STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR

DIVISION OF MEDICAID

STATE PLAN

GUIDELINES FOR THE REIMBURSEMENT

FOR MEDICAL ASSISTANCE RECIPIENTS

OF

HOSPITALS

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 changes to the reimbursement methodology before it is implemented. This will be accomplished by publishing a public notice on the Agency's website 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

1. The cost report and related information listed below must be uploaded electronically to the cost report data base as designated by the Division of Medicaid.
2. A signed signature page with either a scanned wet signature or digitally signed;
3. Working trial balance;
4. Depreciation expense schedule;
5. Supporting workpapers for:
    a. Worksheet S-3
    b. Worksheet A-6;
    c. Worksheet A-8;
    d. 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 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 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.
10. General Information Survey.
11. For cost reporting periods ending on and after December 31, 2015, providers must combine Medicaid fee-for-service and Coordinated Care Organization (CCO) hospital inpatient and outpatient claims data (days, charges, etc.) from the respective Provider Statistical and Reimbursement Reports (PS&Rs) and report the amounts as one number throughout the cost report where Medicaid data is reported including, but not limited to, the Worksheets listed in numbers 5.a., 8, and 9 above. Providers must submit to DOM the CCO PS&Rs used for each cost reporting period as part of the original cost report submission.

G. Where to File

The cost report and related information must be uploaded electronically to the cost report data base as designated by the Division of Medicaid.

H. Desk Reviews

The Division of Medicaid will conduct cost report reviews, as deemed necessary, 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 via the database web portal 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 or that fail to provide all information listed in 2-1F. 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.

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 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 using the Federal Register that applies to the federal fiscal year in effect October 1, 2020. 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 average billed charges for transplant services as published in the *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion* in effect as of July 1, 2019. The transplant case rates are published on the agency's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

2. The *Milliman* categories comprising the sum of average 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.

3. 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. 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.
4. 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.

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

6. For transplant services not available in Mississippi and not listed in the *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion* in effect as of July 1, 2019, 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.

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 ahuse 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 hasis 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 hospital-specific relative value (HSRV) relative weight is multiplied by the APR-DRG base price. (The term "relative weight" used throughout this document refers to the HSRV relative weight.)

D. DRG Relative Weights

Each APR-DRG version 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. Version 35 relative weights under the hospital-specific relative value (HSRV) methodology were calculated as follows:

1. A one-year dataset of ICD-10 NIS records was compiled, representing 1 million stays.
2. All stays were grouped using APR-DRG V.35.
3. Hospital charges are used as the basis for establishing consistent relative resource use across differentiated case types. To mitigate distortion caused by differences from hospital to hospital in marking up charges over cost, claims charges that contribute to relative weights are normalized to a standard value such that each hospital has a similar charge level for a similar case mix.
4. A single hospital is omitted from the standardized value for each DRG so that each hospital's charges are standardized to the charges of the omitted hospital.
5. The standardized average cost of each DRG is normalized by multiplying through the number of cases in each DRG and computing a scaling factor to match the total weight of the total number of cases, which is applied uniformly to each weight such that average weight across the set of DRG weights is 1.0. The result is a set of relative weights that reflect differences in estimated hospital cost per APR-DRG.

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 specific values of each policy adjustor are reflected in Appendix A.

F. DRG Base Price

The same base price is used for all stays in all hospitals. The base price was set at a budget-neutral amount per stay based on an analysis of hospital inpatient stays from the previous state fiscal year. The Division of Medicaid will not make retroactive payment adjustments.

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.

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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. The cost-to-charge ratio in effect as of July 1, 2021, will be used to calculate outlier payments for claims with last dates of service on or after July 1, 2021.

2. Requests for Change in Inpatient Cost-to-Charge Ratio

   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 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. 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 Amount, Allowed Amount and Paid Amount

The DRG Payment Amount equals the DRG Base Payment with any applicable policy adjustors, plus outlier payments if applicable, with transfer and/or prorated adjustments made if applicable. If the sum of these amounts is more than the total billed charges on the claim, the DRG Payment Amount will be limited to the total billed charges. The Allowed Amount equals the DRG Payment Amount 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, through June 30, 2014:

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, through June 30, 2014 – 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, through June 30, 2014, 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.

