Mississippi Medicaid Diagnosis Related Groups (DRG) Payment Method

Frequently Asked Questions (FAQs) for SFY 2026

Effective Date: July 1, 2025

Since October 1, 2012, the Mississippi Division of Medicaid (DOM) has used a DRG payment method to purchase hospital inpatient services. Our goals are to promote access to care, be fair to different hospitals providing similar services, reward efficiency, enable purchasing clarity, and minimize administrative burden for the Division and hospitals. This FAQ document does not supersede applicable laws, regulations, or policies.

THE DRG PAYMENT METHOD

1. What DRG algorithm and version does the Division use?

The Division uses Solventum™ All Patient Refined Diagnosis Related Groups (APR-DRGs) under license from Solventum Health Information Systems. Effective dates for each DRG version are shown in Table 1.

Table 1
DRG Version Effective Dates

Year	Effective Dates (Based on Last Date of Service)	Version
SFY 13-14	10/1/2012 to 9/30/2013	V.29
SFY 14	10/1/2013 to 6/30/2014	V.30
SFY 15	7/1/2014 to 6/30/2015	V.31
SFY 16	7/1/2015 to 6/30/2016	V.32
SFY 17	7/1/2016 to 6/30/2017	V.33
SFY 18	7/1/2017 to 6/30/2018	V.33
SFY 19	7/1/2018 to 6/30/2019	V.35
SFY 20	7/1/2019 to 6/30/2020	V.35
SFY 21	7/1/2020 to 6/30/2021	V.35
SFY 22	7/1/2021 to 6/30/2022	V.38
SFY 23	7/1/2022 to 6/30/2023	V.38
SFY 24	7/1/2023 to 6/30/2024	V.40
SFY 25	7/1/2024 to 6/30/2025	V.40
SFY 26	7/1/2025 to 6/30/2026	V.40

2. What providers and services are affected?

The DRG payment method applies to inpatient care in all acute care hospitals, including general hospitals, freestanding psychiatric hospitals, and freestanding rehabilitation hospitals. The following services provided by acute care hospitals are not affected: outpatient care, Medicare crossover claims, and swing bed services. Psychiatric residential treatment facilities, Indian Health Service hospitals, and nursing facilities are among the providers not affected by DRG payment.

3. How much money is affected?

The Division of Medicaid pays approximately $500 million per year for hospital inpatient care, not including supplementary payments (e.g., disproportionate share hospital payments) and payments for care received by Medicaid patients for whom Medicare was the primary payer.

4. What are the Division's reasons for using DRG-based payment?

The Division has five reasons:

- ***Promote access to care.*** Under DRG payment, the Medicaid payment for a particular inpatient stay is closely tied to the acuity, or casemix, of the inpatient stay. Hospitals that take sicker patients receive higher payment, which improves access to care for the sickest patients.
- ***Increase fairness to hospitals.*** Under DRG payment, all hospitals are paid similarly for treating similar patients.
- ***Reward efficiency.*** Hospitals receive a flat rate for each stay of a given casemix level. If they improve efficiency, they keep the savings.
- ***Improve purchasing clarity.*** The DRG payment method allows the Division greater insight into the utilization of covered services. Each stay is assigned to a single DRG with a single payment. DRGs are organized so that each DRG contains stays that are similar both clinically and in terms of hospital resources used.
- ***Reduce administrative burden.*** Under DRG payment, a hospital receives final payment for a stay shortly after it submits a claim, without the expense and delay of a cost settlement process. (The Division does reserve the right to review the appropriateness of hospital costs e.g., outlier payments.)

COMPONENTS OF THE DRG PAYMENT METHOD

5. Overall, how does the DRG payment method work?

The operation of the APR-DRG payment method is very similar to DRG-based payment methods currently in use by Medicare and many of the nation's other Medicaid programs. Every inpatient stay is assigned to a single DRG that reflects the typical resource use of that case.

