Table of Contents

State/Territory Name: Michigan

State Plan Amendment (SPA) #: MI 15-0014

This file contains the following documents in the order listed:

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

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

Financial Management Group

FEB 10 2016

Mr. Chris Priest, Director
Medical Services Administration
Department of Community Health
400 South Pine
Lansing, MI 48933

RE: Michigan State Plan Amendment (SPA) 15-0014

Dear Mr. Priest.:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-0014. Effective for services on or after October 1, 2015, this amendment updates inpatient hospital rates through a diagnosis related group update and assigned relative weight update.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 15-0014 is approved effective October 1, 2015. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15 - 0014

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2015

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $0
b. FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 3,4,5,6,7,8,8a,9,10,11,12,13, 14,15,16,16a,17,18,19,20,20a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 3,4,5,6,7,8,8a,9,10,11,12,13, 14,15,16,16a,17,18,19,20,20a

Delete Attachment 4.19-A Appendix A Pages 1-30

10. SUBJECT OF AMENDMENT:
Establish Inpatient Hospital Reimbursement Grouper System

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Chris Priest, Director
Medical Services Administration

12. SIGNATUE OF STATE AGENCY OFFICIAL:
[redacted]

13. [illegible]
Chris Priest

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
November 12, 2015

16. RETURN TO:
Medical Services Administration
Actuarial Division - Federal Liaison
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933