PPC Payment Reductions for Dates of Service ending on or after July 1, 2014 – Effective for hospital inpatient dates of service ending on or after July 1, 2014, payment reductions for HCACs and Other Provider Preventable Conditions will be made through the claims payment system through the use of the 3M APR-DRG HCAC utility under the All Patient Refined Diagnosis Related Group payment methodology.

Q. Medical Education Payments

The Mississippi Division of Medicaid (DOM) reimburses Mississippi hospitals which meet the following criteria: (1) accreditation from the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA), (2) has a Medicare approved teaching program for direct graduate medical education (GME) costs, and (3) is eligible for Medicare reimbursement. The hospital must be accredited at the beginning of the state fiscal year in order to qualify for the quarterly payments during the payment year. To be eligible for payment, services must be performed on the campus of the teaching hospital or at a participating hospital site. Only the teaching hospital or the participating hospital site is eligible for reimbursement. DOM does not reimburse for indirect GME costs.

Medical education payments are calculated annually on July 1, as a per resident amount based on the total Medicaid hospital inpatient stays as calculated by DOM. During the year of implementation, effective October 1, 2019, the payments will be made to eligible hospitals in three (3) equal installments in December, March and June. Thereafter, the payments will be made to eligible hospitals on a quarterly basis in September, December, March and June. The number of residents per hospital is defined as the sum of the number of Medicare approved resident full time equivalents (FTEs) reported on the applicable lines on the most recent Medicare cost report filed with DOM for the calendar year immediately prior to the beginning of the state fiscal year for established programs. Any hospital which establishes a new accredited teaching program or is in a five (5) year resident cap building period for the teaching program must submit

documentation of accreditation, Medicare approval, the most recent Medicare interim rate letter, and start date of the GME program prior to the July 1 calculation of the payments. The number of residents used to calculate medical education payments during cap building years will be the number of FTEs as reported on the Medicare interim rate letter. If the number of FTEs reported on the Medicare interim rate letter does not cover the entire cost reporting period, the reported FTEs will be annualized and used to calculate medical education payments. The program must be in operation as of July 1 of the payment year.

The per resident rate will be as follows:

A. For residencies of Mississippi academic health science centers with a Level 1 trauma center:
   1. $65,000 per FTE for hospitals with 7,500 or more Medicaid hospital inpatient stays, or
   2. $55,000 per FTE for hospitals with fewer than 7,500 Medicaid hospital inpatient stays.

B. For residencies of all other accredited hospitals:
   1. $35,000 per FTE for hospitals with greater than 7,500 Medicaid hospital inpatient stays,
   2. $27,500 per FTE for hospitals with 2,000 to 7,500 Medicaid hospital inpatient stays, or
   3. $25,000 per FTE for hospitals with fewer than 2,000 Medicaid hospital inpatient stays.

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, the per diem in effect in the preceding year will be increased by the percentage increase. For hospitals with these patients, for rate years beginning October 1, 2012, and thereafter of the most recent Medicare Inpatient Hospital PPS Market Basket Update as of October 1 of each year as published in the Federal Register. Effective July 1, 2021, the per diem will be the amount calculated as of October 1, 2020. 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.

T. Payments Outside of the DRG Base Payment

The following payments are made outside of, and in addition to, the DRG base payment: Long Acting Reversible Contraceptives (LARCs) and their insertion at the time of delivery will be reimbursed separately from the APR-DRG payment. A separate outpatient claim may be submitted by the hospital for reimbursement for LARCs and their insertion at the time of delivery. Reimbursement for the insertion of LARCs at the time of delivery will be based on the Physician Fee Schedule effective July 1, 2021as described in Attachment 4.19-B. The LARC will be reimbursed at the lesser of the provider's usual and customary charge or the fee listed on the Physician Administered Drugs and Implantable Drug System Devices Fee Schedule effective July 1, 2021, as described in Attachment 4.19-B. All fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

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 (including GME program costs approved in accordance with Section 1.Q. of this plan) by the hospital to patients who either are eligible for medical assistance under this (or another state's) 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. For Medicaid DSH payment purposes, allowable costs include inpatient hospital and outpatient hospital costs of treating patients for whom Medicaid is the primary payor and patients who have no health insurance (or other source of third party coverage), along with any offsetting payments. Allowable uncompensated care costs are defined in accordance with Section 1923(g) of the Social Security Act in effect for the given DSH period. Allowable costs for hospitals that meet the 97th percentile exception will be in accordance with the Consolidated Appropriations Act of 2021.

