

**Joint Legislative Committee on Performance  
Evaluation and Expenditure Review (PEER)**

Report to  
the Mississippi Legislature



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# **Benefits and Limitations of an All Patient Refined-Diagnosis Related Groups Inpatient Hospital Services Payment Method for Mississippi Medicaid Patients**

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House Bill 71, Second Extraordinary Session of 2009, requires that the Mississippi Division of Medicaid develop and publish a set of reimbursement rates that are at least equal to those allowed under Medicare for the identical or closely related Medicare Diagnosis Related Groups (DRG) rate. The bill also requires the PEER Committee to report to the Senate Public Health and Welfare Committee and the House Medicaid Committee on the benefits and liabilities of moving to a Medicaid DRG method of reimbursement.

After comparing the methodologies and the impact of the rate schedules of the current Medicaid cost-based per diem payment method, the Medicare DRG payment method, and the All Patient Refined-Diagnosis Related Groups (APR-DRG) payment method (which was recommended by the division's contractor, ACS State Healthcare), PEER concluded that the state should adopt the APR-DRG inpatient hospital services payment method. PEER believes that this method has the potential to improve access to care, reward hospital efficiency, increase fairness to hospitals, improve purchasing clarity of hospital services, and reduce the administrative burden on the Division of Medicaid and hospitals. Funding must remain sufficient to ensure reasonable reimbursement of provider costs to ensure that Medicaid beneficiaries have adequate access to medical services.

PEER believes that although a budget-neutral payment method is acceptable for introduction of an APR-DRG payment method, it must be maintained and updated on a regular basis to meet federal guidelines and ensure that payments are reasonable and access to care is adequate.

Any payment method will favor some providers over other providers regardless of the payment methodology used. The best interests of Mississippi's Medicaid program as a whole should outweigh individual provider interests.

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The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

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December 8, 2009

Honorable Haley Barbour, Governor  
Honorable Phil Bryant, Lieutenant Governor  
Honorable Billy McCoy, Speaker of the House  
Members of the Mississippi State Legislature

On December 8, 2009, the PEER Committee authorized release of the report entitled **Benefits and Limitations of an All Patient Refined-Diagnosis Related Groups Inpatient Hospital Services Payment Method for Mississippi Medicaid Patients.**

A handwritten signature in cursive script that reads "Harvey Moss". The signature is written in black ink and is positioned above a horizontal line.

Representative Harvey Moss, Chair

**This report does not recommend increased funding or additional staff.**



*Table of Contents*

Letter of Transmittal .....i

Executive Summary ..... vii

Introduction ..... 1

    Authority ..... 1

    Problem Statement ..... 1

    Scope and Purpose..... 3

    Method ..... 4

Background ..... 5

    History of Mississippi’s Medicaid Payment Method ..... 5

    History of the Medicare Payment Method and Diagnosis-Related Groups..... 6

    Cost of Mississippi’s Current Medicaid Payment Method..... 8

    Development of the Recommended APR-DRG Payment Method..... 9

Comparative Analysis of Payment Methods for Potential Use  
in the State’s Medicaid Program ..... 12

    The Division of Medicaid’s Criteria for a New Payment Method ..... 12

    The Current Medicaid Cost Per Diem Payment Method ..... 14

    The Medicare DRG Payment Method ..... 17

    The ACS-Recommended APR-DRG Payment Method ..... 21

    Impact on Hospitals ..... 24

    Accountability Concerns Regarding the ACS-Recommended  
    APR-DRG Payment Method ..... 25

    What’s Next? Maintaining an APR-DRG Payment Method ..... 30

Recommendations ..... 33

Agency Response ..... 35



***List of Exhibits***

1.	FY 2009 Medicaid Payments to Eligible Hospitals for Medicaid Participant Inpatient and Outpatient Hospital Services .....	9
2.	2009 ACS Payment Simulation Comparing Medicare and Medicaid Stays for Inpatient Hospital Services .....	20
3.	2009 ACS Payment Simulation Comparison of the Current Cost Per Diem, Medicare DRG Rates, and ACS-Recommended APR-DRG Payments for Medicare and Medicaid Stays for Inpatient Hospital Services from October 1, 2008, through March 2009.....	24
4.	2009 ACS Payment Simulation Comparison of the Hospital Payment Impact on the Medicaid-Funded Hospitals of Using Either the Medicare DRG Rates or ACS-Recommended APR-DRG Payments for the Medicaid Client Stays for Inpatient Hospital Services from October 1, 2008, through March 2009.....	26





# Benefits and Limitations of an All Patient Refined-Diagnosis Related Groups Inpatient Hospital Services Payment Method for Mississippi Medicaid Patients

## Executive Summary

### Introduction

#### The Management and Financial Needs of the Medicaid Program

The Division of Medicaid (DOM) has used a payment method for years that has not sufficiently addressed the management and financial needs of the hospitals and the Medicaid program. A primary cause of this problem has been the use of a cost per diem payment method per day of client care that did not meet the necessary objectives for a sustainable, rational payment method.

This cost per diem method has depended on audited Medicare cost reports to make final payments, although these reports have created at least a two-year delay in the hospitals receiving final payments for the provided services. Also, the cost per diem method has *not*:

- enabled the DOM and hospital providers to perform timely financial planning and adjustments to cost reports and payment rates;
- rewarded efficiency in hospital care that minimizes the length of stay consistent with good patient care and allows the hospital to keep any cost savings generated through management or treatment efficiencies;
- geared payments for individual client cases to expected costs in order to reward the hospitals, regardless of bed size and location, with more payment dollars toward more expensive cases and fewer payment dollars toward less expensive cases;
- paid similar amounts for patients with a similar diagnosis receiving similar care, thus improving uniformity of payment to hospitals, regardless of their bed size and location--i. e., fairly (uniformly) distributing limited state resources to provide these services; and,
- enabled DOM to control payments and policy priorities of the Medicaid hospital in-patient services program.

## The Payment Method Recommended by ACS

In 2004, the DOM decided to assess alternative payment methods that would help to resolve the problems noted above and better address the management and financial needs of the hospitals and the Medicaid program. The division asked its fiscal agent, ACS State Healthcare LLC<sup>1</sup> (ACS), to analyze the division's method of inpatient hospital payment and offer suggestions for improvement based on management goals set by the division.

ACS conducted a formal evaluation of five alternative payment methods in 2005 and recommended that the DOM use an All Patient Refined-Diagnosis Related Groups (APR-DRG) method. On October 1, 2005, the DOM established an interim cost-based per diem payment method until a new state DRG-based rate schedule could be determined and put into effect for inpatient services at eligible hospital facilities. Since that time, ACS has conducted payment simulations each year (except for 2008) using the previous year's Medicaid cost data and has evaluated possible DRG-based rate schedules, including the Medicare DRG method as well as an APR-DRG method.

## Problems with the Legal Interpretation of H. B. 71, Second Extraordinary Session of 2009

During its Second Extraordinary Session of 2009, the Mississippi Legislature directed the DOM as follows:

*(I) The division shall develop and publish reimbursement rates for each APR-DRG proposed by the division at least equal to the prevailing corresponding Medicare DRG rate or a closely related Medicare DRG rate, applying to each hospital, the applicable federal wage index being used by CMS for the hospital's geographic location, but the division shall not implement that rate schedule or APR-DRG methodology until after July 1, 2010. The PEER Committee shall study the benefits and liabilities of implementing an APR-DRG reimbursement rate schedule, and report its findings to the members of the Senate Public Health and Welfare Committee and the House Medicaid Committee on or before December 15, 2009.*

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<sup>1</sup> ACS State Healthcare LLC (ACS) is the Division of Medicaid's fiscal agent contractor that is responsible for processing claims, handling calls from providers, and maintaining the computer system for Medicaid in Mississippi. One of the services ACS provides is to assist Medicaid programs with analysis, design, and implementation of payment policy.

This language required the following:

- Medicaid must develop and publish a set of payment rates that are at least equal to those allowed under Medicare for the identical or closely related Medicare DRG rate; and,
- the PEER Committee must report to the Senate Public Health and Welfare Committee and the House Medicaid Committee on the benefits and liabilities of moving to a Medicaid DRG method of reimbursement.

To comply with this language, the Division of Medicaid calculated a set of payment rates comprising whichever rate was higher, the original APR-DRG rate or the Medicare payment rate for the Medicare DRG that corresponded most closely to the specific APR-DRG. By definition, the resulting rates equal or exceed those utilized in the Medicare program. PEER notes that while such a model complies with the strict requirements of this provision, it could result in a payment schedule that would not comply with regulations of the Centers for Medicare and Medicaid Services (CMS), because CMS does not allow payments in excess of those allowed under Medicare.

Since PEER's statutory mandate did not state which specific All Patient Refined-Diagnosis Related Groups (APR-DRG) rate schedule to study, in order to determine the actual benefits and limitations of the APR-DRG process in regard to the eligible Medicaid participants, providers, and the state as a whole, PEER's study compares the following methodologies and the impact of their rate schedules:

- the current Medicaid cost-based per diem payment method;
- the Medicare DRG payment method; and,
- the ACS-recommended APR-DRG payment method.

## Comparative Analysis of Payment Methods for Potential Use in the State's Medicaid Program

The State of Mississippi should adopt the APR-DRG inpatient hospital services payment method because it is in the public interest to improve access to care, reward hospital efficiency, increase fairness to hospitals, improve purchasing clarity of hospital services, and reduce the administrative burden on the Division of Medicaid and hospitals. Funding must remain sufficient to ensure reasonable payment of provider costs to ensure that Medicaid beneficiaries have adequate access to medical services.

