Mississippi Medicaid DRG Payment Method

Frequently Asked Questions for FY 2016

Version Date: July 1, 2015 (updated June 16, 2015)

Since October 1, 2012, the Mississippi Division of Medicaid has used a DRG payment method to purchase hospital inpatient services. Our goals are to promote access to care, be fair to different hospitals providing similar services, reward efficiency, enable purchasing clarity, and minimize administrative burden for the Division and hospitals. Please note that this FAQ document does not supersede applicable laws, regulations, and policies.

THE DRG PAYMENT METHOD

1. What DRG algorithm and version does the Division use?

The Division uses 3M™ All Patient Refined Diagnosis Related Groups (APR-DRGs) under license from 3M Health Information Systems. For Mississippi Medicaid claims, Version 29 was effective with dates of admission starting October 1, 2012. Subsequent versions are based on last date of service as follows:

Version 30 was effective for claims with last date of service between October 1, 2013, and June 30, 2014, inclusively.

Version 31 was effective for claims with last date of service on or after July 1, 2014 through June 30, 2015.

Version 32 will be effective for claims with last date of service on or after July 1, 2015.

2. What providers and services are affected?

The DRG payment method applies to inpatient care in all acute care hospitals, including general hospitals, freestanding psychiatric 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, Indian Health Services hospitals and nursing facilities are among the providers not affected by the new method.

3. How much money is affected?

The Division of Medicaid pays approximately $650 million a year for hospital inpatient care, not including supplementary payments (e.g., disproportionate share hospital payments) and payments for care received by Medicaid patients for whom Medicare was the primary payer.

4. What are the Division's reasons for using DRG-based payment?

The Division has five reasons:

- ***Promote access to care.*** Under DRG payment, the Medicaid payment for a particular inpatient stay is closely tied to the acuity, or casemix, of the inpatient stay. Hospitals that take sicker patients receive higher payment, which improves access to care for the sickest patients.
- ***Increase fairness to hospitals.*** Under DRG payment, all hospitals are paid similarly for similar patients.
- ***Reward efficiency.*** Hospitals receive a flat rate for each stay of a given casemix level. If they improve efficiency, they keep the savings.
- ***Improve purchasing clarity.*** The DRG payment method allows 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 DRG payment, a hospital receives final payment for a stay shortly after it submits a claim, without the expense and delay of a cost settlement process. (The Division does reserve the right to review the appropriateness of hospital costs for, e.g., outlier payments.)

5. Was there an independent review before the DRG payment was implemented?

Yes. In 2009, the Performance Evaluation and Expenditure Review (PEER) Committee of the Mississippi Legislature reviewed the proposed new method. Its report (www.peer.state.ms.us/530.html) said:

> "PEER believes that the ACS-recommended APR-DRG payment method better accomplishes the management objectives and goals for a new payment method than the present method or the Medicare DRG method. The APR-DRG payment method would be a sustainable, rational method that better addresses the client service cost care payment requirements for the state Medicaid population while improving client access to hospitals, rewarding hospital efficiency for reducing state costs through more efficient client treatment, increasing fairness to hospitals for payments for client care, improving the purchasing clarity of client hospital services, and reducing the administrative burden for final payments on the hospitals and the DOM."

COMPONENTS OF THE NEW PAYMENT METHOD

6. Overall, how does the DRG payment method work?

The operation of the APR-DRG payment method is very similar to DRG-based payment methods currently in use by Medicare and two-thirds of the nation's other Medicaid programs. Every inpatient stay is assigned to a single DRG that reflects the typical resource use of that case. For example, a patient with uncomplicated pneumonia is assigned to APR-DRG 139-1 and a pneumonia patient with multiple comorbidities is assigned to APR-DRG 139-4. For each stay, the DRG base payment equals:

RELATIVE WEIGHT FOR THAT DRG X BASE PRICE = DRG BASE PAYMENT

For example, DRG 139-1 has a relative weight of 0.42020 and DRG 139-4 has a relative weight of 1.72609.

The base price as of July 1, 2015, is $6,415. The base payments for these DRGs are:

DRG 139-1: 0.42020 X $6,415 = $2,695.58

DRG 139-4: 1.72609 X $6,415 = $11,072.87

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.

7. Where do the DRG relative weights come from?

The Division of Medicaid uses APR-DRG relative weights calculated from the Nationwide Inpatient Sample. An analysis found very close correlation between the national weights and a set of weights calculated specifically from Mississippi Medicaid fee-for-service data. The national weights are updated annually by 3M Health Information Systems.