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 each state fiscal year from 2015 forward, the state shall use uninsured costs from the hospital data related to the most recently filed and longest cost reporting period ending in the calendar year prior to the beginning of the state fiscal year.

   1. Those hospital assessments removed on the facility's cost report in accordance with the Medicare Provider Reimbursement Manual, 15-1, Section 2122, should be identified on the hospital DSH survey for add-back in the computation of the uncompensated care costs for Medicaid DSH payment purposes.

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 DSH payment period is from October 1 through September 30. The determination of a hospital disproportionate share status is made annually for hospitals that meet the DSH requirements as of October 1. 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.

For audits conducted on DSH payments for Federal Fiscal Years (FFY) prior to FFY 2023, 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.

Beginning with the audit of the FFY 2023 DSH payments and thereafter, all facilities meeting the criteria to be a DSH eligible hospital will be audited to determine the uncompensated cost and OBRA limit for each facility for the fiscal period. The allowed uncompensated cost will be compared to any DSH payments received to determine each facility's overpayment or underpayment applicable to the period. Any funds recouped as a result of overpayments determined during the 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. The funds shall be redistributed to those facilities under-compensated for the period based upon the ratio of each facility's under-compensation to the total of all amounts under-compensated. This redistribution will provide each under-compensated facility with a pro-rata share of any recouped funds.

5-6 DSH Allotment Adjustments

If the federal government adjusts the DSH allotment available to Mississippi prior to the month of a scheduled payment within the DSH payment year, this revised Mississippi DSH allotment will be utilized in the next scheduled DSH payment. However, if the federal government revises the Mississippi DSH allotment after June I of the DSH payment year, this revised DSH allotment will be incorporated into an additional DSH distribution, negative or positive, that will be with the next DSH payment but based on the DSH calculation for the DSH payment year. All DSH payments are subject to the State's lower DSH payment limit.

APPENDIX A

APR-DRG KEY PAYMENT VALUES

The table below reflects key payment values for the APR-DRG payment methodology described in this Plan. These values are effective for discharges on and after July 1, 2021.

Payment Parameter	Value	Use
3M™ APR-DRG version	V.38	Groups every claim to a DRG
DRG base price	$5,350	Rel. wt. X DRG base price = DRG base payment
Policy adjustor – obstetrics	1.40	Increases relative weight and payment rate
Policy adjustor – normal newborns	1.45	Increases relative weight and payment rate
Policy adjustor – neonate	1.40	Increases relative weight and payment rate
Policy adjustor – mental health pediatric	1.90	Increases relative weight and payment rate
Policy adjustor – mental health adult	1.45	Increases relative weight and payment rate
Policy adjustor – Rehabilitation	2.00	Increases relative weight and payment rate
Policy adjustor – Transplant (adult and pediatric)	1.50	Increases relative weight and payment rate
DRG cost outlier threshold	$60,000	Used in identifying cost outlier stays
DRG cost outlier marginal cost percentage	50%	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 – 63 – transfer to long-term acute care hospital	63	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
Transfer status – 82 – transfer to hospital with planned	82	Used to identify transfer stays
Transfer status – 85 – transfer to other with planned readmission	85	Used to identify transfer stays
Transfer status – 91 – transfer to long-term hospital with planned readmission	91	Used to identify transfer stays
Transfer status – 93 – transfer to psychiatric hospital with planned readmission	93	Used to identify transfer stays
Transfer status – 94 – transfer to critical access hospital with planned readmission	94	Used to identify transfer stays
DRG interim claim threshold	30	Interim claims not accepted if < 31 days
DRG interim claim per diem amount	$850	Per diem payment for interim claims