For example, a patient with uncomplicated pneumonia is assigned to APR-DRG 139-1 and a pneumonia patient with multiple comorbidities is assigned to APR-DRG 139-4. For each stay, the DRG base payment equals:

RELATIVE WEIGHT FOR THAT DRG X BASE PRICE = DRG BASE PAYMENT

For example, DRG 139-1 has a version 40 (V.40) relative weight of 0.56302 and DRG 139-4 has a relative weight of 1.62806.

The base price as of July 1, 2024, is $5,400. The base payments for these DRGs are:

DRG 139-1: 0.56302 X $5,400 = $3,040.31

DRG 139-4: 1.62806 X $5,400 = $8,791.52

Hospitals are paid more for more difficult cases and less for less complex cases. At the same time, payment does not depend on the hospital's charges or costs, so the hospital has an incentive to improve efficiency.

6. Where do the DRG relative weights come from?

The Division of Medicaid uses APR-DRG relative weights calculated by Solventum from the National Inpatient Sample. During the initial implementation process, an analysis found very close correlation between the national weights and a set of weights calculated specifically from Mississippi Medicaid fee-for-service data. The national weights are updated annually by Solventum Health Information Systems. Starting on July 1, 2021, the national weights have been adjusted so that the average relative weight across Mississippi Medicaid inpatient stays is 1.0. For further information, see question 7.

7. Where can I find a list of weights and rates?

The list of relative weights and payment rates is available as part of the pricing calculator on the Division of Medicaid's website at https://medicaid.ms.gov/providers/reimbursement/. There are weights and rates for 1,332 DRGs. In addition, there are two error DRGs, for a total of 1,334 DRGs.

8. How are hospitals protected against the cost of exceptionally expensive cases?

There are two types of outlier payments.

- For mental health cases, where exceptionally expensive cases tend to be associated with long lengths of stay, hospitals are paid $450 for each day that exceeds the DRG Long Stay Threshold, which is 19 days. This per-diem amount is called the DRG day outlier amount.
- For all other cases, hospitals receive "DRG cost outlier payments" for stays where the estimated loss exceeds $66,000, the DRG outlier threshold. The estimated loss is calculated as the difference between the hospital's estimated cost (charges for that stay times the hospital-specific inpatient cost-to-charge ratio) and the DRG base payment. The hospital's DRG cost outlier payment equals the hospital's estimated loss minus the DRG outlier threshold, times the marginal cost percentage of 45%. The cost outlier payment policy is patterned after Medicare's cost outlier policy.

9. What changes were made to graduate medical education payments (GME), disproportionate-share hospital (DSH) payments and Mississippi Hospital Access Program (MHAP) payments?

The DRG-based payment method is a separate topic from GME, DSH and MHAP payment policy. GME payments are no longer paid on a per APR-DRG stay basis as of 10/1/2019. For more information on GME payments, please refer to attachment 4.19-A of the Mississippi State Plan.

10. What other factors affect payments for individual cases?

As is common in DRG payment methods, there are special calculations for patients who are transferred to other acute care settings and for situations in which the patient has Medicaid coverage for only part of the stay (e.g., loss of eligibility).

The Division pays the same rates to all hospitals without labor-market adjustments, which Medicare uses. This decision promotes access to hospital care in rural areas, since the typical effect of labor-market adjustments is to reduce payments in rural areas.

11. What is Medicaid's transfer policy?

DRG payers typically reduce payment if a transfer to another acute care setting means that the length of stay at the transferring hospital is unusually low. The typical approach is to follow the Medicare model; that is to calculate the DRG base payment, then check if the discharge status qualifies as a transfer to another acute care setting, and, if so, calculate a transfer-adjusted base payment. The actual DRG base payment is then the DRG base payment or the transfer-adjusted amount, whichever is lower. The formula for the transfer-adjusted base payment is:

$$\text{TRANSFER-ADJUSTED BASE PAYMENT} = (\text{DRG BASE PAYMENT} / \text{NATIONAL AVERAGE LOS}) \text{ X } (\text{ACTUAL LOS} + 1)$$

Although Medicare also has a post-acute transfer policy, Medicaid does not have a post-acute transfer policy. The difference in approaches reflects the difference in patient populations.

