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

One (1) copy of the following information is considered a completed cost report:

1. Hard copy of the cost report with original signature;
2. Electronic copy of the cost report (printable text file or adobe acrobat format on a CD). The signatures obtained for the electronic version can be submitted by scanning the signed signature page as an attachment to the file on the CD or by submitting the signed signature page in its original format;
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 partial hospitalization programs or day treatment programs and 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 partial hospitalization programs or day treatment programs and 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.

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

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 version of the APR-DRG relative weights 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. According to 3M Health Information Systems, there were no changes to the relative weights between V.32 and V.33. Version 32 relative weights under the hospital-specific relative value (HSRV) methodology were calculated as follows:

1. A two-year dataset of NIS records was compiled, representing 15 million stays.
2. All stays were grouped using APR-DRG V.32.
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

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 five policy adjustors are described below and the specific values of each are reflected in Appendix A:

1. Obstetrics, neonates and normal newborns – These adjustors were set so that payments for these care categories would be (in aggregate) approximately 100% of estimated hospital cost.
2. Mental health pediatric – This adjustor was set so that payments to freestanding psychiatric hospitals would be approximately budget-neutral in aggregate and therefore not impact access to care across the state because Medicaid patients represent a substantial portion of the patient census at freestanding psychiatric hospitals and provided over half of inpatient psychiatric care for pediatric patients in 2009. The pediatric mental health policy adjustor applies to stays at both freestanding and general hospitals.
3. Mental health adult – This adjustor was set to mitigate the impact of the decrease in payment that would occur during the shift from per diem payment to DRG

payment. Under the previous payment method, the same per diem amount was paid for relatively inexpensive services such as mental health as for relatively expensive services such as cardiac surgery. As a result, the pay-to-cost ratio for mental health was relatively high.

4. Rehabilitation – This adjustor was set so that payment for rehabilitation would be approximately 100% of cost. This level of cost was estimated by reference to average cost per stay at the in-state facility that performs only rehabilitation.

5. Transplant – This adjustor was set so that payment for transplants would be approximately budget-neutral compared with the previous payment method. Because of the very small volume of stays, the calculation was done using two years of paid claims data rather than six months.

A state plan amendment will be submitted any time policy adjustors are added or adjusted.

F. DRG Base Price

The same base price is used for all stays in all hospitals. The base price (effective July 1, 2016) was set at a budget-neutral amount per stay based on the analysis of 110,156 hospital inpatient stays from the period July 1, 2014 through June 30, 2015. These stays were originally paid under the APR-DRG payment methodology using the 3M V.30 and V.31 algorithms. A series of data validation steps were undertaken to ensure that the new analytical dataset

would be as accurate as possible for purposes of calculating the updated APR-DRG base price. All stays from the new dataset were grouped using the APR-DRG V.33 algorithm and policy adjustors as described in Paragraph E were determined and applied to achieve budget neutrality. Within this payment method structure, the APR-DRG base price then determines the overall payment level. By applying the payment method calculations to the 110,156-stay analytical dataset, the budget-neutral APR-DRG base price of $6,415 was calculated. The Division of Medicaid will not make retroactive payment adjustment.

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.

APPENDIX A

APR-DRG KEY PAYMENT VALUES

The table below reflects key payment values for the APR-DRG payment methodology described in this Plan.

Payment Parameter	Value	Use
APR-DRG version	V.33	Groups every claim to a DRG
DRG base price	$6,415	Rel. wt. X DRG base price = DRG base payment
Policy adjustor – obstetrics and normal newborns	1.50	Increases relative weight and payment rate
Policy adjustor – neonate	1.45	Increases relative weight and payment rate
Policy adjustor – mental health pediatric	2.00	Increases relative weight and payment rate
Policy adjustor – mental health adult	1.60	Increases relative weight and payment rate
Policy adjustor – Rehabilitation	2.00	Increases relative weight and payment rate
Policy adjustor – Transplant	1.50	Increases relative weight and payment rate
DRG cost outlier threshold	$50,000	Used in identifying cost outlier stays
DRG 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 readmission	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	93	Used to identify transfer stays
Transfer status - 94 - transfer to critical access hospital with planned	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

State of Mississippi

Title XIX Inpatient Hospital Reimbursement Plan

Appendix B

Out-of-State Hospital Transplant Services' Case Rates Effective July 1, 2016

Column	A	B	C	D	E	F	G	H	I	J	K
Transplant	30 Days Pre-Transplant Average Billed Charges	Procurement Average Billed Charges	Hospital Transplant Admission Average Billed Charges	Physician During Transplant Average Billed Charges	180 Days Post Transplant Discharge Average Billed Charges	Total Average Billed Charges* Sum of A through E	Case Rate F X 40%	Difference of F - G	Max Outlier Days	Hospital Length of Stay	Outlier Per-Diem H ÷ I
Single Organ/Tissue											
Bone Marrow Allogeneic	$57,600	$55,700	$479,600	$23,400	$290,300	$906,600	$362,640	$543,960	60	33	$9,066
Bone Marrow Autologous	56,300	10,700	212,300	10,800	81,800	371,900	148,760	223,140	60	20	3,719
Cornea	0	0	20,000	8,600	0	28,600	11,440	17,160	60		286
Heart	50,900	97,200	771,500	88,600	198,400	1,206,600	482,640	723,960	60	40	12,066
Intestine	78,900	92,100	952,900	112,400	272,700	1,509,000	603,600	905,400	120	79	7,545
Kidney	23,200	84,400	119,600	20,500	66,800	314,500	125,800	188,700	30	7	6,290
Liver	37,300	95,000	399,100	53,100	128,900	713,400	285,360	428,040	60	21	7,134
Lung - Single	21,800	90,200	435,200	44,600	165,800	757,600	303,040	454,560	60	21	7,576
Lung - Double	30,700	129,700	566,900	59,100	219,800	1,006,200	402,480	603,720	60	30	10,062
Multiple Organ											
Heart-Lung	88,500	168,700	1,607,100	108,700	304,200	2,277,200	910,880	1,366,320	120	42	11,386
Intestine with other Organs	88,600	236,400	1,045,400	132,800	297,400	1,800,600	720,240	1,080,360	120		9,003
Kidney- Heart	76,100	136,000	1,162,100	132,500	296,500	1,803,200	721,280	1,081,920	120	54	9,016
Kidney-Pancreas	35,900	123,300	227,000	35,200	114,700	536,100	214,440	321,660	60	11	5,361
Liver-Kidney	60,800	161,500	644,500	86,700	210,300	1,163,800	465,520	698,280	60	33	11,638
Other Multi-Organ	76,700	177,600	926,100	116,500	288,600	1,585,500	634,200	951,300	120		7,928

* Total reimbursement cannot exceed one hundred percent (100%) of the sum of billed charges as published by *Milliman* in columns A-E.