Attn: Erin Black

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18 DATE APPROVED: FEB 10 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPE NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179(07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
1	PRE	SURG	Heart transplant or implant of heart assist system w MCC	*Paid percent of charge*			
2	PRE	SURG	Heart transplant or implant of heart assist system w/o MCC	*Paid percent of charge*			
3	PRE	SURG	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	20.6902	44.38	8	83
4	PRE	SURG	Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.	13.0787	34.51	5	69
5	PRE	SURG	Liver transplant w MCC or intestinal transplant	*Paid percent of charge*			
6	PRE	SURG	Liver transplant w/o MCC	*Paid percent of charge*			
7	PRE	SURG	Lung transplant	*Paid percent of charge*			
8	PRE	SURG	Simultaneous pancreas/kidney transplant	*Paid percent of charge*			
10	PRE	SURG	Pancreas transplant	*Paid percent of charge*			
11	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w MCC	4.5306	14.10	2	50
12	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w CC	3.3179	10.56	2	50
13	PRE	SURG	Tracheostomy for face,mouth & neck diagnoses w/o CC/MCC	2.4372	7.60	2	50
14	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	*Paid percent of charge*			
16	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC	*Paid percent of charge*			
17	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	*Paid percent of charge*			
20	01	SURG	Intracranial vascular procedures w PDX hemorrhage w MCC	9.1131	18.62	3	50
21	01	SURG	Intracranial vascular procedures w PDX hemorrhage w CC	7.2654	15.08	4	50
22	01	SURG	Intracranial vascular procedures w PDX hemorrhage w/o CC/MCC	6.0017	11.53	2	50
23	01	SURG	Craniotomy w major device implant or acute complex CNS PDX w MCC	6.5786	15.78	2	50
24	01	SURG	Craniotomy w major device implant or acute complex CNS PDX w/o MCC	4.5152	12.23	1	50
25	01	SURG	Craniotomy & endovascular intracranial procedures w MCC	5.6543	14.86	2	50
26	01	SURG	Craniotomy & endovascular intracranial procedures w CC	3.7495	8.45	1	50
27	01	SURG	Craniotomy & endovascular intracranial procedures w/o CC/MCC	2.7203	4.71	1	50
28	01	SURG	Spinal procedures w MCC	5.0112	14.09	2	50
29	01	SURG	Spinal procedures w CC	3.4103	9.33	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
30	01	SURG	Spinal procedures w/o CC/MCC	2.0366	4.67	1	50
31	01	SURG	Ventricular shunt procedures w MCC	3.5667	11.67	2	50
32	01	SURG	Ventricular shunt procedures w CC	1.7604	5.37	1	50
33	01	SURG	Ventricular shunt procedures w/o CC/MCC	1.4949	3.92	1	50
34	01	SURG	Carotid artery stent procedure w MCC	6.2910	16.00	5	50
35	01	SURG	Carotid artery stent procedure w CC	2.8705	6.81	1	50
36	01	SURG	Carotid artery stent procedure w/o CC/MCC	1.9268	3.48	1	50
37	01	SURG	Extracranial procedures w MCC	4.3256	11.38	1	50
38	01	SURG	Extracranial procedures w CC	1.8902	5.33	1	50
39	01	SURG	Extracranial procedures w/o CC/MCC	1.4081	2.26	1	50
40	01	SURG	Periph & cranial nerve & other nerv syst proc w MCC	3.9260	13.55	2	50
41	01	SURG	Periph & cranial nerve & other nerv syst proc w CC	1.9984	7.01	1	50
42	01	SURG	Periph & cranial nerve & other nerv syst proc w/o CC/MCC	1.6986	3.47	1	50
52	01	MED	Spinal disorders & injuries w CC/MCC	2.0328	7.36	1	50
53	01	MED	Spinal disorders & injuries w/o CC/MCC	0.9006	3.30	1	50
54	01	MED	Nervous system neoplasms w MCC	1.6962	6.95	2	50
55	01	MED	Nervous system neoplasms w/o MCC	1.3797	5.21	1	50
56	01	MED	Degenerative nervous system disorders w MCC	1.8926	8.68	1	50
57	01	MED	Degenerative nervous system disorders w/o MCC	1.0145	4.83	1	50
58	01	MED	Multiple sclerosis & cerebellar ataxia w MCC	1.5972	8.60	2	50
59	01	MED	Multiple sclerosis & cerebellar ataxia w CC	1.0784	5.61	1	50
60	01	MED	Multiple sclerosis & cerebellar ataxia w/o CC/MCC	0.8736	4.28	1	50
61	01	MED	Acute ischemic stroke w use of thrombolytic agent w MCC	3.5672	10.57	3	50
62	01	MED	Acute ischemic stroke w use of thrombolytic agent w CC	2.1140	5.03	1	50
63	01	MED	Acute ischemic stroke w use of thrombolytic agent w/o CC/MCC	1.8273	3.47	2	50
64	01	MED	Intracranial hemorrhage or cerebral infarction w MCC	2.3942	9.26	1	50
65	01	MED	Intracranial hemorrhage or cerebral infarction w CC	1.4766	6.19	2	50
66	01	MED	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	1.1101	4.02	1	50
67	01	MED	Nonspecific cva & precerebral occlusion w/o infarct w MCC	2.5212	6.19	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
68	01	MED	Nonspecific cva & precerebral occlusion w/o infarct w/o MCC	1.2114	3.71	1	50
69	01	MED	Transient ischemia	0.8423	3.12	1	50
70	01	MED	Nonspecific cerebrovascular disorders w MCC	1.6650	7.54	1	50
71	01	MED	Nonspecific cerebrovascular disorders w CC	1.3073	6.49	1	50
72	01	MED	Nonspecific cerebrovascular disorders w/o CC/MCC	0.8940	3.70	1	50
73	01	MED	Cranial & peripheral nerve disorders w MCC	1.4429	7.07	1	50
74	01	MED	Cranial & peripheral nerve disorders w/o MCC	0.9213	4.63	1	50
75	01	MED	Viral meningitis w CC/MCC	1.0014	4.46	1	50
76	01	MED	Viral meningitis w/o CC/MCC	0.6333	3.24	1	50
77	01	MED	Hypertensive encephalopathy w MCC	1.6856	6.45	1	50
78	01	MED	Hypertensive encephalopathy w CC	1.0836	5.10	2	50
79	01	MED	Hypertensive encephalopathy w/o CC/MCC	0.7184	3.31	1	50
80	01	MED	Nontraumatic stupor & coma w MCC	1.0323	3.95	1	50
81	01	MED	Nontraumatic stupor & coma w/o MCC	0.7595	2.95	1	50
82	01	MED	Traumatic stupor & coma, coma >1 hr w MCC	2.5816	8.70	1	50
83	01	MED	Traumatic stupor & coma, coma >1 hr w CC	1.5911	6.54	1	50
84	01	MED	Traumatic stupor & coma, coma >1 hr w/o CC/MCC	0.9926	2.93	1	50
85	01	MED	Traumatic stupor & coma, coma <1 hr w MCC	2.8486	11.16	1	50
85.1	01	MED	Traumatic stupor & coma, coma <1 hr w MCC	4.0026	8.94	1	50
86	01	MED	Traumatic stupor & coma, coma <1 hr w CC	1.3353	5.12	1	50
86.1	01	MED	Traumatic stupor & coma, coma <1 hr w CC	1.1980	4.35	1	50
87	01	MED	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	0.8240	3.07	1	50
87.1	01	MED	Traumatic stupor & coma, coma <1 hr w/o CC/MCC	0.5315	2.04	1	50
88	01	MED	Concussion w MCC	1.6810	5.68	1	50
88.1	01	MED	Concussion w MCC	0.4631	3.00	2	50
89	01	MED	Concussion w CC	0.9079	3.13	1	50
89.1	01	MED	Concussion w CC	0.6987	1.86	1	50
90	01	MED	Concussion w/o CC/MCC	0.7672	2.02	1	50
90.1	01	MED	Concussion w/o CC/MCC	0.4774	1.50	1	50
91	01	MED	Other disorders of nervous system w MCC	1.8490	7.34	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
92	01	MED	Other disorders of nervous system w CC	1.0774	4.74	1	50
93	01	MED	Other disorders of nervous system w/o CC/MCC	0.8410	3.25	1	50
94	01	MED	Bacterial & tuberculous infections of nervous system w MCC	3.1365	11.32	1	50
95	01	MED	Bacterial & tuberculous infections of nervous system w CC	2.1751	8.94	1	50
96	01	MED	Bacterial & tuberculous infections of nervous system w/o CC/MCC	1.9440	6.55	1	50
97	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w MCC	3.3631	12.98	3	50
98	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w CC	2.0986	9.02	2	50
99	01	MED	Non-bacterial infect of nervous sys exc viral meningitis w/o CC/MCC	1.4304	6.00	1	50
100	01	MED	Seizures w MCC	1.3743	6.06	1	50
100.1	01	MED	Seizures w MCC	0.8576	3.91	1	50
101	01	MED	Seizures w/o MCC	0.7297	3.45	1	50
101.1	01	MED	Seizures w/o MCC	0.5026	2.54	1	50
102	01	MED	Headaches w MCC	1.1370	4.31	1	50
102.1	01	MED	Headaches w MCC	0.6493	2.38	1	50
103	01	MED	Headaches w/o MCC	0.8012	3.38	1	50
103.1	01	MED	Headaches w/o MCC	0.6060	2.57	1	50
113	02	SURG	Orbital procedures w CC/MCC	1.7534	4.92	1	50
114	02	SURG	Orbital procedures w/o CC/MCC	1.1917	3.37	1	50
115	02	SURG	Extraocular procedures except orbit	1.5209	4.61	1	50
116	02	SURG	Intraocular procedures w CC/MCC	2.4315	11.67	1	50
117	02	SURG	Intraocular procedures w/o CC/MCC	1.0589	3.19	1	50
121	02	MED	Acute major eye infections w CC/MCC	1.0165	5.68	1	50
122	02	MED	Acute major eye infections w/o CC/MCC	0.5285	3.12	1	50
123	02	MED	Neurological eye disorders	0.8022	3.31	1	50
124	02	MED	Other disorders of the eye w MCC	2.7054	11.98	1	50
125	02	MED	Other disorders of the eye w/o MCC	0.6099	3.06	1	50
129	03	SURG	Major head & neck procedures w CC/MCC or major device	3.4302	6.25	1	50
130	03	SURG	Major head & neck procedures w/o CC/MCC	1.3476	3.44	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
131	03	SURG	Cranial/facial procedures w CC/MCC	2.0948	5.89	1	50
132	03	SURG	Cranial/facial procedures w/o CC/MCC	1.3225	2.56	1	50
133	03	SURG	Other ear, nose, mouth & throat O.R. procedures w CC/MCC	1.4790	5.29	1	50
134	03	SURG	Other ear, nose, mouth & throat O.R. procedures w/o CC/MCC	0.8095	2.43	1	50
135	03	SURG	Sinus & mastoid procedures w CC/MCC	2.0699	7.74	2	50
136	03	SURG	Sinus & mastoid procedures w/o CC/MCC	1.4561	3.47	1	50
137	03	SURG	Mouth procedures w CC/MCC	1.3001	4.86	1	50
138	03	SURG	Mouth procedures w/o CC/MCC	0.7681	3.02	1	50
139	03	SURG	Salivary gland procedures	1.1618	2.56	1	50
146	03	MED	Ear, nose, mouth & throat malignancy w MCC	2.3897	8.25	2	50
147	03	MED	Ear, nose, mouth & throat malignancy w CC	1.5901	7.72	1	50
148	03	MED	Ear, nose, mouth & throat malignancy w/o CC/MCC	0.9032	3.81	1	50
149	03	MED	Dysequilibrium	0.7843	3.32	1	50
150	03	MED	Epistaxis w MCC	1.3242	7.45	2	50
151	03	MED	Epistaxis w/o MCC	0.6721	3.29	1	50
152	03	MED	Otitis media & URI w MCC	1.0091	4.58	1	50
152.1	03	MED	Otitis media & URI w MCC	0.6495	3.71	1	50
153	03	MED	Otitis media & URI w/o MCC	0.5313	2.72	1	50
153.1	03	MED	Otitis media & URI w/o MCC	0.3819	2.40	1	50
154	03	MED	Nasal trauma & deformity w MCC	1.4549	6.31	1	50
155	03	MED	Nasal trauma & deformity w CC	0.8658	4.01	1	50
156	03	MED	Nasal trauma & deformity w/o CC/MCC	0.6352	3.01	1	50
157	03	MED	Dental & Oral Diseases w MCC	1.1356	5.16	1	50
158	03	MED	Dental & Oral Diseases w CC	0.7076	3.19	1	50
159	03	MED	Dental & Oral Diseases w/o CC/MCC	0.6189	2.70	1	50
163	04	SURG	Major chest procedures w MCC	4.7588	15.26	2	50
164	04	SURG	Major chest procedures w CC	3.0919	10.27	2	50
165	04	SURG	Major chest procedures w/o CC/MCC	1.9659	6.02	2	50
166	04	SURG	Other resp system O.R. procedures w MCC	3.8812	13.95	3	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
167	04	SURG	Other resp system O.R. procedures w CC	2.1942	8.28	2	50
168	04	SURG	Other resp system O.R. procedures w/o CC/MCC	1.4991	5.85	2	50
175	04	MED	Pulmonary embolism w MCC	1.7782	7.70	2	50
176	04	MED	Pulmonary embolism w/o MCC	1.1346	5.30	1	50
177	04	MED	Respiratory infections & inflammations w MCC	2.2751	10.22	2	50
178	04	MED	Respiratory infections & inflammations w CC	1.6429	7.60	1	50
179	04	MED	Respiratory infections & inflammations w/o CC/MCC	1.4644	6.74	1	50
180	04	MED	Respiratory neoplasms w MCC	1.9266	8.48	2	50
181	04	MED	Respiratory neoplasms w CC	1.4681	6.49	1	50
182	04	MED	Respiratory neoplasms w/o CC/MCC	1.1111	4.65	1	50
183	04	MED	Major chest trauma w MCC	1.2548	5.50	1	50
184	04	MED	Major chest trauma w CC	1.0745	3.58	1	50
185	04	MED	Major chest trauma w/o CC/MCC	0.7227	2.73	1	50
186	04	MED	Pleural effusion w MCC	1.6792	7.70	2	50
187	04	MED	Pleural effusion w CC	1.2873	5.31	1	50
188	04	MED	Pleural effusion w/o CC/MCC	0.9190	4.07	1	50
189	04	MED	Pulmonary edema & respiratory failure	1.5195	6.17	1	50
190	04	MED	Chronic obstructive pulmonary disease w MCC	1.1804	5.64	1	50
190.1	04	MED	Chronic obstructive pulmonary disease w MCC	1.4250	6.13	1	50
191	04	MED	Chronic obstructive pulmonary disease w CC	0.9496	4.57	1	50
191.1	04	MED	Chronic obstructive pulmonary disease w CC	1.0892	5.75	1	50
192	04	MED	Chronic obstructive pulmonary disease w/o CC/MCC	0.7204	3.56	1	50
192.1	04	MED	Chronic obstructive pulmonary disease w/o CC/MCC	0.5124	2.72	1	50
193	04	MED	Simple pneumonia & pleurisy w MCC	1.5050	6.82	2	50
193.1	04	MED	Simple pneumonia & pleurisy w MCC	1.0956	5.63	2	50
194	04	MED	Simple pneumonia & pleurisy w CC	0.9911	4.60	1	50
194.1	04	MED	Simple pneumonia & pleurisy w CC	0.5650	3.08	1	50
195	04	MED	Simple pneumonia & pleurisy w/o CC/MCC	0.7326	3.37	1	50
195.1	04	MED	Simple pneumonia & pleurisy w/o CC/MCC	0.4208	2.52	1	50
196	04	MED	Interstitial lung disease w MCC	1.6804	7.89	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
197	04	MED	Interstitial lung disease w CC	1.1190	5.94	1	50
198	04	MED	Interstitial lung disease w/o CC/MCC	0.7845	3.92	1	50
199	04	MED	Pneumothorax w MCC	1.7448	7.43	1	50
200	04	MED	Pneumothorax w CC	0.9991	4.71	1	50
201	04	MED	Pneumothorax w/o CC/MCC	0.6899	3.78	1	50
202	04	MED	Bronchitis & asthma w CC/MCC	0.8081	3.79	1	50
202.1	04	MED	Bronchitis & asthma w CC/MCC	0.5734	3.21	1	50
203	04	MED	Bronchitis & asthma w/o CC/MCC	0.5654	2.86	1	50
203.1	04	MED	Bronchitis & asthma w/o CC/MCC	0.3784	2.24	1	50
204	04	MED	Respiratory signs & symptoms	0.8024	3.17	1	50
204.1	04	MED	Respiratory signs & symptoms	0.5715	3.03	1	50
205	04	MED	Other respiratory system diagnoses w MCC	1.1518	5.62	1	50
206	04	MED	Other respiratory system diagnoses w/o MCC	0.7825	3.22	1	50
207	04	MED	Respiratory system diagnosis w ventilator support 96+ hours	5.3952	16.02	5	50
208	04	MED	Respiratory system diagnosis w ventilator support <96 hours	2.1775	6.90	1	50
215	05	SURG	Other heart assist system implant	4.8814	7.71	1	50
216	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	11.8357	23.96	7	56
217	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	7.6055	17.18	2	50
218	05	SURG	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/MCC	5.7671	6.29	1	50
219	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	8.5973	15.60	4	50
220	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w CC	5.2818	9.31	3	50
221	05	SURG	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/MCC	3.9635	6.10	3	50
222	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	9.1957	15.47	3	50
223	05	SURG	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	7.0508	9.41	2	50
224	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	8.9485	11.77	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
225	05	SURG	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	5.7240	5.92	1	50
226	05	SURG	Cardiac defibrillator implant w/o cardiac cath w MCC	7.2446	11.14	2	50
227	05	SURG	Cardiac defibrillator implant w/o cardiac cath w/o MCC	5.7792	4.71	1	50
228	05	SURG	Other cardiothoracic procedures w MCC	8.1946	16.21	4	50
229	05	SURG	Other cardiothoracic procedures w CC	5.7789	10.33	2	50
230	05	SURG	Other cardiothoracic procedures w/o CC/MCC	3.7969	6.21	1	50
231	05	SURG	Coronary bypass w PTCA w MCC	6.9914	14.67	2	50
232	05	SURG	Coronary bypass w PTCA w/o MCC	6.0844	10.67	6	50
233	05	SURG	Coronary bypass w cardiac cath w MCC	7.0955	15.83	5	50
234	05	SURG	Coronary bypass w cardiac cath w/o MCC	4.8770	10.75	5	50
235	05	SURG	Coronary bypass w/o cardiac cath w MCC	5.7232	12.60	4	50
236	05	SURG	Coronary bypass w/o cardiac cath w/o MCC	3.9421	7.97	4	50
237	05	SURG	Major cardiovascular procedures w MCC	6.6342	14.16	2	50
238	05	SURG	Major cardiovascular procedures w/o MCC	3.2750	7.20	1	50
239	05	SURG	Amputation for circ sys disorders exc upper limb & toe w MCC	5.2365	19.38	4	50
240	05	SURG	Amputation for circ sys disorders exc upper limb & toe w CC	3.2661	12.99	3	50
241	05	SURG	Amputation for circ sys disorders exc upper limb & toe w/o CC/MCC	1.6299	7.32	2	50
242	05	SURG	Permanent cardiac pacemaker implant w MCC	4.8721	11.24	1	50
