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State/Territory Name: Mississippi

State Plan Amendment (SPA) #: 21-0007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

September 23, 2021

Drew L. Snyder
Executive Director
Office of the Governor, Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201

Re: Mississippi State Plan Amendment 21-0007

Dear Mr. Snyder:

We have completed our review of State Plan Amendment (SPA) 21-0007. This SPA modifies Attachment 4.19-A of Mississippi's Title XIX State Plan. Specifically, this amendment proposes to update the following hospital inpatient services effective July l, 2021: 1) Update APR-DRG parameters, 2) use cost-to-charge (CCRs) ratios in effect July 1, 2021 to calculate outlier payments for claims with last dates of service on or after July 1, 2021, and 3) remove language that intensive outpatient programs and partial hospitalization programs are not covered in the outpatient hospital setting.

We conducted our review of this SPA according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving Mississippi State plan amendment 21-0007 with an effective date of July 1, 2021. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, or require additional information, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

For

Rory Howe
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 21-0007	2. STATE MS
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 07/01/2021	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR §§ 447.201, 447.203.	FY 2021: ~~($44,202)~~ $0 FY 2022: ~~($177,968)~~ $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Page 18, 31, 47, 60, 67	Attachment 4.19-A, Page 18, 31, 47, 60, 67

10. SUBJECT OF AMENDMENT:
State Plan Amendment (SPA) 21-0007 All Patient Refined-Diagnosis Related Groups (APR-DRG) Reimbursement is being submitted to update the following hospital inpatient services effective July 1, 2021: 1) Update APR-DRG parameters, 2) use cost-to-charge (CCRs) ratios in effect July 1, 2021 to calculate outlier payments for claims with last dates of service on or after July 1, 2021, and 3) remove language that intensive outpatient programs and partial hospitalization programs are not covered in the outpatient hospital setting.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. [redacted]Y OFFICIAL:	16. RETURN TO:
13. TYPED NAME: Drew L. Snyder	Drew L. Snyder Miss. Division of Medicaid Attn: Margaret Wilson 550 High Street, Suite 1000 Jackson, MS 39201-1399
14. TITLE: Executive Director	
15. DATE SUBMITTED: JUN 3 0 2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/30/2021	18. DATE APPROVED: September 23, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2021	20. [redacted]
21. TYPED NAME: Rory Howe	22. TITLE: Acting Director, Financial Management Group

23. REMARKS:
9/22/2021 - State authorized budget impact update in block 7 to $0.00 - Although the forecasting simulation showed a nominal savings, the overall fiscal impact is budget neutral.

7. Medicare Title XVIII information for the Worksheet D series:
    a. Worksheet D, Parts V & VI. Define what types of services are included on line 76 OP Psych Therapy, IOP, PHP, etc. and what revenue codes are included. Distinguish what part of these costs and charges are related to geriatric patients. The MS Division of Medicaid does not reimburse for geriatric psychiatric services;
    b. Worksheet D-1, Parts I, II & III;
    c. Worksheet D-3;
8. Medicaid Title XIX information for the Worksheet D series:
    a. Worksheet D, Parts V & VI. Define what types of services are included on line 76 OP Psych Therapy, IOP, PHP, etc. and what revenue codes are included. Distinguish what part of these costs and charges are related to geriatric patients. The MS Division of Medicaid does not reimburse for geriatric psychiatric services;
    b. Worksheet D-1, Parts I, II & III;
    c. Worksheet D-3;
9. Medicaid Worksheet E-3, Part VII, specifically lines 8 and 9.
10. General Information Survey.
11. For cost reporting periods ending on and after December 31, 2015, providers must combine Medicaid fee-for-service and Coordinated Care Organization (CCO) hospital inpatient and outpatient claims data (days, charges, etc.) from the respective Provider Statistical and Reimbursement Reports (PS&Rs) and report the amounts as one number throughout the cost report where Medicaid data is reported including, but not limited to, the Worksheets listed in numbers 5.a., 8, and 9 above. Providers must submit to DOM the CCO PS&Rs used for each cost reporting period as part of the original cost report submission.

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