12. Are there changes to the DRG payment policy effective July 1, 2025?

- The Division has not decided on updates for SFY 2026. SFY 2024 policies and values remain in effect, including the APR-DRG grouper version and weights (although regular mapper updates occur).

OVERALL PAYMENT LEVELS

13. How does the DRG payment method affect overall funding to hospitals?

The DRG prospective payment method is a payment distribution methodology. See question 4 for the advantages of the DRG payment methodology. Overall funding for inpatient hospital services is determined independently of the DRG methodology. As of July 1, 2025, there has been no increase in the appropriation of funds for inpatient hospital services. Please note that DRG payments are only part of the total payments received by hospitals for inpatient care; the Division of Medicaid and Coordinated Care Organizations also make substantial supplementary payments.

14. How are mental health services reimbursed by Mississippi Medicaid?

A mental health stay is one that groups to one of the 72 APR-DRGs (740-776) for treatment of psychiatric and substance abuse conditions. Both general and freestanding hospitals are paid using the same range of APR-DRGs and payment weights, with higher payments for more complex stays regardless of setting. The payment rates equal the relative weight for each DRG times a policy adjustor times the DRG base price. The policy adjustor recognizes the importance of Medicaid funding to ensure continued access to acute mental health care in Mississippi. Policy adjustors are used for certain pediatric (under 21 years old) and adult stays.

Exceptionally long mental health stays—those that exceed 19 days—are eligible for day outlier payments for each day that exceeds the threshold.

15. How will payments change in the future?

The Mississippi Division of Medicaid reviews APR-DRG policy and payment factors annually with the goal of strategically aligning the inpatient hospital methodology for long-term sustainability. The combination of the base price, utilization, changes to the grouping algorithm and the impacts of the policy adjustors determine the overall level of payments.

ALL PATIENT REFINED DIAGNOSIS RELATED GROUPS

16. Why are APR-DRGs used? Why not Medicare DRGs?

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal, pediatric, and obstetric care. APR-DRGs incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.

MS-DRGs—the algorithm now used by Medicare—were designed for a Medicare population using only Medicare claims. In Medicare, less than one percent of stays are for obstetrics, pediatrics, and newborn care. In the Mississippi Medicaid fee-for-service population, these categories represent almost 70% of all stays.

17. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by Solventum Health Information Systems and the Children's Hospital Association (formerly NACHRI). According to Solventum, APR-DRGs have been licensed by 30 state agencies. APR-DRGs are also commonly used to adjust for casemix in analyzing hospital performance.

18. Does my hospital need to buy APR-DRG software to be paid by Medicaid?

No. The Medicaid claims processing system will utilize the APR-DRG software to assign the APR-DRG and calculate payment. Hospitals do not need to place the APR-DRG on the claim.

19. What version of APR-DRGs is being used?

The Division implemented APR-DRG Version 40 on July 1, 2023, and remains on Version 40 as of July 1, 2024. Version 40 was released by Solventum on October 1, 2022.

20. For hospitals that are interested in using the APR-DRG grouper, what are the key grouper software settings used by the mainframe grouper installed within the Medicaid Management Information System (MMIS) claims processing system?

Table 2 shows common APR-DRG V.40 grouper settings used in the DRG payment method. This information is provided specifically for hospitals that have the APR-DRG grouper and HAC utility software and need the settings used by the MMIS to generate the APR-DRG assignment. Hospitals do not need this information in order to submit claims.