### Criteria for Evaluation

The Division of Medicaid, working with its contractor ACS, established eight criteria that any new payment method should meet. In 2004, the DOM contracted with ACS to evaluate and determine an inpatient hospital services payment method that the state should use for the Medicaid inpatient services program in order to accomplish the following management goals of the division:

- to improve client access;
- to reward hospital efficiency;
- to increase fairness (uniformity of payment) to hospitals;
- to improve purchasing clarity of hospital services— (i.e., what services that the state is purchasing for clients); and,
- to reduce the administrative burden on the Division of Medicaid and the hospitals.

To determine the best payment method that would enable DOM to meet these goals, ACS conducted four different evaluation cost studies. The first study used the five DOM management goals above as criteria, in addition to the following:

- to determine how well the casemix adjustors capture the variation in hospital utilization;
- to determine the simplicity of the payment method; and,
- to pay the hospitals for providing higher quality care to clients.

ACS used these eight criteria to determine whether DOM should use a payment method similar to its current one or

a DRG payment method (such as the Medicare DRG) or the APR-DRG payment method.

In May 2005, ACS strongly recommended that DOM use an APR-DRG payment method that is a per-client stay payment method with 1,258 APR-DRGs as the casemix adjustors. Each stay would be assigned to a single APR-DRG based on the physician's diagnosis and procedures used to treat the patient. The payment for each stay would equal the assigned relative weight for the DRG multiplied by a statewide base price determined through available funding. Extraordinarily expensive cases would receive additional "outlier" payments for mental health--cost outlier payments for physical health cases and day outlier payments for mental health cases. In response to DOM's direction, ACS would determine the actual statewide base price, the source for the APR-DRG relative weights, participation to out-of-state hospitals, and payment for transfer cases among hospitals, in the detailed design phase.

## Comparison of Payment Methods

In this report, PEER compares the current Medicaid cost-based per diem payment method, the Medicare DRG payment method, and the ACS-recommended APR-DRG payment method in view of the above criteria, summarized as follows:

- *the current Medicaid cost per diem payment method*--The DOM current cost per diem payment method, as modified on October 1, 2005, does not meet five of the division's management goals for a new payment method: to improve client access to hospitals; to reward hospital efficiency for reducing state costs through more efficient client treatment; to increase fairness to hospitals for revenue payments for client care, to improve purchasing clarity of client hospital services, and to reduce the administrative burden for final payments on the hospitals and the DOM. As a result, the current payment method should be replaced with a method that can meet these goals. (See pages 14 through 17 of the report for a summary evaluation of the current Medicaid cost per diem payment method.)
- *the Medicare DRG payment method*--Although a neutral third party developed the rate schedule for the Medicare DRG payment method, this method was designed to pay for inpatient hospital medical services primarily to an elderly population and would require significant modification. Also, according to CMS officials, use of this payment method would likely result in eliminating or

reducing significantly the Medicare Upper Payment Limits payments to hospitals. (See pages 17 through 21 of the report for a summary evaluation of the Medicare DRG payment method.)

- *the ACS-recommended APR-DRG payment method-* While the state would develop the rate schedule for the APR-DRG payment method, an APR-DRG method is designed to pay for hospital inpatient medical services to the Medicaid population and would accomplish the DOM's management goals for client care, hospitals, and program management. (See pages 21 through 24 of the report for a summary evaluation of the ACS-recommended APR-DRG payment method.)

The best interests of Mississippi's Medicaid program as a whole should outweigh individual provider interests. Any payment method will favor some providers over other providers regardless of the payment methodology used.

### **Accountability Concerns Regarding the ACS-Recommended APR-DRG Payment Method**

If funding for payment of inpatient hospital services does not keep pace with provider costs, participation by providers of these services could decrease and as a result, Medicaid beneficiaries' access to care would decline. Therefore, it is vital that funding for the ACS-recommended APR-DRG payment method remain at a sufficient level to reimburse providers at a sufficient rate to ensure participation in the Medicaid program. Currently, on average, the per diem payment method pays hospitals at 91% of cost of services and, after including UPL payments, hospitals are reimbursed at 132% of inpatient costs.

### **What's Next? Maintaining an APR-DRG Payment Method**

The use of an APR-DRG inpatient hospital services payment method would be an improvement from the hospital-specific per diem payment method. PEER believes that although a budget-neutral payment method is acceptable for introduction of an APR-DRG payment method, it must be maintained and updated on a regular basis to meet federal guidelines and ensure that payments are reasonable and access to care is adequate.

## Recommendations

1. Based on PEER's evaluation of the Division of Medicaid's current cost per diem payment method, the Medicare DRG payment method, and the ACS-recommended APR-DRG payment method, the Committee recommends that the Division of Medicaid finalize the development of the ACS-recommended APR-DRG payment method for implementation on July 1, 2010.
2. The APR-DRG payment method should be maintained and updated annually. Reviews should include, but not be limited to:
  - the DRG base price;
  - the DRG relative weights, including any adjustments for enumerated policy goals;
  - DRG cost and day outlier thresholds;
  - DRG length of stay benchmarks used in calculating transfer payments;
  - other provisions of the payment method as necessary;
  - levels and changes in client access to care, both overall and for specific services such as obstetrics, newborn care, and mental health;
  - Medicaid payments relative to the costs of efficiently and economically operated hospitals;
  - changes in hospital input costs;
  - the legislative appropriation;
  - other payments made to hospitals for the care of Medicaid clients that are separate from DRG payments;
  - changes in how hospitals bill for care using diagnosis codes, procedure codes, and other information on claim forms; and,
  - other factors that the division may specifically enumerate that affect the goals of efficiency, economy, quality, and access.
3. The Legislature should amend MISS. CODE ANN. Section 43-13-117 (I) (1972) to direct the Division of

Medicaid to publish and implement an APR-DRG inpatient hospital services payment method that is acceptable to the Centers for Medicare and Medicaid Services. This payment method should comply with provisions of 42 CFR Part 447 regarding reasonableness and adequacy of rates. Such method should become effective after July 1, 2010.

The Legislature should also require the Division of Medicaid to review the APR-DRG payment method and rates and make changes annually, where appropriate, in compliance with the public notice requirements and other requirements of the Mississippi Administrative Procedures Act.

The Legislature should further delete from this provision any references to Medicare DRGs and the requirement that PEER report on the benefits and liabilities of an APR-DRG payment method.

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# Benefits and Limitations of an All Patient Refined-Diagnosis Related Groups Inpatient Hospital Services Payment Method for Mississippi Medicaid Patients

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## Introduction

### Authority

PEER conducted this study pursuant to the authority granted in MISS. CODE ANN. Section 5-3-51 et seq. (1972) and the mandate in House Bill 71, Second Extraordinary Session of 2009.

### Problem Statement

#### The Management and Financial Needs of the Medicaid Program

The Division of Medicaid (DOM) has used a payment method for years that has not sufficiently addressed the management and financial needs of the hospitals and the Medicaid program. A primary cause of this problem has been the use of a cost per diem payment method per day of client care that did not meet the necessary objectives for a sustainable, rational payment method.

As discussed on page 5, this cost per diem method has depended on audited Medicare cost reports to make final payments, although these reports have created at least a two-year delay in the hospitals receiving final payments for the provided services. Also, the cost per diem method has *not*:

- enabled the DOM and hospital providers to perform timely financial planning and adjustments to cost reports and payment rates;
- rewarded efficiency in hospital care that minimizes the length of stay consistent with good patient care and allows the hospital to keep any cost savings generated through management or treatment efficiencies;
- geared payments for individual client cases to expected costs in order to reward the hospitals, regardless of bed size and location, with more

- payment dollars toward more expensive cases and fewer payment dollars toward less expensive cases;
- paid similar amounts for patients with a similar diagnosis receiving similar care, thus improving uniformity of payment to hospitals, regardless of their bed size and location--i. e., fairly (uniformly) distributing limited state resources to provide these services; and,
  - enabled DOM to control payments and policy priorities of the Medicaid hospital inpatient services program.

### **The Payment Method Recommended by ACS**

In 2004, the DOM decided to assess alternative payment methods that would help to resolve the problems noted above and better address the management and financial needs of the hospitals and the Medicaid program. The division asked its fiscal agent, ACS State Healthcare LLC,<sup>2</sup> (ACS) to analyze the division's method of inpatient hospital payment and offer suggestions for improvement based on management goals set by the division (see page 12 for the Division of Medicaid's management goals for a payment method).

ACS conducted a formal evaluation of five alternative payment methods in 2005 and recommended that the DOM use an All Patient Refined-Diagnosis Related Groups (APR-DRG) method (see page 21 for an explanation of this type of payment method). On October 1, 2005, the DOM established an interim cost-based per diem payment method until a new state DRG-based rate schedule could be determined and put into effect for inpatient services at eligible hospital facilities. Since that time, ACS has conducted payment simulations each year (except for 2008) using the previous year's Medicaid cost data and has evaluated possible DRG-based rate schedules, including the Medicare DRG method as well as an APR-DRG method.

