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**From:** Francis Rullan  
**Sent:** Thursday, February 28, 2008 2:05 PM  
**To:** 'ekolbo@whlt.com'; 'adcomp@leadercall.com'; 'ads@dailyleader.com';  
'ads@getthepress.com'; 'ads@tunicatimes.com'; 'advertising@columbianprogress.com';  
'Aimee.Robinette@bolivarcommercial.com'; 'amoryad@bellsouth.net';  
'apeterson@telesouth.com'; 'banner@belzonicable.com'; 'bni@teleclipse.net';  
'boonevillebanner@bellsouth.net'; 'capitolbureau@aol.com'; 'ccj@tycom.net';  
'cct@netpathway.com'; 'chronicle@telepak.net'; 'clarkecountytrib@bellsouth.net';  
'clay@charlestonsun.net'; 'commonwealth@gwcommonwealth.com';  
'dailystar@grenadastar.com'; 'dcavileer@tecinfo.com'; 'dcpilot@sisna.com';  
'ddtnews@ddtonline.com'; 'democrat@datastar.net'; 'dmads@thedmonline.com';  
'dmyers@neshobademocrat.com'; 'Donell.maxie@bolivarcommercial.com';  
'dtlnews@dailytimestleader.com'; 'editor@bellsouth.net'; 'editor@panolian.com';  
'editor@timesstonecounty.com'; 'editor@winonatimes.com'; 'esp@nwnstudios.com';  
'etnews@deltaland.net'; 'examinea@bellsouth.net'; 'gct@datasync.com';  
'gindependent@i-55.com'; 'graphics@enterprise-journal.com'; 'hcgazette@aol.com';  
'HCGazette@aol.com'; 'hcherald@bellsouth.net';  
'heather@stonecountyenterprise.com'; 'herald@tds.net'; 'hpi@watervalley.net';  
'itimes@intop.net'; 'jcnnews@teleclipse.net'; 'jnrbb@olemiss.edu';  
'johnclark@ddtonline.com'; 'jrnlb@bellsouth.net'; 'judy.a.meredith@jsums.edu';  
'lelprog@tecinfo.com'; 'letters@cdispatch.com'; 'letters@onlinemadison.com';  
'lisa.voyles@monitorherald.com'; 'lisa.voyles@timespost.com'; 'lisaad@bellsouth.net';  
'maconbeacon@aol.com'; 'magnoliagazette@telepak.net';  
'mailbag@thedemocrat.com'; 'managing1@bellsouth.net';  
'mark.williams@bolivarcommercial.com'; 'mbj@msbusiness.com';  
'mcourier@bellsouth.net'; 'messenger@neshobademocrat.com'; 'meteor@mspress.org';  
'mspress@themississippipress.com'; 'mynews@southmississippi.biz';  
'natchezsun@hotmail.com'; 'news@columbianprogress.com';  
'news@dailycorinthian.com'; 'news@dailyleader.com'; 'news@deltanewsroom.com';  
'news@desototimes.com'; 'news@enterprise-journal.com'; 'news@getthepress.com';  
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'newsroom@natchezdemocrat.com'; 'jbeavers@telesouth.com';  
'newsroom@winstoncountyjournal.com'; 'okmessenger@bellsouth.net';  
'patsy@prentissheadlight.com'; 'paulott@listentotheeagle.com'; 'pcprogress1  
@bellsouth.net'; 'pgallo@telesouth.com'; 'pontprog@bellsouth.net';  
'press@bellsouth.net'; 'pressregister@cableone.net'; 'pspeights@telepak.net';  
'publisher@deltabusinessjournal.com'; 'publisher@desototimes.com';  
'publisher@meridianstar.com'; 'quitconews@panola.com'; 'rankincn@aol.com';  
'reformer@c-gate.net'; 'reveille@bellsouth.net'; 'richtondispatch@c-gate.net';  
'rossreily@ddtonline.com'; 'rponder@seacoastecho.com';  
'sdnads@starkvilledailynews.com'; 'sentinel@theonlinedispatch.com';  
'sgillespie@themeridianstar.com'; 'shite@pressregister.com'; 'skellogg@hearst.com';  
'south@dixie-net.com'; 'stewart@epaofms.com'; 'sysadm@vicksburgpost.com';  
'tcnews@crossroadsisp.com'; 'thebaldwynnews@dixie-net.com';  
'themetor@bellsouth.net'; 'thetimes@tecinfo.com'; 'timbeeland@msn.com'; 'tncc@c-  
gate.net'; 'ttimes@telepak.net'; 'tunicatimes@watervalley.net';  
'unionappeal@bellsouth.net'; 'wbiitv@yahoo.com'; 'wrepublican@bellsouth.net';

**To:** 'mlillis@iwpnews.com'  
**Subject:** An important message from the Executive Director of the Division of Medicaid for immediate release and publication  
**Attachments:** 02.28.08.Small Town Papers RE Hospital Funding.doc



**STATE OF MISSISSIPPI**

OFFICE OF THE GOVERNOR

DIVISION OF MEDICAID

DR. ROBERT L. ROBINSON

EXECUTIVE DIRECTOR

February 28, 2008

Good Afternoon:

As you all know, our Medicaid program is facing a severe budget shortfall for the current fiscal year (2008) and we are required to ask for a significant increase in revenues for FY 2009. This shortfall was not unpredictable. Last year, we asked the Legislature to provide \$569 million in Medicaid funding for FY 2008; the Legislature appropriated \$513. Additionally, Medicaid asked the Legislature to specifically set a rate for the assessment of hospital gross revenue in order to generate additional sources of non-federal funding for the program. The Legislature did not act on this request.

