

## PUBLIC NOTICE

Under the provisions of Section 447.205, Title 42, Code of Federal Regulations, public notice is hereby given to the submission of a Medicaid State Plan Amendment (SPA). For inpatient hospital services rendered after July 1, 2015, the Mississippi Division of Medicaid, in the Office of the Governor, may implement Mississippi Hospital Access Program (MHAP) Transition Payments and Inpatient Hospital UPL Program Elimination, our Transmittal # 15-012.

1. This proposed SPA allows the Division of Medicaid to make transition payments for inpatient hospital services rendered by in-state hospitals and the out-of-state hospital that is authorized by federal law to submit intergovernmental transfers (IGTs) to the State of Mississippi and is classified as a Level I trauma center located in a county contiguous to the State of Mississippi, subject to the approval by the Centers for Medicare and Medicaid Services (CMS). This proposed SPA also removes the inpatient hospital Upper Payment Limit (UPL) program.
2. The estimated aggregate expenditures of the Division of Medicaid are expected to be budget-neutral.
3. The Division of Medicaid may make transition payments to inpatient hospitals, as defined in number 1 above, to comply with Miss. Code Ann. § 43-13-117(A)(18)(c)(ii) and shall eliminate the inpatient hospital UPL program subject to CMS approval of the MHAP to comply with Miss. Code Ann. § 43-13-117(A)(18)(c)(i).
4. A copy of the proposed SPA will be available in each county health department office and in the Department of Human Services office in Issaquena County for review.
5. Written comments will be received by the Division of Medicaid, Office of the Governor, Office of Policy, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, or [Margaret.Wilson@medicaid.ms.gov](mailto:Margaret.Wilson@medicaid.ms.gov) for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and on the Division of Medicaid's website at [www.medicaid.ms.gov](http://www.medicaid.ms.gov).
6. A public hearing on this SPA will not be held.

David J. Dzielak, Ph.D.  
Executive Director  
Division of Medicaid  
Office of the Governor

July 7, 2015

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CHAPTER 6  
~~UPPER PAYMENT LIMIT (UPL)~~ OTHER PAYMENTS

6 ~~Upper Payment Limit~~ Other Payments

For inpatient services rendered after July 1, 2015, but prior to the effective date of CMS approval and full implementation of the legislated Mississippi Hospital Access Program, the division may pay lump-sum enhanced, transition payments, prorated inpatient UPL payments based upon fiscal year 2015 June distribution levels, enhanced hospital access (PMPM) payments or such other methodologies as are approved by CMS such that the level of additional reimbursement required by Miss. Code Ann. § 43-13-117 is paid for all Medicaid hospital inpatient services delivered in fiscal year 2016.

~~In addition to the Medicaid APR-DRG payment, hospitals located within Mississippi or a hospital within a county or parish contiguous to the State of Mississippi allowed by Federal legislation to submit intergovernmental transfers (IGTs) to the state of Mississippi and otherwise allowed to participate in the UPL program pursuant to Mississippi law may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. The out-of-state hospital allowed by Federal legislation to participate in the MS UPL program, cannot include medical education costs in the computation of their upper payment limit. For each federally defined class of hospitals, the amount trended to the current rate year that Medicare would have paid for the previous year will be calculated and compared to what payments were actually made by Medicaid during that same time period. This calculation may then~~

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~~be used to make payments to hospitals for the current year. The calculated available UPL, as approved by CMS in the Division of Medicaid's annual DSH/UPL demonstration, may be paid to hospitals, within each federally defined class, in accordance with applicable state and federal laws and regulations.~~

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~~6-1 UPL Payments—Hospitals With 50 Beds or Less~~

~~For each state fiscal year from 2015 forward, privately operated and non state government operated general acute care hospitals, within the meaning of 42 CFR Section 447.272, that have fifty (50) or fewer licensed beds as of January 1, 2009, shall receive a supplemental inpatient UPL payment equal to sixty-five percent (65%) of their fiscal year 2013 hospital specific inpatient UPL gap, before any payments under this subsection.~~

~~6-2 UPL Payments—State Hospitals~~

~~For each state fiscal year from 2015 forward, general acute care hospitals licensed within the class of state hospitals shall receive a supplemental inpatient UPL payment equal to twenty-eight percent (28%) of their fiscal year 2013 inpatient payments, excluding DSH and UPL payments.~~

~~6-3 UPL Payments—Government Non State Hospitals~~

~~For each state fiscal year from 2015 forward, general acute care hospitals licensed within the class of government non state hospitals shall receive a supplemental inpatient UPL payment determined by multiplying 2013 inpatient payments, excluding DSH and UPL payments, by the uniform percentage necessary to exhaust the maximum amount of inpatient UPL payments permissible under federal regulations.~~

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~~6.4 — UPL Payments — Private Hospitals~~

