State of Mississippi
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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.

XIV. Plan Evaluation

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

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

Payment Adjustment for Provider Preventable Conditions

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.

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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, 2011:

Once quarterly, paid claims identified in the Mississippi Medicaid 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. (Refer to Appendix J for example.)

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 multiplying the per diem rate in effect at the time the claim is processed times the covered days, less the difference in payment resulting in the paragraph above.
c. Each identified claim will be voided, reprocessed and manually re-priced for any subsequent retro-rate adjustments.

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APPENDIX J

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

Section XV. of the Plan requires a reduction in hospital inpatient payments for Provider-Preventable Conditions (PPC) including Health Care-Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC). Following is the example of the calculation and application of the payment reduction:

A. PPC Payment Reduction Calculation for Dates of Service beginning on or after October 1, 2011 – Once quarterly a report will be run by DOM 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, 2011, as calculated below.

Col. A	Col. B	Col. C	Col. D	Col. E	Col. F	Col. G	Col. J
Provider Number	TCN number	Dates of Service	Covered Days	Original XIX Allowed Amount per MMIS before PPC reduction	Medicare DRG grouper payments for HCAC/OPPC w/o POA*	Medicare DRG grouper payments for HCAC/OPPC with POA*	Reduction in XIX Payments for PPCs (Col. F – Col. G)
0022XXX1	XXXXXXXXXXXXXXXX	10/01/11 – 10/14/11	13	$8,144.63	$11,500	$12,800	($1,300)
00020XX9	XXXXXXXXXXXXXXXX	10/10/11 – 10/14/11	4	$6,374.68	$5,720	$5,720	($0)
00020XX5	XXXXXXXXXXXXXXXX	11/09/11 – 11/14/11	5	$5,695.10	$6,000	$6,540	($540)
0022XXX4	XXXXXXXXXXXXXXXX	11/15/11 – 11/24/11	9	$13,326.66	$10,898	$11,280	($382)
00020XX4	XXXXXXXXXXXXXXXX	12/03/11 – 12/08/11	5	$6,790.60	$8,350	$8,350	($0)
	Total		36	$40,331.67	$44,690	$42,468	($2,222)

*Please note that the Medicare DRG 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 J. 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.

When a provider's rate is adjusted for the reasons indicated in the state plan, the identified claims will be readjusted based on the new rate.