243	05	SURG	Permanent cardiac pacemaker implant w CC	3.4965	7.16	1	50
244	05	SURG	Permanent cardiac pacemaker implant w/o CC/MCC	2.4946	4.11	1	50
245	05	SURG	AICD lead & generator procedures	5.1847	5.05	1	50
246	05	SURG	Percutaneous cardiovascular proc w drug-eluting stent w MCC	3.6421	6.57	1	50
247	05	SURG	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC	2.4529	3.03	1	50
248	05	SURG	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC	3.0366	5.56	1	50
249	05	SURG	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC	2.1611	3.49	1	50
250	05	SURG	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	3.9723	10.50	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
251	05	SURG	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	2.2919	3.15	1	50
252	05	SURG	Other vascular procedures w MCC	3.3611	10.24	2	50
253	05	SURG	Other vascular procedures w CC	2.8412	7.01	1	50
254	05	SURG	Other vascular procedures w/o CC/MCC	2.0388	3.52	1	50
255	05	SURG	Upper limb & toe amputation for circ system disorders w MCC	3.5838	13.22	5	50
256	05	SURG	Upper limb & toe amputation for circ system disorders w CC	1.9320	9.44	2	50
257	05	SURG	Upper limb & toe amputation for circ system disorders w/o CC/MCC	1.1692	5.82	1	50
258	05	SURG	Cardiac pacemaker device replacement w MCC	3.6021	4.00	2	50
259	05	SURG	Cardiac pacemaker device replacement w/o MCC	1.7181	3.44	1	50
260	05	SURG	Cardiac pacemaker revision except device replacement w MCC	3.5637	12.95	3	50
261	05	SURG	Cardiac pacemaker revision except device replacement w CC	1.9536	6.79	1	50
262	05	SURG	Cardiac pacemaker revision except device replacement w/o CC/MCC	1.4370	5.56	1	50
263	05	SURG	Vein ligation & stripping	1.4957	4.33	1	50
264	05	SURG	Other circulatory system O.R. procedures	2.4367	10.64	2	50
265	05	SURG	AICD Lead Procedures	2.2188	5.17	1	50
266	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC	8.9920	8.40	1	50
267	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC	6.7517	5.00	1	50
280	05	MED	Acute myocardial infarction, discharged alive w MCC	2.2386	7.65	1	50
281	05	MED	Acute myocardial infarction, discharged alive w CC	1.4723	4.96	1	50
282	05	MED	Acute myocardia infarction, discharged alive w/o CC/MCC	1.3361	3.08	1	50
283	05	MED	Acute myocardial infarction, expired w MCC	3.0840	7.78	1	50
284	05	MED	Acute myocardial infarction, expired w CC	1.8234	6.64	1	50
285	05	MED	Acute myocardial infarction, expired w/o CC/MCC	0.6147	1.00	1	50
286	05	MED	Circulatory disorders except AMI, w card cath w MCC	2.2800	8.11	1	50
287	05	MED	Circulatory disorders except AMI, w card cath w/o MCC	1.3289	3.89	1	50
288	05	MED	Acute & subacute endocarditis w MCC	3.5488	14.63	2	50
289	05	MED	Acute & subacute endocarditis w CC	2.2577	12.08	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
290	05	MED	Acute & subacute endocarditis w/o CC/MCC	0.8776	4.00	1	50
291	05	MED	Heart failure & shock w MCC	1.4316	6.53	1	50
292	05	MED	Heart failure & shock w CC	0.9585	4.92	1	50
293	05	MED	Heart failure & shock w/o CC/MCC	0.7363	3.61	1	50
294	05	MED	Deep vein thrombophlebitis w CC/MCC	1.5065	6.44	3	50
295	05	MED	Deep vein thrombophlebitis w/o CC/MCC	0.4660	3.25	2	50
296	05	MED	Cardiac arrest, unexplained w MCC	1.6737	4.39	1	50
297	05	MED	Cardiac arrest, unexplained w CC	1.5529	3.75	1	50
298	05	MED	Cardiac arrest, unexplained w/o CC/MCC	1.3577	1.00	1	50
299	05	MED	Peripheral vascular disorders w MCC	1.7386	7.91	1	50
300	05	MED	Peripheral vascular disorders w CC	1.0360	5.15	1	50
301	05	MED	Peripheral vascular disorders w/o CC/MCC	0.7136	3.84	1	50
302	05	MED	Atherosclerosis w MCC	1.4729	5.13	1	50
303	05	MED	Atherosclerosis w/o MCC	0.8948	2.96	1	50
304	05	MED	Hypertension w MCC	1.1888	5.24	1	50
305	05	MED	Hypertension w/o MCC	0.7136	3.05	1	50
306	05	MED	Cardiac congenital & valvular disorders w MCC	5.2862	10.85	1	50
307	05	MED	Cardiac congenital & valvular disorders w/o MCC	1.3701	4.86	1	50
308	05	MED	Cardiac arrhythmia & conduction disorders w MCC	1.4684	6.32	1	50
309	05	MED	Cardiac arrhythmia & conduction disorders w CC	0.9211	3.87	1	50
310	05	MED	Cardiac arrhythmia & conduction disorders w/o CC/MCC	0.6588	2.78	1	50
311	05	MED	Angina pectoris	0.7832	2.58	1	50
312	05	MED	Syncope & collapse	0.7405	3.04	1	50
313	05	MED	Chest pain	0.7092	2.64	1	50
314	05	MED	Other circulatory system diagnoses w MCC	2.0334	8.82	2	50
315	05	MED	Other circulatory system diagnoses w CC	1.2190	5.44	1	50
316	05	MED	Other circulatory system diagnoses w/o CC/MCC	0.9585	3.26	1	50
326	06	SURG	Stomach, esophageal & duodenal proc w MCC	5.3757	17.03	2	50
326.1	06	SURG	Stomach, esophageal & duodenal proc w MCC	4.6434	15.19	2	50
327	06	SURG	Stomach, esophageal & duodenal proc w CC	2.8039	10.05	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
327.1	06	SURG	Stomach, esophageal & duodenal proc w CC	1.4908	5.61	1	50
328	06	SURG	Stomach, esophageal & duodenal proc w/o CC/MCC	1.5199	3.75	1	50
328.1	06	SURG	Stomach, esophageal & duodenal proc w/o CC/MCC	0.8519	3.13	1	50
329	06	SURG	Major small & large bowel procedures w MCC	5.0232	16.83	3	50
330	06	SURG	Major small & large bowel procedures w CC	2.7026	10.62	3	50
331	06	SURG	Major small & large bowel procedures w/o CC/MCC	1.8165	6.32	1	50
332	06	SURG	Rectal resection w MCC	3.5085	12.16	3	50
333	06	SURG	Rectal resection w CC	2.4733	8.76	1	50
334	06	SURG	Rectal resection w/o CC/MCC	2.2394	6.51	1	50
335	06	SURG	Peritoneal adhesiolysis w MCC	4.0807	13.82	2	50
336	06	SURG	Peritoneal adhesiolysis w CC	2.2698	8.21	1	50
337	06	SURG	Peritoneal adhesiolysis w/o CC/MCC	1.5478	4.42	1	50
338	06	SURG	Appendectomy w complicated principal diag w MCC	2.7940	9.13	1	50
339	06	SURG	Appendectomy w complicated principal diag w CC	2.2171	7.52	2	50
340	06	SURG	Appendectomy w complicated principal diag w/o CC/MCC	1.4911	4.57	1	50
341	06	SURG	Appendectomy w/o complicated principal diag w MCC	1.9737	5.51	1	50
342	06	SURG	Appendectomy w/o complicated principal diag w CC	1.3299	3.26	1	50
343	06	SURG	Appendectomy w/o complicated principal diag w/o CC/MCC	1.0195	2.05	1	50
344	06	SURG	Minor small & large bowel procedures w MCC	4.2140	15.83	4	50
345	06	SURG	Minor small & large bowel procedures w CC	1.9636	8.07	2	50
346	06	SURG	Minor small & large bowel procedures w/o CC/MCC	1.2891	4.93	2	50
347	06	SURG	Anal & stomal procedures w MCC	1.9383	8.44	2	50
348	06	SURG	Anal & stomal procedures w CC	1.3067	5.15	1	50
349	06	SURG	Anal & stomal procedures w/o CC/MCC	0.7793	2.95	1	50
350	06	SURG	Inguinal & femoral hernia procedures w MCC	2.1201	7.00	2	50
351	06	SURG	Inguinal & femoral hernia procedures w CC	1.1540	4.44	1	50
352	06	SURG	Inguinal & femoral hernia procedures w/o CC/MCC	0.8659	2.06	1	50
353	06	SURG	Hernia procedures except inguinal & femoral w MCC	2.6113	9.96	1	50
354	06	SURG	Hernia procedures except inguinal & femoral w CC	1.7143	5.28	1	50
355	06	SURG	Hernia procedures except inguinal & femoral w/o CC/MCC	1.3287	3.76	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
356	06	SURG	Other digestive system O.R. procedures w MCC	3.9211	12.94	2	50
357	06	SURG	Other digestive system O.R. procedures w CC	2.1462	8.08	1	50
358	06	SURG	Other digestive system O.R. procedures w/o CC/MCC	1.4814	4.74	1	50
368	06	MED	Major esophageal disorders w MCC	1.9207	7.48	2	50
369	06	MED	Major esophageal disorders w CC	1.2335	5.10	1	50
370	06	MED	Major esophageal disorders w/o CC/MCC	0.8277	3.68	1	50
371	06	MED	Major gastrointestinal disorders & peritoneal infections w MCC	1.8677	8.79	2	50
372	06	MED	Major gastrointestinal disorders & peritoneal infections w CC	1.2427	6.42	1	50
373	06	MED	Major gastrointestinal disorders & peritoneal infections w/o CC/MCC	0.8695	4.16	1	50
374	06	MED	Digestive malignancy w MCC	2.1257	9.72	1	50
375	06	MED	Digestive malignancy w CC	1.5021	6.97	1	50
376	06	MED	Digestive malignancy w/o CC/MCC	1.3976	6.05	1	50
377	06	MED	G.I. hemorrhage w MCC	1.9429	7.48	1	50
378	06	MED	G.I. hemorrhage w CC	1.0725	4.45	1	50
379	06	MED	G.I. hemorrhage w/o CC/MCC	0.7627	3.19	1	50
380	06	MED	Complicated peptic ulcer w MCC	1.8943	7.77	1	50
381	06	MED	Complicated peptic ulcer w CC	1.1439	5.25	2	50
382	06	MED	Complicated peptic ulcer w/o CC/MCC	0.8806	3.88	1	50
383	06	MED	Uncomplicated peptic ulcer w MCC	1.3299	5.42	2	50
384	06	MED	Uncomplicated peptic ulcer w/o MCC	0.9373	3.90	1	50
385	06	MED	Inflammatory bowel disease w MCC	1.9392	10.07	2	50
386	06	MED	Inflammatory bowel disease w CC	1.0865	5.91	2	50
387	06	MED	Inflammatory bowel disease w/o CC/MCC	0.7892	4.11	1	50
388	06	MED	G.I. obstruction w MCC	1.4895	7.63	2	50
389	06	MED	G.I. obstruction w CC	1.0166	5.50	1	50
390	06	MED	G.I. obstruction w/o CC/MCC	0.6786	3.53	1	50
391	06	MED	Esophagitis, gastroent & misc digest disorders w MCC	1.1262	5.45	1	50
392	06	MED	Esophagitis, gastroent & misc digest disorders w/o MCC	0.7160	3.44	1	50
393	06	MED	Other digestive system diagnoses w MCC	1.5730	7.12	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
394	06	MED	Other digestive system diagnoses w CC	1.0958	5.30	1	50
395	06	MED	Other digestive system diagnoses w/o CC/MCC	0.7973	3.04	1	50
405	07	SURG	Pancreas, liver & shunt procedures w MCC	5.4860	16.50	3	50
406	07	SURG	Pancreas, liver & shunt procedures w CC	3.0614	11.18	2	50
407	07	SURG	Pancreas, liver & shunt procedures w/o CC/MCC	1.8741	5.22	1	50
408	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	3.5139	12.32	4	50
409	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	2.4822	9.07	3	50
410	07	SURG	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	2.3211	7.47	2	50
411	07	SURG	Cholecystectomy w c.d.e. w MCC	2.5375	9.13	4	50
412	07	SURG	Cholecystectomy w c.d.e. w CC	1.9253	6.44	2	50
413	07	SURG	Cholecystectomy w c.d.e. w/o CC/MCC	1.9625	4.94	2	50
414	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w MCC	2.9661	10.21	2	50
415	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w CC	2.1643	6.54	2	50
416	07	SURG	Cholecystectomy except by laparoscope w/o c.d.e. w/o CC/MCC	1.3800	4.04	1	50
417	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w MCC	1.9749	6.49	2	50
418	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w CC	1.5861	4.65	1	50
419	07	SURG	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	1.2429	3.02	1	50
420	07	SURG	Hepatobiliary diagnostic procedures w MCC	2.5252	7.85	1	50
421	07	SURG	Hepatobiliary diagnostic procedures w CC	2.0898	6.53	1	50
422	07	SURG	Hepatobiliary diagnostic procedures w/o CC/MCC	2.3571	6.56	2	50
423	07	SURG	Other hepatobiliary or pancreas O.R. procedures w MCC	5.1566	18.41	5	50
424	07	SURG	Other hepatobiliary or pancreas O.R. procedures w CC	3.1933	11.14	2	50
425	07	SURG	Other hepatobiliary or pancreas O.R. procedures w/o CC/MCC	2.0241	8.60	2	50
432	07	MED	Cirrhosis & alcoholic hepatitis w MCC	1.7841	7.80	1	50
433	07	MED	Cirrhosis & alcoholic hepatitis w CC	0.9994	5.52	1	50
434	07	MED	Cirrhosis & alcoholic hepatitis w/o CC/MCC	0.9191	4.67	1	50
435	07	MED	Malignancy of hepatobiliary system or pancreas w MCC	1.9806	9.90	2	50
436	07	MED	Malignancy of hepatobiliary system or pancreas w CC	1.4807	7.27	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
437	07	MED	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	1.1108	4.59	1	50
438	07	MED	Disorders of pancreas except malignancy w MCC	1.9292	9.14	2	50
439	07	MED	Disorders of pancreas except malignancy w CC	1.0261	5.17	1	50
440	07	MED	Disorders of pancreas except malignancy w/o CC/MCC	0.7411	3.81	1	50
441	07	MED	Disorders of liver except malig,cirr,alc hepa w MCC	2.1048	8.52	1	50
442	07	MED	Disorders of liver except malig,cirr,alc hepa w CC	1.0658	5.45	1	50
443	07	MED	Disorders of liver except malig,cirr,alc hepa w/o CC/MCC	0.7376	3.78	1	50
444	07	MED	Disorders of the biliary tract w MCC	1.7658	7.25	1	50
445	07	MED	Disorders of the biliary tract w CC	1.2447	4.81	1	50
446	07	MED	Disorders of the biliary tract w/o CC/MCC	0.8002	3.03	1	50
453	08	SURG	Combined anterior/posterior spinal fusion w MCC	8.7118	17.30	4	50
454	08	SURG	Combined anterior/posterior spinal fusion w CC	4.6510	8.13	1	50
455	08	SURG	Combined anterior/posterior spinal fusion w/o CC/MCC	2.5601	3.31	1	50
456	08	SURG	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w MCC	7.2076	11.46	4	50
457	08	SURG	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w CC	6.8970	7.47	3	50
458	08	SURG	Spinal fusion exc cerv w spinal curv, malig or 9+ fusions w/o CC/MCC	5.3975	4.67	2	50
459	08	SURG	Spinal fusion except cervical w MCC	5.7775	10.42	3	50
460	08	SURG	Spinal fusion except cervical w/o MCC	3.3122	3.81	1	50
461	08	SURG	Bilateral or multiple major joint procs of lower extremity w MCC	7.4465	18.00	6	50
462	08	SURG	Bilateral or multiple major joint procs of lower extremity w/o MCC	3.3855	4.94	3	50
463	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	5.9101	20.57	3	51
464	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	2.6880	11.04	2	50
465	08	SURG	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	1.8663	5.99	1	50
466	08	SURG	Revision of hip or knee replacement w MCC	4.5507	13.15	4	50
467	08	SURG	Revision of hip or knee replacement w CC	3.1108	5.80	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
468	08	SURG	Revision of hip or knee replacement w/o CC/MCC	2.5397	3.69	1	50
469	08	SURG	Major joint replacement or reattachment of lower extremity w MCC	3.3801	8.69	3	50
470	08	SURG	Major joint replacement or reattachment of lower extremity w/o MCC	2.2932	4.01	2	50
471	08	SURG	Cervical spinal fusion w MCC	4.1740	10.11	1	50
472	08	SURG	Cervical spinal fusion w CC	2.7080	4.48	1	50
473	08	SURG	Cervical spinal fusion w/o CC/MCC	1.8893	2.02	1	50
474	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w MCC	4.2544	14.85	3	50
475	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w CC	2.0823	8.82	1	50
476	08	SURG	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	1.1848	4.57	1	50
477	08	SURG	Biopsies of musculoskeletal system & connective tissue w MCC	2.9806	15.24	4	50
478	08	SURG	Biopsies of musculoskeletal system & connective tissue w CC	2.4490	9.18	1	50
479	08	SURG	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	1.5532	5.80	1	50
480	08	SURG	Hip & femur procedures except major joint w MCC	3.6843	10.98	2	50
480.1	08	SURG	Hip & femur procedures except major joint w MCC	1.6949	4.95	2	50
481	08	SURG	Hip & femur procedures except major joint w CC	2.4538	7.65	2	50
481.1	08	SURG	Hip & femur procedures except major joint w CC	1.5955	3.95	1	50
482	08	SURG	Hip & femur procedures except major joint w/o CC/MCC	1.8173	4.28	1	50
482.1	08	SURG	Hip & femur procedures except major joint w/o CC/MCC	1.2497	2.67	1	50
483	08	SURG	Major joint & limb reattachment proc of upper extremity w CC/MCC	2.0378	2.32	1	50
484	08	SURG	Major joint & limb reattachment proc of upper extremity w/o CC/MCC	0.0000	0.00	0	0
485	08	SURG	Knee procedures w pdx of infection w MCC	3.3855	12.90	4	50
486	08	SURG	Knee procedures w pdx of infection w CC	2.4690	9.77	2	50
487	08	SURG	Knee procedures w pdx of infection w/o CC/MCC	1.4187	4.59	1	50
488	08	SURG	Knee procedures w/o pdx of infection w CC/MCC	1.8302	5.35	1	50
489	08	SURG	Knee procedures w/o pdx of infection w/o CC/MCC	1.2643	2.16	1	50
490	08	SURG	Back & neck procedures except spinal fusion w CC/MCC or disc devices	0.0000	0.00	0	0

