Title 23: Division of Medicaid

Part 202: Hospital Services

Part 202 Chapter 1: Inpatient Services

Rule 1.14: Inpatient Hospital Payments

A. For admissions dated October 1, 2012 and after, the Division of Medicaid reimburses all hospitals a per stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs). APR-DRGs classify each case based on information contained on the inpatient Medicaid claim including diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG payment is determined by multiplying the APR-DRG relative weight by the APR-DRG base rate. Medicaid uses a prospective method of reimbursement and will not make retroactive adjustments except as specified in the Title XIX Inpatient Hospital Reimbursement Plan.

B. Medicaid may adjust APR-DRG rates pursuant to changes in federal and/or state laws or regulations or to obtain budget goals. All Plan changes must be approved by the federal grantor agency.

C. Extraordinarily costly cases in relation to other cases within the same DRG because of the severity of the illness or complicating conditions may qualify for a cost outlier payment. This is an add-on payment for expenses that are not predictable by the diagnoses, procedures performed, and other statistical data captured by the DRG grouper.

    1. The additional payment for a cost outlier is determined by calculating the hospital's estimated loss. The estimated loss is determined by multiplying the covered charges by the hospital's inpatient cost-to-charge ratio minus the DRG base payment. If the estimated loss is greater than the DRG cost outlier threshold established by the Division of Medicaid, then the cost outlier payment equals the estimated loss minus the DRG cost outlier threshold multiplied by the DRG Marginal Cost Percentage. For purposes of this calculation, the DRG base payment is net of any applicable transfer adjustment.

    2. Stays assigned to mental health DRGs are not eligible for cost outlier payments, but may qualify for a day outlier payment if the mental health stay exceeds the DRG Long Stay Threshold.

D. 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.

E. Cost-to-Charge Ratio (CCR) Used to Calculate Cost Outlier Payments

1. The Cost-to-Charge Ratios (CCRs) use to calculate cost outlier payments are calculated annually for each provider by performing a desk review program developed by the Division of Medicaid, using the most recent filed cost report. The Division accepts amended original 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. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the amended cost report, no retroactive adjustments are made to cost outlier payments using the amended cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio is entered into the Mississippi Medicaid Management Information System and is in effect from the date of entry through the end of the current reimbursement period.

2. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each out-of-state hospital are set annually using the Federal Register that applies to the federal fiscal year beginning October 1 of each year, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

3. A Mississippi facility which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the sale. The seller must file a final cost report with the Division of Medicaid from the date of the last cost report to the effective date of the sale. The filing of a final cost report may be waived by the Division, if the cost report is not needed for reimbursement purposes. The new owner must file a cost report from the date of change of ownership through the end of the Medicare cost report year end. The new owner must submit provider enrollment information required under the Division of Medicaid policy.

4. The inpatient cost-to-charge ratio of the former owner is used to pay cost outlier payments for the new owner. The new owner's inpatient cost-to-charge ratio used to pay cost outlier payments is calculated for the first rate year beginning October 1, for which the new owner's cost report is available. There are no retroactive adjustments to a new owner's inpatient cost-to-charge ratio used to pay cost outlier payments.

5. New Mississippi hospitals beginning operations during a reporting year must file an initial cost report from the date of certification to the end of the cost report year end. Each rate year the inpatient cost-to-charge ratio used to pay outlier payments for each Mississippi hospital is grouped by bed class of facilities and an average inpatient cost-to-charge ratio is determined for each class. The initial inpatient cost-to-charge ratio used to pay cost outlier payments to a new hospital will be the average inpatient cost-to-charge ratio used for the bed class of Mississippi hospitals as of the effective date of the Medicaid provider agreement until the inpatient cost-to-charge ratio is recalculated based on the new hospital's initial cost report. There are no retroactive adjustments to a new

hospital's inpatient cost-to-charge ratio used to pay cost outlier payments.

Source: 42 U.S.C. §§ 1395f, 1395ww; 42 C.F.R. § 447.325; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 18-0004.

History: Revised to correspond with SPA 18-0004 (eff. 07/01/2018) eff. 11/01/2018; Revised - 10/01/2012.

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hospital’s inpatient cost-to-charge ratio used to pay cost outlier payments.

Source: ~~Social Security Act § 1814 1~~42 U.S.C. §§ 1395f~~; 42 U.S.C. §~~, 139~~5 SWW~~ww~~. Also known as Social Security Act § 1886~~; 42 C.F.R. § 447.325; Miss. Code Ann. §§ 43-13-117~~121, 43-13-121~~117 (A)(1)(d)~~; SPA 18-0004.

History: Revised to correspond with SPA 18-0004 (eff. 07/01/2018) eff. 11/01/2018; Revised - 10/01/2012.