AMENDED
PUBLIC NOTICE

May 3, 2021

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 (DOM), in the Office of the Governor, is submitting SPA 21-0007 All Patient Refined Diagnosis Related Groups (APR-DRG) Reimbursement to update the hospital inpatient payment methodology with an effective date of July 1, 2021 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 # 21-0007.

1. Mississippi Medicaid SPA 21-0007 APR-DRG Reimbursement contains the following updates to hospital inpatient services effective July 1, 2021:

   a. DOM will adopt V.38 of the 3M Health Information Systems (3M HIS) APR-DRG Grouper and Hospital-Specific Relative Value (HSRV) weights

   b. Re-center V.38 HSRV weights to a population Case-Mix Index (CMI) of 1.0

   c. The following APR-DRG parameters will be updated:
      - Base Payment – will change from $6,590 to $5,350
      - Pediatric mental health policy adjustor – will change from 1.95 to 1.90
      - Adult mental health policy adjustor – will change from 1.50 to 1.45
      - Obstetrics policy adjustor – will change from 1.50 to 1.40
      - Normal Newborn policy adjustor – will change from 1.50 to 1.45
      - DRG Cost Outlier Threshold – will change from $53,500 to $60,000
        *The DRG cost outlier threshold will increase by 5% in state fiscal years 2023 and 2024
      - DRG Cost Outlier Marginal Percentage – will change from 60% to 50%

   d. Effective July 1, 2021, all inpatient hospital rates and fees will remain the same as those effective as of July 1, 2021.

2. The estimated annual aggregate expenditures of the Division of Medicaid relative to simulations of APR-DRG State Fiscal Year 21 overall, calculated on a Federal Fiscal Year (FFY) basis, are expected to be a savings of $8,445 in state funds and $44,202 in federal funds for FFY-21 and savings of $32,620 in state funds and $177,968 in federal funds for FFY-22.

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 requested at 601-359-5248 or by emailing at Margaret.Wilson@medicaid.ms.gov.

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 on 10:00 a.m. Thursday, May 13, 2021 via a conference line using the following call-in information:

   Call in (Audio Only): 888-822-7517
   Access code: 4282244 (enter when prompted)

out-of-state hospital are set using the Federal Register that applies to the federal fiscal year in effect October 1, 2020. 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 in the *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion* in effect as of July 1, 2019. 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.

this calculation, the DRG base payment is net of any applicable transfer adjustment (see Section J of this chapter).

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 (see Section I of this chapter and Appendix A).

1. Cost-to-Charge Ratio – The inpatient cost-to-charge ratio used to pay inpatient cost outlier payments will be calculated as noted in Section 2-1, H. The cost-to-charge ratio in effect as of July 1, 2021, will be used to calculate outlier payments for claims with last dates of service on or after July 1, 2021.

2. Requests for Change in Inpatient Cost-to-Charge Ratio

   Changes Due to a Certificate of Need (CON) - A hospital may at times offer to the public new or expanded services, purchase equipment, drop such services, or retire equipment which requires (CON) approval. Within thirty (30) calendar days of implementing a CON approved change, the hospital must submit to the Division of Medicaid an allocation of the approved amount to the Medicaid Program. This amount must be separated as applicable between capital costs, educational costs and operating costs. The budget must show an estimate of any increase or decrease in operating costs and charges applicable to the Medicaid Program due to the change, as well as the effective date of the change. Such amounts will be subject to desk review and audit by the Division of Medicaid. Allowance for such changes shall be made to the hospital's inpatient cost-to-charge ratio as provided elsewhere in

R. Long-term Ventilator-dependent Patients Admitted Prior to October 1, 2012

Payment for ventilator-dependent patients admitted to the hospital prior to October 1, 2012 will continue to be reimbursed on a per diem basis until they are discharged from the hospital, the per diem in effect in the preceding year will be increased by the percentage increase. For hospitals with these patients, for rate years beginning October 1, 2012, and thereafter of the most recent Medicare Inpatient Hospital PPS Market Basket Update as of October 1 of each year as published in the Federal Register. Effective July 1, 2021, the per diem will be the amount calculated as of October 1, 2020. All patients admitted to a hospital on or after October 1, 2012 will be reimbursed under the APR-DRG methodology.

S. Post-Payment Review

All claims paid under the APR-DRG payment methodology are subject to post-payment review.

T. Payments Outside of the DRG Base Payment

The following payments are made outside of, and in addition to, the DRG base payment: Long Acting Reversible Contraceptives (LARCs) and their insertion at the time of delivery will be reimbursed separately from the APR-DRG payment. A separate outpatient claim may be submitted by the hospital for reimbursement for LARCs and their insertion at the time of delivery. Reimbursement for the insertion of LARCs at the time of delivery will be based on the Physician Fee Schedule effective July 1, 2021as described in Attachment 4.19-B. The LARC will be reimbursed at the lesser of the provider's usual and customary charge or the fee listed on the Physician Administered Drugs and Implantable Drug System Devices Fee Schedule effective July 1, 2021, as described in Attachment 4.19-B. All fees are published on the Division of Medicaid's website at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

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, 2021.

Payment Parameter	Value	Use
3M™ APR-DRG version	V.38	Groups every claim to a DRG
DRG base price	$5,350	Rel. wt. X DRG base price = DRG base payment
Policy adjustor – obstetrics	1.40	Increases relative weight and payment rate
Policy adjustor – normal newborns	1.45	Increases relative weight and payment rate
Policy adjustor – neonate	1.40	Increases relative weight and payment rate
Policy adjustor – mental health pediatric	1.90	Increases relative weight and payment rate
Policy adjustor – mental health adult	1.45	Increases relative weight and payment rate
Policy adjustor – Rehabilitation	2.00	Increases relative weight and payment rate
Policy adjustor – Transplant (adult and pediatric)	1.50	Increases relative weight and payment rate
DRG cost outlier threshold*	$60,000	Used in identifying cost outlier stays
DRG cost outlier 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	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

*The DRG cost outlier threshold will increase by 5% in state fiscal years 2023 and 2024.

out-of-state hospital are set ~~annually~~ using the Federal Register that applies to the federal fiscal year ~~beginning~~ in effect October 1, 2020. ~~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.

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