Mississippi Division of Medicaid January 28, 2026
SFY 2027 MHAP Preprint Parameters

Following are the proposed parameters for inclusion in the Section 438.6(c) preprint to be submitted to the Centers for Medicare & Medicaid Services (CMS) for the Mississippi Hospital Access Program (MHAP) for the state fiscal year beginning July 1, 2026. These approaches and funding mechanisms were developed to preserve critically needed MHAP funding to Mississippi hospitals.

MHAP Pool Amounts

For SFY 2027, the Division of Medicaid (DOM or Division) intends to request a total dollar amount of $1,540,423,694, which the Division expects to qualify for grandfathering based on CMS communication about the applicable rating period included in CMS letter dated Sept. 9, 2025 regarding "SUBJECT: Section 71116 of One Big Beautiful Bill Act on State Directed Payments". The pools will be allocated fifty percent (50%) to Fee Schedule Adjustment (FSA) and fifty percent (50%) to Quality Incentive Payment Program (QIPP).

SFY	MHAP-TPP	MHAP-FSA	MHAP-QIPP	Total MHAP
2016	$533,110,956	$0	$0	$533,110,956
2017	$533,110,956	$0	$0	$533,110,956
2018	$422,241,632	$110,869,324	$0	$533,110,956
2019	$380,017,469	$153,093,487	$0	$533,110,956
2020	$215,886,793	$275,000,000	$42,224,163	$533,110,956
2021	$0	$317,886,793	$215,224,163	$533,110,956
2022	$0	$285,603,168	$247,507,788	$533,110,956
2023	$0	$313,053,124	$288,100,478	$601,153,602
2024	$0	$733,317,426	$788,996,459	$1,522,313,885
2025	$0	$719,679,373	$820,744,321	$1,540,423,694
2026	$0	$719,679,373	$820,744,321	$1,540,423,694
2027	**$0**	**$770,211,847**	**$770,211,847**	**$1,540,423,694**
		50%	**50%**	**100.0%**

Please note that in SFY 2025, the Health Information Network (HIN) was included in the QIPP pool ($820M) but starting in SFY 2027 will be included in FSA ($770M).

The Quality Incentive Payment Program (QIPP) pool of $770,211,847 will be allocated among the following components:

Allocation of QIPP components for SFY 2027:		
Quality Measures: 100%		
Potentially Preventable Hospital Returns (PPHR)*	33%	$256,737,283
Potentially Preventable Compliactions (PPC)*	33%	$256,737,282
Ambulatory PPCs (AM-PPC)	33%	$256,737,282
Total of QIPP Components		**$770,211,847**

* For SFY 2027, the Division will carve out $50.0M from the initial payment of the PPHR and PPC portions of QIPP for a Value Based Payment (VBP) pool. For those hospitals that improve their Actual to Expected Ratios (a/e ratio) by greater than or equal to two- and one-half percent (2.5%) or already have an a/e ratio less than the statewide threshold, they will receive their pro-rated portion of the VBP pool allocated between the PPHR and PPC quality metrics. The Division will fully disburse the VBP pool only to those hospitals achieving the required improvement on a pro-rata basis. This additional payment will occur after the issuance of the July 2027 PPHR and PPC reports. The consideration for improvement will be evaluated by comparing July 2026 and July 2027 reports for PPHR (cycle 7) and PPC (cycle 6).

MHAP Pool Amounts at Risk of Forfeiture

For SFY 2027, the following amounts shown by each component of MHAP pool amounts would be at risk of forfeiture by the receiving hospital.

- Fee Schedule Adjustment (FSA) – With the FSA component the only “risk” associated with the initial payments to a hospital provider are the possible fluctuations in managed care volume that could cause a required payback of initially received funds. There is no separate risk of “forfeiture”.
- Quality Incentive Payment Program (QIPP) – With the QIPP component hospital providers are required to meet quality metrics associated with each component of QIPP (PPHR, PPC and AM-PPC). There is a risk of forfeiture of funds if the hospital provider is required to submit a Corrective Action Plan (CAP) and then does not meet the required improvements associated with that CAP. The forfeitures associated with the improvements in quality metrics are capped at twenty-five percent (25%). For the separate Value-Based Payment (VBP) component of QIPP ($50M), the hospital provider is at risk of not receiving the VBP portion if they do not meet the improvement requirements associated with the VBP.

The following chart shows that total amount of MHAP (QIPP) funds that are “At-Risk” if all hospital providers were required to submit a CAP and then did not meet the required quality improvements:

QIPP Funds At Risk of Forfeiture	$180,052,962
VBP Portion - 100% "At Risk"	$50,000,000
Total QIPP Funds "At Risk"	$230,052,962
% of Total MHAP	14.9%

Rural Emergency Hospital (REH) Payments

For SFY 2027, REH providers will continue to participate in the MHAP program with their payments based on OP FSA and only the AM-PPC portion of QIPP.

Since REH designated hospitals do not have inpatient stays, the FSA portion will be based solely on outpatient managed care encounters.

Fee Schedule Adjustment (FSA)

The Fee Schedule Adjustment (FSA) is paid based on each providers utilization of managed care encounters, IP discharges, and OP payments. These payments are currently paid out using a base period of data as shown below in the interim payments and then reconciled to actual encounters paid in the state fiscal year. Beginning in SFY 2027, the HIN component has been added to FSA to differentiate payments between hospitals participating in the HIN versus hospitals that do not participate in the HIN.

Health Information Network (HIN)

The Health Information Network (HIN) has been added to the FSA component. DOM has subdivided each of the hospital provider classes between those that are participating in the HIN and those that are not participating. A payment differential will be calculated to allow for an increased payment rate for those hospitals in each class that are participating in the HIN.