### **Problems with the Legal Interpretation of H. B. 71, Second Extraordinary Session of 2009**

During its Second Extraordinary Session of 2009, the Mississippi Legislature directed the DOM as follows:

*(I) The division shall develop and publish reimbursement rates for each APR-DRG proposed by the division at least equal to the prevailing corresponding Medicare DRG rate*

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<sup>2</sup> ACS State Healthcare, LLC (ACS) is the Division of Medicaid's fiscal agent contractor that is responsible for processing claims, handling calls from providers, and maintaining the computer system for Medicaid in Mississippi. One of the services ACS provides is to assist Medicaid programs with analysis, design, and implementation of payment policy.

*or a closely related Medicare DRG rate, applying to each hospital, the applicable federal wage index being used by CMS for the hospital's geographic location, but the division shall not implement that rate schedule or APR-DRG methodology until after July 1, 2010. The PEER Committee shall study the benefits and liabilities of implementing an APR-DRG reimbursement rate schedule, and report its findings to the members of the Senate Public Health and Welfare Committee and the House Medicaid Committee on or before December 15, 2009.*

This language required the following:

- Medicaid must develop and publish a set of payment rates that are at least equal to those allowed under Medicare for the identical or closely related Medicare DRG rate; and,
- the PEER Committee must report to the Senate Public Health and Welfare Committee and the House Medicaid Committee on the benefits and liabilities of moving to a Medicaid DRG method of reimbursement.

To comply with this language, the Division of Medicaid calculated a set of payment rates comprising whichever rate was higher, the original APR-DRG rate or the Medicare payment rate for the Medicare DRG that corresponded most closely to the specific APR-DRG. By definition, the resulting rates equal or exceed those utilized in the Medicare program. PEER notes that while such a model complies with the strict requirements of this provision, it could result in a payment schedule that would not comply with regulations of the Centers for Medicare and Medicaid Services (CMS), because CMS does not allow payments in excess of those allowed under Medicare.

## Scope and Purpose

Since PEER's statutory mandate did not state which specific All Patient Refined-Diagnosis Related Groups (APR-DRG) rate schedule to study, in order to determine the actual benefits and limitations of the APR-DRG process in regard to the eligible Medicaid participants, providers, and the state as a whole, PEER's study compares the following methodologies and the impact of their rate schedules:

- the current Medicaid cost-based per diem payment method;
- the Medicare DRG payment method; and,
- the ACS-recommended APR-DRG payment method.

## Method

In accomplishing its objectives, PEER was required to work closely with the DOM and ACS staffs in order to accomplish the methodology described below. These staffs have provided open access to and understanding of their records, appropriate reports, and evaluative processes (including assumptions, governing principles, and methodology). As a result, PEER believes that the 2005 evaluation report for the ACS-recommended payment method and the three payment simulation studies conducted in 2006, 2007, and 2009 have produced objective third-party results in each case. Thus, PEER could rely on these reports to accomplish the legislative purpose for this report.

In order to compare the rate-setting methods and their resulting cost reimbursement schedules, PEER examined each rate-setting method in order to understand the theory and/or impact of the:

- management objectives behind each;
- cost reimbursement objectives behind each;
- cost reimbursement components of each; and,
- the applicability of the eligible participant population and cost reimbursement rates.

In conducting this study, PEER:

- reviewed appropriate state laws and the DOM's payment policies and processes;
- reviewed research literature about All Patient Refined-Diagnosis Related Groups (APR-DRG) and other DRG payment processes for medical services;
- reviewed and analyzed the APR-DRG payment simulation process and studies of the ACS State Healthcare LLC for Medicaid-funded inpatient services in eligible medical facilities; and,
- interviewed appropriate staff of the DOM, ACS, Mississippi Hospital Association (MHA), staff of some Mississippi hospitals, and staff at other Medicaid states that use an APR-DRG payment method; and,
- analyzed the comparative cost reimbursement differences of the two methods with the current per diem payment method using FY 2009 data to determine the financial impact on the hospital service providers and the state cost reimbursements for their inpatient services to eligible Medicaid patients.

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## Background

### History of Mississippi's Medicaid Payment Method

#### Cost Per Diem Payment Method

According to an ACS document, *A New Inpatient Hospital Payment Method for Mississippi Medicaid* (May 15, 2007), until October 1, 2005, the DOM paid each eligible hospital provider an interim cost-based per diem payment per day of care for inpatient services to Medicaid-eligible participants. The amount was specific to each hospital and ranged from approximately \$500 a day to approximately \$1,500 a day. Under this method, a hospital received its per diem payment regardless of the inpatient diagnosis. In other words, the hospital's payment for a gall bladder surgery was the same as for open-heart surgery, even though the procedures and associated costs are vastly different.

For example, the hospital would receive an interim payment in 2005 based on its 2003 initial cost report. DOM would then calculate the final hospital inpatient per diem rate once the fiscal intermediary issued a final settlement cost report. DOM used this final settlement rate to reprocess retroactively 100% of all inpatient claims paid to this provider during the 2005 rate period. This "cost settlement process" would typically be completed two to three years after the end of the rate period--e. g., in 2007 or 2008.

Effective October 1, 2005, the DOM established an interim payment method until a new state DRG-based payment method could be determined and put into effect for inpatient services at eligible hospital facilities (i. e., general hospital, freestanding adolescent mental health hospital, and freestanding rehabilitation hospital). This interim payment method consisted of trending the higher of the 2005 per diem rate or the average of the 2004 and 2005 per diem rates for each hospital without the cost settlement discussed above. Each hospital's per diem amount increases annually based on CMS's Prospective Payment System inflation factor. As with the previous payment method, hospitals receive their per diem regardless of the inpatient diagnosis and treatment.

#### The Medicare Upper Payment Limits (UPL) Program

In addition to the inpatient funds paid using this interim payment method, MISS. CODE ANN. Section 43-13-117 (2) (K) (18) (b) (1972) requires the DOM to pay eligible

hospitals additional funds for inpatient hospital services under the Medicare Upper Payment Limits Program (UPL). As defined in the federal regulation 42 CFR 447.272, this UPL payment is the cost difference between a reasonable estimated cost for these services using Medicare payment principles and the actual Medicaid payment, if it is smaller than the Medicare payment amount.

In accordance with the Social Security Act, Section 1902 (a) (30) and appropriate federal regulations, these UPL payments are funded by federal and state match funds, which are paid through an annual assessment of all Mississippi hospitals in accordance with MISS. CODE ANN. Section 43-13-117 (1972). The state collects these assessments and combines them with federal funds received to produce a pool of funds subsequently distributed as UPL payments to eligible providers of inpatient and outpatient services. In FY 2009, DOM made UPL payments to eligible hospitals totaling \$289,672,862 that included federal and state shares of \$242,593,202 and \$47,079,660, respectively.

## **The Need to Change the DOM Payment Method**

The DOM needed to replace its cost per diem payment method because it had failed to achieve the objectives necessary to meet the management and financial needs of the hospitals and the DOM. See “Comparison of the Current Cost Per Diem Payment Method to the DOM’s Goals for a New Payment Method” on pages 15 through 17.

As discussed on page 9, the DOM asked ACS to present options in order to determine the most appropriate method to accomplish its goals. In its evaluation, ACS included three different variations of the Prospective Payment System that Medicare began using in 1985 that are significantly different from the cost per diem payment method. The following section includes a discussion of these differences and PEER’s evaluations of the use of Medicare-DRG and ACS-recommended APR-DRG payment method.

## **History of the Medicare Payment Method and Diagnosis-Related Groups**

### **The Move to the Prospective Payment System**

From October 1, 1967, to September 30, 1983, the U. S. Department of Health and Human Services paid hospitals in the United States on the basis of the actual cost of

providing services to Medicare beneficiaries.<sup>3</sup> Under this system, each hospital submitted a “cost report” that itemized expenditures incurred during the hospital’s prior fiscal year. During this period, federal policymakers viewed the health care system as wasteful, since the inflationary costs from the system were enormous because payment methods paid providers based on their charges for providing services and consequently created an incentive to provide more services.

In response to payment growth, Congress adopted a prospective payment system to curtail the amount of resources the federal government spent on medical care for the elderly and disabled. The Social Security Amendments of 1983 mandated the Prospective Payment System (PPS), which was intended to motivate hospitals to change the way they deliver services. This system introduced the use of diagnosis-related groups (DRGs) as the payment basis for Medicare participants, a system that is still used today.

## **Use of Diagnosis-Related Groups (DRGs)**

An integral part of the PPS is the categorization of medical and surgical services into DRGs. The DRGs bundle services (both labor and non-labor services) needed to treat a patient with a particular disease. The DRG payment rates cover most routine operating costs attributable to patient care, including routine nursing services, room and board, and diagnostic and ancillary services. The DRG rates do not include direct medical education costs, outpatient services, or services covered by Medicare Part B.

The CMS assigns a unique weight to each DRG. The weight reflects the average level of resources for an average Medicare patient in the DRG relative to the average level of resources for all Medicare patients. The weights are intended to account for cost variations between different types of treatments.

The methodology for calculating the DRG weights has been refined over time, but the core process remains the same. Summing the cost for all cases in the DRG and dividing that amount by the number of cases classified in the DRG yields the average standardized cost for each DRG. Cost of living adjustments are removed for hospitals in Alaska and Hawaii. The average cost for each DRG is re-computed and then divided by the national average standardized cost per case to determine the weighting factor.