8. Where can I find a list of weights and rates?

The list of relative weights and payment rates is available by clicking on the Xerox Mississippi Envision website at https://www.ms-mediciad.com/msenvision/index.do on the link under the heading "Visit – Division of Medicaid" –Providers-Finance and the Division of Medicaid website at http://www.medicaid.ms.gov/providers/finance/ on the "APR-DRG Pricing calculator V32." There are weights and rates for 1,256 DRGs. In addition, there are two error DRGs, for a total of 1,258 groups.

9. How are hospitals protected against the cost of exceptionally expensive cases?

About 5% of payments are made as "outlier" payments. There are two types of outlier payments.

- For mental health cases, where exceptionally expensive cases tend to be associated with long lengths of stay, hospitals are paid $450 for each day that exceeds the DRG Long Stay Threshold, which is 19 days. This per-diem amount is called the DRG day outlier amount.
- For all other cases, hospitals receive "DRG cost outlier payments" for stays where the estimated loss, or the difference between the hospital's estimated cost (charges for that stay times the hospital-specific inpatient cost-to-charge ratio) and the DRG base payment, exceeds $50,000, the DRG Outlier Threshold. The hospital's DRG cost outlier payment equals the hospital's estimated loss minus the DRG Outlier Threshold, times the marginal cost percentage. The cost outlier payment policy is patterned after Medicare's cost outlier policy.

10. What changes were made to disproportionate-share hospital (DSH) payments, upper payment limit (UPL) payments, medical education payments and payments for capital?

The DRG-based payment method is a separate topic from DSH and UPL payment policy.

Payments for medical education are made on the claim, as a flat amount per stay.

Under DRG-based payment, there is no separate payment for capital. Previous payments for capital are rolled into the DRG payment.

11. What other factors affect payments for individual cases?

As is common in DRG payment methods, there are special calculations for patients who are transferred to other acute care settings and for situations in which the patient has Medicaid coverage for only part of the stay (e.g., loss of eligibility).

The Division pays the same rates to all hospitals, without labor-market adjustments such as Medicare has. This decision promotes access to hospital care in rural areas, since the typical effect of labor-market adjustments is to reduce payments in rural areas.

12. What is Medicaid's transfer policy?

DRG payers typically reduce payment if a transfer to an acute care setting means that the length of stay at the transferring hospital is unusually low. The typical approach is to follow the Medicare model, that is, to calculate the DRG base payment, then check if the discharge status qualifies as a transfer to another acute care setting and, if so, calculate a transfer-adjusted base payment. The actual DRG base payment is then the DRG base payment or the transfer-adjusted amount, whichever is lower. The formula for the transfer-adjusted base payment is:

TRANSFER-ADJUSTED BASE PAYMENT = (DRG BASE PAYMENT / NATIONAL AVERAGE LOS) X (ACTUAL LOS + 1)

Although Medicare also has a post-acute transfer policy, Medicaid does not have a post-acute transfer policy. The difference in approaches reflects the difference in patient populations.

OVERALL PAYMENT LEVELS

13. How does the new payment method affect overall funding to hospitals?

The Division intends that overall payments for hospital inpatient care for the period starting July 1, 2015, be budget-neutral to average payment per stay for APR-DRG Years 1, 2 and 3. Please note that DRG payments are only part of total payments received by hospitals for inpatient care; the Division also makes substantial supplementary payments.

14. How is a mental health stay paid?

A mental health stay is one that groups to one of the 72 APR-DRGs for treatment of psychiatric and substance abuse conditions. Both general and freestanding hospitals are paid using the same set of 72 payment rates, with higher payments for more complex stays regardless of setting. The payment rates equal the relative weight for each DRG times a policy adjustor times the DRG base price. The policy adjustor recognizes the importance of Medicaid funding in ensuring continued access to acute mental health care in Mississippi. Policy adjustors are used for pediatric (under 21 years old) and adult stays.

Exceptionally long mental health stays—those that exceed 19 days—are eligible for day outlier payments for each day that exceeds the threshold.

15. How will payments change in the future?

The Division plans to do an annual review of what change, if any, in the DRG base price would be appropriate. The combination of the base price, the number of stays, the average casemix per stay, the impacts of the mental health policy adjustor, rehabilitation policy adjustor, obstetrics policy adjustor, neonate policy adjustor and transplant policy adjustor will determine the overall level of payments. We will also update the APR-DRG grouping algorithm as applicable.

