To: All acute care hospitals, other than Indian Health Services, including general hospitals, freestanding mental health hospitals and freestanding rehabilitation hospitals

Date: August 22, 2012

Re: Change to Hospital Inpatient payment method

Effective with first dates of service on or after October 1, 2012, Mississippi Medicaid will implement a new reimbursement methodology, which will be based on "All Patient Refined Diagnosis Related Groups" (APR-DRGs). The new method will apply to inpatient care in all acute care hospitals, other than Indian Health Services, including general hospitals, freestanding mental health hospitals and freestanding rehabilitation hospitals. The following services provided by acute care hospitals are not affected: outpatient care, Medicare crossover claims, and swing bed services. Psychiatric residential treatment facilities and nursing facilities are among the provider types not affected by the new method.

The Division will assign an APR-DRG to each Medicaid patient discharge in accordance with the current APR-grouper program version as developed by 3M Health Information Systems. The assignment of each APR-DRG is based on the ICD-9 –CM principal diagnoses, all ICD-9-CM secondary diagnoses and all ICD-9-CM medical procedures performed during the recipient's hospital stay. For each APR-DRG, the Department determines a relative weight using a national weight from 3M that reflects the cost of hospital resources used to treat similar cases.

The importance of coding for APR-DRG

Severity adjusted methodologies require a comprehensive coding approach for successful implementation. The APR DRG classification system utilizes many diagnosis and procedure codes and combinations thereof, to assign the most accurate APR DRG and severity level to a claim. Every inpatient stay will be assigned to a single DRG that reflects the difficulty of that case. For example, a patient with pneumonia will be assigned to one DRG and a patient with pneumonia and heart failure will be assigned to a different DRG. For each stay, the DRG base payment equals:

Relative weight for that DRG x base price = DRG base payment

The first DRG would have a lower weight than the second DRG. Hospitals are therefore paid more for more difficult cases and less for less difficult cases. At the same time, payment does not depend on the hospital's charges or costs, so the hospital has an incentive to improve efficiency. It is important to use complete diagnosis and procedure coding on claims with first date of service on or after October 1, 2012.

Why change to APR-DRG?

The Division has five reasons.

- Improve access to care. Under the new method, the Medicaid payment for a particular inpatient stay will be closely tied to the acuity, or casemix, of the inpatient stay. Hospitals that take sicker patients can expect higher payments, which should improve access to care.
- Increase fairness to hospitals. Under the previous method, two hospitals were often paid very different amounts for the care of very similar patients. Under the new method, all hospitals will be paid similarly for similar patients.
- Reward efficiency. Under the previous method, hospitals that became more efficient and decreased cost were penalized with lower payments. Under the new method, hospitals will receive a flat rate for each stay of a given casemix level. If they improve efficiency, they will keep the savings.
- Improve purchasing clarity. The new method will allow the Division clearer insight into the services being covered. Each stay is assigned to a single DRG with a single payment. DRGs are organized so that each DRG contains stays that are similar both clinically and in terms of hospital resources used.
- Reduce administrative burden. Under the previous method, delays and adjustments to cost reports and payment rates bedeviled financial planning for both the hospitals and the Division. After a patient was discharged, hospital and Division financial managers had to wait several years before payment for that stay was finalized. Under the new method, a hospital will receive final payment for a stay shortly after it submits a claim. As well, the previous method depended on the Division receiving audited hospital cost reports from Medicare contractors. The future accuracy and timeliness of these audits is in question because hardly any Medicare payment now depends on these audits.

Additional documents detailing the change to APR-DRGs will be posted at http://www.medicaid.ms.gov prior to implementation.

Inpatient hospital provider WebEx trainings are planned for:

Critical Access Hospitals

August 22, 2012 – 2:00 p.m.

All Other Hospitals

August 24, 2012 – 10:00 a.m.

September 4, 18 and 20, 2012 – 10:00 a.m.

October 11, 2012 – 2:00 p.m.

Training registration information regarding the above dates is posted at http://www.medicaid.ms.gov.

For questions, please contact Karen Thomas, Division of Medicaid, 601-359-5186 or karen.thomas@medicaid.ms.gov.