Medicare DRG payments are adjusted to take in consideration four factors that are considered to reflect

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<sup>3</sup> Information on the history of the Medicare payment system and DRGs was derived from a U. S. Department of Health and Human Services Inspector General, Region IX White Paper, *Medicare Hospital Prospective Payment System: How DRG Rates Are Calculated and Updated*, August 2001.

more accurately the costs of services provided by hospitals:

- *Wage Index:* Medicare's purpose for applying a wage index to its DRG rates is because salaries generally represent the largest component of hospital costs. Prevailing salary levels vary substantially among different areas of the country. Use of a single national or regional DRG payment for all hospitals without any consideration of prevailing wages would severely penalize hospitals located in high-wage areas and unfairly benefit hospitals located in low-wage areas. The CMS adjusts federal DRG rates to reflect prevailing wages in the local area, which is defined as either "large urban" or "other." The CMS annually publishes an index of prevailing relative wages for each area. As a result, DRG payments in high-wage areas are greater than DRG payments in low-wage areas.
- *Indirect Medical Education Costs:* Medicare assumes that teaching institutions have higher costs than other institutions due to extra tests and procedures performed for teaching purposes and the treatment of more serious cases. Accordingly, the DRG payments for these hospitals are increased by a percentage based on the number of full-time equivalent residents, number of hospital beds, and number of discharges.
- *Cost Outliers:* Medicare makes additional payments for cases with extremely high overall costs, commonly referred to as "cost outliers." The CMS annually establishes the limits that must be met to qualify for "cost outlier" payments. If the cost of a particular case exceeds the limits, the hospital may qualify for a cost outlier payment.
- *Disproportionate Share Payments:* Disproportionate share hospitals are those that treat a large percentage of low-income patients, including Medicaid and Medicare beneficiaries. Medicare makes these additional payments to hospitals that qualify to account for the cost of treating this population.

## Cost of Mississippi's Current Medicaid Payment Method

According to the DOM staff, the state used federal and state matching funds to pay \$1,029,748,771 to eligible hospitals for inpatient hospital or outpatient Medicaid services in FY 2009. This amount included \$502,026,203 (Medicaid- and state-funded inpatient services), \$238,049,706 (Medicaid- and state-funded outpatient services), and \$289,672,862 (Medicaid- and UPL-funded inpatient services). Exhibit 1, page 9, shows these inpatient and outpatient service payments to the various categories of hospital providers.



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**Exhibit 1: FY 2009 Medicaid Payments to Eligible Hospitals for Medicaid Participant Inpatient and Outpatient Hospital Services**

<b>Hospital Providers</b>	<b>Medicaid Inpatient Service Payments</b>	<b>Medicaid Outpatient Service Payments</b>	<b>Medicaid UPL Inpatient Service Payments</b>	<b>Medicaid Service Payment Costs</b>
Government non-state owned hospitals (39)	\$147,586,837	\$ 72,208,957	\$ 96,270,462	\$316,066,256
Privately owned hospitals (61)	256,241,332	104,388,363	147,436,064	508,065,759
State-owned hospitals (4)	98,198,034	61,452,386	45,966,336	205,616,756
<b>Total</b>	<b>\$502,026,203</b>	<b>\$238,049,706</b>	<b>\$289,672,862</b>	<b>\$1,029,748,771</b>

SOURCE: DOM financial records.

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**Development of the Recommended APR-DRG Payment Method**

As noted previously, in 2004, the DOM contracted with ACS to recommend options for improving the current cost-based per diem payment method. To do so, the DOM and/or ACS:

- analyzed the existing Medicaid payment method, a new per diem method, and three alternative DRG methods;
- consulted extensively with hospital executives;
- consulted with a Medicaid Healthcare Advisory Committee that included members from ACS, hospital providers, the DOM, and the Mississippi Hospital Association;
- published documents and information including design and assessment reports for three of four ACS cost payment simulation studies; the 2008 Health Affairs article, “New Directions in Medicaid Payment for Hospital Care;” frequently asked questions about the new APR-DRG payment method; pricing examples; and presentation slides; and,

- conducted eleven statewide training courses for approximately 750 hospital provider staff members.

Using Mississippi Medicaid claims data from January 2004 through June 2004, ACS conducted its first formal evaluation (i. e., first *payment simulation*) of three different DRG payment methods in 2005. These included:

- CMS's Basic DRGs that were used to pay for Medicare beneficiaries;
- All Patient DRGs, an alternative DRG algorithm developed for the New York Medicaid program and used by four other Medicaid programs; and,
- APR-DRGs that incorporated severity of illness subclasses into All Patient DRGs.

This formal evaluation used statistical tests that are standard in payment method development. ACS determined in this study that APR-DRGs consistently fit the Mississippi data very well, better than either of the first two DRG payment methods mentioned above.

ACS conducted three additional payment simulations to compare the financial impact on hospital providers and the state, as well as the appropriateness of using an APR-DRG payment method. These cost reimbursement simulations included:

- *Second Simulation*--ACS conducted this simulation in October 2006, using January-June 2006 data and methodology. Its purpose was to verify the validity of APR-DRGs, set the base price and other payment parameters, and simulate impacts on a hospital-specific basis. According to the ACS staff, this simulation confirmed the appropriateness of an APR-DRG payment method for the Mississippi Medicaid population.
- *Third Simulation*--ACS conducted this simulation in 2007, using January-June 2007 data and methodology with the same results as the first and second payment simulations.
- *Fourth Simulation*--ACS conducted this simulation in 2009, using October 2008-March 2009 data that compared the current payment method with the same results as the three other payment simulations.

This fourth cost simulation study allowed PEER to evaluate the use and effect of the current Medicaid payment method, the statutory Medicare DRG cost reimbursement rates, and the ACS-recommended APR-

DRG cost reimbursement rates on the hospital providers and the state in order to fulfill the statutory requirement.

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# Comparative Analysis of Payment Methods for Potential Use in the State's Medicaid Program

The State of Mississippi should adopt the APR-DRG inpatient hospital services payment method because it is in the public interest to improve access to care, reward hospital efficiency, increase fairness to hospitals, improve purchasing clarity of hospital services, and reduce the administrative burden on the Division of Medicaid and hospitals. Funding must remain sufficient to ensure reasonable payment of provider costs to ensure that Medicaid beneficiaries have adequate access to medical services.

## The Division of Medicaid's Criteria for a New Payment Method

*The Division of Medicaid, working with its contractor ACS, established eight criteria that any new payment method should meet.*

As noted previously, in 2004, the DOM contracted with ACS to evaluate and determine an inpatient hospital services payment method that the state should use in order to accomplish the following management goals of the division:

- *to improve client access*--requires a wide variety of quality, appropriate medical services that would reward the hospitals, regardless of bed size and location, with more payment dollars toward more expensive cases and fewer payment dollars toward less expensive cases;
- *to reward hospital efficiency*--requires achieving the minimal length of stay and minimal cost per day consistent with good patient care. Any payment method that would accomplish this goal would allow hospitals to keep any cost savings generated through management or treatment efficiencies;
- *to increase fairness (uniformity of payment) to hospitals*--requires paying different hospitals similar amounts for similar work for client treatment and ensuring that the payments take into account differences in costs truly beyond a hospital's control-- e. g., prevailing wage levels in its area;
- *to improve purchasing clarity of hospital services*--clearly documents what services that the state is purchasing for clients and how well hospitals are providing these services to them; and,

- *to reduce the administrative burden on the Division of Medicaid and the hospitals*--requires reducing delays and adjustments to cost reports and payment rates so that hospitals and the DOM can plan more accurately and in a timely manner.

To determine the best payment method that would enable the DOM to meet these goals, ACS conducted four different evaluation cost studies, as noted on page 10. The first study used eight criteria. These criteria included the five DOM management goals above, in addition to the following listed below, to determine whether the DOM should use a payment method similar to its current one or a DRG payment method (such as the Medicare DRG) or the ACS-recommended APR-DRG payment method:

- *to determine how well the casemix adjustors capture the variation in hospital utilization*--the payment method should have casemix adjustors, such as the severity of the illness or risk of death, that credibly measure the resource demands placed upon the hospital by the full range of patients in order to pay more for cases that require more hospital resources;
- *to determine the simplicity of the payment method*--the payment method must be simple enough for the hospitals to use effectively and efficiently and recognize the incentives for efficiency that the method provides to them; and,
- *to pay the hospitals for providing higher quality care to clients*--the payment method should reward hospitals that improve their quality of care for clients in order to specifically encourage quality care (e. g., reduce the mortality rate for a stroke client).

In its evaluation report, *Purchasing Hospital Inpatient Care: Options for Improvement*, dated May 24, 2005, ACS strongly recommended that DOM use an APR-DRG payment method that is a per-client stay payment method with 1,258 APR-DRGs as the casemix adjustors. Each stay would be assigned to a single APR-DRG based on the physician's diagnosis and procedures used to treat the patient. The payment for each stay would equal the assigned relative weight for the DRG multiplied by a statewide base price determined through available funding. Extraordinarily expensive cases would receive additional "outlier" payments—cost outlier payments for physical health cases and day outlier payments for mental health cases. In response to DOM's direction, ACS would determine the actual statewide base price, the source for the APR-DRG relative weights, participation to out-of-state hospitals, and payment for transfer cases among hospitals, in the detailed design phase.

In this report, PEER compares the current Medicaid cost-based per diem payment method, the Medicare DRG payment method, and the ACS-recommended APR-DRG payment method in view of the above criteria.