Table 2
Selected Grouper Settings for MMIS

Grouper Field	Setting	Comments
APR-DRG Grouper Settings		
Grouper Version	V.40 effective October 1, 2022	Effective with discharge dates on or after July 1, 2023.
Mapping Version	Automatically Determine Code Mapping	APR-DRG V.40 was released October 1, 2022, reflecting the ICD-10-CM/PCS diagnosis and procedure code set that is effective between October 1, 2022, and September 30, 2023. ICD-10-CMS/PCS codes that became active after the V.40 grouper was released on 10/1/2022 will be mapped back to earlier ICD-10-CMS/PCS codes. The grouping assignment will be based on the Version 40 APR-DRG algorithm.
Birth Weight Option	Option 5 coded weight with default	The MMIS reads the diagnosis codes (not the value codes) to identify birth weight and/or gestational age if coded using appropriate diagnosis codes on the claim. If the claim does not include a diagnosis code indicating birth weight or gestational age, then the grouper default is to a birth weight that indicates “normal newborn.”
Discharge DRG Option	Compute excluding non-POA complication of care	Effective July 1, 2015 the Discharge DRG Option was changed to Option 0 - "Compute excluding only non-POA Complication of Care codes," Prior to this the setting was Option 1 "Compute excluding all Complication of Care codes."
Healthcare Acquired Condition Utility (HAC Utility) Settings		
HAC Version	V.40.1	HAC utility Version 40.1 was implemented in April 13, 2023.
Agency Indicator	MS Medicaid	Version 40 of the HAC utility has a Mississippi specific agency indicator for claims with healthcare acquired conditions (HCACs). This indicator recognizes a pediatric age threshold as less than 21, which aligns with the Division's policy for recognition of the pediatric demographic. Current HCAC policy requires that payment adjustments not be applied to Medicaid pediatric and obstetric populations within HCAC Deep Vein Thrombosis/Pulmonary Embolism (DVT/PE) after certain orthopedic procedures. Using the MS agency code, Solventum implemented logic to process MS claims defining pediatrics as less than 21 rather than less than 18.

Table 2 Selected Grouper Settings for MMIS		
Grouper Field	**Setting**	**Comments**
Suppress HAC Categories	No HAC suppression is needed	Currently, the Division recognizes all of the Medicaid HCAC categories. As a result, no category will be suppressed in the HAC Settings.
POA Indicators		For the present-on-admission (POA) diagnosis fields, no POA value (blank) is acceptable for exempt diagnosis codes. POA values W (clinically undetermined) and U (documentation insufficient) are treated in the claims processing system the same as value N (not present on admission).

IMPACTS ON CODING, BILLING AND OTHER HOSPITAL OPERATIONS

21. How does the DRG payment method affect medical coding requirements?

Assignment of the APR-DRG and calculation of payment use the standard information already on the hospital claim. APR-DRG assignment depends chiefly on the ICD-10-CM/PCS codes, age, gender, and other claim specific information. Hospitals are advised to ensure that claims are coded completely, accurately and defensibly.

Similar to other DRG payers, the Division of Medicaid reviews claims from hospitals whose claims show anomalies in average casemix.

22. Does Medicaid use an "outpatient window" similar to Medicare?

Yes. In 2012, Medicaid changed its definition of the "outpatient window" with the intention of mirroring Medicare. This window refers to outpatient services immediately preceding the admission that are considered to be part of the inpatient stay. Hospitals are already very familiar with the Medicare window, which is described at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Three_Day_Payment_Window. As is true in Medicare, hospitals can indicate that outpatient services are unrelated to the inpatient stay through the appropriate use of condition code 51 on the outpatient claim.

Claims for outpatient services within the three days prior to the admission date that are considered to be part of the inpatient stay should be billed using the statement from date (date the beneficiary entered the hospital outpatient setting) and through date (ending with the hospital inpatient discharge date) in the UB-04 box 6. The admission date in box 12 should match the admission date as ordered by the physician and may or may not agree with the beginning treatment authorization number (TAN) date if the beneficiary is admitted prior to Medicaid eligibility. Box 41 should include only the covered inpatient days using value code 80. Outpatient days included in the stay should not be billed in box 41 using value code 81.

Please take care not to bill Medicaid managed care plans for outpatient services that are defined to be within the three day window.

Although Medicaid's intention was to mirror the Medicare three-day window definition, please note that if there are any differences then the Medicaid approach will prevail.