The update for July 1, 2015 is the third occurrence of this review since implementation of the APR-DRG pricing method on October 1, 2012. A review and update occurred effective October 1, 2013 and July 1, 2014.

16. How will ICD-10 affect the use of APR-DRGs?

At the national level, ICD-10 implementation is now scheduled for October 1, 2015. 3M Health Information Systems will release an ICD-10 version of the APR-DRG algorithm. The Division has been informed by 3M that the APR-DRG payment system/grouper will be ICD-10 compliant with the implementation of V.32 at July 1, 2015, along with the V.33 mapper at October 1, 2015.

ALL PATIENT REFINED DIAGNOSIS RELATED GROUPS

17. Why are APR-DRGs used? Why not Medicare DRGs?

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal, pediatric and obstetric care, and because they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.

MS-DRGs—the algorithm now used by Medicare—were designed for a Medicare population using only Medicare claims. In Medicare, less than 1% of stays are for obstetrics, pediatrics, and newborn care. In the Mississippi Medicaid fee-for-service population, these categories represent almost 70% of all stays.

18. What was done to verify that APR-DRGs are appropriate for the Mississippi Medicaid population?

The Division hired Xerox State Healthcare, the Division's current fiscal agent, to conduct a thorough assessment of the options. Using the statistical tests that are standard in payment method development, the contractor found that APR-DRGs consistently fit the Mississippi data very well, and better than the alternatives. The results were described in "New Directions in Medicaid Payment for Hospital Care," published in the January/February 2008 issue of *Health Affairs*. For neonatal care, the results were similar to those found in an evaluation of national data described in "Structure and Performance of Different DRG Systems for Neonatal Medicine," published in the January 1999 issue of *Pediatrics*.

19. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M Health Information Systems and the Children's Hospital Association (formerly NACHRI). According to 3M, APR-DRGs have been licensed by over 30 state agencies and payers and approximately 3,200 hospitals across the country. APR-DRGs are currently in use by Medicaid programs in Alabama, Arizona, California, Colorado, Connecticut, Florida, Illinois, Indiana, Massachusetts, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Virginia, Washington, and the District of Columbia. APR-DRGs are also commonly used to adjust for casemix in analyzing hospital performance, for example at www.FloridaHealthFinder.gov and www.health.utah.gov.

20. Does my hospital need to buy APR-DRG software to be paid by Medicaid?

No. The Medicaid claims processing system assigns the APR-DRG and calculates payment without any need for the hospital to put the APR-DRG on the claim. More information about APR-DRGs is available at http://solutions.3m.com/wps/portal/3M/en_US/Health-Information-Systems.

21. What version of APR-DRGs is being used?

APR-DRG versions are released each October 1. Effective July 1, 2015, Medicaid will use APR-DRG Version 32, which was released by 3M on October 1, 2014. The Division has been informed by 3M that the APR-DRG payment system/grouper will be ICD-10 compliant with the implementation of V.32 at July 1, 2015, along with the V.33 mapper at October 1, 2015.

22. For hospitals that are interested in using the APR-DRG grouper, what are some key grouper software settings used by the Envision claims processing system?

Table 1 shows common APR-DRG V.32 grouper settings used in the DRG payment method. This information is provided specifically for hospitals that have the grouper and HCAC utility software and need the settings used by Envision to generate the APR-DRG assignment. Hospitals do not need this information in order to submit claims.