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
491	08	SURG	Back & neck procedures except spinal fusion w/o CC/MCC	0.0000	0.00	0	0
492	08	SURG	Lower extrem & humer proc except hip,foot,femur w MCC	3.1663	9.70	3	50
492.1	08	SURG	Lower extrem & humer proc except hip,foot,femur w MCC	1.2417	2.83	1	50
493	08	SURG	Lower extrem & humer proc except hip,foot,femur w CC	2.0881	5.34	1	50
493.1	08	SURG	Lower extrem & humer proc except hip,foot,femur w CC	1.4667	3.12	1	50
494	08	SURG	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC	1.4038	3.11	1	50
494.1	08	SURG	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC	1.0431	2.01	1	50
495	08	SURG	Local excision & removal int fix devices exc hip & femur w MCC	3.0150	9.10	1	50
496	08	SURG	Local excision & removal int fix devices exc hip & femur w CC	2.0147	7.16	1	50
497	08	SURG	Local excision & removal int fix devices exc hip & femur w/o CC/MCC	1.3012	2.85	1	50
498	08	SURG	Local excision & removal int fix devices of hip & femur w CC/MCC	1.8700	6.83	2	50
499	08	SURG	Local excision & removal int fix devices of hip & femur w/o CC/MCC	1.2482	4.00	1	50
500	08	SURG	Soft tissue procedures w MCC	2.5746	9.10	1	50
501	08	SURG	Soft tissue procedures w CC	1.5084	5.75	1	50
502	08	SURG	Soft tissue procedures w/o CC/MCC	1.0784	2.85	1	50
503	08	SURG	Foot procedures w MCC	2.5496	8.90	4	50
504	08	SURG	Foot procedures w CC	1.7995	7.05	2	50
505	08	SURG	Foot procedures w/o CC/MCC	1.0637	2.48	1	50
506	08	SURG	Major thumb or joint procedures	0.9916	3.64	2	50
507	08	SURG	Major shoulder or elbow joint procedures w CC/MCC	1.1072	3.82	1	50
508	08	SURG	Major shoulder or elbow joint procedures w/o CC/MCC	1.2278	3.11	1	50
509	08	SURG	Arthroscopy	1.5592	5.40	1	50
510	08	SURG	Shoulder,elbow or forearm proc,exc major joint proc w MCC	2.0954	5.11	2	50
511	08	SURG	Shoulder,elbow or forearm proc,exc major joint proc w CC	1.4999	3.55	1	50
512	08	SURG	Shoulder,elbow or forearm proc,exc major joint proc w/o CC/MCC	1.0260	2.03	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
513	08	SURG	Hand or wrist proc, except major thumb or joint proc w CC/MCC	1.3443	4.19	1	50
514	08	SURG	Hand or wrist proc, except major thumb or joint proc w/o CC/MCC	0.9573	2.67	1	50
515	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w MCC	3.5518	10.76	1	50
516	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w CC	2.4943	6.00	1	50
517	08	SURG	Other musculoskelet sys & conn tiss O.R. proc w/o CC/MCC	2.0641	3.85	1	50
518	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM	2.8928	6.79	1	50
519	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC	1.7553	4.63	1	50
520	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.0399	2.19	1	50
533	08	MED	Fractures of femur w MCC	1.3524	5.00	2	50
534	08	MED	Fractures of femur w/o MCC	0.8025	3.32	1	50
535	08	MED	Fractures of hip & pelvis w MCC	2.0732	8.91	1	50
536	08	MED	Fractures of hip & pelvis w/o MCC	0.9787	4.52	1	50
537	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w CC/MCC	1.0484	7.00	7	50
538	08	MED	Sprains, strains, & dislocations of hip, pelvis & thigh w/o CC/MCC	0.7658	1.80	1	50
539	08	MED	Osteomyelitis w MCC	2.0137	10.71	1	50
540	08	MED	Osteomyelitis w CC	1.2710	7.02	1	50
541	08	MED	Osteomyelitis w/o CC/MCC	0.9924	5.09	1	50
542	08	MED	Pathological fractures & musculoskelet & conn tiss malig w MCC	3.2093	11.91	3	50
543	08	MED	Pathological fractures & musculoskelet & conn tiss malig w CC	1.5212	6.77	1	50
544	08	MED	Pathological fractures & musculoskelet & conn tiss malig w/o CC/MCC	0.9542	4.27	1	50
545	08	MED	Connective tissue disorders w MCC	2.7145	11.03	2	50
546	08	MED	Connective tissue disorders w CC	1.2826	5.94	1	50
547	08	MED	Connective tissue disorders w/o CC/MCC	0.9404	3.92	1	50
548	08	MED	Septic arthritis w MCC	2.4509	10.06	3	50
549	08	MED	Septic arthritis w CC	1.2575	6.91	1	50
550	08	MED	Septic arthritis w/o CC/MCC	0.7116	3.67	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
551	08	MED	Medical back problems w MCC	1.7432	6.83	1	50
552	08	MED	Medical back problems w/o MCC	1.0871	3.84	1	50
553	08	MED	Bone diseases & arthropathies w MCC	1.8715	6.09	1	50
554	08	MED	Bone diseases & arthropathies w/o MCC	1.3357	3.63	1	50
555	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w MCC	1.3270	5.54	1	50
556	08	MED	Signs & symptoms of musculoskeletal system & conn tissue w/o MCC	0.8039	3.33	1	50
557	08	MED	Tendonitis, myositis & bursitis w MCC	2.0623	7.18	1	50
558	08	MED	Tendonitis, myositis & bursitis w/o MCC	0.8551	4.50	1	50
559	08	MED	Aftercare, musculoskeletal system & connective tissue w MCC	1.7682	8.05	1	50
560	08	MED	Aftercare, musculoskeletal system & connective tissue w CC	1.4418	6.00	1	50
561	08	MED	Aftercare, musculoskeletal system & connective tissue w/o CC/MCC	1.4222	3.20	1	50
562	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w MCC	1.2860	4.20	1	50
563	08	MED	Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC	0.8242	3.03	1	50
564	08	MED	Other musculoskeletal sys & connective tissue diagnoses w MCC	1.7505	5.95	2	50
565	08	MED	Other musculoskeletal sys & connective tissue diagnoses w CC	1.0575	5.18	1	50
566	08	MED	Other musculoskeletal sys & connective tissue diagnoses w/o CC/MCC	0.9228	3.44	1	50
570	09	SURG	SKIN DEBRIDEMENT W MCC	2.3740	11.74	2	50
571	09	SURG	SKIN DEBRIDEMENT W CC	1.5595	7.11	1	50
572	09	SURG	SKIN DEBRIDEMENT W/O CC/MCC	1.1523	4.97	1	50
573	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w MCC	2.6676	14.00	3	50
574	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w CC	2.5762	13.49	3	50
575	09	SURG	Skin graft &/or debrid for skn ulcer or cellulitis w/o CC/MCC	1.5410	7.60	1	50
576	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w MCC	4.0833	12.33	3	50
577	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w CC	3.0489	10.18	1	50
578	09	SURG	Skin graft &/or debrid exc for skin ulcer or cellulitis w/o CC/MCC	1.4726	3.95	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
579	09	SURG	Other skin, subcut tiss & breast proc w MCC	2.5848	10.99	2	50
580	09	SURG	Other skin, subcut tiss & breast proc w CC	1.6204	6.52	1	50
581	09	SURG	Other skin, subcut tiss & breast proc w/o CC/MCC	0.9742	3.21	1	50
582	09	SURG	Mastectomy for malignancy w CC/MCC	1.2095	2.76	1	50
583	09	SURG	Mastectomy for malignancy w/o CC/MCC	1.1732	2.15	1	50
584	09	SURG	Breast biopsy, local excision & other breast procedures w CC/MCC	1.4818	5.56	1	50
585	09	SURG	Breast biopsy, local excision & other breast procedures w/o CC/MCC	1.2459	2.76	1	50
592	09	MED	Skin ulcers w MCC	1.2480	7.15	1	50
593	09	MED	Skin ulcers w CC	0.9065	5.58	1	50
594	09	MED	Skin ulcers w/o CC/MCC	0.7737	4.11	1	50
595	09	MED	Major skin disorders w MCC	1.7227	8.10	2	50
596	09	MED	Major skin disorders w/o MCC	0.7787	4.92	1	50
597	09	MED	Malignant breast disorders w MCC	1.6096	7.27	1	50
598	09	MED	Malignant breast disorders w CC	1.3129	5.75	1	50
599	09	MED	Malignant breast disorders w/o CC/MCC	0.9724	4.00	1	50
600	09	MED	Non-malignant breast disorders w CC/MCC	0.8450	4.51	1	50
601	09	MED	Non-malignant breast disorders w/o CC/MCC	0.6034	3.30	1	50
602	09	MED	Cellulitis w MCC	1.3564	6.94	1	50
603	09	MED	Cellulitis w/o MCC	0.6553	3.72	1	50
604	09	MED	Trauma to the skin, subcut tiss & breast w MCC	1.3498	4.25	1	50
605	09	MED	Trauma to the skin, subcut tiss & breast w/o MCC	0.6870	2.54	1	50
606	09	MED	Minor skin disorders w MCC	1.0297	5.25	1	50
607	09	MED	Minor skin disorders w/o MCC	0.5719	3.60	1	50
614	10	SURG	Adrenal & pituitary procedures w CC/MCC	2.6574	7.89	1	50
615	10	SURG	Adrenal & pituitary procedures w/o CC/MCC	1.6720	3.15	1	50
616	10	SURG	Amputat of lower limb for endocrine,nutrit,& metabol dis w MCC	4.6150	18.91	7	50
617	10	SURG	Amputat of lower limb for endocrine,nutrit,& metabol dis w CC	2.1368	9.22	3	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
618	10	SURG	Amputat of lower limb for endocrine,nutrit,& metabol dis w/o CC/MCC	1.8282	7.00	7	50
619	10	SURG	O.R. procedures for obesity w MCC	2.3924	7.33	2	50
620	10	SURG	O.R. procedures for obesity w CC	2.4572	3.59	1	50
621	10	SURG	O.R. procedures for obesity w/o CC/MCC	2.0667	2.19	1	50
622	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w MCC	4.2391	12.54	3	50
623	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w CC	1.6810	8.23	2	50
624	10	SURG	Skin grafts & wound debrid for endoc, nutrit & metab dis w/o CC/MCC	1.6182	8.40	4	50
625	10	SURG	Thyroid, parathyroid & thyroglossal procedures w MCC	2.5377	11.00	3	50
626	10	SURG	Thyroid, parathyroid & thyroglossal procedures w CC	1.4316	3.04	1	50
627	10	SURG	Thyroid, parathyroid & thyroglossal procedures w/o CC/MCC	1.0119	1.85	1	50
628	10	SURG	Other endocrine, nutrit & metab O.R. proc w MCC	3.1952	12.08	2	50
629	10	SURG	Other endocrine, nutrit & metab O.R. proc w CC	2.2213	9.90	2	50
630	10	SURG	Other endocrine, nutrit & metab O.R. proc w/o CC/MCC	1.5695	5.78	1	50
637	10	MED	Diabetes w MCC	1.4788	6.47	1	50
638	10	MED	Diabetes w CC	0.8122	4.03	1	50
639	10	MED	Diabetes w/o CC/MCC	0.5825	2.88	1	50
640	10	MED	Nutritional & misc metabolic disorders w MCC	1.0622	4.99	1	50
640.1	10	MED	Nutritional & misc metabolic disorders w MCC	1.0364	6.27	1	50
641	10	MED	Nutritional & misc metabolic disorders w/o MCC	0.8303	3.94	1	50
641.1	10	MED	Nutritional & misc metabolic disorders w/o MCC	0.4764	3.11	1	50
642	10	MED	Inborn errors of metabolism	2.9637	10.24	2	50
642.1	10	MED	Inborn errors of metabolism	1.4792	6.03	1	50
643	10	MED	Endocrine disorders w MCC	1.6300	8.05	1	50
644	10	MED	Endocrine disorders w CC	1.0652	5.61	1	50
645	10	MED	Endocrine disorders w/o CC/MCC	0.7152	3.19	1	50
652	11	SURG	Kidney transplant	6.7494	7.25	4	50
653	11	SURG	Major bladder procedures w MCC	4.5360	15.23	2	50
654	11	SURG	Major bladder procedures w CC	2.9239	10.19	1	50
655	11	SURG	Major bladder procedures w/o CC/MCC	2.0393	6.47	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
656	11	SURG	Kidney & ureter procedures for neoplasm w MCC	3.4138	9.45	1	50
657	11	SURG	Kidney & ureter procedures forneoplasm w CC	2.2189	6.97	2	50
658	11	SURG	Kidney & ureter procedures for neoplasm w/o CC/MCC	1.9054	4.45	1	50
659	11	SURG	Kidney & ureter procedures for non-neoplasm w MCC	4.5783	14.02	2	50
660	11	SURG	Kidney & ureter procedures for non-neoplasm w CC	1.6828	5.44	1	50
661	11	SURG	Kidney & ureter procedures for non-neoplasm w/o CC/MCC	1.2076	2.74	1	50
662	11	SURG	Minor bladder procedures w MCC	2.9397	11.75	7	50
663	11	SURG	Minor bladder procedures w CC	1.6701	6.00	1	50
664	11	SURG	Minor bladder procedures w/o CC/MCC	1.2114	3.04	1	50
665	11	SURG	Prostatectomy w MCC	3.7500	14.85	1	50
666	11	SURG	Prostatectomy w CC	2.5752	7.67	1	50
667	11	SURG	Prostatectomy w/o CC/MCC	0.9974	3.11	1	50
668	11	SURG	Transurethral procedures w MCC	2.0487	7.60	1	50
669	11	SURG	Transurethral procedures w CC	1.1020	3.57	1	50
670	11	SURG	Transurethral procedures w/o CC/MCC	1.0108	2.64	1	50
671	11	SURG	Urethral procedures w CC/MCC	1.9870	10.21	1	50
672	11	SURG	Urethral procedures w/o CC/MCC	1.4132	3.27	1	50
673	11	SURG	Other kidney & urinary tract procedures w MCC	3.2816	12.36	1	50
674	11	SURG	Other kidney & urinary tract procedures w CC	2.1826	8.48	1	50
675	11	SURG	Other kidney & urinary tract procedures w/o CC/MCC	1.6096	3.76	1	50
682	11	MED	Renal failure w MCC	1.4913	6.68	1	50
683	11	MED	Renal failure w CC	1.0700	5.08	1	50
684	11	MED	Renal failure w/o CC/MCC	0.7794	3.74	1	50
685	11	MED	Admit for renal dialysis	0.9376	3.40	1	50
686	11	MED	Kidney & urinary tract neoplasms w MCC	2.0607	8.25	2	50
687	11	MED	Kidney & urinary tract neoplasms w CC	1.1046	4.68	1	50
688	11	MED	Kidney & urinary tract neoplasms w/o CC/MCC	1.3217	5.00	1	50
689	11	MED	Kidney & urinary tract infections w MCC	1.0942	5.66	1	50
690	11	MED	Kidney & urinary tract infections w/o MCC	0.6205	3.43	1	50
691	11	MED	Urinary stones w esw lithotripsy w CC/MCC	1.0607	4.67	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
692	11	MED	Urinary stones w esw lithotripsy w/o CC/MCC	0.9242	2.00	1	50
693	11	MED	Urinary stones w/o esw lithotripsy w MCC	1.2069	4.41	1	50
694	11	MED	Urinary stones w/o esw lithotripsy w/o MCC	0.7517	2.68	1	50
695	11	MED	Kidney & urinary tract signs & symptoms w MCC	0.7319	3.38	1	50
696	11	MED	Kidney & urinary tract signs & symptoms w/o MCC	0.6865	3.24	1	50
697	11	MED	Urethral stricture	1.3233	2.14	1	50
698	11	MED	Other kidney & urinary tract diagnoses w MCC	1.4813	7.05	1	50
699	11	MED	Other kidney & urinary tract diagnoses w CC	1.0006	4.86	1	50
700	11	MED	Other kidney & urinary tract diagnoses w/o CC/MCC	0.7597	3.60	1	50
707	12	SURG	Major male pelvic procedures w CC/MCC	2.2598	5.18	1	50
708	12	SURG	Major male pelvic procedures w/o CC/MCC	1.5338	2.92	1	50
709	12	SURG	Penis procedures w CC/MCC	1.7822	7.40	1	50
710	12	SURG	Penis procedures w/o CC/MCC	0.9992	2.60	1	50
711	12	SURG	Testes procedures w CC/MCC	1.8126	6.47	1	50
712	12	SURG	Testes procedures w/o CC/MCC	0.8479	2.26	1	50
713	12	SURG	Transurethral prostatectomy w CC/MCC	1.5896	6.88	1	50
714	12	SURG	Transurethral prostatectomy w/o CC/MCC	0.8631	1.79	1	50
715	12	SURG	Other male reproductive system O.R. proc for malignancy w CC/MCC	2.7001	9.20	6	50
716	12	SURG	Other male reproductive system O.R. proc for malignancy w/o CC/MCC	1.6560	3.75	1	50
717	12	SURG	Other male reproductive system O.R. proc exc malignancy w CC/MCC	3.0487	12.86	5	50
718	12	SURG	Other male reproductive system O.R. proc exc malignancy w/o CC/MCC	1.2029	4.00	2	50
722	12	MED	Malignancy, male reproductive system w MCC	2.5064	14.33	12	50
723	12	MED	Malignancy, male reproductive system w CC	1.9084	6.78	2	50
724	12	MED	Malignancy, male reproductive system w/o CC/MCC	1.0554	3.88	1	50
725	12	MED	Benign prostatic hypertrophy w MCC	0.6848	1.00	1	50
726	12	MED	Benign prostatic hypertrophy w/o MCC	1.0634	7.00	1	50
727	12	MED	Inflammation of the male reproductive system w MCC	1.1024	5.14	1	50
727.1	12	MED	Inflammation of the male reproductive system w MCC	0.9497	3.67	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
728	12	MED	Inflammation of the male reproductive system w/o MCC	0.7775	4.03	1	50
728.1	12	MED	Inflammation of the male reproductive system w/o MCC	0.3912	2.68	1	50
729	12	MED	Other male reproductive system diagnoses w CC/MCC	1.1531	4.81	1	50
730	12	MED	Other male reproductive system diagnoses w/o CC/MCC	0.5643	2.96	1	50
734	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w CC/MCC	2.0706	5.66	1	50
735	13	SURG	Pelvic evisceration, rad hysterectomy & rad vulvectomy w/o CC/MCC	1.4965	2.89	1	50
736	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w MCC	5.0187	15.13	4	50
737	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w CC	2.0378	7.35	3	50
738	13	SURG	Uterine & adnexa proc for ovarian or adnexal malignancy w/o CC/MCC	1.3209	3.71	2	50
739	13	SURG	Uterine,adnexa proc for non-ovarian/adnexal malig w MCC	2.5323	8.50	2	50
740	13	SURG	Uterine,adnexa proc for non-ovarian/adnexal malig w CC	1.7336	4.91	1	50
741	13	SURG	Uterine,adnexa proc for non-ovarian/adnexal malig w/o CC/MCC	1.0348	2.54	1	50
742	13	SURG	Uterine & adnexa proc for non-malignancy w CC/MCC	1.4682	3.93	1	50
743	13	SURG	Uterine & adnexa proc for non-malignancy w/o CC/MCC	1.0620	2.25	1	50
744	13	SURG	D&C, conization, laparoscopy & tubal interruption w CC/MCC	1.6374	6.41	1	50
745	13	SURG	D&C, conization, laparoscopy & tubal interruption w/o CC/MCC	1.1162	3.00	1	50
746	13	SURG	Vagina, cervix & vulva procedures w CC/MCC	1.2448	4.43	1	50
747	13	SURG	Vagina, cervix & vulva procedures w/o CC/MCC	0.8054	2.70	1	50
748	13	SURG	Female reproductive system reconstructive procedures	0.9610	1.94	1	50
749	13	SURG	Other female reproductive system O.R. procedures w CC/MCC	1.9366	6.07	1	50
750	13	SURG	Other female reproductive system O.R. procedures w/o CC/MCC	0.9925	2.75	1	50
754	13	MED	Malignancy, female reproductive system w MCC	2.1888	8.05	1	50
755	13	MED	Malignancy, female reproductive system w CC	1.4355	6.26	1	50
756	13	MED	Malignancy, female reproductive system w/o CC/MCC	0.8989	3.55	1	50
757	13	MED	Infections, female reproductive system w MCC	1.3849	6.60	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
758	13	MED	Infections, female reproductive system w CC	0.8164	3.67	1	50
759	13	MED	Infections, female reproductive system w/o CC/MCC	0.6210	2.91	1	50
760	13	MED	Menstrual & other female reproductive system disorders w CC/MCC	0.8322	3.07	1	50
761	13	MED	Menstrual & other female reproductive system disorders w/o CC/MCC	0.7521	2.18	1	50
765	14	SURG	Cesarean section w CC/MCC	0.9811	4.56	2	50
766	14	SURG	Cesarean section w/o CC/MCC	0.7644	3.35	2	50
767	14	SURG	Vaginal delivery w sterilization &/or D&C	0.8044	2.67	1	50
768	14	SURG	Vaginal delivery w O.R. proc except steril &/or D&C	0.9677	4.24	1	50
769	14	SURG	Postpartum & post abortion diagnoses w O.R. procedure	1.6116	4.63	1	50
770	14	SURG	Abortion w D&C, aspiration curettage or hysterotomy	0.8112	2.46	1	50
774	14	MED	Vaginal delivery w complicating diagnoses	0.6202	3.07	1	50
775	14	MED	Vaginal delivery w/o complicating diagnoses	0.4783	2.45	1	50
776	14	MED	Postpartum & post abortion diagnoses w/o O.R. procedure	0.6879	3.26	1	50
777	14	MED	Ectopic pregnancy	0.9842	2.37	1	50
778	14	MED	Threatened abortion	0.4727	3.87	1	50
779	14	MED	Abortion w/o D&C	0.5051	2.19	1	50
780	14	MED	False labor	0.2995	2.08	1	50
781	14	MED	Other antepartum diagnoses w medical complications	0.6090	3.87	1	50
782	14	MED	Other antepartum diagnoses w/o medical complications	0.5439	4.07	1	50
789	15	MED	Neonates, died or transferred to another acute care facility	0.2562	1.78	1	50
789.1	15	MED	Neonates, died or transferred to another acute care facility	4.8692	15.65	1	51
790	15	MED	Extreme immaturity or respiratory distress syndrome, neonate	1.3739	10.17	1	50
790.1	15	MED	Extreme immaturity or respiratory distress syndrome, neonate	9.1651	39.04	6	73
791	15	MED	Prematurity w major problems	1.1156	9.41	2	50
791.1	15	MED	Prematurity w major problems	3.9599	21.65	4	53
792	15	MED	Prematurity w/o major problems	0.3983	4.54	1	50
792.1	15	MED	Prematurity w/o major problems	2.0802	13.20	3	50
793	15	MED	Full term neonate w major problems	0.5707	5.06	1	50
793.1	15	MED	Full term neonate w major problems	2.0495	10.56	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
794	15	MED	Neonate w other significant problems	0.2224	3.02	1	50
794.1	15	MED	Neonate w other significant problems	0.8863	5.41	2	50
795	15	MED	Normal newborn	0.1417	2.52	1	50
799	16	SURG	Splenectomy w MCC	3.8067	10.30	3	50
800	16	SURG	Splenectomy w CC	2.4411	6.30	2	50
801	16	SURG	Splenectomy w/o CC/MCC	1.5998	3.76	1	50
802	16	SURG	Other O.R. proc of the blood & blood forming organs w MCC	4.2528	15.56	3	52
803	16	SURG	Other O.R. proc of the blood & blood forming organs w CC	1.9985	8.80	2	50
804	16	SURG	Other O.R. proc of the blood & blood forming organs w/o CC/MCC	1.3859	4.96	1	50
808	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w MCC	2.3931	9.48	2	50
809	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w CC	1.3661	6.15	1	50
810	16	MED	Major hematol/immun diag exc sickle cell crisis & coagul w/o CC/MCC	0.9255	3.95	1	50
811	16	MED	Red blood cell disorders w MCC	1.5537	8.27	2	50
811.1	16	MED	Red blood cell disorders w MCC	1.0697	6.17	2	50
812	16	MED	Red blood cell disorders w/o MCC	0.8104	4.84	1	50
812.1	16	MED	Red blood cell disorders w/o MCC	0.4385	3.59	1	50
813	16	MED	Coagulation disorders	1.5265	4.25	1	50
814	16	MED	Reticuloendothelial & immunity disorders w MCC	2.6760	11.14	1	50
815	16	MED	Reticuloendothelial & immunity disorders w CC	0.9314	4.60	1	50
816	16	MED	Reticuloendothelial & immunity disorders w/o CC/MCC	0.6659	3.55	1	50
820	17	SURG	Lymphoma & leukemia w major O.R. procedure w MCC	11.7215	28.78	2	61
821	17	SURG	Lymphoma & leukemia w major O.R. procedure w CC	4.2753	12.19	1	50
822	17	SURG	Lymphoma & leukemia w major O.R. procedure w/o CC/MCC	1.5878	4.59	1	50
823	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w MCC	5.5160	18.69	1	50
824	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w CC	2.9294	10.80	2	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
825	17	SURG	Lymphoma & non-acute leukemia w other O.R. proc w/o CC/MCC	1.9083	5.84	2	50
826	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w MCC	8.5294	23.83	1	55
827	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w CC	3.3773	10.91	1	50
828	17	SURG	Myeloprolif disord or poorly diff neopl w maj O.R. proc w/o CC/MCC	2.1507	5.43	1	50
829	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w CC/MCC	2.6137	10.08	2	50
830	17	SURG	Myeloprolif disord or poorly diff neopl w other O.R. proc w/o CC/MCC	1.2448	3.77	2	50
834	17	MED	Acute leukemia w/o major O.R. procedure w MCC	8.2987	22.48	3	54
835	17	MED	Acute leukemia w/o major O.R. procedure w CC	4.1500	13.54	2	50
836	17	MED	Acute leukemia w/o major O.R. procedure w/o CC/MCC	2.0475	7.19	1	50
837	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	5.6882	20.59	5	51
837.1	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w MCC	2.8975	10.84	3	50
838	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w CC	2.4176	9.18	3	50
838.1	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w CC	2.2853	12.27	1	50
839	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	0.9910	5.58	2	50
839.1	17	MED	Chemo w acute leukemia as sdx or w high dose chemo agent w/o CC/MCC	0.8672	4.52	1	50
840	17	MED	Lymphoma & non-acute leukemia w MCC	3.7158	13.45	2	50
841	17	MED	Lymphoma & non-acute leukemia w CC	1.9041	7.47	1	50
842	17	MED	Lymphoma & non-acute leukemia w/o CC/MCC	1.3335	5.16	1	50
843	17	MED	Other myeloprolif dis or poorly diff neopl diag w MCC	2.6640	11.94	1	50
844	17	MED	Other myeloprolif dis or poorly diff neopl diag w CC	1.5981	7.31	2	50
845	17	MED	Other myeloprolif dis or poorly diff neopl diag w/o CC/MCC	0.8825	4.62	1	50
846	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	1.9666	8.23	2	50
847	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	1.0317	4.28	1	50
848	17	MED	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	0.8378	3.69	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
849	17	MED	Radiotherapy	0.8438	2.97	1	50
853	18	SURG	Infectious & parasitic diseases w O.R. procedure w MCC	6.0133	19.49	4	51
854	18	SURG	Infectious & parasitic diseases w O.R. procedure w CC	2.5856	11.32	2	50
855	18	SURG	Infectious & parasitic diseases w O.R. procedure w/o CC/MCC	3.7916	14.08	1	50
856	18	SURG	Postoperative or post-traumatic infections w O.R. proc w MCC	4.1018	14.50	3	50
857	18	SURG	Postoperative or post-traumatic infections w O.R. proc w CC	1.9229	8.45	2	50
858	18	SURG	Postoperative or post-traumatic infections w O.R. proc w/o CC/MCC	1.4609	5.93	1	50
862	18	MED	Postoperative & post-traumatic infections w MCC	1.8863	8.62	2	50
863	18	MED	Postoperative & post-traumatic infections w/o MCC	0.9397	4.74	1	50
864	18	MED	Fever of unknown origin	0.9989	4.67	1	50
864.1	18	MED	Fever of unknown origin	0.4369	2.73	1	50
865	18	MED	Viral illness w MCC	1.4074	6.00	1	50
865.1	18	MED	Viral illness w MCC	0.8514	5.06	2	50
866	18	MED	Viral illness w/o MCC	0.7176	3.42	1	50
866.1	18	MED	Viral illness w/o MCC	0.4364	2.68	1	50
867	18	MED	Other infectious & parasitic diseases diagnoses w MCC	2.6175	10.89	1	50
868	18	MED	Other infectious & parasitic diseases diagnoses w CC	1.1954	5.75	1	50
869	18	MED	Other infectious & parasitic diseases diagnoses w/o CC/MCC	0.7737	4.46	1	50
870	18	MED	Septicemia w MV 96+ hours	5.9490	16.75	5	50
871	18	MED	Septicemia w/o MV 96+ hours w MCC	1.9977	8.34	1	50
872	18	MED	Septicemia w/o MV 96+ hours w/o MCC	1.1152	5.56	1	50
876	19	SURG	O.R. procedure w principal diagnoses of mental illness	1.5106	7.38	1	50
880	19	MED	Acute adjustment reaction & psychosocial dysfunction	0.7899	3.35	1	50
881	19	MED	Depressive neuroses	0.5729	3.11	1	50
882	19	MED	Neuroses except depressive	0.7801	4.10	1	50
883	19	MED	Disorders of personality & impulse control	1.7448	9.85	1	50
884	19	MED	Organic disturbances & mental retardation	0.8467	4.36	1	50
885	19	MED	Psychoses	0.6844	6.43	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
886	19	MED	Behavioral & developmental disorders	0.4072	2.40	2	50
887	19	MED	Other mental disorder diagnoses	0.3984	2.43	1	50
894	20	MED	Alcohol/drug abuse or dependence, left ama	0.4665	2.31	1	50
895	20	MED	Alcohol/drug abuse or dependence w rehabilitation therapy	0.7559	8.05	2	50
896	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	1.6608	7.89	1	50
897	20	MED	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.7246	4.27	1	50
901	21	SURG	Wound debridements for injuries w MCC	5.9565	22.21	4	53
902	21	SURG	Wound debridements for injuries w CC	2.5914	12.04	2	50
903	21	SURG	Wound debridements for injuries w/o CC/MCC	1.5340	5.83	1	50
904	21	SURG	Skin grafts for injuries w CC/MCC	5.4661	20.31	2	53
905	21	SURG	Skin grafts for injuries w/o CC/MCC	1.9230	7.65	2	50
906	21	SURG	Hand procedures for injuries	1.0465	2.70	1	50
907	21	SURG	Other O.R. procedures for injuries w MCC	4.1760	12.41	1	50
908	21	SURG	Other O.R. procedures for injuries w CC	1.9352	6.67	1	50
909	21	SURG	Other O.R. procedures for injuries w/o CC/MCC	1.1866	3.23	1	50
913	21	MED	Traumatic injury w MCC	1.2439	6.35	1	50
914	21	MED	Traumatic injury w/o MCC	0.6520	2.65	1	50
915	21	MED	Allergic reactions w MCC	1.7619	6.42	2	50
915.1	21	MED	Allergic reactions w MCC	0.4332	1.50	1	50
916	21	MED	Allergic reactions w/o MCC	0.5193	2.48	1	50
916.1	21	MED	Allergic reactions w/o MCC	0.3369	1.97	1	50
917	21	MED	Poisoning & toxic effects of drugs w MCC	1.5177	5.03	1	50
917.1	21	MED	Poisoning & toxic effects of drugs w MCC	0.8722	3.00	1	50
918	21	MED	Poisoning & toxic effects of drugs w/o MCC	0.5827	2.66	1	50
918.1	21	MED	Poisoning & toxic effects of drugs w/o MCC	0.4468	2.19	1	50
919	21	MED	Complications of treatment w MCC	1.6986	7.49	1	50
919.1	21	MED	Complications of treatment w MCC	1.0535	5.14	1	50
920	21	MED	Complications of treatment w CC	1.1075	5.41	1	50
920.1	21	MED	Complications of treatment w CC	0.8452	4.06	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
921	21	MED	Complications of treatment w/o CC/MCC	0.7502	3.49	1	50
921.1	21	MED	Complications of treatment w/o CC/MCC	0.4161	2.10	1	50
922	21	MED	Other injury, poisoning & toxic effect diag w MCC	1.4359	6.46	1	50
923	21	MED	Other injury, poisoning & toxic effect diag w/o MCC	0.8012	4.30	1	50
927	22	SURG	Extensive burns or full thickness burns w MV 96+ hrs w skin graft	12.9058	27.23	9	50
928	22	SURG	Full thickness burn w skin graft or inhal inj w CC/MCC	5.0658	17.48	2	50
929	22	SURG	Full thickness burn w skin graft or inhal inj w/o CC/MCC	2.7044	9.43	1	50
933	22	MED	Extensive burns or full thickness burns w MV 96+ hrs w/o skin graft	5.2923	11.90	1	50
934	22	MED	Full thickness burn w/o skin grft or inhal inj	1.5344	6.46	1	50
935	22	MED	Non-extensive burns	0.8631	3.89	1	50
939	23	SURG	O.R. proc w diagnoses of other contact w health services w MCC	4.3479	15.44	1	50
940	23	SURG	O.R. proc w diagnoses of other contact w health services w CC	1.9195	9.04	1	50
941	23	SURG	O.R. proc w diagnoses of other contact w health services w/o CC/MCC	1.1167	3.23	1	50
945	23	MED	Rehabilitation w CC/MCC	1.9485	13.11	3	50
946	23	MED	Rehabilitation w/o CC/MCC	1.3373	9.56	2	50
947	23	MED	Signs & symptoms w MCC	1.1739	5.53	1	50
948	23	MED	Signs & symptoms w/o MCC	0.7425	3.85	1	50
949	23	MED	Aftercare w CC/MCC	1.2272	4.93	1	50
950	23	MED	Aftercare w/o CC/MCC	0.3641	2.89	1	50
951	23	MED	Other factors influencing health status	0.3552	2.30	1	50
955	24	SURG	Craniotomy for multiple significant trauma	7.1339	18.56	3	50
956	24	SURG	Limb reattachment, hip & femur proc for multiple significant	5.6505	13.37	1	50
957	24	SURG	Other O.R. procedures for multiple significant trauma w MCC	7.3110	16.75	1	50
958	24	SURG	Other O.R. procedures for multiple significant trauma w CC	4.1452	9.94	3	50
959	24	SURG	Other O.R. procedures for multiple significant trauma w/o CC/MCC	2.2803	5.73	1	50
963	24	MED	Other multiple significant trauma w MCC	3.8574	11.29	1	50
964	24	MED	Other multiple significant trauma w CC	1.5075	4.96	1	50