Interim Payments

- The Division will make “interim” payments during the fiscal year (July 1, 2026 – June 30, 2027) based on historical encounters from the period July 1, 2024 – June 30, 2025 (SFY 2025), with the encounters run on a “date of service” basis. The Division will withhold ten percent (10%) of interim FSA payments until the final reconciliation.
- FSA payments will be included in the SFY 2027 MHAP Model at sixty-five percent (65%) inpatient and thirty-five percent (35%) outpatient.

- The Division will utilize the 2024 RAND report for the calculation of a statewide average commercial rate (ACR) to be included in the total MHAP payments.
- The Division has removed all attestation requirements for SFY 2027.

Reconciliation of Payments to Utilization During the State Fiscal Year

- The Division will plan to run encounter reports during March 2028, for the period July 1, 2026 – June 30, 2027, based on incurred dates of service with six months of runout through December 31, 2027. (This timing may vary depending on encounter completeness review from the Division.)
- The Division may run "initial" encounter reconciliation reports prior to the final reconciliation to determine if significant variation in the managed care encounters have occurred for any hospital providers comparing the SFY 2027 rating period to the base period of SFY 2025. If the Division determines that significant variation has occurred for any hospital provider, the Division may require payment from or make payments to the hospitals based on the interim reconciliation amount prior to the end of the SFY 2027 rating period.
- After producing the encounter reports for SFY 2027, which is expected to occur in April 2028, the Division will reconcile the interim payments made to hospitals compared to the encounters run during the state fiscal year 2027 (the rate year) and produce an updated hospital payment report.
- In May 2028, the Division expects to process the final SFY 2027 MHAP payments. All SFY 2027 final payment adjustments will be netted against the May 2028 MHAP (SFY 2028) payments made to hospitals. If necessary, the Division may extend the payment reconciliation amount over more than one month but not exceed the conclusion of SFY 2028 (June 30, 2028).

Additional Provisions

- For hospitals that may have merged during SFY 2027, the hospital in operation at the time of the reconciliation payments in May 2028 will be responsible for adjustments related to interim payments to all hospitals prior to the merger.
- For any hospital that may cease operations during state fiscal year 2027, the interim payments to this hospital will be counted as final without any reconciliation payment.
- For any hospital that may be involved in bankruptcy proceedings during state fiscal year 2027, the Division will make interim payments and reconciliation payments only as available and directed by the bankruptcy court.
- Any Quality Incentive Payment Program (QIPP) reallocations that are needed due to hospital forfeitures during the state fiscal year are expected to be reconciled and adjusted in June 2027.
- For hospitals that begin operations during the state fiscal year, the Division may estimate the managed care inpatient discharge encounters and outpatient payments to make interim payments. For hospitals that experience material service line changes (such as

opening or closing a Behavioral Health unit), the Division may estimate the impact on the managed care inpatient encounters and outpatient payments to adjust interim payments. The estimation of encounters from this section will apply to both Fee Schedule Adjustment (FSA) payments and FSA Incentive Payments (QIPP).

Evaluation Strategies

The state's evaluation strategies will measure the directed payment plans success in improving access to quality and appropriate health care services in a timely manner. To evaluate access and the success of the directed payments toward this goal, DOM will assess the following:

Hospital Network Access: DOM's targeted goal is to incur no loss of hospital provider participation. Active hospital provider participation in the MississippiCAN network as of June 30, 2027, will be compared to the active hospital provider participation as of July 1, 2026, as well as the baseline measurement as of July 1, 2018. Performance measurements will include an annual participation assessment in the network. Any decrease in hospital provider participation will be reviewed, and the reasons for the decrease will be explored and follow-up will be conducted under DOM's direction. Any increase in hospital participation in the MississippiCAN program will also be noted.

Potentially Preventable Hospital Return (PPHR), Potentially Preventable Complication (PPC), and Ambulatory Potentially Preventable Complication (AM-PPC) Rates: Hospitals will receive quarterly re-admission and complication rate reports with a rolling two years' worth of data. These reports will be used in the assessment of hospitals' progress toward targeted improvement goals. Hospitals that meet or exceed the statewide targeted improvement goal during an annual performance assessment will be required to submit a corrective action plan to reduce their actual to expected PPHR, PPC, and AM-PPC ratios. The PPHR, PPC, and AM-PPC quality metrics will each include new cycles for reporting during this new rating period.

POA (Present on Admission): Beginning in SFY 2027, the Division has designated ten percent (10%) of the PPC funding specifically for POA Reporting. To receive this portion of funding, hospitals must pass the POA Flags. Hospitals that do not pass the POA Flags will be required to submit a Corrective Action Plan (CAP). If a hospital either fails to submit the required POA CAP or submits it late, it will forfeit ten percent (10%) of the PPC payment calculated for the December payment cycle. This forfeiture is in addition to any forfeiture tied to late or non-submission of the PPC CAP. Furthermore, forfeitures related to hospitals not meeting required POA improvement targets will be capped at 25% in addition to any forfeiture tied to the not meeting PPC CAP improvement.

Health Information Network (HIN): In SFY 2027, hospitals are expected to be connected to the statewide Health Information Network (HIN). For SFY 2027 DOM will pay a differential of the FSA component of MHAP for those hospitals that are connected to the HIN and submitting admission, discharge, and transfer data for Medicaid beneficiaries as of July 1, 2026, to qualify

for the higher payment rate. DOM will monitor receipt of participating hospitals' admission, discharge, and transfer data for Medicaid beneficiaries to determine compliance with participation requirements.