~~For each state fiscal year from 2015 forward, in addition to other payments provided above, all hospitals licensed within the class of private hospitals shall receive an additional inpatient UPL payment determined by multiplying 2013 inpatient payments, excluding DSH and UPL payments, by the uniform percentage necessary to exhaust the maximum amount of inpatient UPL payments permissible under federal regulations.~~

~~6.5 — UPL Payments — State Hospitals Additional Distribution~~

~~For each state fiscal year from 2015 forward, in addition to other payments provided above, all hospitals licensed within the class of state hospitals, shall receive an additional inpatient UPL payment determined by multiplying 2013 inpatient payments, excluding DSH and UPL payments, by the uniform percentage necessary to exhaust the maximum amount of inpatient UPL payments permissible under federal regulations.~~

~~6.6 — UPL Payments — Maximization of Federal Funds~~

~~The Division of Medicaid shall implement UPL calculation methodologies that result in the maximization of available federal funds.~~

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~~6-7~~ Timing of UPL Payments

~~The UPL payments shall be paid on or before December 31, March 31, and June 30 of each fiscal year, in increments of one third (1/3) of the total calculated UPL amounts.~~

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**APPENDIX A**

**APR-DRG KEY PAYMENT VALUES**

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

<u>Payment Parameter</u>	<u>Value</u>	<u>Use</u>
APR-DRG version	V.32	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 readmission	93	Used to identify transfer stays
Transfer status 94 – transfer to critical access hospital with planned readmission	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



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Appendix B

Out-of-State Hospital Transplant Services' Case Rates Effective October 1, 2012

Table 1 - Case Rates for Beneficiaries Not Enrolled in a Coordinated Care Organization (CCO)

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	\$41,400	\$38,900	\$419,600	\$22,400	\$259,800	\$782,100	\$312,840	\$469,260	60	33	\$7,821
Bone Marrow Autologous	44,600	18,200	198,200	10,800	84,900	356,700	142,680	214,020	60	20	3,567
Cornea	0	0	16,500	7,900	0	24,400	9,760	14,640	60		244
Heart	47,200	80,400	634,300	67,700	137,800	967,400	386,960	580,440	60	40	9,674
Intestine	55,100	78,500	787,900	104,100	146,600	1,172,200	468,880	703,320	120	70	5,861
Kidney	17,000	67,200	91,200	18,500	50,800	244,700	97,880	146,820	30	7	4,894
Liver	25,400	71,000	316,900	46,600	93,900	553,800	221,520	332,280	60	21	5,538
Lung - Single	10,300	73,100	302,900	33,500	117,700	537,500	215,000	322,500	60	19	5,375
Lung - Double	21,400	90,300	458,500	56,300	142,600	769,100	307,640	461,460	60	30	7,691
Multiple Organ											
Heart-Lung	56,800	130,500	777,700	81,000	169,100	1,215,100	486,040	729,060	120	45	6,076
Intestine with other Organs	57,900	172,700	795,900	116,300	160,900	1,303,700	521,480	782,220	120		6,518
Kidney- Heart	48,800	123,600	813,000	93,900	184,800	1,264,100	505,640	758,460	120	47	6,321
Kidney-Pancreas	20,800	102,500	194,900	34,700	100,400	453,300	181,320	271,980	60	12	4,533
Liver-Kidney	46,800	117,500	574,100	83,100	180,100	1,001,600	400,640	600,960	60	28	10,016
Other Multi-Organ	75,400	131,000	1,050,100	139,500	278,600	1,674,600	669,840	1,004,760	120		8,373

Table 2 - Case Rates for Beneficiaries Enrolled in a Coordinated Care Organization (CCO)

Column	A	B	C	D	E	F	G	H	I
Transplant	Procurement Average Billed Charges	Hospital Transplant Admission Average Billed Charges	Physician During Transplant Average Billed Charges	Total Average Billed Charges* Sum of A through C	Case Rate D X 40%	Difference of D - E	Max. Outlier Days	Hospital Length of Stay	Outlier Per-Diem F ÷ G
Single Organ/Tissue									
Bone Marrow Allogeneic	\$38,900	\$419,600	\$22,400	\$480,900	\$192,360	\$288,540	60	33	\$4,809
Bone Marrow Autologous	18,200	198,200	10,800	227,200	90,880	136,320	60	20	2,272
Cornea	0	16,500	7,900	24,400	9,760	14,640	60		244
Heart	80,400	634,300	67,700	782,400	312,960	469,440	60	40	7,824
Intestine	78,500	787,900	104,100	970,500	388,200	582,300	120	70	4,853
Kidney	67,200	91,200	18,500	176,900	70,760	106,140	30	7	3,538
Liver	71,000	316,900	46,600	434,500	173,800	260,700	60	21	4,345
Lung - Single	73,100	302,900	33,500	409,500	163,800	245,700	60	19	4,095
Lung - Double	90,300	458,500	56,300	605,100	242,040	363,060	60	30	6,051
Multiple Organ									
Heart-Lung	130,500	777,700	81,000	989,200	395,680	593,520	120	45	4,946
Intestine with other Organs	172,700	795,900	116,300	1,084,900	433,960	650,940	120		5,425
Kidney- Heart	123,600	813,000	93,900	1,030,500	412,200	618,300	120	47	5,153
Kidney-Pancreas	102,500	194,900	34,700	332,100	132,840	199,260	60	12	3,321
Liver-Kidney	117,500	574,100	83,100	774,700	309,880	464,820	60	28	7,747
Other Multi-Organ	131,000	1,050,100	139,500	1,320,600	528,240	792,360	120		6,603

