CHAPTER 1
PRINCIPLES AND PROCEDURES

1-1 Plan Implementation

A. Payments under this plan will be effective for services with admission dates October 1, 2012 and thereafter. The reimbursement period will run from October 1 through September 30 of each year.

B. The Division of Medicaid will provide an opportunity for interested members of the public to review and comment on changes to the reimbursement methodology before it is implemented. This will be accomplished by publishing a public notice on the Agency's website prior to implementing the reimbursement methodology. A period of thirty (30) days will be allowed for comment. The Division of Medicaid will notify the administrator of each hospital of their inpatient Medicaid DRG base rate and inpatient cost-to-charge ratio used to pay cost outlier payments.

C. The Division of Medicaid shall maintain any comments received on the plan, subsequent changes to the plan, or APR-DRG parameters for a period of five (5) years from the date of receipt.

1-2 Plan Evaluation

Documentation will be maintained to effectively monitor and evaluate experience during administration of the plan.

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.

B. Payment for transplant services is made under the Mississippi APR-DRG payment methodology including a policy adjustor. (Refer to Appendix A.) If access to quality services is unavailable under the Mississippi APR-DRG payment methodology, a case rate may be set.

1. A case rate is set at forty percent (40%) of the sum of average billed charges for transplant services as published triennially in the *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion*. The transplant case rates are published on the agency's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.
2. The *Milliman* categories comprising the sum of average billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) discharge. Outpatient immune-suppressants and other prescriptions are not included in the case rate.

3. If the transplant stay exceeds the hospital length of stay published by *Milliman,* an outlier per-diem payment will be made for each day that exceeds the hospital length of stay. The outlier per-diem payment is calculated by taking the difference between the sum of *Milliman's* total average billed charges including thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) discharge and the case rate, divided by the maximum outlier days. The outlier per-diem is added to the case rate for each day that exceeds the hospital length of stay.
4. Total reimbursement of transplant services cannot exceed one-hundred percent (100%) of the sum of average billed charges for the categories listed in B.2.

5. Contracts for transplant services negotiated prior to October 1, 2012, are honored through the term of the contract.

6. For transplant services not available in Mississippi and not listed in the triennially published *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion,* the Division of Medicaid will make payment using the Mississippi APR-DRG payment methodology. If Mississippi APR-DRG payment impacts access to care, the Division will reimburse what the domicile state pays for the service.

C. For specialized services not available in Mississippi, the Division of Medicaid will make payment based on Mississippi APR-DRG payment methodology. If Mississippi APR-DRG payment affects access to care, the Division will reimburse what the domicile state pays for the service or a comparable payment other states reimburse under APR-DRG.

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.

A state plan amendment will be submitted any time policy adjustors are added or changed. 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 was set at a budget-neutral amount per stay based on an analysis of hospital inpatient stays from the previous state fiscal year. 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.

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State of Mississippi
Title XIX Inpatient Hospital Reimbursement Plan

APPENDIX A

APR-DRG KEY PAYMENT VALUES

The table below reflects key payment values for the APR-DRG payment methodology described in this Plan. These values are effective for discharges on and after July 1, 2019.

Payment Parameter	Value	Use
3M™ APR-DRG version	V.35	Groups every claim to a DRG
DRG base price	$6,574	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	$47,000	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	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

CHAPTER 1
PRINCIPLES AND PROCEDURES

1-1 Plan Implementation

A. Payments under this plan will be effective for services with admission dates October 1, 2012 and thereafter. The reimbursement period will run from October 1 through September 30 of each year.

B. The Division of Medicaid will provide an opportunity for interested members of the public to review and comment on changes to the reimbursement methodology before it is implemented. This will be accomplished by publishing a public notice on the Agency's website ~~in newspapers of widest circulation in each city in Mississippi with a population of 50,000 or more~~ prior to implementing the reimbursement methodology. A period of thirty (30) days will be allowed for comment. The Division of Medicaid will notify the administrator of each hospital of their inpatient Medicaid DRG base rate and inpatient cost-to-charge ratio used to pay cost outlier payments.

C. The Division of Medicaid shall maintain any comments received on the plan, subsequent changes to the plan, or APR-DRG parameters for a period of five (5) years from the date of receipt.

1-2 Plan Evaluation

Documentation will be maintained to effectively monitor and evaluate experience during administration of the plan.

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.

B. Payment for transplant services is made under the Mississippi APR-DRG payment methodology including a policy adjustor. (Refer to Appendix A.) If access to quality services is unavailable under the Mississippi APR-DRG payment methodology, a case rate may be set.

1. A case rate is set at forty percent (40%) of the sum of average billed charges for transplant services as published triennially in the ~~most current~~ *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion*. The transplant case rates are published on the agency's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.
2. The *Milliman* categories comprising the sum of average billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) discharge. Outpatient immune-suppressants and other prescriptions are not included in the case rate. ~~(Refer to Appendix B.)~~

3. If the transplant stay exceeds the hospital length of stay published by *Milliman,* an outlier per-diem payment will be made for each day that exceeds the hospital length of stay. The outlier per-diem payment is calculated by taking the difference between the sum of *Milliman's* total average billed charges including thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) discharge and the case rate, divided by the maximum outlier days. The outlier per-diem is added to the case rate for each day that exceeds the hospital length of stay. ~~(Refer to Appendix B.)~~
4. Total reimbursement of transplant services cannot exceed one-hundred percent (100%) of the sum of average billed charges for the categories listed in B.2.

