital or leaves the hospital against medical advice. It does not apply when a patient is discharged to a post-acute setting such as a skilled nursing facility. The receiving hospital is not impacted by the transfer payment adjustment unless it transfers the patient to another hospital.

The transfer payment is initially calculated as a full payment. The full payment calculation is divided by the nationwide average length of stay for the assigned DRG to arrive at a per diem amount. The per diem amount is then multiplied by the actual length of stay, except that payment is doubled for the first day. The payment is the lesser of transfer-adjusted payment or what the payment would have been if the patient had not been transferred.

See Appendix A for the discharge status values that define an acute care transfer for purposes of APR-DRG payment.

L. Prorated Payment Adjustment

When a beneficiary has Medicaid coverage for fewer days than the length of stay, then payment is prorated. The payment amount is divided by the nationwide average length of stay for the assigned DRG to arrive at a per diem amount. The per diem amount is then multiplied by the actual length of stay, except that payment is doubled for the first day. The payment will be the lesser of prorated payment or regular payment for the entire stay.

M. DRG Payment Allowed Amount and Paid Amount

The DRG Payment equals the DRG Base Payment with any applicable policy

adjustors, plus outlier payments if applicable, with transfer and/or prorated adjustments made if applicable. The allowed amount equals the DRG Payment plus applicable add-on payments such as medical education. The Paid Amount equals the Allowed Amount minus copayments and third-party liability.

N. Three-Day Payment Window

The three-day payment window applies to inpatient stays in hospitals. The window applies to services provided to a patient by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital. Under the three-day window, certain services are considered to be included in the fee-for-service inpatient stay. Services included in the inpatient stay may not be separately billed to the Division of

Medicaid or to a Medicaid managed care plan when a beneficiary has managed care coverage for outpatient care but fee-for-service coverage for inpatient care. Specific provisions are as follows.

1. Diagnostic services provided to a patient within three (3) days prior to and including the date of an inpatient admission are included within the inpatient stay.
2. Therapeutic (non-diagnostic) services related to an inpatient admission and provided to a beneficiary within three (3) days prior to and including the date of the inpatient admission are included within the inpatient stay. Therapeutic services clinically distinct or independent from the reason for the beneficiary's inpatient admission may be separately billed on an outpatient claim with the appropriate code. Such separately billed services are subject to review. Medical record documentation must support that the services are unrelated to the inpatient admission.
3. Maintenance renal dialysis provided on an outpatient basis within the three days prior to and including the date of the inpatient admission may be separately billed and separately paid.
4. Although the Division of Medicaid's policy is based on Medicare policy, Medicaid's policy applies if there is a difference.

O. Baclofen Pumps

Reimbursement for baclofen pumps, as for other supplies, services and devices, will be included within the DRG payment. No separate reimbursement will be made.

P. Payment Adjustment for Provider Preventable Conditions

Citation - 42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 of the Social Security Act, with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A:

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Section 2702 of the Patient Protection and Affordable Care Act of 2010 prohibits Federal payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for certain hospital inpatient provider-preventable conditions (PPC) and health care-acquired conditions (HCAC) for dates of service effective October 1, 2011, for individuals for which Medicaid is

primary and those dually eligible for both the Medicare and Medicaid programs. This policy applies to all Mississippi Medicaid enrolled hospitals except for Indian Health Services. Reduced payment to providers is limited to the amounts directly identifiable as related to the PPC and the resulting treatment. The payment reduction will not apply to Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) as related to a total knee replacement or hip replacement for children under age twenty-one or pregnant women.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19A:

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied).