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

DRG	MDC	Type	Description	Relative Weight	Avg LOS	Low Day	High Day
965	24	MED	Other multiple significant trauma w/o CC/MCC	1.1289	3.51	1	50
969	25	SURG	HIV w extensive O.R. procedure w MCC	5.0377	17.58	2	50
970	25	SURG	HIV w extensive O.R. procedure w/o MCC	2.4884	7.90	3	50
974	25	MED	HIV w major related condition w MCC	2.4870	11.65	1	50
975	25	MED	HIV w major related condition w CC	1.4055	7.58	1	50
976	25	MED	HIV w major related condition w/o CC/MCC	0.8336	4.82	1	50
977	25	MED	HIV w or w/o other related condition	1.1943	6.15	1	50
981		SURG	Extensive O.R. procedure unrelated to principal diagnosis w MCC	5.5506	17.49	2	50
982		SURG	Extensive O.R. procedure unrelated to principal diagnosis w CC	2.7950	9.43	2	50
983		SURG	Extensive O.R. procedure unrelated to principal diagnosis w/o CC/MCC	1.7000	5.09	1	50
984		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	2.7899	15.05	1	50
985		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w CC	2.1388	10.00	1	50
986		SURG	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	0.9737	2.00	2	50
987		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w MCC	3.1604	13.03	2	50
988		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w CC	1.9715	8.84	2	50
989		SURG	Non-extensive O.R. proc unrelated to principal diagnosis w/o CC/MCC	1.2391	4.72	1	50
998			Principal diagnosis invalid as discharge diagnosis	0.0000	0.00	0	0
999			Ungroupable	0.0000	0.00	0	0

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital Services

For cost reporting purposes, the MSA requires each eligible hospital provider to submit periodic reports which generally cover consecutive 12 month periods of operation. Inpatient and/or outpatient cost reports must be filed within five (5) months of the end of the hospital's cost reporting year. State owned hospitals must file cost reports within 180 days after the end of the State's cost reporting year.

Extensions of the filing period may be granted when exceptional circumstances establish good cause. If the hospital requests an extension in writing and documents the exceptional circumstances prior to the date due, extensions may be granted up to a maximum of 30 days. Failure to submit all necessary items and schedules will only delay processing and will result in a reduction of payment or termination as a provider.

Hospitals that fail to submit cost reports as defined previously will receive a delinquency letter from the MSA. If the cost report is not submitted within 30 days of the notice of delinquency, a second notice of delinquency will be issued. If the cost report is not submitted within 30 days of a second notice of delinquency, the provider's payments will be stopped. Restitution of withheld payments will be made by the State agency after receipt, of an acceptable cost report.

B. Data Correction

Once a hospital report (e.g. cost, indigent volume, and/or data) has been reviewed and provisionally accepted by the MSA, the hospital is notified in writing of the MSA's acceptance of the report. The hospital then has thirty (30) calendar days in which to notify the MSA of any errors or corrections to the report/data. After the 30 day notification period, the report is deemed accepted by the MSA and shall be used to rebase or update the hospital payments as appropriate.

Only those reports on file and accepted nine months prior to the beginning of a new rate period are used for rebasing.

C. Audit

Audits are performed for Michigan inpatient hospital services provided after February 1, 1985 to determine program cost for capital using Medicare Principles of Reimbursement.

Once any appropriate limits are applied, the capital cost is added to the amount approved as payment for the program operating cost to obtain a total amount approved. The total amount approved in a hospital's fiscal year is compared to the hospital's program charges. The lesser of amount approved or charges is then compared to the amount actually paid throughout the year to determine the amount overpaid or underpaid to the hospital.

III. Payment Determination

A. REIMBURSEMENT FOR MEDICAL AND SURGICAL HOSPITALS FOR OPERATING EXPENSES ~~The DRG reimbursement for operating expenses is:~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

~~(Relative Weight x DRG Price) + Outlier Payment~~

1. DESCRIPTION OF MEDICAL/SURGICAL EPISODE FILE

THE EPISODE FILE IS COMPRISED OF THE UNDERLYING DATA USED TO CALCULATE THE STATEWIDE RATE, RELATIVE WEIGHTS, AND ALTERNATE WEIGHTS. THE COSTS ASSOCIATED WITH EPISODES FROM THE EPISODE FILE ARE STANDARDIZED AS DESCRIBED BELOW. THE EPISODE FILE IS COMPRISED OF TWO YEARS OF MEDICAID AND CHILDREN'S SPECIAL HEALTH CARE SERVICES FEE FOR SERVICE (FFS) PAID CLAIMS AND MANAGED CARE ENCOUNTERS.

EACH CLAIM OR ENCOUNTER FROM THE EPISODE FILE IS ASSIGNED A DRG VALUE USING THE APR-DRG GROUPER IN EFFECT NATIONALLY ON OCTOBER 1 OF THE APPLICABLE RATE YEAR. THE DATA ARE ADJUSTED TO:

- ELIMINATE EPISODES FOR DUAL MEDICARE/MEDICAID ELIGIBLE BENEFICIARIES, UNLESS PAID A FULL MEDICAID DRG.
- ELIMINATE CERTAIN TRANSPLANTS AND LOW DAY OUTLIER EPISODES ASSIGNED TO DRGS REIMBURSED BY MULTIPLYING A HOSPITAL'S OPERATING COST-TO-CHARGE RATIO BY CHARGES.
- ELIMINATE EPISODES WITHOUT ANY CHARGES OR DAYS.
- ASSIGN ALTERNATE WEIGHTS FOR NEONATAL SERVICES. TWO SETS OF WEIGHTS ARE CALCULATED FOR THE DRG CLASSIFICATIONS REPRESENTING NEONATAL SERVICES (DRGS 580X-640X). THESE ALTERNATE WEIGHTS ARE CALCULATED BASED ON EPISODES THAT ARE ASSIGNED TO ONE OF THESE DRGS AND INCLUDE CHARGES FOR SERVICES IN A NEONATAL INTENSIVE CARE UNIT (NICU). THE REMAINING CLAIMS ASSIGNED TO THESE DRGS ARE USED FOR THE BASE WEIGHTS. NO OTHER ALTERNATE WEIGHTS ARE ASSIGNED.
- LIMIT EPISODES TO THOSE FROM MICHIGAN HOSPITALS, INCLUDING HOSPITALS THAT ARE NO LONGER IN OPERATION (PROVIDED THAT HOSPITAL COST REPORT DATA IS AVAILABLE).
- LIMIT EPISODES TO THOSE WITH A VALID DISCHARGE STATUS.
- ELIMINATE EPISODES WITH A ZERO DOLLAR MEDICAID LIABILITY.
- ELIMINATE EPISODES THAT QUALIFY FOR THE SHORT HOSPITAL STAY RATE.
- DETERMINE THE LOW DAY TRIM POINT AND AVERAGE LENGTH OF STAY.
  - SEE THE RELATIVE WEIGHTS SECTION OF THE REIMBURSEMENT FOR MEDICAL AND SURGICAL HOSPITAL SECTION OF THE STATE PLAN FOR ADDITIONAL INFORMATION.
- LIMIT EPISODES ENDING IN A TRANSFER TO ANOTHER ACUTE SETTING TO THOSE WHOSE LENGTH OF STAY WAS AT LEAST EQUAL TO THE PUBLISHED AVERAGE LENGTH OF STAY FOR THE DRG (SINCE DRGS 580X AND 581X ARE TRANSFER DRGS, ALL TRANSFER COSTS ARE INCLUDED WITHIN THOSE DRGS).
- INFLATE THE FIRST YEAR OF EPISODES TO THE SECOND YEAR THROUGH APPLICATION OF AN INFLATION FACTOR DERIVED FROM IHS GLOBAL INSIGHT.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

- RECOGNIZE AREA COST DIFFERENCES BY DIVIDING THE CHARGES FOR EACH HOSPITAL BY AN AREA WAGE INDEX.
  - SEE THE AREA WAGE INDEX SECTION OF THE REIMBURSEMENT FOR MEDICAL AND SURGICAL HOSPITAL SECTION OF THE STATE PLAN FOR ADDITIONAL INFORMATION REGARDING THE AREA WAGE INDEX.
- ADJUST CHARGES FOR HIGH COST OUTLIERS TO REMOVE THE AMOUNT PAID AS AN OUTLIER.
  - SEE THE HIGH COST OUTLIER SECTION OF THE REIMBURSEMENT FOR MEDICAL AND SURGICAL HOSPITAL SECTION OF THE STATE PLAN FOR ADDITIONAL INFORMATION REGARDING COST OUTLIERS.
- THE ADJUSTED COST FOR EACH EPISODE IS CALCULATED BY MULTIPLYING THE ADJUSTED CHARGES FOR THE EPISODE BY THE INPATIENT OPERATING COST-TO-CHARGE RATIO.
  - SEE THE COST-TO-CHARGE RATIO SECTION OF THE REIMBURSEMENT FOR MEDICAL AND SURGICAL HOSPITAL SECTION OF THE STATE PLAN FOR ADDITIONAL INFORMATION REGARDING COST-TO-CHARGE RATIOS.

~~Each inpatient hospital claim is assigned to a DRG using the same DRG grouper version used to establish the relative weights.~~

~~A. Relative Weight:~~

~~A state wide relative weight is assigned to each DRG. The statewide relative weights are calculated using Medicaid and Children's Special Health Care Services Program Fee-For-Service (FFS) and Medicaid Health Plan (MHP) encounter inpatient paid claims for admissions during two consecutive state fiscal years and hospital specific cost report data drawn from two consecutive cost report years used to establish the relative weights.~~

~~The claim file was adjusted to:~~

~~1. Combine multiple billings for the same episode of service, including:~~

~~a. Invoices from a single episode of service billed as a transfer from a hospital and an admission to the same hospital caused by a change of ownership and issuance of a new Medicaid ID number,~~

~~a. Invoices for a single episode of service billed as a transfer from a hospital and an admission to a hospital created from a merger of two or more hospitals and the assignment of patient bills from multiple hospitals to a single Medicaid ID number.~~

~~2. Eliminate episodes with any Medicare charges (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid DRG are included);~~

~~3. Eliminate episodes assigned to DRGs reimbursed by multiplying a hospital's inpatient operating cost to charge ration by charges;~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

~~4. Eliminate episodes without any charges or days;~~

~~5. Assign alternate weights for neonatal services. Two sets of weights are calculated for six (6) DRG classifications representing neonatal services (789-794). One set of weights is identified as "alternate weights" (789.1, 790.1, 791.1, 792.1, 793.1 AND 794.1). These alternate weights are calculated from episodes that are assigned to one of these DRGs and include charges for services in an intensive care unit of one of the hospitals designated as having a neonatal intensive care unit (NICU). The remaining claims assigned to these DRGs are used for the other set of weights.~~

~~In order to receive the alternate weights, a hospital must have a Certificate of Need (CON) to operate a NICU or a special newborn nursery unit (SNNU) or the hospital must have previously received alternate weight reimbursement by Medicaid for its SNNU.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

2. STATEWIDE DRG RATES

TWO STATEWIDE MEDICAL/SURGICAL HOSPITAL DRG RATES ARE DEVELOPED BY THE STATE USING THE EPISODE FILE. FOR HOSPITAL DRG RATE SETTING PURPOSES, THE MEDICAL/SURGICAL EPISODE FILE IS LIMITED TO THOSE HOSPITALS ENROLLED WITH THE STATE AS OF OCTOBER 1 OF THE APPLICABLE RATE YEAR. TWO SEPARATE STATEWIDE RATES ARE DEVELOPED: ONE RATE IS DEVELOPED FOR PROSPECTIVE PAYMENT SYSTEM (PPS) HOSPITALS AND ANOTHER RATE IS DEVELOPED FOR HOSPITALS DESIGNATED AS CRITICAL ACCESS BY CMS AS OF OCTOBER 1 OF THE APPLICABLE RATE YEAR. IN THE EVENT A HOSPITAL STATUS CHANGES FROM PPS TO CRITICAL ACCESS HOSPITAL (CAH), THE STATE RECOGNIZES THE HOSPITAL UNDER CAH STATUS AS OF THE CMS EFFECTIVE DATE. THE REVERSE IS ALSO TRUE. IF A HOSPITAL STATUS CHANGES FROM CAH TO PPS, THE STATE RECOGNIZES THE HOSPITAL UNDER PPS STATUS AS OF THE CMS EFFECTIVE DATE. STATEWIDE RATES ARE UPDATED ANNUALLY ON OCTOBER 1.