Table 1 Selected Grouper Settings for Envision		
Grouper Field	**Setting**	**Comments**
APR-DRG Grouper Settings		
Grouper Version	V.32	Effective with discharge dates on or after July, 1, 2015.
Mapping Version	V.33 effective October 1, 2015	APR-DRG V.32 was released October 1, 2014, reflecting the ICD-9-CM diagnosis and procedure code set that is effective between October 1, 2014, and September 30, 2015. 3M Health Information Systems, the developer of the APR-DRG software, advises that the mapper functionality will not be needed for V.32 between July 1, 2015, and September 30, 2015. Beginning October 1, 2015 version V.33 of the mapper will be enabled using Historical mapping.
Birth Weight Option	Option 5 coded weight with default	Envision reads the diagnosis codes (not the value codes) to identify birth weight and/or gestational age if coded using appropriate diagnosis codes on the claim. If the claim does not include a diagnosis code indicating birth weight or gestational age, then the grouper default is to a birth weight that indicates “normal newborn.”
Discharge DRG Option	Compute excluding non-POA complication of care	Effective July 1, 2015 the Discharge DRG Option will be set at Option 0 - "Excluding non-POA Complication of Care" (default). Prior to this the setting was Option 1 - "Compute Excluding All Complication of Care".
Health-Care Acquired Condition (HCAC) Utility Settings		
HCAC Version	V.32	HCAC utility version 32 will be implemented on July 1, 2015.
Agency Indicator	MS	Version 31 of the HCAC utility defines pediatric as less than age 18. However, DOM policy defines pediatric as less than age 21. Current HCAC policy requires that payment adjustments not be applied to Medicaid pediatric and obstetric populations within HAC Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE), after certain orthopedic procedures. Using the MS agency code, 3M implemented logic to process MS claims defining pediatrics as less than 21 rather than less than 18.
Suppress HCAC Categories	No HCAC suppression is needed	Currently, the Department recognizes all of the Medicaid HCAC categories. As a result, no category will be suppressed.
POA Indicators		For the present-on-admission (POA) diagnosis fields, no POA value (blank) is acceptable for exempt diagnosis codes. POA values W (clinically undetermined) and U (documentation insufficient) are treated in the claims processing system the same as value N (not present on admission).

IMPACTS ON CODING, BILLING AND OTHER HOSPITAL OPERATIONS

23. How does the DRG payment method affect medical coding requirements?

Assignment of the APR-DRG and calculation of payment use the standard information already on the hospital claim. APR-DRG assignment depends chiefly on the diagnosis fields and the ICD-9-CM procedure fields, so hospitals are advised to ensure that these fields are coded completely, accurately and defensibly.

As do other DRG payers, the Division reviews claims from hospitals whose claims shows anomalies in average casemix.

The Division has been informed by 3M that the APR-DRG payment system/grouper will be ICD-10 compliant with the implementation of V.32 at July 1, 2015, along with the V.33 mapper at October 1, 2015.

24. Does Medicaid use an "outpatient window" similar to Medicare?

Yes. In 2012, Medicaid changed its definition of the "outpatient window" with the intention of mirroring Medicare. This window refers to outpatient services immediately preceding the admission that are considered to be part of the inpatient stay. Hospitals are already very familiar with the Medicare window, which is described at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Three_Day_Payment_Window.html. As is true in Medicare, hospitals can indicate that outpatient services are unrelated to the inpatient stay through the appropriate use of condition code 51 on the outpatient claim.

Claims for outpatient services within the three (3) days prior to the admission date that are considered to be part of the inpatient stay should be billed using the statement from date (date the beneficiary entered the hospital outpatient setting) and through date (ending with the hospital inpatient discharge date.) in the UB-04 box 6. The admission date in box 12 should match the admission date as ordered by the physician and may or may not agree with the beginning treatment authorization (TAN) date if the beneficiary is admitted prior to Medicaid eligibility. Box 41 should include only the covered inpatient days using value code 80. Outpatient days included in stay should not be billed in box 41 using value code 81.

Please take care not to bill Medicaid managed care plans for outpatient services that are defined to be within the window.

Although Medicaid's intention was to mirror the Medicare three-day window definition, please note that if there are any differences then the Medicaid approach will prevail.

25. What is the policy for interim claims?

Hospitals are not required to submit interim claims under any circumstances.

However, the Division (unlike many DRG payers) will make interim payments if a hospital chooses to submit an interim claim during an exceptionally long stay. This policy is intended to encourage access for patients who may need weeks or months of acute care.

If a stay exceeds 30 days then the hospital can submit an interim claim and will be paid an interim per diem amount multiplied by the number of days. The interim payment rate for FY 2016 is $850. After the patient is discharged, the interim claims should be voided or adjusted and a single payment will be made to cover the entire stay. If the hospital has submitted one interim claim, it should adjust that claim. If the hospital has submitted more than one interim claim, it should adjust one of the interim claims and void the others. The procedures for submitting adjustments and voids to Mississippi Medicaid have not changed.

Bill types 114 (interim claim—final bill) and 115 (late charges) will be denied. Instead, hospitals should submit a single claim (either bill type 111 or an adjustment) covering all services provided during the stay.

26. How are hospitals paid for newborns?

Hospitals bill each newborn on his or her individual claim. As do other DRG payers, the Division makes separate payments for the mother and the baby depending on the DRG that is assigned to each patient's stay.