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to

the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

1. The identified provider-preventable conditions would otherwise result in an increase in payment.
2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

The following method will be used to determine the related reduction in payments for hospital inpatient Health Care-Acquired Conditions and Other Provider Preventable Conditions which includes Never Events as defined by the National Coverage Determination for dates of service beginning on or after October 1, 2012: Once per quarter, paid claims identified in the Mississippi Medicaid Management Information System (MMIS) with a POA indicator of "N" or "U", will be run through a Medicare DRG Grouper, once without the appropriate POA indicator with the application of the Medicare list of Health Care-Acquired Conditions and Other Provider-Preventable Conditions, and once with the appropriate POA indicator with the application of the Medicare list of Health Care-Acquired Conditions and Other

Provider-Preventable Conditions. If a difference in payment between the two claims is indicated, the following steps will be performed.

a. The original claim will be voided.

b. The original claim will be reprocessed and manually re-priced to reflect the reduction in payment due to the PPC. The payment amount will be calculated by taking the original APR-DRG Medicaid allowed amount, less the difference in payment resulting in the paragraph above.

Calculation of the Provider-Preventable Conditions (PPC) Reduction in Payment for Hospital Inpatient Services

The following example reflects the calculation and application of the reduction in hospital inpatient payments for Provider-Preventable Conditions (PPC) including Health Care-Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC).

PPC Payment Reduction Calculation for Dates of Service beginning on or after October 1, 2012 – Once quarterly a report will be run by the Division of Medicaid to identify those paid claims with a Present on Admission (POA) indicator of "N" or "U" with Health Care-Acquired Conditions and Other Provider Preventable Conditions. The payment reduction will be based on the Medicare DRG grouper for claims with dates of service on or after October 1, 2012, as calculated below.

Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	Col. G
Provider Number	TCN number	Dates of Service	Original XIX APR-DRG Allowed Amount per MMIS before PPC reduction	Medicare grouper payments for HCAC/OPPC w/o POA*	Medicare grouper payments for HCAC/OPPC with POA*	Reduction in XIX Payments for PPCs (Col. E – Col. F)
0022XXX1	XXXXXXXXXXXXXXXX	10/01/12 – 10/14/12	$8,144.63	$11,500	$12,800	($1,300)
00020XX9	XXXXXXXXXXXXXXXX	10/10/12 – 10/14/12	$6,374.68	$5,720	$5,720	($0)
00020XX5	XXXXXXXXXXXXXXXX	11/09/12 – 11/14/12	$5,695.10	$6,000	$6,540	($540)
0022XXX4	XXXXXXXXXXXXXXXX	11/15/12 – 11/24/12	$13,326.66	$10,898	$11,280	($382)
00020XX4	XXXXXXXXXXXXXXXX	12/03/12 – 12/08/12	$6,790.60	$8,350	$8,350	($0)
	Total		$40,331.67	$44,690	$42,468	($2,222)

*Please note that the Medicare grouper payment amounts are for illustrative purposes only and do not reflect actual grouper amounts.

The original paid claims indicated above would be voided and reprocessed and manually re-priced to reflect the reduction in Column G. For instance, the first claim that originally paid $8,144.63 would be voided and manually re-priced to pay $6,844.63 ($8144.63 - $1,300.00). The payment reduction of $1,300.00 would be recovered from the provider on their remittance advice.

Q. Medical Education Payments

Mississippi hospitals which have an approved teaching program or have received legislative approval to begin a teaching program as of July 1, 2012, will be reimbursed for direct graduate medical education costs applicable to interns and residents and the nursing school, as a per case add-on to the APR-DRG payment provided that services are performed on the campus of the teaching hospital and only the teaching hospital is eligible for reimbursement. Hospitals that enter into contractual arrangements with the teaching hospital to utilize the services of interns and residents are not eligible for this add-on payment.

The medical education per case add-on as of October 1, 2012, will be considered the medical education per case base rate. The base rate will be calculated as follows: the FY 11 medical education cost per day included in the FY 11 per diem rate will be multiplied times the number of Medicaid covered days used in the simulation for the parameters effective October 1, 2012; the resulting product will be divided by the number of Medicaid cases used in the simulation from October 1, 2010 through March 31, 2011 for the parameters effective October 1, 2012. For rate years beginning October 1, 2013, and thereafter, the medical education per case add-on for the preceding year will be increased by the percentage increase of the most recent Medicare Inpatient Hospital PPS Market Basket updated as of October 1 of each year as published in the Federal Register.