## The Current Medicaid Cost Per Diem Payment Method

*The DOM's current cost per diem payment method, as modified on October 1, 2005, does not meet five of the division's management goals for a new payment method: to improve client access to hospitals; to reward hospital efficiency for reducing state costs through more efficient client treatment; to increase fairness to hospitals for revenue payments for client care, to improve purchasing clarity of client hospital services, and to reduce the administrative burden for final payments on the hospitals and the DOM. As a result, the current payment method should be replaced with a method that can meet these goals.*

As discussed on page 5, until October 1, 2005, the DOM paid each eligible hospital provider an interim cost-based per diem payment per day of care for inpatient services to Medicaid-eligible participants. Effective October 1, 2005, the DOM established an interim payment method until a new state DRG-based payment method could be determined and put into effect for inpatient services at eligible hospital facilities.

The following sections describe the current cost per diem payment method that the Division of Medicaid uses and discusses why that payment method does not meet some of the management goals that the division had articulated for its new payment method.

### Description of the Current Cost Per Diem Payment Method

*With the current method, each hospital is paid a set rate per day of care.*

According to the 2005 ACS report entitled, *Purchasing Hospital Inpatient Care: Options for Improvement*, dated May 24, 2005, the Medicaid payment method for hospital inpatient services is a cost per diem payment method with rates that consider hospital-specific allowable costs that are subject to financial limits established in the *Mississippi Title XIX Inpatient Hospital Reimbursement Plan in the Mississippi Medicaid State Plan (Attachment 4.19-A)*. In this payment method, each hospital is paid a set rate per day of care, including a patient who is admitted and discharged on the same day but excluding the discharge day for other patients. For a given hospital, the rate is the same for all patients regardless of how simple or complex their care.

Each hospital's payment rate has four components:

- *Operating:* This component includes all allowable costs except the costs in the capital and medical education

components and is the most important, since it usually accounts for approximately 85% of total Medicaid payments. To determine allowable costs, each hospital is assigned to a class of hospitals based on the number of beds, excluding nursery and neonatal intensive care beds.

The daily reimbursement amount for a hospital cannot exceed the cost of the hospital that is at the 80<sup>th</sup> percentile of its class--e. g., \$800, regardless of the individual hospital's cost. The purpose of this cap is to limit recognition of costs generated through the inefficiency of the hospital. (The DOM does adjust this cost cap based on the variance of the prevailing wage among the state localities, which does benefit hospitals that operate in higher-wage areas.)

- *Capital:* These costs for capital improvements, such as new or improved facilities, are not capped.
- *Medical Education:* These costs are paid to the teaching hospitals in Mississippi and four out-of-state hospitals. See discussion on page 8 regarding how the DOM determines the percentage used for these payments.
- *Low-Disproportionate Share Hospitals:* Hospitals are designated as a Disproportionate Share Hospital (DSH) if they offer obstetric services and meet certain percentage criteria for patients who are either Medicaid clients or low-income patients--i. e., Medicaid or people ineligible for Medicaid. These hospitals are classified as either High-DSH (government owned hospitals) that are paid separately from this payment or Low-DSH (all other hospitals) that are paid a DSH component cost equal to 6% of the operating component cost.

These payment rates change each October 1 with the changes based on each hospital's previous costs that are allowed under Medicare and Medicaid cost reporting principles.

## **Comparison of the Current Cost Per Diem Payment Method to the DOM's Goals for a New Payment Method**

*The DOM current cost per diem payment method, as modified on October 1, 2005, does not meet five of the division's management goals for a payment method.*

The Medicaid cost per diem payment method used since October 1, 2005, does not accomplish the five DOM management goals listed on page 12 of this report. Specifically, the current payment method does not:

- *improve client access*--The current payment method does not meet this goal because it pays the hospital a flat hospital-specific cost per diem rate for each stay,

regardless of the severity of the illness and the length of stay;

- *reward hospital efficiency*--The current payment method does not meet this goal because it penalizes hospitals that become more efficient and decrease costs in the treatment of clients with lower payments due to a decreased cost per diem rate when these rates are adjusted. The current method also does not encourage a hospital to become more efficient, since it will continue to draw the established cost per diem rates for inefficient treatment of clients, as adjusted annually for inflation.
- *increase fairness to hospitals*--The current payment method does not meet this goal because it often pays two hospitals very different amounts for the care of similarly ill patients due to its paying each hospital a flat hospital-specific cost per diem rate for each stay, regardless of the severity of the illness and length of the stay.

For example, the 2005 ACS assessment report of the cost per diem payment method showed that the top five hospitals by number of procedures for the two most common surgical procedures for births received the following amounts:

- *Procedure 73.59: Assist Spontaneous Delivery.* The payments ranged from \$2,108 to \$3,214 (a \$1,106 range) for this procedure. The specific hospital payments were South Central Regional Medical Center (\$2,108), Forrest General (\$2,395), BMH DeSoto (\$2,851), River Oaks Hospital (\$3,040), and the University of Mississippi Medical Center (\$3,214).
- *Procedure 74.1: Low Cervical Cesarean Section.* The payments ranged from \$2,696 to \$4,171 (a \$1,475 range) for this procedure. The specific hospital payments were Forrest General (\$2,696), North Mississippi Medical Center (\$3,494), River Oaks Hospital (\$3,584), Central Mississippi Medical Center (\$4,104), and the University of Mississippi Medical Center (\$4,171).
- *improve the purchasing clarity of hospital services*--Due to the complexity of hospital utilization and billing practices, the current payment method can obscure what services are being purchased and how well they are provided to the client.
- *reduce the administrative burden on the hospitals and the DOM*--As discussed on page 5, DOM addressed this



problem to some degree when it modified the cost per diem payment method effective October 1, 2005, to eliminate the final cost settlement process two years after CMS audits the cost reports of a hospital. If another reimbursement methodology is not implemented by October 1, 2010, Mississippi's current State Medicaid Plan requires that all inpatient payment rates be rebased for the federal fiscal year ending September 30, 2011. However, another reimbursement method may make further administrative improvements possible.

## The Medicare DRG Payment Method

*Although a neutral third party developed the rate schedule for the Medicare DRG payment method, this method was designed to pay for inpatient hospital medical services primarily to an elderly population and would require significant modification. Also, according to CMS officials, use of this payment method would likely result in eliminating or reducing significantly the Medicare Upper Payment Limits payments to Mississippi hospitals.*

### Description of the Medicare DRG Payment Method

*The Medicare DRG payment method was developed by a neutral third party--the Centers for Medicare and Medicaid Services.*

As discussed on page 7, the Centers for Medicare and Medicaid Services of the U. S. Department of Health and Human Services developed the Medicare DRG payment method to cover most routine operating costs attributable to patient care, including routine nursing services, room and board, diagnostic services, and ancillary services and adjusted these rates annually for inflation. The Medicare DRGs were designed to pay for hospital inpatient medical services, primarily to an elderly adult population.

In determining the payment rate for a specific DRG, CMS first calculates a relative weight that measures the average costliness of that DRG nationwide compared with all DRGs. The relative weight is then multiplied by a DRG base price (called the "standard amount" by CMS) to yield a national schedule of 746 DRG-specific payment rates. Payments to individual hospitals are then adjusted for wage differences in the local area, direct and indirect medical education costs, and supplemental payments to hospitals that serve a disproportionate share of low-income residents. Hospitals may also receive "outlier" payments for extraordinarily expensive cases.

Use of the Medicare DRGs would require modifications to reflect Mississippi's Medicaid population and could result in elimination of UPL payments to hospitals, as discussed in the following subsections.

## Limitations of the Medicare DRG Payment Method

### ***Need for Modifications to Reflect the Medicaid Population***

*Because the Medicare DRG payment method was designed to pay for inpatient hospital medical services primarily for an elderly population, with a set of specific assumptions about that population, this payment method would require significant modification for Mississippi's Medicaid population.*

While the Medicare DRG cost reimbursement rates could be used for the state's Medicaid program, the state would need to modify them to reflect the actual Medicaid population, which is primarily composed of low-income adults, children, and pregnant women. To accomplish this modification would require meeting at least the following challenges:

- inadequate neonatal DRGs in the Medicare method due to no use of birth weight, no updates to logic in twenty years, fewer than ten Medicare births a year nationwide, and underpayment for neonatal intensive care unit stays;
- outdated obstetric DRGs due to no recognition of critical care differences and almost non-existent obstetric stays;
- insufficient pediatric DRGs due to elimination of forty-one DRGs that were in the Medicare method until 2007; and,
- no separate DRGs for certain pediatric and young adult conditions.

Modifications would cost additional state resources and require another set of assumptions, as well as periodic changes. Thus the state would enter into a relatively continuous cycle of changes to accomplish what the ACS-recommended APR-DRG payment method already does with one exception--i. e., to update its cost reimbursement rates periodically with actual hospital cost data in order to ensure that the hospitals receive a reasonable payment for their cost to provide patient care to each individual patient.

The CMS has officially taken the position that non-Medicare payers should not use the Medicare DRGs, since they are developed specifically for Medicare's client population. Specifically, CMS stated in its annual rate adjustment information published in *Medicare Program Changes to the Hospital Inpatient Prospective Payment Systems* for Federal Fiscal Years 2005 and 2008:

*We advise those non-Medicare systems that need a more up-to-date system to choose*

*from other systems currently in use in this country, or to develop their own modifications. . . Our mission in maintaining the Medicare DRGs is to serve the Medicare population.<sup>4</sup>*

.....

