

Mississippi Title XIX Inpatient Hospital
Reimbursement Plan

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

A. Prospective Rate

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

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

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

B. Subsequent Adjustment

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

C. Class of Facilities

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

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D. Upper Payment Limit

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

E. Requests for Rate Change

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

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

- A. Each Mississippi hospital participating in the Mississippi Medicaid Hospital program will submit a Uniform Cost Report using the appropriate Medicare/Medicaid forms postmarked no later than five (5) calendar months after the close of its cost reporting year. No routine extensions will be granted. All other filing requirements shall be the same as those for Title XVIII. Extraordinary circumstances will be considered on a case-by-case basis. One (1) complete copy of the cost report shall be submitted to the Division of Medicaid (DOM). The cost reports for periods ending in the prior calendar year will be used to calculate the per diem rates for the following October 1 – September 30 fiscal year. For example, the cost report of a hospital with a June 30, 1996 year end would be used to set the rate effective October 1, 1997 through September 30, 1998.
- B. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII.
- C. Cost reports used to initiate this plan will be for reporting periods beginning April 1, 1980, or earlier.
- D. All hospitals are required to detail their cost reports for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals must adhere to all requirements of Section 25, Provider Policy Manual.

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- E. 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 except where further interpreted by the Provider Policy Manual or as modified by this plan.
- F. Cost reports that are not postmarked by the specified due date, unless a waiver by the Division of Medicaid, Office of the Governor, is granted, will result in a penalty of \$50.00 per day the cost report is delinquent. Cost reports with a due date that falls on Saturday, Sunday, a State of Mississippi holiday or a federal holiday will be due the next business day.

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.

- G. 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 in accordance with Section 25, Provider Policy Manual.
- H. All hospitals are required to maintain financial and statistical records. All records must be available upon demand to representatives, employees or contractors of the Division of Medicaid, Office of the Governor, Mississippi State Department of Audit, General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS).

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I. Records of related organizations as defined by 42 CFR 405.427 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.

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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.

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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 DOM the results of the field audits of those hospitals located in Mississippi. For years prior to the rate year beginning October 1, 2005, DOM will review these field audits and will adjust the prospective rate paid to in-state hospitals as appropriate. Only the original final settlement will be reviewed and adjustments made therefrom.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreements with Medicare intermediaries, DOM 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 audit 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.

E. Overpayments/Underpayments

Overpayments as a result of an error or misrepresentation will be reimbursable to Medicaid within sixty (60) days of the date of notification to the provider of the amount due. Underpayments, likewise determined, will be reimbursable to the provider.

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V. 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 guidelines in the Provider Policy Manual, except 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 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 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:

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F. Hospital inpatient general routine operating costs shall be the lesser of actual costs incurred or the limits established by HHS and set forth in 42 CFR 405.460.

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.

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

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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
 - A. A hospital is deemed to be a disproportionate share hospital if the criteria listed below are met.

- (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.

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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.

- (c) Disproportionate share payments to High Disproportionate Share Hospitals will be made as follows:

The amount of funds shall be distributed to hospitals based upon the ratio of each hospital's cost of uncompensated care provided to Mississippi residents to the sum of the total cost of uncompensated care provided to Mississippi residents for all High Disproportionate Share Hospitals. Uncompensated care data will be reported to the Division of Medicaid through an annual survey submitted by the hospitals. The inpatient days and outpatient visits for which the facilities were not compensated as reported in this survey will be converted to cost by the Division of Medicaid based upon the cost report information from the most recently filed and reviewed cost reports available at the time of the survey. In no case may a hospital exceed any other limitations for payments described elsewhere in this plan.

- (2) Low Disproportionate Share Hospitals

- (a) A hospital is determined to be a low disproportionate share hospital if it meets the qualifications of a disproportionate share hospital but does not qualify as a High Disproportionate Share Hospital.
- (b) Low Disproportionate Share Hospitals shall receive an increase to their Medicaid prospective rate of six percent (6%) of the operating cost component.

- (3) 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 six (6) years may, within sixty (60) days of the rate letter, request an outlier payment adjustment to the established rate for those individuals. Adversely affected is defined as exceeding the operating

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cap of the class of the facility, trended forward as applicable. The outlier adjustment is only for claims filed for Medicaid recipients under six (6) 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.