If a provider received legislative approval to begin a teaching program as of July 1, 2012, but has not begun the program as of October 1, 2012, once the provider implements the teaching program it will submit a budget to Medicaid that includes estimated total Medicaid education costs and stays for the first year. The initial medical education add-on for the provider upon implementation of the teaching program, will be determined by dividing Medicaid budgeted costs by Medicaid budgeted stays. If the provider has not submitted a cost report that includes medical education by October 1 of the second reimbursement period, the initial budgeted medical education add-on will be increased by the percentage increase of the most recent Medicare Inpatient Hospital PPS Market Basket updated as of October 1 of each year as published in the Federal Register. Once the provider submits the first cost report that includes medical education costs, the Division of Medicaid will perform a desk review. After the desk review is completed and the thirty (30) day appeal option has been exhausted the new medical education base rate will be input into the Mississippi Medicaid Management Information System and will be in effect through the end of the current reimbursement period. No retroactive adjustments will be made. For rate years beginning October 1, and thereafter, the medical education per case add-on for the preceding year will be increased by the percentage increase of the most recent Medicare Inpatient Hospital PPS Market Basket updated as of October 1 of each year as published in the Federal Register.

Medical education costs will not be reimbursed to out-of-state hospitals.

R. Long-term Ventilator-dependent Patients Admitted Prior to October 1, 2012

Payment for ventilator-dependent patients admitted to the hospital prior to October 1, 2012 will continue to be reimbursed on a per diem basis until they are discharged from the hospital. For hospitals with these patients, for rate years beginning October 1, 2012, and thereafter, the per diem in effect in the preceding year will be increased by the percentage increase of the most recent Medicare Inpatient Hospital PPS Market Basket updated as of October 1 of each year as published in the Federal Register. All patients admitted to a hospital on or after October 1, 2012 will be reimbursed under the APR-DRG methodology.

S. Post-Payment Review

All claims paid under the APR-DRG payment methodology are subject to post-payment review.

CHAPTER 5
DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

5-1 Qualifying Criteria

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

A. Except as provided in a. and b. 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 A., above, shall not apply to a hospital:

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

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

and;

B. 1. 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

2. 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:

a. 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;

b. 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.

5-2 Computation of Disproportionate Share Payments

A. 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.

B. 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 uninsured 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).

C. For state fiscal year 2013, the state shall use uninsured costs from 2011 hospital data.

D. The Division of Medicaid shall implement DSH calculation methodologies that result in the maximization of available federal funds.

5-3 Disproportionate Share Payment Period

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.

5-4 Timing of Disproportionate Share Payments

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.

5-5 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.

CHAPTER 6
UPPER PAYMENT LIMIT (UPL) PAYMENTS

6 Upper Payment Limit Payments

In addition to the Medicaid APR-DRG payment, 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. The out-of-state hospital allowed by Federal legislation to participate in the MS UPL program, cannot include medical education costs in the computation of their upper payment limit. For each federally defined class of hospitals, the amount trended to the current rate year 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 the Division of Medicaid's annual DSH/UPL demonstration, may be paid to hospitals, within each federally defined class, in accordance with applicable state and federal laws and regulations.

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6-1 UPL Payments – Hospitals With 50 Beds or Less

For state fiscal year 2013, 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 2012 hospital specific inpatient UPL gap, before any payments under this subsection.

6-2 UPL Payments – State Hospitals

For state fiscal year 2013, 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.

6-3 UPL Payments – Government Non-State Hospitals

For state fiscal year 2013, general acute care hospitals licensed within the class of government non-state hospitals shall receive a supplemental inpatient UPL payment determined by multiplying 2010 inpatient payments, excluding DSH and UPL, by the uniform percentage necessary to exhaust the maximum amount of inpatient UPL payments permissible under federal regulations.

