

Table of Contents

State/Territory Name: Mississippi

State Plan Amendment (SPA) MS: 23-0016

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

**DEPARTMENT OF HEALTH AND HUMAN
SERVICES**

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Financial Management Group

November 13, 2023

Mr. Drew Snyder, Executive Director
Mississippi Division of Medicaid
Attention: Margaret Wilson
550 High Street, Suite 1000
Jackson, MS 39201-1399

RE: Mississippi State Plan Amendment (SPA) Transmittal Number 23-0016

Dear Mr. Snyder:

We have reviewed the proposed Mississippi State Plan Amendment (SPA) 23-0016, which was submitted to the Centers for Medicare & Medicaid Services (CMS) August 16, 2023. SPA MS-23-0016 is being submitted to allow the Division of Medicaid (DOM) to change the payment per resident effective July 1, 2023.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 01, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Douglas Spitler via email at douglas.spitler@cms.hhs.gov

Sincerely,

A solid black rectangular box used to redact the signature of the sender.

Rory Howe
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER <u>2 3</u> — <u>0 0 1 6</u>	2. STATE <u>MS</u>
	3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <p style="text-align: center;">July 1, 2023</p>	
5. FEDERAL STATUTE/REGULATION CITATION 42 CFR §§ 447.201, 447.203.	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>23</u> \$ <u>28,570</u> b. FFY <u>24</u> \$ <u>107,632</u>	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-A, Page 31, 47, 60, and 67	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19-A, Page 31, 47, 60, and 67	

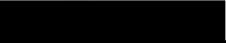
9. SUBJECT OF AMENDMENT
State Plan Amendment (SPA) 23-0016 All Patient Refined-Diagnosis Related Groups (APR-DRG) Reimbursement is being submitted to update the following hospital inpatient services effective July 1, 2023: 1) Update APR-DRG parameters and 2) Unfreeze inpatient rates

10. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED


NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. RETURN TO Drew L. Snyder Miss. Division of Medicaid Attn: Robin Bradshaw 550 High Street, Suite 1000 Jackson, MS 39201-1399
12. TYPED NAME Drew L. Snyder	
13. TITLE Executive Director	
14. DATE SUBMITTED <p style="text-align: center; font-size: 1.2em;">AUG 16 2023</p>	

FOR CMS USE ONLY

16. DATE RECEIVED August 16, 2023	17. DATE APPROVED November 13, 2023
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PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2023	19. SIGNATURE OF APPROVING OFFICIAL 
20. TYPED NAME OF APPROVING OFFICIAL Rory Howe	21. TITLE OF APPROVING OFFICIAL Director, Financial Management Group

22. REMARKS

State of Mississippi
Title XIX Inpatient Hospital Reimbursement 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 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.

State of Mississippi
Title XIX Inpatient Hospital Reimbursement Plan

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.

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

State of Mississippi
Title XIX Inpatient Hospital Reimbursement Plan

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. 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, 2023, and updated annually as 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, 2023, and updated quarterly 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/>.

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, 2023.

<u>Payment Parameter</u>	<u>Value</u>	<u>Use</u>
3M™ APR-DRG version	V.40	Groups every claim to a DRG
DRG base price	\$5,400	Rel. wt. X DRG base price = DRG base payment
Policy adjustor – obstetrics	1.50	Increases relative weight and payment rate
Policy adjustor – normal newborns	1.55	Increases relative weight and payment rate
Policy adjustor – neonate	1.60	Increases relative weight and payment rate
Policy adjustor – mental health pediatric	1.90	Increases relative weight and payment rate
Policy adjustor – mental health adult	1.50	Increases relative weight and payment rate
Policy adjustor – Rehabilitation	2.10	Increases relative weight and payment rate
Policy adjustor – Transplant (adult and pediatric)	1.50	Increases relative weight and payment rate
DRG cost outlier threshold	\$66,000	Used in identifying cost outlier stays
DRG cost outlier marginal cost percentage	45%	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