27. What if the patient is not Medicaid-eligible during the entire length of stay?

For various reasons, a patient may not be eligible for Medicaid for the entire length of stay. Under the DRG payment method, if a patient is not eligible for the entire length of stay, the claims processing system prices the entire stay using DRG-based logic (including outlier provisions as appropriate) and then prorates the payment. The prorated payment is the DRG payment divided by the nationwide average length of stay for that DRG times the Medicaid covered days, with double payment for the first day to reflect increased hospital costs on the first day.

For hospitals, the first step is to verify that the patient was, in fact, not eligible for the entire stay. In many cases, patients can obtain Medicaid eligibility retroactive to the date of admission.

If it is a partial eligibility situation, the entire stay should be billed on one claim using the header statement from date (date the beneficiary entered the hospital inpatient or outpatient setting if within 72 hours of inpatient admission) and through date (ending with the hospital inpatient discharge date) in the UB-04 box 6. Hospitals should bill non-covered hospital inpatient days due to Medicaid ineligibility in UB-04 box 41 using value code 81 and covered hospital inpatient days using value code 80. The sum of the covered and non-covered days should agree with the total number of days beginning with the "admit" date through the "through" date.

The admission date in box 12 should match the admission date as ordered by the physician. The claims processing system will compare the service dates with both the eligibility file and with the treatment authorization file, to see if the admission date equals the first date of the TAN. If the patient had Medicaid eligibility on admission and lost eligibility during the stay, then the admission date should equal the first date of the TAN. If the patient did not have Medicaid eligibility on the admission date, then the first date of the TAN will not equal the admission date.

The Medicaid payment is considered payment in full for only those days that were covered by Medicaid. For non-covered days, hospitals may seek payment from other payers or patients as they do now.

28. Is the present-on-admission indicator to be used?

Yes. Hospitals should submit valid values of the POA indicator.

29. How are hospitals inpatient payments affected if a health-care acquired condition (HCAC) is present on the claim?

Federal law prohibits payment for HCACs; prior to July 1, 2014 claims with HCACs were identified through post-payment review and payment reductions were made as appropriate.

On July 1, 2014 Mississippi Division of Medicaid implemented the 3M HCAC utility effective for claims with last date of service on or after this date. The 3M utility identifies HCAC conditions on a claim and regroups the claim without the HCAC condition. If a different DRG is assigned, the claim is re-priced with the new DRG and an adjustment to the payment amount results. Claims with HCAC conditions for last date of service on or after July 1, 2015 will be re-priced using V.32 of the HCAC utility. (See question 22 for HCAC utility settings.)

30. Does Mississippi Medicaid still have annual service limits?

No. In 2012, House Bill 421 allowed the Division to remove service limits previously in place. An adjustment was made to the overall DRG base price so that there was no net impact on Medicaid spending. This change improved fairness to hospitals and patients who were previously affected by the 30-day limit.

31. How are claims paid when a dually eligible Medicare/Medicaid beneficiary exhausts his or her Medicare days?

If Medicare days are exhausted prior to the admission previously being billed, the entire stay should be billed to Medicaid with the Medicare exhausted days reflected as an occurrence code and date. If Medicare days are exhausted during the stay, then two claims should be submitted to Medicaid. For the days where Medicare is the primary payer, Medicaid pays the coinsurance and deductible. For the days where Medicaid is the primary payer, Medicaid prices the claim by DRG like any other claim. On the second claim, the fact that Medicare days have been exhausted must be shown as an occurrence code and date.

32. How many diagnosis and procedure codes does Medicaid use in assigning the APR-DRG?

The Envision claims processing system and the APR-DRG grouper accepts as many as 24 secondary diagnosis codes and 24 secondary procedure codes in addition to the principal diagnosis and principal procedure. The UB-04 paper claim form enables the hospital to show a principal diagnosis, 17 secondary diagnoses, the principal procedure, and 5 secondary procedures.

33. What date of admission should be used if the patient has been in observation or other outpatient status prior to admission?

The date of the inpatient admission will be the date the patient enters inpatient status as indicated by the physician's order. This is a change from the policy in place before October 1, 2012; we believe the change reduces administrative burden on hospitals. (See question 23 for related billing information.)