6-4 UPL Payments – Free-standing Psychiatric Hospitals

For fiscal year 2013, free-standing psychiatric hospitals shall receive an additional inpatient UPL payment equal to Eight Hundred Fifty Dollars ($850.00) per day, less the hospital's fiscal year 2010 average Medicaid inpatient per diem rate, multiplied by the hospital's fiscal year 2010 Medicaid inpatient days. Residential treatment days and payments shall be excluded from this calculation. Nothing in this paragraph shall prevent the Division of Medicaid from reimbursing private free-standing psychiatric hospitals based upon an APR-DRG reimbursement methodology.

6-5 UPL Payments – Private Hospitals

For FY 2013, in addition to other payments provided above, all hospitals licensed within the class of private hospitals, other than free-standing psychiatric hospitals, shall receive an additional inpatient UPL payment determined by multiplying 2010 inpatient payments, excluding DSH and UPL, by the uniform percentage necessary to exhaust the maximum amount of inpatient UPL payments permissible under federal regulations.

6-6 UPL Payments – Maximization of Federal Funds

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

6-7 Timing of UPL Payments

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.

APPENDIX A

APR-DRG KEY PAYMENT VALUES

The table below reflects key payment values for the APR-DRG payment methodology described in this Plan.

Payment Parameter	Value	Use
APR-DRG version	V.29	Groups every claim to a DRG
DRG base price	$6,223	Rel. wt. X DRG base price = DRG base payment
Policy adjustor – obstetrics and newborns	1.40	Increases relative weight and payment rate
Policy adjustor – mental health pediatric	2.08	Increases relative weight and payment rate
Policy adjustor – mental health adult	1.75	Increases relative weight and payment rate
Policy adjustor – Rehabilitation	2.11	Increases relative weight and payment rate
Policy adjustor – Transplant	1.50	Increases relative weight and payment rate
DRG cost outlier threshold	$30,000	Used in identifying cost outlier stays
DRG marginal cost percentage	60%	Used in calculating cost outlier payment
DRG long stay threshold	19	All stays above 19 days require TAN on days
DRG day outlier statewide amount	$450	Per diem payment for mental health stays over 19 days
Transfer status 02 – transfer to hospital	02	Used to identify transfer stays
Transfer status 05 –transfer other	05	Used to identify transfer stays
Transfer status – 07 – against medical advice	07	Used to identify transfer stays
Transfer status – 65 – transfer to psychiatric hospital	65	Used to identify transfer stays
Transfer status – 66 – transfer to critical access hospital	66	Used to identify transfer stays
DRG interim claim threshold	30	Interim claims not accepted if < 31 days
DRG interim claim per diem amount	$450	Per diem payment for interim claims
Documentation and coding adjustment	0.035	Applies to general hospitals
Documentation and coding adjustment	0.071	Applies to freestanding psychiatric hospitals

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Appendix B

Out-of-State Hospital Transplant Services' Case Rates Effective October 1, 2012

Table 1 - Case Rates for Beneficiaries Not Enrolled in a Coordinated Care Organization (CCO)