A BUDGET NEUTRALITY FACTOR IS INCLUDED IN THE HOSPITAL PRICE CALCULATION. HOSPITAL PRICES ARE REDUCED BY THE PERCENTAGE NECESSARY SO THAT TOTAL AGGREGATE HOSPITAL PAYMENTS USING THE NEW HOSPITAL PRICES AND DRG RELATIVE WEIGHTS DO NOT EXCEED THE TOTAL AGGREGATE HOSPITAL PAYMENTS MADE USING THE PRIOR HOSPITAL BASE PERIOD DATA AND DRG GROUPER RELATIVE WEIGHTS. THE ESTIMATE IS BASED ON ONE YEAR'S PAID CLAIMS, INCLUDING MHP ENCOUNTER DATA WITH FFS RATES APPLIED. THE CALCULATED DRG PRICES ARE DEFLATED BY THE PERCENTAGE NECESSARY FOR THE TOTAL PAYMENTS TO EQUATE TO THE AMOUNT PAID PRIOR TO THE CHANGE. BUDGET NEUTRALITY FOR CAHS IS DETERMINED AS A GROUP, INDEPENDENT OF PPS.

HOSPITALS' FINAL DRG RATES ARE CALCULATED AS FOLLOWS:

- THE CASE MIX IS CALCULATED USING THE SUM OF ALL RELATIVE WEIGHTS ASSIGNED TO EACH HOSPITAL'S CLAIMS DURING THE BASE PERIOD, DIVIDED BY THE TOTAL NUMBER OF EPISODES FOR THE HOSPITAL DURING THE SAME PERIOD.
- THE CASE MIX INDEX ADJUSTED COST FOR EACH HOSPITAL IS SUMMED.
- A HOSPITAL-SPECIFIC STANDARDIZED COST PER DISCHARGE IS COMPUTED.
    - DIVIDE TOTAL ADJUSTED COSTS BY THE TOTAL NUMBER OF EPISODES.
    - DIVIDE AVERAGE COSTS BY THE CASE MIX.
    - MULTIPLY THE RESULT BY THE APPLICABLE INFLATION FACTOR TO BRING COSTS TO A COMMON POINT IN TIME. COSTS ARE INFLATED THROUGH THE RATE PERIOD. FOR EXAMPLE, FOR FY 2015 RATES, COSTS ARE INFLATED THROUGH SEPTEMBER 30, 2016. INFLATION FACTORS ARE OBTAINED FROM IHS GLOBAL INSIGHT.
- THE STATEWIDE RATE PER DISCHARGE IS THE WEIGHTED MEAN OF ALL HOSPITAL-SPECIFIC STANDARDIZED COST.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

- THE STATEWIDE RATE IS ADJUSTED BY AN AREA WAGE INDEX AND BUDGET NEUTRALITY FACTOR TO DETERMINE THE HOSPITAL'S FINAL DRG RATE.

IN DEVELOPING THE STATEWIDE DRG RATE, THE FOLLOWING DATA AND CALCULATIONS ARE USED FOR EACH HOSPITAL:

1) HOSPITAL'S ADJUSTED CHARGES;
2) INPATIENT COST-TO-CHARGE RATIO;

~~6. Limit episodes to those from Michigan hospitals, including hospitals that are no longer in operation (provided that hospital cost report data are available);~~

~~7. Limit episodes to those with a valid patient status (incomplete episodes are excluded as are additional pages of multiple page claims where there is no initial claim containing a valid patient status);~~

~~8. Eliminate episodes with a zero dollar Medicaid liability;~~

~~9. Eliminate episodes where the beneficiary was enrolled in a Michigan Medicaid clinic plan.~~

~~10. Determine the 3rd and 97th percentile length of stays by DRG, the average length of stay, and the maximum length of stay.~~

~~a. Set the low day outlier threshold at the greater of one day or the 3rd percentile length of stay.~~

~~b. Set the high day outlier threshold at the lesser of the average length of stay plus 30 days or the 97th percentile length of stay.~~

~~c. If the DRG has less that an adequate number of episodes (currently 32), the low day threshold will be set at the lesser of the average length of stay plus 30 days, the maximum length of stay, or the Medicare DRG 90th percentile length of stay (from the corresponding Grouper as published in the Federal Register). If the Medicare DRG also has an inadequate number of claims, then the threshold is set based upon the expert advice of the MSA's medical staff.~~

~~11. Eliminate low day outliers (Low day outliers are those episodes whose length of stay are less than the published low day threshold for each DRG. Since low day outliers are paid under a percent of charge method using the hospital's cost to charge ratio times charges, and do not receive a DRG payment, they are excluded from the weight calculations);~~

~~12. Calculate the arithmetic mean length of stay for each DRG with each episode's length of stay limited to the high day threshold set above. This serves as the final published average length of stay.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

~~13. Limit episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the published average length of stay for the DRG (for DRGs 385 and 385.1 all transfers are included);~~

~~14. Bring all charges for admissions in the first year of the base period up to second year charges through application of inflation and weighting factors;~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital

3) HOSPITAL'S ADJUSTED COSTS (LINE 1 X LINE 2);
4) HOSPITAL'S EPISODES;
5) COST PER DISCHARGE (LINE 3/LINE 4);
6) HOSPITAL'S CASE MIX;
7) STANDARDIZED COST PER DISCHARGE (LINE 5/LINE 6);
8) ESTABLISH STATEWIDE RATE AS WEIGHTED STANDARDIZED COST PER DISCHARGE ((∑LINE 7 X LINE 4)/∑ LINE 4);
9) HOSPITAL'S AREA WAGE INDEX;
10) APPLY BUDGET NEUTRALITY FACTOR; AND
11) HOSPITAL'S FINAL DRG RATE (LINE 8 X LINE 9 X LINE 10). THE DRG RATE IS ROUNDED TO THE NEAREST WHOLE DOLLAR AMOUNT.

THE STATEWIDE RATES ARE LISTED ON THE STATE INPATIENT HOSPITAL WEBSITE AT WWW.MICHIGAN.GOV/MEDICAIDPROVIDERS >> BILLING AND REIMBURSEMENT >> PROVIDER SPECIFIC INFORMATION >> INPATIENT HOSPITALS.

3. RELATIVE WEIGHTS

MICHIGAN-SPECIFIC RELATIVE WEIGHTS ARE DEVELOPED UTILIZING THE ADJUSTED COSTS FROM THE EPISODE FILE. THE AVERAGE COST FOR EPISODES WITHIN EACH DRG IS CALCULATED BY DIVIDING THE SUM OF THE COSTS FOR THE EPISODES BY THE NUMBER OF EPISODES WITHIN THE DRG. THE RELATIVE WEIGHT FOR EACH DRG IS CALCULATED BY DIVIDING THE AVERAGE COST FOR EPISODES WITHIN EACH DRG BY THE AVERAGE COST PER EPISODE FOR ALL EPISODES. A TABLE SHOWING THE RELATIVE WEIGHTS, AVERAGE LENGTHS OF STAY, AND LOW DAY OUTLIER THRESHOLD FOR EACH DRG IS AVAILABLE ON THE STATE INPATIENT HOSPITAL WEBSITE AT WWW.MICHIGAN.GOV/MEDICAIDPROVIDERS >> BILLING AND REIMBURSEMENT >> PROVIDER SPECIFIC INFORMATION >> INPATIENT HOSPITALS. RELATIVE WEIGHTS ARE UPDATED ANNUALLY ON OCTOBER 1.

THE STATE ESTABLISHES ALTERNATE WEIGHTS FOR NEONATAL SERVICES FROM EPISODES THAT ARE ASSIGNED TO ONE OF THE DRGS IN THE FOLLOWING RANGE: 580X-640X. THESE WEIGHTS ARE UTILIZED FOR SERVICES RENDERED IN A NEONATAL INTENSIVE CARE UNIT (NICU). THE REMAINING CLAIMS ASSIGNED TO THESE DRGS ARE USED FOR THE BASE WEIGHTS (NON ALTERNATE WEIGHTS). NO OTHER ALTERNATE WEIGHTS ARE ASSIGNED.

TO ENSURE EACH RELATIVE WEIGHT ADEQUATELY REFLECTS RESOURCE UTILIZATION FOR A PARTICULAR DRG IN THE STATE, THE STATE REQUIRES THAT EACH DRG HAVE A MINIMUM OF 10 EPISODES. IF A DRG DOES NOT HAVE AT LEAST 10 EPISODES, AN ALTERNATIVE SOLUTION IS APPLIED AS FOLLOWS:

STATE-SPECIFIC RELATIVE WEIGHT METHODOLOGY:

- IF THE EPISODE COUNT FOR A DRG IS 10 OR MORE, USE THE RELATIVE WEIGHT SETTING METHODOLOGY OUTLINED. OTHERWISE:
  - FOR SEVERITY LEVELS 1 THROUGH 3 WHERE THE TARGETED SEVERITY LEVEL IS EQUAL TO *N:*

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital

- IF THE EPISODE COUNT FOR THE NEXT GREATER SEVERITY LEVEL IS 10 OR MORE, THE FOLLOWING CALCULATION IS COMPLETED: (MI DRG SEVERITY$_{N+1}$ RELATIVE WEIGHT) X (NATIONAL DRG SEVERITY$_N$ RELATIVE WEIGHT) / (NATIONAL DRG SEVERITY$_{N+1}$ RELATIVE WEIGHT) = (MI RELATIVE WEIGHT FACTOR$_N$)
- OTHERWISE, (NATIONAL DRG SEVERITY$_N$ RELATIVE WEIGHT) X (MI CASE MIX FACTOR$_N$)

~~15. Recognize area cost differences by dividing the charges for each hospital by an area cost adjustor factor. Hospitals are grouped by U.S. Census Core Based Statistical Areas (CBSAs) as determined by the Centers for Medicare and Medicaid Services for the Medicare program for wage data. Each area cost adjustor is calculated as follows:~~

~~a. Cost Adjustor = 0.71066 x Wage Adjustor + 0.28934~~

~~1) The cost formula reflects Medicare estimate of labor-related costs as a portion of total hospital costs as published in the federal register.~~

~~2) Each area wage factor is area wage per F.T.E. divided by the statewide average hospital wage per F.T.E. Medicare audited wage is collected using the source described in state policy for the rate-setting period in question. Contract labor cost, as defined by Medicare, are included in determining a hospital's wage costs. Physician Medicare Part B labor costs are excluded.~~

~~3) Each hospital's wage costs are adjusted for different fiscal year ends by multiplying the hospital's wage costs by inflation and weighting factors. All wages are brought to a common point in time.~~

~~4) For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the fiscal year ends is used.~~

~~5) The wage adjuster is based on a two year moving average with the most recent year weighted 60%, and the second year weighted 40%.~~

~~6) If two or more hospitals merged and are now operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data will be inflated to a common point in time.~~

~~b. Indirect medical education (IME) charges are removed by dividing each hospital's adjusted charges by an IME adjustor. Each hospital's IME adjustor is calculated as follows:~~

$$1+\left(\left[\left(1+\frac{\text{Interns \& Residents}}{\text{Beds}}\right)^{.5795}-1\right]\times 0.3575\right)$$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital

~~1) The number of beds for each hospital is the average number of available beds for the hospital. Available licensed beds are limited to beds in the medical/surgical~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
Inpatient Hospital

- FOR SEVERITY LEVEL 4:
  - IF THE EPISODE COUNT FOR THE PRIOR SEVERITY LEVEL IS 10 OR MORE, THE FOLLOWING CALCULATION IS COMPLETED: (MI DRG $SEVERITY_{N-1}$ RELATIVE WEIGHT) X (NATIONAL DRG $SEVERITY_N$ RELATIVE WEIGHT) / (NATIONAL DRG $SEVERITY_{N-1}$ RELATIVE WEIGHT) = (MI RELATIVE WEIGHT $FACTOR_N$)
  - OTHERWISE, (NATIONAL DRG $SEVERITY_N$ RELATIVE WEIGHT) X (MI CASE MIX $FACTOR_N$)
- WHERE:
  - (MI CASE MIX $FACTOR_N$) = SUM OF MICHIGAN SPECIFIC RELATIVE WEIGHTS MULTIPLIED BY THE NUMBER OF EPISODES IF THE NUMBER OF EPISODES IS 10 OR MORE DIVIDED BY THE SUM OF NATIONAL RELATIVE WEIGHTS MULTIPLIED BY THE NUMBER OF EPISODES IF THE NUMBER OF EPISODES IS 10 OR MORE.
  - (MI ALTERNATE WEIGHT CASE MIX FACTOR) = AVERAGE OF (MI ALTERNATE WEIGHT DRG SEVERITY) / (MI DRG SEVERITY RELATIVE WEIGHT) FOR DRGS WITH AN EPISODE COUNT OF 10 OR MORE.

- FURTHER ADJUSTMENTS ARE NECESSARY IF THE RESULTING ADJUSTMENT DESCRIBED ABOVE IS INCONSISTENT WITH MICHIGAN OR NATIONAL TRENDS AND DATA.
  - EXAMPLE 1: IF AN EPISODE COUNT IS BETWEEN 10 AND 20 AND THE ALTERNATE WEIGHT WOULD BE LESS THAN THE STANDARD RELATIVE WEIGHT, BUT OTHER SEVERITY LEVELS ARE NOT CONSISTENT WITH THIS, THEN APPLY THE NEXT SEVERITY LEVEL IMPUTING METHOD.
  - EXAMPLE 2: IF THE EPISODE COUNT IS BETWEEN 10 AND 20, THE STATE MAY CONSIDER USING THE ALTERNATE WEIGHT CASE MIX FACTOR APPLIED TO THE NATIONAL ALTERNATE WEIGHT IF THE ALTERNATE WEIGHT IS NOT CONSISTENT WITH OTHER SEVERITY LEVELS OF THE SAME DRG.
  - ALL RELATIVE WEIGHTS ARE SUBJECT TO REASONABLENESS TESTING.

RELATIVE WEIGHT TRIM POINTS:
THE FOLLOWING TRIM POINTS ARE ESTABLISHED FOR THE RELATIVE WEIGHTING SYSTEM.

- THE LOW DAY TRIM POINT IS USED TO DETERMINE WHETHER AN EPISODE QUALIFIES FOR A LOW DAY OUTLIER AND IS ESTABLISHED AS FOLLOWS.
  - IF THE EPISODE COUNT FOR A DRG IS 10 OR MORE, THE LOW DAY TRIM POINT IS SET TO THE 3RD PERCENTILE OF THE LENGTH OF STAY FOR THE DRG.
  - IF THE EPISODE COUNT FOR A DRG IS LESS THAN 10, THE LOW DAY TRIM POINT IS SET TO THE LESSER OF THE NATIONAL LOW DAY TRIM POINT OR 3RD PERCENTILE OF LENGTH OF STAY FOR THE DRG.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
Inpatient Hospital

- IF THE EPISODE COUNT FOR A DRG IS ZERO, THE LOW DAY THRESHOLD IS SET TO THE NATIONAL LOW DAY TRIM POINT FOR THE DRG.

- THE AVERAGE LENGTH OF STAY (ALOS) IS USED TO PRICE CLAIMS EPISODES INVOLVING A TRANSFER FROM A HOSPITAL AND IS ESTABLISHED AS FOLLOWS.
  - IF THE EPISODE COUNT FOR A DRG IS 10 OR MORE, SET THE ALOS TO THE SIMPLE AVERAGE LENGTH OF STAY FOR THE DRG.
  - IF THE EPISODE COUNT FOR A DRG IS LESS THAN 10, SET THE ALOS TO THE LESSER OF NATIONAL ALOS OR THE SIMPLE AVERAGE LENGTH OF STAY FOR THE DRG.
  - IF THE EPISODE COUNT FOR A DRG IS ZERO, SET THE ALOS TO THE NATIONAL ALOS.

~~portion of the hospital. Interns and residents are only those allocated to the medical/surgical portion of the hospital.~~

~~2) Data taken from the hospital's cost report for the two fiscal years is weighted as follows: 60% for the most recent year, and 40% for the second year.~~

~~3) If two or more hospitals merge and are operating as a single hospital, IME data is computed after the merger using the combined cost report data from all hospitals involved in the merger.~~

~~c. Adjust charges for high day and/or cost outliers to approximate the charges for the non-outlier portion of the stay.~~

~~1) If a claim's length of stay is greater than the high day outlier threshold for the DRG, then it is considered a high day outlier claim. Adjusted charges representing an estimate of the non-outlier portion of charges for high day outliers are used for the relative weight and price calculations as follows:~~

$$\text{Adj Chrg} = \frac{\text{Charges} \times \text{High Day Threshold}}{\text{High Day Threshold} + [.6 \times (\text{LOS} - \text{High Day Threshold})]}$$

~~2) A claim is a cost outlier if its costs (i.e. charges times hospital's inpatient operating cost to charge ratio) are greater than the cost threshold for that DRG (the threshold is set at the larger of twice the DRG payment or $35,000).~~

~~a) The cost to charge ratio is each hospital's inpatient operating cost to charge ratio, not to exceed 1.0.~~

~~b) The adjusted charges for cost outliers use a cost threshold estimate the greater of:~~

~~*Cost Threshold = 2 x Avg. Cost for DRG*~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
Inpatient Hospital

~~Or $35,000.~~

~~c) Adjusted charges are calculated as follows:~~

$$\text{Adj Chrg} = \text{Charges} - \frac{[(\text{Charges} \times \text{Cost Ratio}) - \text{Cost Threshold}] \times 0.85}{\text{Cost Ratio}}$$

~~d) If an episode is both a high day and a cost outlier, the lesser of the two adjusted charges is used in computing the relative weights and DRG prices.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

4. AREA WAGE INDEX

THE AREA WAGE INDEX DESCRIBED IN THIS SECTION IS USED TO DETERMINE ADJUSTED HOSPITAL COSTS AS DESCRIBED IN THE EPISODE FILE SECTION. IN ADDITION, IT IS USED TO ADJUST THE STATEWIDE RATE TO RECOGNIZE VARIANCES IN AREA LABOR COSTS.