*The MS-DRGs were specifically designed for purposes of Medicare hospital inpatient services payment. As we stated above, we generally use MedPAR data to evaluate possible DRG classification changes and recalibrate the DRG weights. The MedPAR data only represent hospital inpatient utilization by Medicare beneficiaries. We do not have comprehensive data from non-Medicare payers to use for this purpose. The Medicare program only provides health insurance benefits for people over the age of 65 or who are disabled or suffering from end-stage renal disease. Therefore, newborns, maternity, and pediatric patients are not well represented in the MedPAR data that we used in the design of the MS-DRGs. We simply do not have enough data to establish stable and reliable DRGs and relative weights to address the needs of non-Medicare payers for pediatric, newborn, and maternity patients. For this reason, we encourage those who want to use MS-DRGs for patient populations other than Medicare make the relevant refinements to our system so it better serves the needs of those patients.<sup>5</sup>*

Exhibit 2, page 20, illustrates why the Medicare DRGs should not be used or modified for the Medicaid program, since these DRGs lose the precision of having costs appropriate for the Medicaid population. The exhibit shows the percentage differences in the Medicare and Medicaid client populations that were provided with hospital inpatient services between October 2008 and March 2009.

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<sup>4</sup> *Federal Register* 69:154 (Aug. 11, 2004), p. 48939.

<sup>5</sup> *Federal Register* 72:162 (Aug. 22, 2007), p. 47158.

**Exhibit 2: 2009 ACS Payment Simulation Comparing Medicare and Medicaid Stays for Inpatient Hospital Services**

<b>Client Service Categories</b>	<b>Medicare Hospital Stays</b>	<b>Medicaid Hospital Stays</b>	<b>Difference Between Medicare and Medicaid</b>
Adult Medical and Surgical	96%	23%	73%
Adult Mental Health	4%	7%	(3%)
Obstetric*	0%	27%	(27%)
Pediatric*	0%	43%	(43%)
<b>Total</b>	<b>100%</b>	<b>100%</b>	

\* Medicare clients received obstetric and pediatric services, but the total of the two services was less than 0.05%, so ACS reported them as 0% each.

SOURCE: ACS Cost Simulation Study of Medicare and Medicaid in October 2009.

***Reduction or Possible Elimination of the UPL Program***

*Use of the Medicare DRG payment method would likely result in reducing or possibly eliminating the Upper Payment Limits payments to hospitals, according to CMS officials, because the purpose of these payments is to ensure that the hospitals receive the maximum payment for the provided client care and is the difference between the maximum Medicare payment and a lower Medicaid payment for that care.*

As discussed on page 5, MISS. CODE ANN. Section 43-13-117 (2) (K) (18) (b) (1972) requires DOM to pay eligible hospitals additional funds for inpatient hospital services under the Medicare Upper Payment Limits Program. According to the program's regulations, this payment is the difference between the Medicare reimbursement service amounts and the Medicaid amount, if it is smaller than the Medicare amount.

According to CMS officials, the use of the higher Medicare rates in House Bill 71, Second Extraordinary Session of 2009, will likely eliminate or reduce significantly the Medicare Upper Limit Payments to the eligible hospitals. These UPL payments totaled \$289,672,862 in FY 2009 (according to DOM records). The significance of a reduced UPL program cannot be determined until comparative information for the Medicare and ACS-recommended APR-DRG rates is available--i. e., the number and the total dollars for the Medicare rates that are higher, equal, or lower than the APR-DRG rates.

If the UPL program were eliminated, all hospitals, with the exception of four that did not receive UPL payments during FY 2009, would lose UPL payments ranging from approximately \$5,000 (to the hospital receiving the smallest amount under the UPL program) to \$41 million (to the hospital receiving the largest amount under the UPL program).

The Medicare DRG rates mentioned in H. B. 71, Second Extraordinary Session of 2009, would not pay hospitals the same amounts as under the UPL program because the Medicare DRG rates include only the applicable federal wage index used by CMS for a hospital's geographic location. UPL payments take into consideration other factors such as medical education, disproportionate share hospital payments, and payments for critical access hospitals that increase UPL payments above the payments hospitals would receive under the Medicare DRG rate.

Since these additional factors are not part of the Medicare DRG rate, payments utilizing the Medicare DRG rate would be significantly less than payments under the UPL program.

#### ***No Change in Disproportionate Share Payments***

*The use of the Medicare DRGs would not affect the disproportionate share payments to eligible hospitals.*

The use of the Medicare DRGs would not affect the disproportionate share payments to eligible hospitals because the basis for these payments does not consider how much in Medicare or Medicaid funds that the hospital receives for providing inpatient services. As discussed above, eligible hospitals are the ones that treat a large percentage of low-income patients.

### **The ACS-Recommended APR-DRG Payment Method**

***While the state would develop the rate schedule for the APR-DRG payment method, an APR-DRG method is designed to pay for inpatient hospital medical services to the Medicaid population and would accomplish the DOM's management goals for client care, hospitals, and program management.***

According to the ACS briefing, *Simulation of APR-DRG Payment Method*, dated October 29, 2009, the DOM contracted with ACS to study the best alternative method of payment for the state's Medicaid program because the division wanted to start using a method that achieved certain objectives. This method needed to:

- *provide payments based on inpatient diagnoses rather than a flat per diem amount--Rather than pay a hospital specific per diem for each inpatient admission*

regardless of diagnosis, the new payment method needed to provide hospitals reimbursement relative to the patient's diagnosis and related expenses.

- *include a sustainable, rational payment method that was not dependent on audited Medicare cost reports--* Federal audits had delayed final DOM payments to hospitals at least two years, thus imposing administrative burdens on both parties.
- *enable DOM and hospital providers to perform better financial planning--*As discussed on page 13, the payment method needed to reduce delays and adjustments to cost reports and payment rates.
- *reward efficiency in hospital care--*As discussed on page 12, the payment method needed to minimize the length of stay consistent with good patient care, thus allowing the hospital to keep any savings generated through management or treatment efficiencies.
- *gear payment for individual cases to expected costs, thus improving hospital access for patients needing high cost care--*As discussed on page 12, the payment method needed to provide a wide variety of quality, appropriate medical services at the closest possible location to the client and reward the hospitals, regardless of bed size and location, with more payment dollars toward more expensive cases and fewer payment dollars toward less expensive cases.
- *pay similar amounts for patients receiving similar care, thus improving fairness to hospitals--*As discussed on page 12, the payment method needed to pay different hospitals similar amounts for similar work for client treatment and ensure that the payments took into account differences in costs truly beyond a hospital's control--e. g., prevailing wage levels in its area.
- *enable DOM to control payments and policy priorities of the Medicaid hospital inpatient services program.*

Based on the above concerns, PEER believes that the ACS-recommended APR-DRG payment method better accomplishes the management objectives and goals for a new payment method than the present method or the Medicare DRG method. The APR-DRG payment method would be a sustainable, rational method that better addresses the client service cost care payment requirements for the state Medicaid population while improving client access to hospitals, rewarding hospital efficiency for reducing state costs through more efficient client treatment, increasing fairness to hospitals for payments for client care, improving the purchasing clarity

of client hospital services, and reducing the administrative burden for final payments on the hospitals and the DOM.

PEER also found that the ACS-recommended APR-DRG inpatient hospital services payment method:

- *is specifically designed for the population of children, low-income adults, and pregnant women that it serves—* Thus it will not require using a set of assumptions to create cost reimbursement rates that may or may not approximate the hospital inpatient service needs of the Medicaid population, which would be the case if the state uses the Medicare DRG rate.
- *is less expensive than the Medicare DRG rates but more expensive than the current cost per diem method—*In its payment simulation study using the Medicaid claims data from October 2008 through March 2009, ACS estimated the six-month payment totals for the three payment methods that are shown in Exhibit 3, page 24.
- *should allow the state and hospitals to continue to participate in the Medicare Upper Payment Limits Program that is funded with federal and state match funds.* See discussion of this payment program on page 5.
- *should allow hospitals that reduce their patient costs through reduced length of stays or cost per day to experience 100% of the savings in their financial bottom line.* Thus it should allow hospitals to receive the same payments when they reduce their costs, which the current system does not do.

Although PEER believes that the ACS-recommended APR-DRG inpatient hospital services payment method better accomplishes the management objectives and goals for a new payment method than the present method or the Medicare DRG method, PEER has accountability concerns about the APR-DRG method, as discussed on page 25.

**Exhibit 3: 2009 ACS Payment Simulation Comparison of the Current Cost Per Diem, Medicare DRG Rates, and ACS-Recommended APR-DRG Payments for Medicare and Medicaid Stays for Inpatient Hospital Services from October 1, 2008, through March 2009**

Payment Method	State Medicaid Payments	Increased State Medicaid Payments Over Current Method's Cost
Medicare DRG	\$279,071,022	\$6,808,836
ACS-Recommended APR-DRG *	272,955,769	693,583
Current Medicaid **	272,262,186	
Cost Difference Between Medicare-DRG and ACS-Recommended APR-DRG Payments		\$6,115,253

\*The increase of \$693,583 would be redeployed from funds currently paid to out-of-state hospitals to in-state hospitals as reimbursement for their costs of medical education. The sum of APR-DRG payments and medical education payments would be budget-neutral.