Once the agency determines that a deficit situation exists, the Constitution and the Legislature requires the Governor and Medicaid management to implement cost containment strategies in order to avoid exceeding the limits of Medicaid's appropriation. The Division of Medicaid and the Office of the Governor have repeatedly stated that neither the Governor nor Medicaid have any desire to reduce services to beneficiaries or eliminate recipients. The agency has recommended reducing reimbursement rates to providers as well as implementing other changes based on prudent business practices to enable Medicaid to financially survive the remainder of FY 2008. Some of these cost containments will reduce the costs of Medicaid programs going forward into future years as well. A significant piece of DOM's proposal includes an increase in hospital revenue assessments. The proposed increase in hospital revenue assessments will allow hospitals to maintain \$375 million of total Medicaid medical services payments without a reduction in services to beneficiaries.

Since 1993, a large portion of the direct medical payments to hospitals have been financed through the Disproportionate Share Hospital (DSH) program by requiring a few qualifying public hospitals to transfer funds directly to Medicaid. These additional funds were transferred as

“intergovernmental transfers” or “IGTs.” Private hospitals did not contribute these additional funds. The funds transferred by public hospitals were then used as the state match to generate funds for the Disproportionate Share Hospital Program (“DSH”), and medical service payments. In June 2005, CMS issued an ultimatum to DOM to stop collecting the IGTs for medical service payments and only collect the state share for the DSH program. This created the funding gap of approximately \$90 million per year for the Medicaid program.

For the past two and half years the funding gap has been filled with Katrina money, federal funds appropriated to rebuild our state after the devastation caused by Hurricane Katrina. Now, the one-time money is gone and tough decisions have to be made. DOM has advocated using the revenue assessment evenly distributed to all hospitals as the means to fill the funding gap. Until June 2005 the public hospitals were required to pay a portion of the state match for all hospitals’ medical service payments. CMS and Medicaid do not believe this funding arrangement was fair to the struggling public hospitals—especially when some of the private not for profit hospitals are making huge profits.

As described above, by late 2005, two major changes relating to Medicaid funding occurred. First, by 2006, MHA had lost its \$5 million per year, statutorily protected, contract for the administration of the DSH/UPL Program which required MHA to advise, calculate, and collect the revenue assessment. Second, in late 2005, CMS informed the State that it must stop forcing public hospitals to transfer an extra \$90 million for the benefit of both public and private, not for profit, hospitals without requiring private hospitals to contribute. Thus, when the Governor and DOM sought to make up \$45 million of the \$90 million shortfall by increasing the revenue assessment, MHA stepped forward to pronounce that the revenue assessment program, the one MHA had previously administered, was unconstitutional and detrimental to its private hospital members.

In fact, the idea to raise the revenue assessment percentage in order to fund greater payments to hospitals was MHA’s idea—not the Legislature’s, Governor Barbour’s or DOM’s. In a March 29, 2005, MHA Memorandum to Members, MHA stated that “MHA proposed generating the needed state funds through a combination of an increased bed tax and an increased assessment on gross revenue. The legislature was receptive to our proposal . . . .”

Using assessments paid by health care providers to fund state medical services is a tried and tested method employed by many states for a number of years. Mississippi followed the lead of several other states in funding Mississippi Medicaid. Revenue assessments began in Florida in 1994 and have evolved to the point that 20 states are currently using some form of a revenue assessment. And now, Sam Cameron CEO of MHA consistently refers to this assessment, brought into existence by the MHA, as ill-conceived.

The American Hospital Association (“AHA”) is a national organization which represents over 5,000 hospitals. This organization conducts a survey of financial trends in health care which is the benchmark for the hospital industry. AHA’s 2006 survey of hospital profitability concluded that Mississippi hospitals, with a profit margin of 8.01%, are the ninth most profitable in the nation! Mississippi’s exceptionally high profitability ranking was not a one year aberration. From 2000-2004 Mississippi hospitals had a profit margin of 7.61%, compared to 5.52% for Louisiana, 5.81% for Alabama, and a national average of 4.66%. Over the 2000-2004 period, Mississippi’s hospitals were the fifth most profitable in the nation. And the most profitable of Mississippi hospitals were primarily our private not for profit hospitals. Our small safety net hospitals are the ones hurting and the ones who need our help to stay in business. We have proposed, to no avail,

a new payment methodology to better help this group. Mississippi will never have state wide quality health care if we don't strengthen our rural safety net hospitals.

I strongly believe it only fair to remind your readers, regardless of the court case, this "tax" or "assessment" was the idea of the Mississippi Hospital Association. Only half of the public hospitals paid an assessment in order to fund a portion of the state match for hospital medical service payments to all public and private hospitals. This occurred for about 15 years until the federal government changed the rules by saying the practice could not be continued. Our position is to have all hospitals pay the assessment because the vast majority of hospitals share in revenues the assessment produces.

Dr. Robert L. Robinson

Executive Director

Division of Medicaid

Francis Rullan, CPM

Director of Communications

10th Floor Sillers Building

550 High Street

Jackson, MS 39201

Phone: 601-359-6078

Fax: 601-359-6048

Email: [exfxr@medicaid.state.ms.us](mailto:exfxr@medicaid.state.ms.us)

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