Title 23: Division of Medicaid

Part 202: Hospital Services

Chapter 1: Inpatient Hospitals

Rule 1.14: Inpatient Hospital Payments

A. For admissions dated October 1, 2012 and after, the Division of Medicaid reimburses all hospitals a per stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs). APR-DRGs classify each case based on information contained on the inpatient Medicaid claim including diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG payment is determined by multiplying the APR-DRG relative weight by the APR-DRG base rate. Medicaid uses a prospective method of reimbursement and will not make retroactive adjustments except as specified in the Title XIX Inpatient Hospital Reimbursement Plan.

B. The Division of Medicaid may adjust APR-DRG rates pursuant to changes in federal and/or state laws or regulations or to obtain budget goals. All Plan changes must be approved by the federal grantor agency.

C. Extraordinarily costly cases in relation to other cases within the same DRG because of the severity of the illness or complicating conditions may qualify for a cost outlier payment. This is an add-on payment for expenses that are not predictable by the diagnoses, procedures performed, and other statistical data captured by the DRG grouper.

    1. The additional payment for a cost outlier is determined by calculating the hospital's estimated loss. The estimated loss is determined by multiplying the covered charges by the hospital's inpatient cost-to-charge ratio minus the DRG base payment. If the estimated loss is greater than the DRG cost outlier threshold established by the Division of Medicaid, then the cost outlier payment equals the estimated loss minus the DRG cost outlier threshold multiplied by the DRG Marginal Cost Percentage. For purposes of this calculation, the DRG base payment is net of any applicable transfer adjustment.

    2. 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.

D. Cost-to-Charge Ratio (CCR) Used to Calculate Cost Outlier Payments

    1. The Cost-to-Charge Ratios (CCRs) use to calculate cost outlier payments are calculated annually for each provider by performing a desk review program developed by the Division of Medicaid, using the most recent filed cost report. The Division accepts amended original cost reports if the cost report is submitted prior to the end of the reimbursement period in which the cost report is used for payment purposes. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the amended

cost report, no retroactive adjustments are made to cost outlier payments using the amended cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio is entered into the Mississippi Medicaid Management Information System and is in effect from the date of entry through the end of the current reimbursement period.

2. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each 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.

3. A Mississippi facility which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the sale. The seller must file a final cost report with the Division of Medicaid from the date of the last cost report to the effective date of the sale. The filing of a final cost report may be waived by the Division, if the cost report is not needed for reimbursement purposes. The new owner must file a cost report from the date of change of ownership through the end of the Medicare cost report year end. The new owner must submit provider enrollment information required under the Division of Medicaid policy.

4. The inpatient cost-to-charge ratio of the old owner is used to pay cost outlier payments for the new owner. The new owner's inpatient cost-to-charge ratio used to pay cost outlier payments is calculated for the first rate year beginning October 1, for which the new owner's cost report is available. There are no retroactive adjustments to a new owner's inpatient cost-to-charge ratio used to pay cost outlier payments.

5. New Mississippi hospitals beginning operations during a reporting year must file an initial cost report from the date of certification to the end of the cost report year end. Each rate year the inpatient cost-to-charge ratio used to pay outlier payments for each Mississippi hospital is grouped by bed class of facilities and an average inpatient cost-to-charge ratio is determined for each class. The initial inpatient cost-to-charge ratio used to pay cost outlier payments to a new hospital will be the average inpatient cost-to-charge ratio used for the bed class of Mississippi hospitals as of the effective date of the Medicaid provider agreement until the inpatient cost-to-charge ratio is recalculated based on the new hospital's initial cost report. There are no retroactive adjustments to a new hospital's inpatient cost-to-charge ratio used to pay cost outlier payments.

E. The Division of Medicaid reimburses for Graduate Medical Education (GME). Payment schedules and calculations are defined in Attachment 4.19-A of the Medicaid State Plan. The Division of Medicaid does not reimburse for indirect GME costs. To qualify for GME payments, Mississippi hospitals must meet the following criteria:

1. Be located in the state of Mississippi.

2. Have accreditation from the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) at the beginning of the state fiscal year in order to qualify for the quarterly payments during the payment year.

3. Have a Medicare approved teaching program for direct GME costs.

4. Be eligible for Medicare GME reimbursement.

5. Render services on the campus of the teaching hospital or at a participating hospital site.

    a) The participating site must be listed on the ACGME website.

    b) If the participating site uses the teaching hospital's ACGME accreditation, there must be a current affiliation agreement in place with the teaching hospital as of July 1st of the payment year.

    c) Only the teaching hospital or the participating hospital site is eligible for GME reimbursement.

6. Have full-time equivalents (FTEs) reported on Worksheet E-4, line 6, line 15 or line 16 columns 1 and 2 of the most recent Medicare cost report filed with DOM for the calendar year immediately prior to the beginning of the fiscal year for sponsoring/participating hospitals.

7. Any hospital which is a newly accredited sponsoring/participating hospital or is within the five (5) year resident cap building period for the newly accredited sponsoring/participating hospital must be in operation as of July 1 of the payment year and must submit:

    a) Documentation of accreditation,

    b) Medicare's most recent interim rate letter, and

        (1) The number of residents used to calculate medical education payments during cap building years will be the number of FTEs as reported on the Medicare interim rate letter.

        (2) If the number of FTEs reported on the Medicare interim rate letter does not cover the entire cost reporting period, the reported FTEs will be annualized and used to calculate medical education payments,

    c) Start date of the GME accredited sponsoring/participating hospital prior to the July 1 calculation of the payments.

8. Has GME eligibility determined each year with the submission of the following annually:

    a) Documentation of accreditation,

b) Medicare's most recent interim rate letter,

c) Number of filled resident positions,

d) Start date of the GME program prior to the July 1 calculation of the payments, and

e) Documentation that the program was in operation as of July 1 of the payment year.

F. Outpatient services provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital, within the three (3) days prior to an inpatient hospital admission that are related to the reason for the inpatient hospital stay must be included in the APR-DRG payment for the inpatient hospital stay. This is referred to as the three (3) day payment window rule.

1. The inpatient hospital claim must include the following:

   a) Diagnostic services provided to a beneficiary within three (3) days prior to and including the date of an inpatient hospital admission, and

   b) Therapeutic (non-diagnostic) services related to an inpatient hospital admission and provided to a beneficiary within three (3) days prior to and including the date of the inpatient admission.

2. If outpatient services are provided more than three (3) days prior to admission to a beneficiary by the admitting hospital, or an entity wholly owned or operated by the admitting hospital, and the outpatient service dates span to days outside of the three (3) day window the hospital must:

   a) Split bill for the outpatient services provided outside of the three (3) day window on a claim separate from the inpatient claim, and

   b) Include the outpatient services provided that are related to the reason for the inpatient hospital stay within the three (3) day window on the inpatient hospital claim.

3. Maintenance renal dialysis services are excluded from the three (3) day window payment rule.

4. Although the Division of Medicaid's policy is based on Medicare policy, the Division of Medicaid's policy applies if there is a difference.

Source: 42 U.S.C. § 1395f; 42 C.F.R. § 447.325; Miss. Code Ann. §§ 43-13-121, 43-13-117; SPA 20-0018; SPA 19-0019.

History: Revised to correspond with SPA 19-0019 (eff. 10/01/2019) and SPA 20-0018 (eff. 07/01/2020) eff. 12/01/2020; Revised eff. 03/01/2019; Revised - 10/01/2012.