- C. Amended cost reports must be received by the Division of Medicaid on or before the thirtieth (30th) day following the due date of the initially filed cost report in order for that cost report to be used to determine a hospital's eligibility for disproportionate share status for the state fiscal year.
- D. The determination of a hospital disproportionate share status is made annually and is for the period of the state fiscal year (July 1 - June 30). Once the list of disproportionate share hospitals is determined for a state 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, if the hospital is required to provide such services.
- 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 six years may 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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VI. Appeals

Inpatient hospital providers who disagree with an adjustment to their allowable cost or a calculation in the rate setting information may file an appeal to the Division of Medicaid. The following reasons would be grounds to file an appeal with the Division of Medicaid:

- A. For rate years prior to October 1, 2005, the addition of new and necessary services not requiring 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.
- B. For rate years prior to October 1, 2005, the cost of capital improvements receiving CON approval after payment rates 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.
- C. For rate years prior to October 1, 2005, cost of improvements incurred because of certification or licensing requirements established after payment rates were set if those costs were not considered in the rate 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.
- D. Incorrect data were used or an error was made in the rate calculation.

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VII. Method – For Rate Years Prior to October 1, 2005

A. Prospective Rate

Medicaid will utilize a prospective rate of reimbursement and will not make retroactive adjustments except as specified in this plan. The prospective rates will be determined from cost reports and will be set on a yearly (October 1 -September 30) basis from date established and will be applicable to all facilities with a valid provider agreement.

B. Cost Containment

1. Medicaid, prior to setting the prospective rate for each year, will make appropriate adjustments to account for increased cost as outlined in the plan and will designate the maximum percentile at the 80th percentile of the operating component cost for each class of facility as outlined in Section VII, D of this plan. The percentile is based on the determination of a reimbursement percentile which will enable an efficiently and economically operated hospital to care for Medicaid recipients.

2. The Medicaid Prospective Capital Cost Component will be determined at the hospital's actual occupancy rate.

3. Out-of-State hospital providers with a participation agreement shall be excluded from the determination of the 80th percentile limit on the operation cost component.

C. Class of Facilities

The following statewide classes of facilities shall be used

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3. Medicaid Prospective Capital Cost Component
 - a. Total capital costs apportioned to the Medicaid Program will be divided by actual Medicaid inpatient days.
 - b. In accordance with Section V K, an amount will be added or deducted for the capital cost applicable to the Medicaid Program for new or deleted services or equipment which requires Certificate of Need approval.
 - c. The addition of 3a. and 3b. shall be called the Medicaid Prospective Capital Cost Component.
4. Medicaid Prospective Educational Cost Component
 - a. Total educational costs apportioned to the Medicaid Program will be adjusted for the number of months between the mid-point of the hospital's reporting year and the mid-point of the calendar year most recently ended by the payroll expense and employee benefits portion of the latest rate of

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to lowest by class of facility. The designated percentile will be selected as the maximum operating cost component.

e. The lesser of actual cost in d. above or the maximum operating cost component will be separated into labor and non-labor categories.

f. The corresponding labor cost per diem wage index adjustment will be made to the lower of the actual adjusted labor cost per diem in d. above, or the ratio of the actual adjusted labor cost per diem to the total per diem in d. times the maximum operating cost component.

g. An industry trend factor as described in Appendix C of this plan will be applied to the sum of the labor per diem in f. above and the non-labor per diem in e. above for the number of months between the mid-point of the most recent calendar year ended and the mid-point of the reimbursement period. The labor portion of the trend factor is set at zero (0) for the period referenced in Appendix C.

h. In accordance with Section V G, an amount will be added (or deducted) for the operating cost applicable to the Medicaid Program for new (or deleted) services or equipment which requires CON approval.

i. The sum of g. and h. to be called the Medicaid Prospective Operating Cost Component.

E. Setting the Individual Hospital Rates

The individual hospital rate will be the sum of the Medicaid Prospective

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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

In addition to the Medicaid prospective rate, hospitals located within Mississippi 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 difference between Medicaid payments and what Medicare would have paid, or allowable multiple of that difference, may be paid to hospitals, within each specified class, in accordance with applicable state and federal laws and regulations, including any provisions specified in appropriations by the Mississippi Legislature.

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 therefor.

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Unless a timely and proper request for a hearing is received by the Division from the provider, the findings of the Division 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.

XI. Payments Assurance

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.

XII. 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.

XIII. Payment In Full

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.

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XIV. Plan Evaluation

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

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