5. Contracts for transplant services negotiated prior to October 1, 2012, are honored through the term of the contract.

6. For transplant services not available in Mississippi and not listed in the triennially published ~~most current~~ *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion*, the Division of Medicaid will make payment using the Mississippi APR-DRG payment methodology. If Mississippi APR-DRG payment impacts access to care, the Division will reimburse what the domicile state pays for the service.

C. For specialized services not available in Mississippi, the Division of Medicaid will make payment based on Mississippi APR-DRG payment methodology. If Mississippi APR-DRG payment affects access to care, the Division will reimburse what the domicile state pays for the service or a comparable payment other states reimburse under APR-DRG.

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:~~

A state plan amendment will be submitted any time policy adjustors are added or changed. 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 was set at a budget-neutral amount per stay based on an analysis of hospital inpatient stays from the previous state fiscal year. 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.

~~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~~**THIS PAGE IS RESERVED**

~~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.~~

~~C.~~ ~~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.~~**THIS PAGE IS RESERVED**

APPENDIX A

APR-DRG KEY PAYMENT VALUES

The table below reflects key payment values for the APR-DRG payment methodology described in this Plan. These values are effective for discharges on and after July 1, 2019.

Payment Parameter	Value	Use
3M™ APR-DRG version	V.35	Groups every claim to a DRG
DRG base price	$~~6,585~~6,574	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~~47,000	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
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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

State of Mississippi

Title XIX Inpatient Hospital Reimbursement Plan

~~Appendix B~~

~~Out-of-State Hospital Transplant Services' Case Rates Effective July 1, 2016~~

~~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~~	~~$57,600~~	~~$55,700~~	~~$479,600~~	~~$23,400~~	~~$290,300~~	~~$906,600~~	~~$362,640~~	~~$543,960~~	~~60~~	~~33~~	~~$9,066~~
~~Bone Marrow Autologous~~	~~56,300~~	~~10,700~~	~~212,300~~	~~10,800~~	~~81,800~~	~~371,900~~	~~148,760~~	~~223,140~~	~~60~~	~~20~~	~~3,719~~
~~Cornea~~	~~0~~	~~0~~	~~20,000~~	~~8,600~~	~~0~~	~~28,600~~	~~11,440~~	~~17,160~~	~~60~~		~~286~~
~~Heart~~	~~50,900~~	~~97,200~~	~~771,500~~	~~88,600~~	~~198,400~~	~~1,206,600~~	~~482,640~~	~~723,960~~	~~60~~	~~40~~	~~12,066~~
~~Intestine~~	~~78,900~~	~~92,100~~	~~952,900~~	~~112,400~~	~~272,700~~	~~1,509,000~~	~~603,600~~	~~905,400~~	~~120~~	~~79~~	~~7,545~~
~~Kidney~~	~~23,200~~	~~84,400~~	~~119,600~~	~~20,500~~	~~66,800~~	~~314,500~~	~~125,800~~	~~188,700~~	~~30~~	~~7~~	~~6,290~~
~~Liver~~	~~37,300~~	~~95,000~~	~~399,100~~	~~53,100~~	~~128,900~~	~~713,400~~	~~285,360~~	~~428,040~~	~~60~~	~~21~~	~~7,134~~
~~Lung - Single~~	~~21,800~~	~~90,200~~	~~435,200~~	~~44,600~~	~~165,800~~	~~757,600~~	~~303,040~~	~~454,560~~	~~60~~	~~21~~	~~7,576~~
~~Lung - Double~~	~~30,700~~	~~129,700~~	~~566,900~~	~~59,100~~	~~219,800~~	~~1,006,200~~	~~402,480~~	~~603,720~~	~~60~~	~~30~~	~~10,062~~
~~Multiple Organ~~											
~~Heart-Lung~~	~~88,500~~	~~168,700~~	~~1,607,100~~	~~108,700~~	~~304,200~~	~~2,277,200~~	~~910,880~~	~~1,366,320~~	~~120~~	~~42~~	~~11,386~~
~~Intestine with other Organs~~	~~88,600~~	~~236,400~~	~~1,045,400~~	~~132,800~~	~~297,400~~	~~1,800,600~~	~~720,240~~	~~1,080,360~~	~~120~~		~~9,003~~
~~Kidney- Heart~~	~~76,100~~	~~136,000~~	~~1,162,100~~	~~132,500~~	~~296,500~~	~~1,803,200~~	~~721,280~~	~~1,081,920~~	~~120~~	~~54~~	~~9,016~~
~~Kidney-Pancreas~~	~~35,900~~	~~123,300~~	~~227,000~~	~~35,200~~	~~114,700~~	~~536,100~~	~~214,440~~	~~321,660~~	~~60~~	~~11~~	~~5,361~~
~~Liver-Kidney~~	~~60,800~~	~~161,500~~	~~644,500~~	~~86,700~~	~~210,300~~	~~1,163,800~~	~~465,520~~	~~698,280~~	~~60~~	~~33~~	~~11,638~~
~~Other Multi-Organ~~	~~76,700~~	~~177,600~~	~~926,100~~	~~116,500~~	~~288,600~~	~~1,585,500~~	~~634,200~~	~~951,300~~	~~120~~		~~7,928~~

~~* Total reimbursement cannot exceed one hundred percent (100%) of the sum of billed charges as published by *Milliman* in columns A-E.~~