\* Total reimbursement cannot exceed one-hundred percent (100%) of the sum of billed charges as published by Milliman in columns A-E in Table 1 for beneficiaries not enrolled in a COO or columns A-C in Table 2 for beneficiaries enrolled in a CCO.

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**CHAPTER 6**  
**OTHER PAYMENTS**

6 Other Payments

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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
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Bone Marrow Autologous	44,600	18,200	198,200	10,800	84,900	356,700	142,680	214,020	60	20	3,567
Cornea	0	0	16,500	7,900	0	24,400	9,760	14,640	60		244
Heart	47,200	80,400	634,300	67,700	137,800	967,400	386,960	580,440	60	40	9,674
Intestine	55,100	78,500	787,900	104,100	146,600	1,172,200	468,880	703,320	120	70	5,861
Kidney	17,000	67,200	91,200	18,500	50,800	244,700	97,880	146,820	30	7	4,894
Liver	25,400	71,000	316,900	46,600	93,900	553,800	221,520	332,280	60	21	5,538
Lung - Single	10,300	73,100	302,900	33,500	117,700	537,500	215,000	322,500	60	19	5,375
Lung - Double	21,400	90,300	458,500	56,300	142,600	769,100	307,640	461,460	60	30	7,691
Multiple Organ											
Heart-Lung	56,800	130,500	777,700	81,000	169,100	1,215,100	486,040	729,060	120	45	6,076
Intestine with other Organs	57,900	172,700	795,900	116,300	160,900	1,303,700	521,480	782,220	120		6,518
Kidney- Heart	48,800	123,600	813,000	93,900	184,800	1,264,100	505,640	758,460	120	47	6,321
Kidney-Pancreas	20,800	102,500	194,900	34,700	100,400	453,300	181,320	271,980	60	12	4,533
Liver-Kidney	46,800	117,500	574,100	83,100	180,100	1,001,600	400,640	600,960	60	28	10,016
Other Multi-Organ	75,400	131,000	1,050,100	139,500	278,600	1,674,600	669,840	1,004,760	120		8,373

Table 2 - Case Rates for Beneficiaries Enrolled in a Coordinated Care Organization (CCO)

Column	A	B	C	D	E	F	G	H	I
Transplant	Procurement Average Billed Charges	Hospital Transplant Admission Average Billed Charges	Physician During Transplant Average Billed Charges	Total Average Billed Charges* Sum of A through C	Case Rate D X 40%	Difference of D - E	Max. Outlier Days	Hospital Length of Stay	Outlier Per-Diem F ÷ G
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Bone Marrow Autologous	18,200	198,200	10,800	227,200	90,880	136,320	60	20	2,272
Cornea	0	16,500	7,900	24,400	9,760	14,640	60		244
Heart	80,400	634,300	67,700	782,400	312,960	469,440	60	40	7,824
Intestine	78,500	787,900	104,100	970,500	388,200	582,300	120	70	4,853
Kidney	67,200	91,200	18,500	176,900	70,760	106,140	30	7	3,538
Liver	71,000	316,900	46,600	434,500	173,800	260,700	60	21	4,345
Lung - Single	73,100	302,900	33,500	409,500	163,800	245,700	60	19	4,095
Lung - Double	90,300	458,500	56,300	605,100	242,040	363,060	60	30	6,051
Multiple Organ									
Heart-Lung	130,500	777,700	81,000	989,200	395,680	593,520	120	45	4,946
Intestine with other Organs	172,700	795,900	116,300	1,084,900	433,960	650,940	120		5,425
Kidney- Heart	123,600	813,000	93,900	1,030,500	412,200	618,300	120	47	5,153
Kidney-Pancreas	102,500	194,900	34,700	332,100	132,840	199,260	60	12	3,321
Liver-Kidney	117,500	574,100	83,100	774,700	309,880	464,820	60	28	7,747
Other Multi-Organ	131,000	1,050,100	139,500	1,320,600	528,240	792,360	120		6,603

\* Total reimbursement cannot exceed one-hundred percent (100%) of the sum of billed charges as published by Milliman in columns A-E in Table 1 for beneficiaries not enrolled in a COO or columns A-C in Table 2 for beneficiaries enrolled in a CCO.