\*\* Total payments under the current Medicaid method are defined as the allowed amount (\$282,968,244) plus payments that are currently made for care within the "outpatient window" (\$1,558,934) minus payment for medical education to in-state and out-of-state hospitals (\$12,264,992). Under either APR-DRG payment or Medicare DRG payment, services provided immediately before the inpatient admission would become part of the inpatient stay; they are now paid under the outpatient payment method. Payment for medical education would continue to be made separately.

SOURCE: ACS Payment Simulation Study of Medicare and Medicaid in October 2009 and discussion with ACS staff on November 5, 2009.

**Impact on Hospitals**

*The best interests of Mississippi's Medicaid program as a whole should outweigh individual provider interests. Any payment method will favor some providers over other providers regardless of the payment methodology used.*

The current per diem method favors some hospitals over other hospitals. Under a new system, no matter whether it uses the ACS-recommended APR-DRG method or the Medicare DRG method, some hospitals will receive more money and some will receive less money.



Exhibit 4, page 26, shows by bed size group (i. e., number of beds in the hospital) the impact of the ACS-recommended APR-DRG payment method and the Medicare DRG payment method in comparison to the current per diem payment method.

PEER believes that the debate of which payment method to adopt should not focus on which individual hospital or which group of hospitals receives more or less money under a particular payment method. Rather, PEER believes the debate should focus on which payment method best meets the needs of Mississippi's Medicaid inpatient hospital services program over the next ten to twenty years that the chosen payment method is likely to be in place. Therefore, PEER urges readers of this report to weigh each payment method on its own merits rather than on the effect of a particular method on a particular hospital. The best interests of Mississippi's Medicaid program as a whole should outweigh individual provider interests.

## Accountability Concerns Regarding the ACS-Recommended APR-DRG Payment Method

***If funding for payment of inpatient hospital services does not keep pace with provider costs, participation by providers of these services could decrease and as a result, Medicaid beneficiaries' access to care would decline. Therefore, it is vital that funding for the ACS-recommended APR-DRG payment method remain at a sufficient level to reimburse providers at a sufficient rate to ensure participation in the Medicaid program.***

The DOM proposes to implement the APR-DRG inpatient hospital services payment method on a budget-neutral basis—i. e., the APR-DRG base price would be set initially based on the same level as hospital inpatient payments paid with dates of service from the prior year's claims simulation. In other words, the base price is determined by considering the casemix associated with payments from the prior year's claims and the amount of the initial year's budgeted hospital inpatient payment funds. The base price would then be adjusted annually based on various factors (such as new diagnosis codes, new procedure codes, and cost outliers) that would determine the sufficiency of Medicaid hospital inpatient payments under the APR-DRG system.

DOM will have to monitor payments during the fiscal year and adjust the base price on a periodic basis in order to reach the targeted--i. e., budgeted--amount of total hospital inpatient payments. These fluctuations will result in increasing or decreasing the base price due to changes in

utilization, casemix, and the accuracy of inpatient claims coding by hospitals.

**Exhibit 4: 2009 ACS Payment Simulation Comparing Medicaid Payments to Hospitals for Client Stays for Inpatient Hospital Services (for the period October 1, 2008, through March 2009) Using ACS-Recommended APR-DRG or Medicare DRG Rates Versus Current Medicaid Rates**

Hospital Class	Client Stays	Current Medicaid Payments	ACS-Recommended APR-DRG Payments*	Medicare DRG Payments
<b>&lt;50 Beds</b>	2,927	\$8,509,802	\$9,137,703	\$10,390,384
% of \$ Change			7%	22%
\$ Difference			\$627,901	1,880,583
<b>51 to 100 Beds</b>	5,167	15,448,734	16,025,786	16,714,063
% of \$ Change			4%	8%
\$ Difference			577,052	1,265,329
<b>101-200 Beds</b>	14,172	52,404,681	49,818,903	50,749,726
% of \$ Change			(5%)	(3%)
\$ Difference			(2,585,778)	(1,654,955)
<b>&gt;200 Beds</b>	33,066	157,803,315	163,164,861	168,302,411
% of \$ Change			3%	7%
\$ Difference			5,361,546	10,499,095
<b>Free-Standing Mental Health Hospitals</b>	1,291	10,146,839	9,270,868	5,479,327
% of \$ Change			(9%)	(46%)
\$ Difference			(875,972)	(4,667,513)
<b>Out-of-State Hospitals</b>	2,119	27,948,815	25,537,648	27,435,112
% of \$ Change			(9%)	(2%)
\$ Difference			(2,411,167)	(513,704)
<b>Total</b>	58,742	\$272,262,186	\$272,955,769	\$279,071,023
% of \$ Change			.003 of 1%	3%
\$ Difference			**\$693,583	\$6,808,836

\*Total payments under the current Medicaid method are defined as the allowed amount (\$282,968,244) plus payments that are currently made for care within the "outpatient window" (\$1,558,934) minus payment for medical education to in-state and out-of-state hospitals (\$12,264,992). Under either APR-DRG payment or Medicare DRG payment, services provided immediately before the inpatient admission would become part of the inpatient stay; they are now paid under the outpatient payment method. Payment for medical education would continue to be made separately.

\*\*The increase of \$693,583 would be redeployed from funds currently paid to out-of-state hospitals as reimbursement for their costs of medical education. The sum of APR-DRG payments and medical education payments would be budget-neutral.

NOTE: Due to rounding, percentages and dollar amounts shown in the exhibit may vary slightly from those actually yielded by calculations.

SOURCE: ACS Payment Simulation Study of Medicare and Medicaid in October 2009 and discussion with ACS staff on November 5, 2009.

Under an APR-DRG or any other inpatient payment method, funding must be maintained at a level sufficient to ensure that providers receive adequate reimbursement

and encourage hospitals to participate in providing these services. CMS requires Medicaid reimbursement rates to be reasonable and adequate for the services provided in order to maintain access to care.

CMS determines the reasonableness and adequacy of Medicaid hospital inpatient payments by analyzing two payment components--inpatient payments when the hospitals' claims are submitted and any supplemental payments made to hospitals for services rendered to Medicaid beneficiaries. In Mississippi, UPL payments are supplemental inpatient payments.

Therefore, the hospitals' claims payments and the UPL payments must be considered when determining the reasonableness and adequacy of payments to ensure access to care. The combination of hospitals' claims payments and UPL payments would ensure that fluctuations in hospital inpatient utilization would result in corresponding increases or decreases in UPL payments in order to maintain current reimbursement levels.

***Currently, on average, the per diem payment method pays hospitals at 91% of cost of services and, after including UPL payments, hospitals are reimbursed at 132% of inpatient costs.***

When considering any inpatient payment method, payments to providers must be reasonable and adequate to ensure access to care. According to the DOM, under the current per diem method in FY 2009, hospitals, on average, were paid 91% of the hospitals' cost of services for FY 2007 inpatient services. Hospitals also received an additional \$289,672,862 through the UPL program. When claims payments and UPL payments are combined, hospitals received 132% of their Medicaid inpatient costs during FY 2009. These figures do not include outpatient costs, outpatient payments, DSH payments, or uninsured costs.

In a simulation prepared by ACS for Medicaid claims from October 2008 to March 2009, the APR-DRG payment method would have reimbursed hospitals at the same budgeted funding level as the current per diem method. DOM believes that the UPL program, when combined with payments through the APR-DRG method, would provide sufficient funds to reimburse the hospitals for inpatient care at an amount above actual inpatient costs.

In future years, DOM proposes using a health care inflation increase based on CMS's hospital PPS inflationary factor, as one among several factors, to calculate the increase for the hospital inpatient budget. The budget, in combination with the number of projected inpatient stays, the average casemix per stay, and the impact of add-on programs, would determine each fiscal year's DRG base price under the APR-DRG payment method. DOM currently uses CMS's

hospital Prospective Payment System inflationary factor for increases to the hospitals' per-diem rates.

Given that an APR-DRG inpatient services hospital payment method designed to comply with the budgeted amount of total hospital inpatient payments would ease a portion of the fiscal pressures associated with the Medicaid program, a tendency could develop to shift costs from the state to providers. Careful oversight of the APR-DRG method would be necessary to ensure that the state continues to bear the cost burden for inpatient services and that the DOM does not attempt to use the APR-DRG payment method as a substitute for addressing budgetary shortfalls instead of following the remedies currently provided by law, as discussed below.

*MISS. CODE ANN. §43-13-117 (1972) contains provisions for addressing Medicaid budgetary shortfalls through expenditure reductions, cost containment, additional assessments, or additional funding.*

MISS. CODE ANN. §43-13-117 (1972) provides remedies for addressing budgetary shortfalls in the Medicaid program. Under this statute, the Governor may implement expenditure reductions and cost containments, of which hospitals would be responsible for twenty-five percent of provider reductions to a maximum of \$24 million in FY 2010, \$32 million in FY 2011, and \$40 million in FY 2012 and thereafter. However, the statute further provides that the hospital's share shall be in the form of an additional assessment not to exceed \$10 million. MISS. CODE ANN. §43-13-117 (1972) also provides that in the event of budgetary shortfalls, funds shall be transferred from the Health Care Trust Fund to the Health Care Expendable Fund to the Division of Medicaid to address the deficit.