AUTHORIZATION OF SERVICES

34. How did the treatment authorization requirements change with implementation of payment by DRG October 1, 2012?

Requirements for treatment authorization on the admission did not change. Requirements for continued stay review (i.e., the length of stay) were significantly simplified. Only stays that exceed 19 days now require continued stay review. This change reflects the fact that for almost all stays, payment is per stay based on the patient's diagnoses and procedures, regardless of the length of stay. The exceptions are that mental health stays that exceed 19 days receive day outlier payments and that physical health stays that qualify as cost outlier stays receive cost outlier payments. Cost outlier status does not depend on length of stay as such, but in practice cost outlier stays tend to be long stays—hence the requirement for concurrent review on stays that exceed 19 days. Please see Table 2.

Table 2
Summary of Treatment Authorization Changes with DRG Implementation

	TAN--Admission		TAN--Continued Stay Review	
	Previous Policy	Effective Oct. 1, 2012	Previous Policy	Effective Oct. 1, 2012
Deliveries	Yes, by reporting	Yes, by reporting	Only after 3 days (vag) or 5 days (ces)	Only after 19 days
"Well baby" = newborn LOS less than or equal to 5 days	No	No	Not applicable	Not applicable
"Sick baby" = Newborn LOS more than 5 days	Yes	Yes—Should be obtained before Day 6	All days	Only after 19 days
All other stays	Yes	Yes	All days	Only after 19 days

Notes:
1. LOS = length of stay. A newborn is identified by the presence of admit type = 4 on the claim.
2. Newborns who are well babies or newborn sick babies who become ill and are discharged on or before Day 5 will not require a TAN. Only newborns that remain sick and continue to require inpatient care on or after Day 6 will require a TAN.
3. LOS is used to differentiate well babies and sick babies only for purposes of TAN authorization. Payment for the baby's stay will depend on the assigned APR-DRG. There are 116 newborn APR-DRGs that reflect the baby's birthweight, diagnoses and procedures.

35. How is length of stay calculated?

The length of stay equals the last day of service minus the first day of service, with two exceptions. First, if the patient is admitted and discharged on the same day, then the length of stay is one day. Second, if the patient is still a patient (discharge status 30) on the last day of service, then the last day also counts in the length of stay. For example:

Monday → Wednesday with discharge status 30 = 3 days

Monday → Wednesday with any other discharge status = 2 days

Monday → Tuesday = 1 day

Monday → Monday = 1 day

36. In some cases, a hospital moves a patient from a medical/surgical unit to a rehabilitation unit or psychiatric unit within the same hospital. Does this count as one stay or two for purposes of calculating DRG payment?

If both stays are authorized as having met the criteria for medical necessity of the admission, then the hospital can discharge the patient from the medical/surgical unit and admit him or her to the rehabilitation or psychiatric unit. Two claims are submitted, each with its individual treatment authorization number (TAN), and two DRG payments are made.

37. Is Medicaid authorization required for dually eligible beneficiaries when Medicare is the primary payer?

No.

OTHER QUESTIONS

38. Do hospitals still have to submit cost reports?

Yes. Cost reports are used in calculating the cost-to-charge ratios used to make in DRG outlier payments and in calculating supplemental payments. The Division also uses cost reports as a data source in the annual review of the DRG base price.

39. Are payments subject to adjustment after cost reports have been submitted?

No, excluding some limited circumstances. Payments based on DRG are generally final. A major benefit of the new payment method is that payments are not subject to adjustment two to three years after the date of service. Cost outlier payments may be subject to adjustment in cases of suspected fraud and/or abuse.

40. What does Medicaid do to educate hospitals about the new payment method?

Training materials are available on both the Xerox Mississippi Envision website at https://www.ms-medicaid.com/msenvision/index.do on the link under the heading "Visit – Division of Medicaid" –Providers-Finance and the Division of Medicaid website at https://www.medicaid.ms.gov/providers/finance/ . These materials include this FAQ document, and an interactive DRG pricing calculator in spreadsheet form, provider training presentations, and a quick tips sheet.

41. Who can I contact for more information?

- ***Xerox Provider and Beneficiary Services*** at 1-800-884-3222.
- ***Technical questions about APR-DRGs, outliers, etc.*** Kevin Quinn, Vice President, Payment Method Development, Xerox State Healthcare LLC, kevin.quinn@xerox.com, 406-457-9550.
- ***Questions about Division policy.*** Karen Thomas, Accounting Director, Hospital Program, karen.thomas@medicaid.ms.gov, 601-359-5186.