TO CALCULATE EACH HOSPITAL'S AREA WAGE INDEX, TWO YEARS OF MEDICARE-AUDITED WAGE DATA, AS PUBLISHED IN THE MEDICARE INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) FINAL RULE, ARE OBTAINED FOR THE MOST RECENT AVAILABLE HOSPITAL FISCAL YEARS. CONTRACT LABOR COSTS, AS DEFINED BY MEDICARE, ARE INCLUDED IN DETERMINING A HOSPITAL'S WAGE COSTS. HOSPITALS ARE GROUPED BY U.S. CENSUS CORE BASED STATISTICAL AREAS (CBSAS) AS DETERMINED BY CMS FOR THE MEDICARE PROGRAM. CONSISTENT WITH CMS, THE COST REPORT REFERENCES ARE OBTAINED FROM THE MEDICARE PROVIDER MANUAL, WORKSHEET S3, PART 3, LINE 6 FOR WAGES AND HOURS.

THE FOLLOWING CALCULATIONS ARE COMPLETED:

- EACH HOSPITAL'S WAGE COSTS ARE BROUGHT TO A COMMON POINT IN TIME BY MULTIPLYING THE HOSPITAL'S FISCAL YEAR END COSTS BY INFLATION FACTORS DERIVED FROM IHS GLOBAL INSIGHT AND WEIGHTING FACTORS.
- FOR HOSPITALS WITH COST REPORTING PERIODS ENDING OTHER THAN THE END OF A QUARTER, THE INFLATION UPDATE FOR THE QUARTER IN WHICH THE HOSPITAL'S FISCAL YEAR ENDS IS USED.
- THE COST REPORTS DO NOT DIFFERENTIATE SALARIES/HOURS BY UNIT TYPE.
- THE WAGE ADJUSTOR IS BASED ON A TWO-YEAR MOVING AVERAGE WITH THE MOST RECENT YEAR WEIGHTED AT 60 PERCENT AND THE SECOND YEAR WEIGHTED AT 40 PERCENT.
- IF TWO OR MORE HOSPITALS MERGE AND ARE OPERATING AS A SINGLE HOSPITAL, SALARY AND WAGES ARE COMPUTED USING THE COMBINED COST REPORT DATA FROM ALL HOSPITALS INVOLVED IN THE MERGER. SALARY DATA IS INFLATED TO A COMMON POINT IN TIME.
- THE AVERAGE WAGE FOR EACH CBSA IS CALCULATED WITH AND WITHOUT HOSPITAL RECLASSIFICATIONS:
  (A) THE AVERAGE WAGE FOR EACH CBSA WITHOUT RECLASSIFICATIONS IS DETERMINED. THE STATEWIDE AVERAGE WAGE FOR ALL HOSPITALS IN THE STATE IS CALCULATED. USING THESE DATA, CBSA-SPECIFIC AREA WAGE INDICES ARE CALCULATED BY DIVIDING THE AVERAGE WAGE FOR THE CBSA BY THE STATEWIDE AVERAGE WAGE. THIS QUOTIENT IS AREA WAGE INDEX A.
  (B) THE AVERAGE WAGE FOR EACH CBSA WITH RECLASSIFICATIONS IS DETERMINED. USING THESE DATA AND THE STATEWIDE AVERAGE WAGE FOR ALL HOSPITALS IN THE STATE, CBSA-SPECIFIC AREA WAGE INDICES ARE CALCULATED BY DIVIDING THE AVERAGE WAGE FOR THE CBSA BY THE STATEWIDE AVERAGE WAGE. THIS QUOTIENT IS AREA WAGE INDEX B.
- FOR HOSPITALS THAT DID NOT RECLASSIFY:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

- IF AREA WAGE INDEX A IS GREATER THAN ONE PERCENT VARIATION FROM ITS AREA WAGE INDEX B, AREA WAGE INDEX A WILL BE USED. OTHERWISE, AREA WAGE INDEX B WILL BE USED.

- FOR HOSPITALS THAT RECLASSIFIED, AREA WAGE INDEX B WILL BE USED.
- THE STATE WILL APPLY A RURAL FLOOR WHEREBY NO HOSPITAL WILL HAVE AN AREA WAGE INDEX LESS THAN THE RURAL INDEX.

ONLY THE LABOR SHARE OF THE STATEWIDE RATE IS ADJUSTED BY THE AREA

WAGE INDEX USING THE FOLLOWING FORMULA:

MEDICAL/SURGICAL AREA WAGE INDEX ADJUSTED RATE = 0.70 X AREA WAGE INDEX + 0.30

d. ~~The adjusted cost for each episode is calculated by multiplying the adjusted charges for the episode by the inpatient operating cost to charge ratio.~~

   ~~1) Each hospital's Title XIX operating cost to total charge ratio is obtained from the hospital's filed cost reports for the fiscal year ending in the second year of the base period. If the cost to charge ratio is greater than 1.0, then 1.0 is used.~~
   ~~2) If two or more hospitals merge, and are operating as a single hospital, a cost to charge ratio for the period is computed using the combined cost report data from all hospitals involved in the merger. Cost and charge data will be inflated to a common point in time.~~

~~e. The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG.~~

~~f. The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and outlier thresholds for each DRG is included in Appendix A.~~

~~g. Bring all charges for discharges to the applicable time period through application of inflation and weighting factors.~~

~~Data for current wage adjustors are taken from hospital cost reporting periods ending between September 1, 2006 and August 31, 2008 for the base, and September 1, 2010 through August 31, 2012 for the update period. Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation and weighting factors. All wages are brought to a common point in time. Filed wage data is used for hospitals where audited data is not available. The following adjustment factors derived from the Global Insight PPS-Type Hospital Market Basket Index, employee cost component relative to the period, are used:~~

~~Fiscal Year Ending~~	~~Wage Inflation Factors~~	~~Base Weighting Factors~~	~~Update Weighting Factors~~
~~9/30/06~~	~~1.2331~~	~~0.40~~	
~~12/31/06~~	~~1.2233~~	~~0.40~~	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

~~3/31/07~~	~~1.2159~~	~~0.40~~	
~~6/30/07~~	~~1.2080~~	~~0.40~~	
~~9/30/07~~	~~1.1972~~	~~0.60~~	
~~12/31/07~~	~~1.1852~~	~~0.60~~	
~~3/31/08~~	~~1.1712~~	~~0.60~~	
~~6/30/08~~	~~1.1576~~	~~0.60~~	
~~9/30/10~~	~~1.0551~~		~~0.40~~
~~12/31/10~~	~~1.0447~~		~~0.40~~
~~3/31/11~~	~~1.0354~~		~~0.40~~
~~6/30/11~~	~~1.0271~~		~~0.40~~
~~9/30/11~~	~~1.0179~~		~~0.60~~
~~12/31/11~~	~~1.0111~~		~~0.60~~
~~3/31/12~~	~~1.0051~~		~~0.60~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

THIS PAGE INTENTIONALLY LEFT BLANK.

~~Fiscal Year Ending~~	~~Wage Inflation Factors~~	~~Base Weighting Factors~~	~~Update Weighting Factors~~
~~6/30/12~~	~~1.0017~~		~~0.60~~
~~8/31/12~~	~~1.0000~~		~~0.60~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

5. COST TO CHARGE RATIO

THE OPERATING COST-TO-CHARGE RATIOS DESCRIBED IN THIS SECTION ARE USED TO DETERMINE ADJUSTED HOSPITAL COSTS AS DESCRIBED IN THE EPISODE FILE SECTION. IN ADDITION, THEY ARE USED TO REIMBURSE HOSPITALS FOR TRANSPLANT SERVICES, COST OUTLIERS AND LOW-DAY OUTLIERS. THE OPERATING COST-TO-CHARGE RATIOS ARE UPDATED ANNUALLY ON OCTOBER 1 BY ROLLING THE DATA FORWARD BY ONE YEAR.

THE MOST RECENT TWO YEARS OF COST REPORT DATA FOR HOSPITALS ARE USED TO CALCULATE HOSPITAL-SPECIFIC OPERATING COST-TO-CHARGE RATIOS. FOR EXAMPLE, FOR THE ONE YEAR RATE THAT BEGINS ON OCTOBER 1, 2015, DATA FROM COST REPORTS WITH FISCAL YEARS ENDING BETWEEN OCTOBER 1, 2011 AND SEPTEMBER 30, 2013 ARE USED. DATA FOR THE MOST RECENT YEAR ARE WEIGHTED AT 60 PERCENT WHILE DATA FOR THE SECOND PREVIOUS YEAR ARE WEIGHTED AT 40 PERCENT. COSTS AND CHARGES FOR BOTH FFS AND MANAGED CARE ARE COMBINED SO THAT A WEIGHTED OPERATING COST-TO-CHARGE RATIO IS DEVELOPED. COST AND CHARGE DATA ARE INFLATED TO A COMMON POINT IN TIME USING INFLATION FACTORS FROM IHS GLOBAL INSIGHT. THE COST-TO-CHARGE RATIO WILL NOT EXCEED 1.0.

IF TWO OR MORE HOSPITALS MERGE AND ARE OPERATING AS A SINGLE HOSPITAL, A COST TO CHARGE RATIO FOR THE PERIOD IS COMPUTED USING THE COMBINED COST REPORT DATA FROM ALL HOSPITALS INVOLVED IN THE MERGER.

THE OPERATING COST-TO-CHARGE RATIOS ARE PUBLISHED ON THE STATE INPATIENT HOSPITAL WEBSITE AT WWW.MICHIGAN.GOV/MEDICAIDPROVIDERS >> BILLING AND REIMBURSEMENT >> PROVIDER SPECIFIC INFORMATION >> INPATIENT HOSPITALS.

6. SPECIAL CIRCUMSTANCES

NORMAL REIMBURSEMENT FOR A MEDICAL/SURGICAL INPATIENT HOSPITAL STAY IS EQUAL TO THE APPLICABLE STATEWIDE RATE MULTIPLIED BY THE DRG WEIGHT. HOWEVER, FOR THE FOLLOWING SPECIAL CIRCUMSTANCES, DIFFERENT REIMBURSEMENT METHODOLOGIES APPLY.

A. HIGH COST OUTLIERS

FOR UNUSUALLY HIGH COST STAYS, THE STATE WILL USE A SPECIAL REIMBURSEMENT METHODOLOGY.

AN EPISODE IS A HIGH COST OUTLIER WHEN COSTS (CHARGES X THE HOSPITAL'S OPERATING COST-TO-CHARGE RATIO) EXCEED THE COMPUTED COST THRESHOLD. TRANSPLANT CLAIMS CANNOT QUALIFY AS A HIGH COST OUTLIER.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

REIMBURSEMENT FOR COST OUTLIERS IS DEPENDENT UPON THE COST THRESHOLD.

THE COST THRESHOLD IS THE GREATER OF:

- 2 X HOSPITAL DRG RATE X RELATIVE WEIGHT (TWICE THE REGULAR PAYMENT FOR A TRANSFER PAID ON A PER DAY BASIS FOR EPISODES GETTING LESS THAN A FULL DRG); OR
- $35,000.

COST OUTLIERS ARE REIMBURSED ACCORDING TO THE FOLLOWING FORMULA:

~~For hospitals with cost reporting periods ending other than at the end of a quarter, the inflation update for the quarter in which the hospital" fiscal year ends is used.~~

~~B. DRG Price:~~

~~The episode file used for DRG price calculations is the same as the file used to set the relative weights with the following exceptions:~~

1. ~~The episode file is limited to those hospitals enrolled as of a specified date.~~
2. ~~Hospitals identified with Medicare Critical Access Hospital (CAH) status as of July 1, 2011 are grouped and paid a single DRG price. The DRG price is the truncated mean of the hospital specific base prices of all CAHS adjusted by the rural cost adjustor and budget neutrality. This is the sum of the product of the hospitals' specific base price times discharges divided by the sum of all group discharges. In the event a hospital status changes from Prospective Payment System (PPS) to CAH status, MDCH recognizes the hospital under CAH status as of the CMS effective date.~~
3. ~~The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.~~
4. ~~The adjusted cost for each hospital is summed.~~
5. ~~The hospital specific base price (cost per discharge for a case mix of 1.00) is computed~~
   a) ~~Divide total adjusted cost by total number of episodes~~
   b) ~~Divide average costs by the case mix.~~
   c) ~~Multiply the result by the applicable inflation and weighting factors. Costs are inflated through the rate period. Inflation factors are obtained from the 1st Quarter 2006 Data Resources, Inc. PPS – Type Hospital Market Basket Index. The following inflation and weighting factors are used:~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

~~Fiscal Year Ending~~	~~Cost Inflation Factors~~	~~Weighting Factors~~
~~9/30/07~~	~~1.0731~~	~~0.40~~
~~12/31/07~~	~~1.0612~~	~~0.40~~
~~3/31/08~~	~~1.0471~~	~~0.40~~
~~6/30/08~~	~~1.0311~~	~~0.40~~
~~9/30/08~~	~~1.0138~~	~~0.60~~
~~12/31/08~~	~~1.0048~~	~~0.60~~
~~3/31/09~~	~~1.0008~~	~~0.60~~
~~6/30/09~~	~~1.0000~~	~~0.60~~
~~8/31/09~~	~~1.0000~~	~~0.60~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

(HOSPITAL DRG RATE X RELATIVE WEIGHT) + [(CHARGES X OPERATING COST-TO-CHARGE RATIO) - (COST THRESHOLD)] X 85 PERCENT) = REIMBURSEMENT FOR COST OUTLIER CLAIM

B. LOW DAY OUTLIERS

FOR SERVICES WHERE THE LENGTH OF STAY IS LESS THAN THE PUBLISHED LOW DAY THRESHOLD, REIMBURSEMENT IS CHARGES MULTIPLIED BY THE INDIVIDUAL HOSPITAL'S OPERATING COST TO CHARGE RATIO, NOT TO EXCEED THE FULL DRG PAYMENT. THE SPECIFIC LOW DAY OUTLIER THRESHOLD FOR EACH DRG IS LISTED ON THE STATE WEBSITE.

C. TRANSFERS

PAYMENT TO A HOSPITAL THAT RECEIVES A PATIENT AS A TRANSFER FROM ANOTHER INPATIENT HOSPITAL DIFFERS DEPENDING ON WHETHER THE PATIENT IS DISCHARGED OR IS SUBSEQUENTLY TRANSFERRED AGAIN.

1. PAYMENT TO THE TRANSFERRING HOSPITAL

EXCEPT IN THE CASES WHERE THE DRG IS DEFINED AS A TRANSFER OF A PATIENT (FOR WHICH A FULL DRG PAYMENT IS MADE, PLUS AN OUTLIER PAYMENT, IF APPROPRIATE) THE TRANSFERRING HOSPITAL IS PAID A DRG DAILY RATE FOR EACH DAY OF THE BENEFICIARY'S STAY, NOT TO EXCEED THE APPROPRIATE FULL DRG PAYMENT, PLUS AN OUTLIER PAYMENT, IF APPROPRIATE.

2. PAYMENT TO THE RECEIVING HOSPITAL

IF THE PATIENT IS DISCHARGED, THE RECEIVING HOSPITAL IS PAID THE FULL DRG PAYMENT, PLUS AN OUTLIER PAYMENT IF APPROPRIATE.

REIMBURSEMENT IS BASED ON DISCHARGE IN THE FOLLOWING SITUATIONS. IF THE BENEFICIARY:

A. IS FORMALLY RELEASED FROM THE HOSPITAL, OR

B. IS TRANSFERRED TO HOME HEALTH SERVICES, OR

C. DIES WHILE HOSPITALIZED, OR

D. LEAVES THE HOSPITAL AGAINST MEDICAL ADVICE, OR

E. IS TRANSFERRED TO A LONG-TERM CARE FACILITY.

IF THE PATIENT IS TRANSFERRED AGAIN, THE HOSPITAL IS PAID AS A TRANSFERRING HOSPITAL.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

D. READMISSIONS

READMISSIONS WITHIN 15 DAYS FOR A RELATED CONDITION, WHETHER TO THE SAME OR A DIFFERENT HOSPITAL, ARE CONSIDERED A PART OF A SINGLE EPISODE FOR PAYMENT PURPOSES.

IF THE READMISSION IS TO A DIFFERENT HOSPITAL, FULL PAYMENT IS MADE TO THE SECOND HOSPITAL. THE FIRST HOSPITAL'S PAYMENT IS REDUCED BY THE AMOUNT PAID TO THE SECOND HOSPITAL. THE FIRST HOSPITAL'S PAYMENT IS NEVER LESS THAN ZERO FOR THE EPISODE.

READMISSIONS FOR AN UNRELATED CONDITION, WHETHER TO THE SAME OR A DIFFERENT HOSPITAL, ARE CONSIDERED SEPARATE EPISODES FOR PAYMENT PURPOSES.