If the cost containment measures described above are implemented and the Health Care Trust Fund does not have sufficient funds to satisfy a remaining deficit fully, the Governor may institute any other additional cost containment measures on any program(s) deemed optional services under Title XIX of the federal Social Security Act to the extent allowed under federal law. Hospitals would be responsible for twenty-five percent of the additional cuts. The hospitals' share of the cuts would be in the form of additional assessments.

*DOM should not use the APR-DRG payment method exclusively as a way to address budgetary shortfalls in inpatient hospital services.*

As shown above, legal remedies are in place to address budgetary shortfalls. Such legal remedies should not be replaced by establishing a payment method geared toward balancing the budget rather than paying providers a

reasonable reimbursement for service provided under a government program.

Under an APR-DRG payment method operated as a budgetary control, the APR-DRG base price for Mississippi hospitals would likely have to be modified during a fiscal year to meet budgetary constraints. Changes in the base price during a fiscal year could have a detrimental effect on the ability of hospitals to plan for anticipated revenues and would greatly impair hospitals' ability to budget. Further, such changes would introduce an element of uncertainty that could impact providers' decisions regarding the extension of services to Medicaid recipients.

PEER contacted personnel of CMS and reviewed appropriate regulations governing the administration of the Medicaid program to determine what impact the use of the APR-DRG base prices to balance the budget would have on Mississippi's continued eligibility to participate in the Medicaid program. In the course of this fieldwork, PEER learned:

- Personnel of the Centers for Medicare and Medicaid Services note that there is no federal regulation that would specifically bar states from modifying their APR-DRG base price for Mississippi hospitals during the course of a fiscal year to achieve targeted--i. e., budgeted--total hospital inpatient payments.
- A review of 42 CFR Part 447 shows that states must formulate base prices that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers.
- The same provision requires that inpatient base prices are adequate to assure that recipients have reasonable access to inpatient services of adequate quality.

PEER notes that the division's rate setting must comply with these regulations and any modification of rates that causes them to fall below a reasonable and adequate rate could result in violation of federal requirements for the Medicaid program.

Through MISS. CODE ANN. §43-13-117 (1972), the Legislature has provided a way to address budgetary shortfalls. The legally prescribed method for addressing budgetary shortfalls should not be abandoned in favor of a payment method that introduces uncertainty into the Medicaid program and circumvents a legislative mandate.

*Under an APR-DRG payment method, certain areas, such as obstetrics, mental health, or certain hospital types, such as small rural hospitals, may be targeted to receive add-on payments as a way to further the achievement of public health goals, such as improving access to care.*

Add-on payments above the APR-DRG base rate may be targeted toward designated areas, such as obstetrics, mental health, or certain hospital types, such as small rural hospitals, as a means for achieving public health goals such as improving access to care. For example, add-on payments may be targeted for obstetrics. By paying add-on rates above the APR-DRG base rate, providers would have an incentive to establish or expand prenatal and postnatal services to women. Add-on payments may further be used for APR-DRG payments related to mental health as recognition of the importance of Medicaid funding in ensuring access to acute mental health care in the state. Add-on payments can be targeted to health issues such as improving access to care in rural areas by providing a slightly higher base price for small rural hospitals meeting predetermined qualifying criteria. Other health issues, such as cardiac services or oncology services, could also be targeted for add-on payments.

Although such add-ons may be a valid mechanism for implementing and achieving public health objectives, care must be taken to ensure that such add-ons are always viewed as an incentive and not an entitlement. The incentive may be to build capacity and build participation. Once the capacity and participation goals are met, public policy decision makers must adjust or, if justified, remove the add-on incentives.

## **What's Next? Maintaining an APR-DRG Payment Method**

*While basing payment rates to providers on APR-DRG rates is a reasonable payment determination methodology and merits serious consideration by the DOM for future inclusion in determining provider payments, a relevant question must be answered: "How should an APR-DRG based payment method be maintained and updated?"*

The use of an APR-DRG inpatient hospital services payment method would be an improvement from the hospital-specific per diem payment method. PEER believes that although a budget-neutral payment method is acceptable for introduction of an APR-DRG payment method, an important question is "How should an APR-DRG based payment method be maintained and updated?"

If the APR-DRG payment method is not reviewed regularly, then technical and policy problems may arise. For example, new diagnosis and procedure codes are implemented on a nationwide basis each October 1. If the

DRG grouping algorithm is not updated to recognize these codes, then hospital claims will not group to the appropriate DRG. On the policy side, payment rates that are initially reasonable and adequate may no longer meet this standard if they are not updated regularly.

Federal statutory provisions (SSA §1902[a] et seq.) and regulations (42 CFR Part 447) address this important issue in the following ways:

- Payments must be consistent with efficiency, economy, quality of care, and with access for clients comparable to that of the general population (SSA §1902[a][30][a] and 42 CFR 447.200 et seq.).
- Medicaid must provide public notice of any significant proposed change in methods or standards for setting payment rates (SSA §1902[a][13][A] and 42 CFR 447.205).
- Medicaid must provide assurances at least annually that rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers. Rates must also be adequate to assure that clients have reasonable access to care of adequate quality, taking into account geographic location and reasonable travel time (42 CFR 447.253).

Any payment method must be reviewed on a regular basis to ensure payments meet the federal requirements listed above and consider relevant points such as:

- DRG base price and DRG relative weights;
- DRG cost and day outlier thresholds;
- levels and changes in client access to care, both overall and for specific services such as obstetrics, newborn care, and mental health;
- Medicaid payments relative to the costs of efficiently and economically operated hospitals;
- changes in how hospitals bill for care using diagnosis codes, procedures codes, and other information on claim forms;
- the legislative appropriation; and,
- other payments made to hospitals for the care of Medicaid clients that are separate from DRG payments.

Basing payment rates to providers on APR-DRG costs is a reasonable payment determination methodology and merits serious consideration by DOM for future inclusion in determining provider payments. Regardless of which

payment method is implemented, it must be maintained and updated on a regular basis to meet federal guidelines and ensure payments are reasonable and access to care is adequate.



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## Recommendations

### Administrative Action

1. Based on PEER's evaluation of the Division of Medicaid's current cost per diem payment method, the Medicare DRG payment method, and the ACS-recommended APR-DRG payment method, the Committee recommends that the Division of Medicaid finalize the development of the ACS-recommended APR-DRG payment method for implementation on July 1, 2010.
2. The APR-DRG payment method should be maintained and updated annually. Reviews should include, but not be limited to:
  - the DRG base price;
  - the DRG relative weights, including any adjustments for enumerated policy goals;
  - DRG cost and day outlier thresholds;
  - DRG length of stay benchmarks used in calculating transfer payments;
  - other provisions of the payment method as necessary;
  - levels and changes in client access to care, both overall and for specific services such as obstetrics, newborn care, and mental health;
  - Medicaid payments relative to the costs of efficiently and economically operated hospitals;
  - changes in hospital input costs;
  - the legislative appropriation;
  - other payments made to hospitals for the care of Medicaid clients that are separate from DRG payments;
  - changes in how hospitals bill for care using diagnosis codes, procedure codes, and other information on claim forms; and,

- other factors that the division may specifically enumerate that affect the goals of efficiency, economy, quality, and access.

## Legislative Action

3. The Legislature should amend MISS. CODE ANN. Section 43-13-117 (I) (1972) to direct the Division of Medicaid to publish and implement an APR-DRG inpatient hospital services payment method that is acceptable to the Centers for Medicare and Medicaid Services. This payment method should comply with provisions of 42 CFR Part 447 regarding reasonableness and adequacy of rates. Such method should become effective on July 1, 2010.

The Legislature should also require the Division of Medicaid to review the APR-DRG payment method and rates and make changes annually, where appropriate, in compliance with the public notice requirements and other requirements of the Mississippi Administrative Procedures Act.

The Legislature should further delete from this provision any references to Medicare DRGs and the requirement that PEER report on the benefits and liabilities of an APR-DRG payment method.

# Agency Response



STATE OF MISSISSIPPI  
OFFICE OF THE GOVERNOR  
DIVISION OF MEDICAID  
DR. ROBERT L. ROBINSON  
EXECUTIVE DIRECTOR



November 25, 2009

Max K. Arinder, Ph.D.  
Director  
PEER Committee  
P.O. Box 1204  
Jackson, MS 39215-1204

Dear Dr. Arinder,

My staff and I would sincerely like to thank you for the objectivity and professionalism you and your staff have demonstrated in conducting your review of the Division of Medicaid's (DOM) hospital reimbursement system. DOM is in full agreement with your recommendation to implement an All Patient Refined-Diagnosis Related Groups (APR-DRG) payment methodology for Medicaid payments to hospitals for inpatient services. An APR-DRG payment system specifically designed for the MS Medicaid population is the optimal payment system for meeting all of the goals DOM set when our initial study began in 2004.

You and your staff have eloquently summarized five years of research and effort by DOM, ACS, and MS hospitals to get this system implemented. "Benefits and Limitations of an All Patient Refined-Diagnosis Related Groups Inpatient Hospital Services Payment Method for Mississippi Medicaid Patients" clearly walks through the logic of this research in arriving at your recommendation.

We hope PEER's recommendation will result in assisting DOM to implement an APR-DRG payment method on July 1, 2010. We appreciate the work you and your staff have dedicated to this report, and we look forward to working with you in the future. Thank you again for your unbiased support of this process.

Sincerely,

A large, stylized handwritten signature in black ink, appearing to read "Robert L. Robinson".

Robert L. Robinson  
Executive Director

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