Column	A	B	C	D	E	F	G	H	I	J	K
Transplant	30 Days Pre-Transplant Average Billed Charges	Procurement Average Billed Charges	Hospital Transplant Admission Average Billed Charges	Physician During Transplant Average Billed Charges	180 Days Post Transplant Discharge Average Billed Charges	Total Average Billed Charges* Sum of A through E	Case Rate F X 40%	Difference of F - G	Max Outlier Days	Hospital Length of Stay	Outlier Per-Diem H ÷ I
Single Organ/Tissue											
Bone Marrow Allogeneic	$41,400	$38,900	$419,600	$22,400	$259,800	$782,100	$312,840	$469,260	60	33	$7,821
Bone Marrow Autologous	44,600	18,200	198,200	10,800	84,900	356,700	142,680	214,020	60	20	3,567
Cornea	0	0	16,500	7,900	0	24,400	9,760	14,640	60		244
Heart	47,200	80,400	634,300	67,700	137,800	967,400	386,960	580,440	60	40	9,674
Intestine	55,100	78,500	787,900	104,100	146,600	1,172,200	468,880	703,320	120	70	5,861
Kidney	17,000	67,200	91,200	18,500	50,800	244,700	97,880	146,820	30	7	4,894
Liver	25,400	71,000	316,900	46,600	93,900	553,800	221,520	332,280	60	21	5,538
Lung - Single	10,300	73,100	302,900	33,500	117,700	537,500	215,000	322,500	60	19	5,375
Lung - Double	21,400	90,300	458,500	56,300	142,600	769,100	307,640	461,460	60	30	7,691
Multiple Organ											
Heart-Lung	56,800	130,500	777,700	81,000	169,100	1,215,100	486,040	729,060	120	45	6,076
Intestine with other Organs	57,900	172,700	795,900	116,300	160,900	1,303,700	521,480	782,220	120		6,518
Kidney- Heart	48,800	123,600	813,000	93,900	184,800	1,264,100	505,640	758,460	120	47	6,321
Kidney-Pancreas	20,800	102,500	194,900	34,700	100,400	453,300	181,320	271,980	60	12	4,533
Liver-Kidney	46,800	117,500	574,100	83,100	180,100	1,001,600	400,640	600,960	60	28	10,016
Other Multi-Organ	75,400	131,000	1,050,100	139,500	278,600	1,674,600	669,840	1,004,760	120		8,373

Table 2 - Case Rates for Beneficiaries Enrolled in a Coordinated Care Organization (CCO)

Column	A	B	C	D	E	F	G	H	I
Transplant	Procurement Average Billed Charges	Hospital Transplant Admission Average Billed Charges	Physician During Transplant Average Billed Charges	Total Average Billed Charges* Sum of A through C	Case Rate D X 40%	Difference of D - E	Max. Outlier Days	Hospital Length of Stay	Outlier Per-Diem F ÷ G
Single Organ/Tissue									
Bone Marrow Allogeneic	$38,900	$419,600	$22,400	$480,900	$192,360	$288,540	60	33	$4,809
Bone Marrow Autologous	18,200	198,200	10,800	227,200	90,880	136,320	60	20	2,272
Cornea	0	16,500	7,900	24,400	9,760	14,640	60		244
Heart	80,400	634,300	67,700	782,400	312,960	469,440	60	40	7,824
Intestine	78,500	787,900	104,100	970,500	388,200	582,300	120	70	4,853
Kidney	67,200	91,200	18,500	176,900	70,760	106,140	30	7	3,538
Liver	71,000	316,900	46,600	434,500	173,800	260,700	60	21	4,345
Lung - Single	73,100	302,900	33,500	409,500	163,800	245,700	60	19	4,095
Lung - Double	90,300	458,500	56,300	605,100	242,040	363,060	60	30	6,051
Multiple Organ									
Heart-Lung	130,500	777,700	81,000	989,200	395,680	593,520	120	45	4,946
Intestine with other Organs	172,700	795,900	116,300	1,084,900	433,960	650,940	120		5,425
Kidney- Heart	123,600	813,000	93,900	1,030,500	412,200	618,300	120	47	5,153
Kidney-Pancreas	102,500	194,900	34,700	332,100	132,840	199,260	60	12	3,321
Liver-Kidney	117,500	574,100	83,100	774,700	309,880	464,820	60	28	7,747
Other Multi-Organ	131,000	1,050,100	139,500	1,320,600	528,240	792,360	120		6,603

* Total reimbursement cannot exceed one-hundred percent (100%) of the sum of billed charges as published by *Milliman* in columns A-E in Table 1 for beneficiaries not enrolled in a COO or columns A-C in Table 2 for beneficiaries enrolled in a CCO.