23. What is the policy for interim claims?

Hospitals are not required to submit interim claims under any circumstances.

However, the Division of Medicaid (unlike many DRG payers) will make interim payments if a hospital chooses to submit an interim claim during an exceptionally long stay. This policy is intended to encourage access for patients who may need weeks or months of acute care.

If a stay exceeds 30 days then the hospital can submit an interim claim and will be paid an interim per diem amount multiplied by the number of days. The interim payment rate for SFY 2026 is $850. After the patient is discharged, the interim claims should be voided or adjusted and a single payment will be made to cover the entire stay. If the hospital has submitted one interim claim, it should adjust that claim. If the hospital has submitted more than one interim claim, it should adjust one of the interim claims and void the others. The procedures for submitting adjustments and voids to Mississippi Medicaid have not changed.

Bill types 114 (interim claim—final bill) and 115 (late charges) will be denied. Instead, hospitals should submit a single claim (either bill type 111 or an adjustment) covering all services provided during the stay.

24. How are hospitals paid for newborns?

Hospitals bill each newborn on an individual claim. Like other DRG payers, the Division of Medicaid makes separate payments for the mother and the baby depending on the DRG that is assigned to each patient's stay.

25. What if the patient is not Medicaid-eligible during the entire length of stay?

For various reasons, a patient may not be eligible for Medicaid for the entire length of stay. Under the DRG payment method, if a patient is not eligible for the entire length of stay, the claims processing system prices the entire stay using DRG-based logic (including outlier provisions as appropriate) and then prorates the payment. The prorated payment is the DRG payment divided by the nationwide average length of stay for that DRG times the Medicaid covered days, with double payment for the first day to reflect increased hospital costs on the first day.

For hospitals, the first step is to verify that the patient was, in fact, not eligible for the entire stay. In many cases, patients can obtain Medicaid eligibility retroactive to the date of admission.

If it is a partial eligibility situation, the entire stay should be billed on one claim using the header statement from date (date the beneficiary entered the hospital inpatient or outpatient setting if within 72 hours of inpatient admission) and through date (ending with the hospital inpatient discharge date) in the UB-04 box 6. Hospitals should bill non-covered hospital inpatient days due to Medicaid ineligibility in UB-04 box 41 using value code 81 and covered hospital inpatient days using value code 80. The sum of the covered and non-covered days should agree with the total number of days beginning with the "admit" date through the "through" date.

The admission date in box 12 should match the admission date as ordered by the physician. The claims processing system will compare the service dates with both the eligibility file and with the treatment authorization file, to see if the admission date equals the first date of the TAN. If the patient had Medicaid eligibility on admission and lost eligibility during the stay, then the admission date should equal the first date of the TAN. If the patient did not have Medicaid eligibility on the admission date, then the first date of the TAN will not equal the admission date.

The Medicaid payment is considered payment in full for only those days that were covered by Medicaid. For non-covered days, hospitals may seek payment from other payers or patients.

26. What if the patient does not have a TAN for the entire length of stay?

If the length of stay is less than or equal to 19 days, and the TAN issued covers only a portion of the stay, the claims processing system prices the entire stay using DRG-based logic (including outlier provisions as appropriate) and then prorates the payment. The prorated payment is the DRG payment divided by the nationwide average length of stay for that DRG times the Medicaid covered days, with double payment for the first day to reflect increased hospital costs on the first day. For stays that exceed 19 days, the claims processing system will only prorate the claim after a continued stay review has been approved for additional days.

27. Is the present-on-admission (POA) indicator to be used?

Yes. Hospitals should submit valid values for the POA indicators.

28. How are hospitals' inpatient payments affected if a health-care acquired condition (HCAC) is present on the claim?

Federal law prohibits payment for HCACs; prior to July 1, 2014, claims with HCACs were identified through post-payment review and payment reductions were made as appropriate.

