PUBLIC NOTICE

June 13, 2018

Pursuant to 42 C.F.R. Section 447.205, public notice is hereby given to the submission of a Medicaid State Plan Amendment (SPA). The Division of Medicaid, in the Office of the Governor, is submitting SPA 18-0004 All Patient Refined Diagnosis Related Groups (APR-DRG) Reimbursement to update the hospital inpatient payment methodology with an effective date of July 1, 2018 contingent upon approval from the Centers for Medicare and Medicaid Services (CMS). This proposed SPA is to comply with approved SPA 2012-008, our Transmittal # 18-0004.

1. Mississippi Medicaid SPA 18-0004 APR-DRG Reimbursement contains the following updates to hospital inpatient services effective July 1, 2018:

    a. The transition from V.33 to V.35 of the 3M Health Information Systems Hospital Inpatient APR-DRG Grouper and Hospital-Specific Relative Value (HSRV) weights.

    b. Update the existing methodology used to assign pediatric and adult policy adjustors, which is based on principal diagnosis codes and the age of the beneficiary. The new methodology will use the APR-DRG assigned to the stay and the age of the beneficiary to assign a pediatric or adult Medicaid Care Category (as established by the Division of Medicaid.) The Medicaid Care Category will be used to assign a policy adjustor to the inpatient stay.

    c. Modify Section M to implement a Charge Cap policy. If the sum of the APR-DRG base payment including effects of policy adjustors, APR-DRG cost outlier payment, APR-DRG day outlier payment, and transfer and/or prorated adjustments, if applicable, is more than the total billed charges on the claim, the total APR-DRG payment amount, net of medical education payments, will be limited to the total billed charges.

    d. The following APR-DRG parameters will be updated:
        - The base payment will change from $6,415 to $6,585.
        - The neonate policy adjustor will change from 1.45 to 1.40.
        - The DRG cost outlier threshold will change from $50,000 to $45,000.
        - The DRG cost outlier marginal cost percentage will change from 50% to 60%.

    e. Clarify language regarding the definition of a change of ownership.

2. The estimated annual aggregate expenditures of the Division of Medicaid relative to APR-DRG Year 6 overall, calculated on a Federal Fiscal Year basis is expected to be a savings of $9,186 in state funds and $28,538 in federal funds for FY-18 and savings of $35,626 in state funds and $115,269 in federal funds for FY-19.

3. SPA 2012-008 APR-DRG requires the Division of Medicaid to submit a SPA for changes to the APR-DRG hospital inpatient payment methodology.

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. A hard copy can be downloaded and printed from www.medicaid.ms.gov or may be requested at Margaret.Wilson@medicaid.ms.gov or 601-359-5779.

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 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.

6. A public hearing on this SPA will be held Friday, June 22, 2018, at 10:00 a.m. at the Woolfolk State Office Building, Room 145, 501 N. West St. Jackson, MS 39201.

2-9 Change of Ownership

A. Change in Ownership of Depreciable Assets - For purposes of this plan, a change in ownership of assets includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship. In a case in which a change in ownership of a provider's depreciable assets occurs, and if a bona fide sale is established, the Title XIX basis for depreciation will be the lower of:

1. The portion of the purchase price properly allocable to a depreciable asset; or
2. The fair market value of the depreciable asset determined by an independent appraiser who is a member of the Society of Real Estate Appraisers; or
3. The allowable cost basis under Title XVIII (Medicare) cost principles to the owner of record on July 18, 1984.

If the basis of a provider's depreciable assets is limited to 3 above, then the estimated useful life of the assets as used by the seller must be used by the buyer.

B. Interest Expense – Where interest expense is incurred to finance the purchase of a hospital of a depreciable asset used therein and the purchase price exceeds the allowable cost basis, interest expense on that portion of the debt or other interest

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 APR-DRG version 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. Version 35 relative weights under the hospital-specific relative value (HSRV) methodology were calculated as follows:

1. A one-year dataset of ICD-10 NIS records was compiled, representing 1 million stays.
2. All stays were grouped using APR-DRG V.35.
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 original policy adjustors are described below for historical purposes:

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. The specific values of each policy adjustor are reflected in Appendix A.

F. DRG Base Price

The same base price is used for all stays in all hospitals. The base price (effective July 1, 2018) was set at a budget-neutral amount per stay based on the analysis of 96,422 hospital inpatient stays from the period July 1, 2016 through June 30, 2017. These stays were originally paid under the APR-DRG payment methodology using the 3M V.33 algorithm. 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.35 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 96,422 stay analytical dataset, the budget-neutral APR-DRG base price of $6,585 was calculated. The Division of Medicaid will not make retroactive payment adjustments.

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.

L. Prorated Payment Adjustment

When a beneficiary has Medicaid coverage for fewer days than the length of stay, then payment is prorated. The payment amount is divided by the nationwide average length of stay for the assigned DRG to arrive at a per diem amount. The per diem amount is then multiplied by the actual length of stay, except that payment is doubled for the first day. The payment will be the lesser of prorated payment or regular payment for the entire stay.

M. DRG Payment Amount, Allowed Amount and Paid Amount

The DRG Payment Amount equals the DRG Base Payment with any applicable policy adjustors, plus outlier payments if applicable, with transfer and/or prorated adjustments made if applicable. If the sum of these amounts is more than the total billed charges on the claim, the DRG Payment Amount will be limited to the total billed charges. The Allowed Amount equals the DRG Payment Amount plus applicable add-on payments such as medical education. The Paid Amount equals the Allowed Amount minus copayments and third-party liability.

N. Three-Day Payment Window

The three-day payment window applies to inpatient stays in hospitals. The window applies to services provided to a patient by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital. Under the three-day window, certain services are considered to be included in the fee-for-service inpatient stay. Services included in the inpatient stay may not be separately billed to the Division of

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.35	Groups every claim to a DRG
DRG base price	$6,585	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	1.40	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	$45,000	Used in identifying cost outlier stays
DRG cost outlier marginal cost percentage	60%	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

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1. The portion of the purchase price properly allocable to a depreciable asset; or
2. The fair market value of the depreciable asset determined by an independent appraiser who is a member of the ~~society~~ Society of Real Estate Appraisers; or
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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 version~~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~~ 35 relative weights under the hospital-specific relative value (HSRV) methodology were calculated as follows:

1. A ~~two~~one-year dataset of ICD-10 NIS records was compiled, representing 1~~5~~ million stays.
2. All stays were grouped using APR-DRG V.~~32~~35.
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.

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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~~ 35 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~~96,422 stay analytical dataset, the budget-neutral APR-DRG base price of $~~6,415~~6,585 was calculated. The Division of Medicaid will not make retroactive payment adjustments.

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