On July 1, 2014, the Mississippi Division of Medicaid implemented the Solventum HAC utility effective for claims with last date of service on or after this date. The Solventum HAC utility identifies HCAC conditions on a claim and regroups the claim without the HCAC condition. If a different DRG is assigned, the claim is re-priced with the new DRG and an adjustment to the payment amount results. Claims with HCAC conditions for last date of service on or after July 1, 2023, will be processed using V.40.1 of the HAC utility. (See question 20 for HAC utility settings.)

29. How many diagnosis and procedure codes does Medicaid use in assigning the APR-DRG?

The MMIS claims processing system and the APR-DRG grouper accepts as many as 24 secondary diagnosis codes and 24 secondary procedure codes in addition to the principal diagnosis and principal procedure. The UB-04 paper claim form enables the hospital to show a principal diagnosis, 17 secondary diagnoses, the principal procedure, and five secondary procedures.

30. What Date of admission should be used if the patient has been observation or other outpatient status prior to admission?

The date of the inpatient admission will be the date the patient enters inpatient status as indicated by the physician's order. This is a change from the policy in place before October 1, 2012; we believe the change reduces administrative burden on hospitals.

AUTHORIZATION OF SERVICES

31. How did the treatment authorization requirements change with implementation of payment by DRG on October 1, 2012?

Requirements for treatment authorization on the admission did not change. Requirements for continued stay review (i.e., the length of stay) were significantly simplified. Only stays that exceed 19 days now require continued stay review. This change reflects the fact that for almost all stays, payment is per stay based on the patient's diagnoses and procedures, regardless of the length of stay. The exceptions are that mental health stays that exceed 19 days receive day outlier payments and that physical health stays that qualify as cost outlier stays receive cost outlier payments. Cost outlier status does not depend on length of stay as such, but in practice cost outlier stays tend to be long stays—hence the requirement for concurrent review on stays that exceed 19 days.

32. How is length of stay calculated?

The length of stay equals the last day of service minus the first day of service, with two exceptions. First, if the patient is admitted and discharged on the same day, then the length of stay is one day. Second, if the patient is still a patient (discharge status 30) on the last day of service, then the last day also counts in the length of stay. For example:

Monday ➔ Wednesday with discharge status 30 = 3 days

Monday ➔ Wednesday with any other discharge status = 2 days

Monday ➔ Tuesday = 1 day

Monday ➔ Monday = 1 day

33. In some cases, a hospital moves a patient from a medical/surgical unit to a rehabilitation unit or psychiatric unit within the same hospital. Does this count as one stay or two for purposes of calculating DRG payment?

If both stays are authorized as having met the criteria for medical necessity of the admission, then the hospital can discharge the patient from the medical/surgical unit and admit him or her to the rehabilitation or psychiatric unit. Two claims are submitted, each with its own individual treatment authorization number (TAN), and two DRG payments are made.

34. Is Medicaid authorization required for dually eligible beneficiaries when Medicare is the primary payer?

No.

OTHER QUESTIONS

35. Do hospitals still have to submit cost reports?

Yes. Cost reports are used in calculating the cost-to-charge ratios used to make DRG outlier payments and in calculating supplemental payments. The Division of Medicaid also uses cost reports as a data source in the annual review of the DRG base price.

36. Are payments subject to adjustment after cost reports have been submitted?

No, excluding some limited circumstances. Payments based on DRG are generally final. A major benefit of the DRG payment method is that payments are not subject to adjustment two to three years after the date of service. Cost outlier payments may be subject to adjustment in cases of suspected fraud and/or abuse.

37. What does Medicaid do to educate hospitals about the new payment method?

Training materials are available on the Division of Medicaid website at https://medicaid.ms.gov/providers/reimbursement/. These materials include this FAQ document, an interactive DRG pricing calculator in spreadsheet form and a quick tips sheet.

38. Who can I contact for more information?

- ***Questions about Division of Medicaid policy.*** Korlynn Trice, Accounting Manager – Office of Reimbursement, Korlynn.Trice@medicaid.ms.gov, 1-601-359-5191.