~~Rates will be adjusted by an inflation factor of 1.076 for the period from August 31, 2009 to December 31, 2014.~~

~~5. Determine the DRG base price by:~~

~~a. Calculate each hospital's limited base price. This is the lesser of the hospital specific base price or the mean of all base prices, plus one standard deviation.~~

~~b. Calculate the statewide operating cost limitation. This is a truncated, weighted mean of all hospitals' limited base prices divided by base period discharges.~~

~~c. The lesser of the truncated mean or the hospital specific base price then becomes the DRG base price (before the cost adjustor and incentives are added) for each hospital.~~

~~6. Calculate any incentive. For hospitals with base DRG prices below the operating limit (truncated mean), the hospital's base DRG price is increased by adding 10% of the difference between the hospital specific base price and the limit.~~

~~Adjust each hospital's DRG base price, plus any incentive, by the updated cost adjustor. The updated cost adjustor is calculated, to reflect the most current data available, in the same manner as the base cost adjustor, except that:~~

~~1. Wage data is collected using the source described within State policy for the rate-setting period.~~

~~2. The wage and benefit inflation factors are derived from the employee cost component of the Global Insight PPS – Type Hospital Market Basket Index relative to the period.~~

~~3. In the event that changes in federal regulations result in incompatible data between the base and update periods, adjustments are made either to the base or the update period to render the data comparable.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

~~4. A budget neutrality factor is included in the hospital price calculation. Hospital prices are reduced by the percentage necessary so that total aggregate hospital payments using the new hospital prices and DRG relative weights do not exceed the total aggregate hospital payments made using the prior hospital base period data and DRG Grouper relative weights. The estimate is based on one year's paid claims, including MHP encounter data with FFS rates applied. The calculated DRG prices are deflated by the percentage necessary for the total payments to equate to the amount currently paid. Budget neutrality for CAHS is determined as a group, independent of Non-CAHS.~~

~~5. For payment purposes, a single cost to charge ratio is published on the MDCH website. The single cost to charge ratio is used for calculating payments paid a percent of charge, cost outliers, and low-day outliers. The ratio is calculated from the averages of FFS and MHP ratios, net of IME.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

E. TRANSPLANT SERVICES

TRANSPLANT SERVICES ARE PAID USING THE FOLLOWING FORMULA:

HOSPITAL CHARGES X HOSPITAL OPERATING COST-TO-CHARGE RATIO = HOSPITAL PAYMENT

TRANSPLANT SERVICES ARE DEFINED AS CLAIMS WHICH FALL UNDER THE FOLLOWING DRGS:

DRG	DESCRIPTION
001X	LIVER TRANSPLANT &/OR INTESTINAL TRANSPLANT
002X	HEART &/OR LUNG TRANSPLANT
006X	PANCREAS TRANSPLANT
440X	KIDNEY TRANSPLANT

ORGAN ACQUISITION WITHIN THESE DRGS IS BILLED AT ACQUISITION COST, AND IS REIMBURSED AT 100% OF ACQUISITION COST.

F. HOSPITALS OUTSIDE MICHIGAN

MEDICAL/SURGICAL HOSPITALS NOT LOCATED IN MICHIGAN ARE REIMBURSED UNDER THE DRG SYSTEM. THE DRG PRICE IS THE STATEWIDE RATE MULTIPLIED BY AN AREA WAGE INDEX OF 1.0. ALL OTHER REIMBURSEMENT POLICIES APPLY.

HOSPITALS THAT HAVE CHARGES THAT EXCEED $250,000 DURING A SINGLE FISCAL YEAR (USING THE STATE OF MICHIGAN FISCAL YEAR – OCTOBER 1ST THROUGH SEPTEMBER 30TH) MAY BE REIMBURSED THE HOSPITAL'S INPATIENT OPERATING COST TO CHARGE RATIO FOR THOSE MICHIGAN MEDICAID DRGS REIMBURSED BY PERCENTAGE OF CHARGE. THE HOSPITALS' CHIEF FINANCIAL OFFICER MUST SUBMIT AND THE MSA MUST ACCEPT DOCUMENTATION STATING THE HOSPITAL'S MEDICAID COST TO CHARGE RATIO IN THE STATE THAT THE HOSPITAL IS LOCATED. ONCE ACCEPTED, THE HOSPITAL'S ACTUAL COST TO CHARGE RATIO IS APPLIED PROSPECTIVELY TO THOSE DRGS AND CLAIMS SUBJECT TO PERCENTAGE OF CHARGE REIMBURSEMENT USING THE MICHIGAN DRG PAYMENT SYSTEM.

G. NEW HOSPITALS

A NEW MEDICAL/SURGICAL HOSPITAL IS ONE FOR WHICH NO MICHIGAN MEDICAID PROGRAM COST OR PAID CLAIMS DATA EXISTS DURING THE PERIOD USED TO ESTABLISH HOSPITAL RATES OR ONE WHICH WAS NOT ENROLLED IN THE MEDICAID PROGRAM WHEN HOSPITAL RATES WERE LAST ESTABLISHED. HOSPITALS THAT EXPERIENCE A CHANGE OF OWNERSHIP OR

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

THAT ARE CREATED AS THE RESULT OF A MERGER ARE NOT CONSIDERED NEW HOSPITALS.

THE DRG RATE FOR NEW GENERAL HOSPITALS IS THE STATEWIDE RATE MULTIPLIED BY THE APPLICABLE AREA WAGE INDEX.

~~To summarize the above, the DRG price for each hospital is calculated using the following procedure:~~

~~1. Hospital's adjusted charges.~~
~~2. Inpatient cost to charge ratio.~~
~~3. Hospital's adjusted costs (line 1* line 2).~~
~~4. Hospital's episodes.~~
~~5. Cost per discharge (line 3nine 4).~~
~~6. Hospital's casemix.~~
~~7. Weighted inflation.~~
~~8. Hospital's base price (line s• line 7/line 6).~~
~~9. Establish the statewide base limit (mean plus one standard deviation).~~
~~10. Hospital's limited base price (lesser of lines 8 or 9).~~
~~11. Establish the state wide operating cost limit (truncated, weighted mean of line 10).~~
~~12. Hospital's DRG base price (lesser of lines 8 or 11)~~
~~13. Calculate the hospital's incentive is applied (if line 12< line 11, 10% of line 12 - line 11, otherwise 0).~~
~~14. Hospital's DRG base price plus any incentive (line 12 plus line 13).~~
~~15. Hospital's Area Cost Adjustor.~~
~~16. Apply budget neutrality factor~~
~~17. Hospital's final DRG price (line 14 x line 15 x line 16). The DRG price is rounded to the nearest whole dollar amount.~~

~~C. Special Circumstances Under DRG Reimbursement~~

~~In some special circumstances, reimbursement for operating costs uses a DRG daily rate. The DRG daily rate is:~~

$$\frac{\text{DRG Price x Relative Weight}}{\text{Average Length of Stay for the DRG}}$$

~~The average length of stay, low day and the high day outlier thresholds for each DRG are listed in Appendix A at the end of this section.~~

~~1. High Day Outliers:~~

~~The high day outlier for each DRG is set at the lesser of the average length of stay plus 30 days or the 97th percentile length of stay; or 50 days, whichever is greater. Reimbursement for high day outliers is:~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

B. REIMBURSEMENT FOR LONG TERM ACUTE CARE HOSPITALS (LTACHS) AND FREESTANDING REHABILITATION HOSPITALS/DISTINCT PART REHAB UNITS

EPISODES OF CARE FOR LTACHS AND FREESTANDING REHABILITATION HOSPITALS/DISTINCT PART REHABILITATION UNITS WILL BE REIMBURSED USING A STATEWIDE PER DIEM RATE.

1. DESCRIPTION OF LTACH AND FREESTANDING REHABILITATION HOSPITALS/DISTINCT PART REHABILITATION UNITS EPISODE FILE

THE EPISODE FILE IS COMPRISED OF THE UNDERLYING DATA USED TO CALCULATE THE STATEWIDE PER DIEM RATES. THE COSTS ASSOCIATED WITH EPISODES FROM THE EPISODE FILE ARE STANDARDIZED AS DESCRIBED BELOW. THE EPISODE FILE IS COMPRISED OF TWO YEARS OF MEDICAID AND CHILDREN'S SPECIAL HEALTH CARE SERVICES FFS PAID CLAIMS AND MANAGED CARE ENCOUNTERS.

THE DATA IS ADJUSTED TO:

- ELIMINATE EPISODES WITH ANY MEDICARE CHARGES. (FOR DUAL MEDICARE/MEDICAID ELIGIBLE BENEFICIARIES, ONLY CLAIMS PAID A FULL MEDICAID PAYMENT ARE INCLUDED.)
- ELIMINATE EPISODES WITHOUT ANY CHARGES OR DAYS.
- ELIMINATE EPISODES WITH A ZERO DOLLAR MEDICAID LIABILITY.
- LIMIT EPISODES TO THOSE FROM MICHIGAN HOSPITALS (PROVIDED THAT HOSPITAL COST REPORT DATA IS AVAILABLE)
- LIMIT EPISODES TO THOSE WITH A VALID DISCHARGE STATUS.

TOTAL CHARGES AND DAYS PAID ARE SUMMED BY HOSPITAL.

THE COST FOR EACH HOSPITAL IS CALCULATED BY MULTIPLYING THE CHARGES FOR THE HOSPITAL BY THE OPERATING COST-TO-CHARGE RATIO FOR THE HOSPITAL.

- SEE THE COST-TO-CHARGE SECTION OF THE REIMBURSEMENT FOR MEDICAL/SURGICAL HOSPITALS SECTION OF THE STATE PLAN FOR ADDITIONAL INFORMATION.

THE COST PER DAY BY HOSPITAL IS CALCULATED BY DIVIDING THE SUM OF THE COSTS BY THE NUMBER OF DAYS FOR THE HOSPITAL. TO DETERMINE A STATEWIDE PER DIEM BASE RATE:

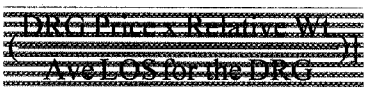
- MULTIPLY THE RESULT BY THE APPLICABLE INFLATION FACTOR TO BRING COSTS TO A COMMON POINT IN TIME. COSTS ARE INFLATED THROUGH THE RATE PERIOD. FOR EXAMPLE, FOR FY 2015 RATES, COSTS ARE INFLATED THROUGH SEPTEMBER 30, 2016. INFLATION FACTORS ARE OBTAINED FROM IHS GLOBAL INSIGHT.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

- RECOGNIZE AREA COST DIFFERENCES BY DIVIDING THE COSTS FOR EACH HOSPITAL BY AN AREA WAGE INDEX.
  - SEE THE AREA WAGE INDEX SECTION OF THE REIMBURSEMENT FOR MEDICAL/SURGICAL HOSPITALS SECTION OF THE STATE PLAN FOR ADDITIONAL INFORMATION.
- CALCULATE THE STATEWIDE OPERATING RATE (BY PROVIDER TYPE). A SEPARATE OPERATING RATE WILL BE CALCULATED FOR LTACHS AND FOR FREESTANDING REHABILITATION HOSPITALS/DISTINCT PART REHABILITATION UNITS. THIS IS A WEIGHTED MEAN OF ALL HOSPITALS' INDIVIDUAL RATES.

~~DRG Price x Rel. Wt. + [60% x Outlier Days x~~ 

~~The multiplier for the daily rate is 60% for all services including those provided in children's hospitals and children's distinct part units of at least 150 beds.~~

~~If an episode is both a high day and a cost outlier, reimbursement will be the greater of the two amounts.~~

~~2. Low Day Outliers'~~

~~For services where the length of stay is less than the published low day threshold, reimbursement is actual charges multiplied by the individual hospital's inpatient operating cost to charge ratio net of IME, not to exceed the full DRG payment. The specific low day outlier threshold for each DRG is listed in Appendix A.~~

~~3. Less than Acute Care~~

~~If a claim is a high day outlier and review shows that the beneficiary required less than acute continuous medical care during the outlier day period, Medicaid payment is made at the statewide nursing facility per diem rate for the continuous subacute outlier days, if nursing care was medically necessary.~~

~~4. Cost Outliers~~

~~An episode is a cost outlier when costs for the episode (charges times the hospital's inpatient operating cost to charge ratio excluding IME) exceed the computed cost threshold. Claims assigned to DRGs paid a percent of charge cannot be cost outliers.~~

~~Reimbursement for cost outliers will be dependent upon the cost threshold. The~~

~~Cost Threshold is the larger of:~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

~~a) 2 x DRG Price x Rel. Wt. (twice the regular payment for a transfer paid on a per diem basis for episodes getting less than a full DRG), or~~

~~b) $35,000~~

~~Cost Outliers will be reimbursed according to the following formula:~~

~~(DRG Price x Rel. Wt.) + (85% x [(Charges x Operating Ratio) - Cost Threshold])~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

- THE PER DIEM RATE FOR EACH PROVIDER TYPE IS THE WEIGHTED MEAN ADJUSTED BY THE AREA WAGE INDEX SPECIFIC TO THE HOSPITAL.

2. LTACH AND FREESTANDING REHABILITATION HOSPITALS/DISTINCT PART REHABILITATION UNITS OUTSIDE OF MICHIGAN

   LTACHS, FREESTANDING REHABILITATION HOSPITALS, AND DISTINCT PART REHABILITATION UNITS NOT LOCATED IN MICHIGAN ARE REIMBURSED USING THE PER DIEM RATE APPLICABLE TO THEIR PROVIDER TYPE.

3. NEW LTACHS, FREESTANDING REHABILITATION HOSPITALS, AND DISTINCT PART REHABILITATION UNITS

   IF A HOSPITAL AT LEAST DOUBLES THE NUMBER OF LICENSED BEDS IN ITS DISTINCT PART UNIT AND THE NUMBER OF LICENSED BEDS IN THE UNITS INCREASES BY AT LEAST 20, THE ENTIRE UNIT IS TREATED AS A NEW DISTINCT PART UNIT FOR DETERMINING THE PER DIEM RATE. IN ORDER FOR THIS PROVISION TO APPLY, THE HOSPITAL MUST REQUEST IN WRITING THAT THE UNIT IS TREATED AS A NEW UNIT. THE NEW UNIT RATE WILL BECOME EFFECTIVE ON THE DATE THAT THE NUMBER OF LICENSED BEDS DOUBLES AND THE INCREASE IS AT LEAST 20 BEDS, OR THE DATE ON WHICH THE REQUEST IS RECEIVED BY MSA, WHICHEVER IS LATER.

   NEW LTACHS, FREESTANDING HOSPITALS, AND DISTINCT PART UNITS ARE REIMBURSED USING THE PER DIEM RATE APPLICABLE TO THEIR PROVIDER TYPE.

~~If an episode is both a high day and a cost outlier, reimbursement is the greater of the two amounts.~~

~~5. Transfers~~

~~Payment to a hospital that receives a patient as a transfer from another inpatient hospital differs depending on whether the patient is discharged or is subsequently transferred again.~~

~~a. Payment to the Transferring Hospital~~

~~Except in the cases where the DRG is defined as a transfer of a patient (for which a full DRG payment is made, plus an outlier payment, if appropriate) the transferring hospital is paid a DRG daily rate for each day of the beneficiary's stay, not to exceed the appropriate full DRG payment, plus an outlier payment, if appropriate.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

~~b. Payment to the Receiving Hospital~~

~~If the patient is discharged, the receiving hospital is paid the full DRG payment, plus an outlier payment if appropriate.~~

~~Reimbursement is based on discharge in the following situations. If the beneficiary:~~

~~1) Is formally released from the hospital, or~~

~~2) Is transferred to home health services, or~~

~~3) Dies while hospitalized, or~~

~~4) Leaves the hospital against medical advice, or~~

~~5) Is transferred to a long-term care facility.~~

~~If the patient is transferred again, the hospital is paid as a transferring hospital.~~

~~6. Readmissions~~

~~Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single episode for payment purposes.~~

~~If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates - Inpatient Hospital

THIS PAGE INTENTIONALLY LEFT BLANK.

~~Readmissions for an unrelated condition, whether to the same or a different hospital, are considered separate episodes for payment purposes.~~

~~7. Percent of Charge Reimbursement~~

~~The payment amount for claims that fall into DRGs 1, 2, 5, 6, 7, 8, 10, 14, 16, OR 17 is total hospital charges times the hospital's inpatient operating cost to charge ratio excluding IME.~~

~~The ratio is the hospital's Title XIX inpatient operating cost to charge ratio as obtained from weighted filed cost reports for fiscal years ending between September 1, 2007 and August 31, 2009.~~

~~8. Hospitals Outside of Michigan~~

~~Medical/surgical hospitals not located in Michigan are reimbursed under the DRG system. The DRG price is the statewide operating cost limit (truncated mean of base prices located in Michigan).~~

~~Hospitals that have charges that exceed $250,000 during a single fiscal year (using the State of Michigan fiscal year – October 1st through September 30th) may be reimbursed the hospital's inpatient operating cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospitals' chief financial officer must submit and the MSA must accept documentation stating the hospital's Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital's actual cost to charge ratio is applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.~~

~~9. New Hospitals~~

~~A new medical/surgical hospital is one for which no Michigan Medicaid program cost or paid claims data exists during the period used to establish hospital specific base rates or one which was not enrolled in the Medicaid program when hospital specific base prices/rates were last established. Hospitals that experience a change of ownership or that are created as the result of a merger are not considered new hospitals.~~

~~The DRG base price for new general hospitals is the statewide operating limit until new DRG base prices are calculated for all hospitals using data from time periods during which the new hospital provided services to Medicaid beneficiaries.~~

~~D. Hospitals and Units Exempt from DRG Reimbursement~~

~~1. Calculating Per Diem Rates~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

THIS PAGE INTENTIONALLY LEFT BLANK.

~~The per diem prices are calculated in part on Medicaid and Children's Special Health Care Services FFS paid claims data taken from hospital admissions between September 1, 2008 and August 31, 2010, and paid by August 2011. Per diem prices are also calculated based in part on encounter paid claims data taken from hospital admissions between September 1, 2008 and August 31, 2010, and received by August 2011. Two years of fee for service and encounter paid claims are used.~~

~~The claim file is limited to those hospitals enrolled as of the specified date.~~

~~a) The invoice file is adjusted to:~~

~~1) Eliminate episodes with any Medicare charges. (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid DRG are included);~~

~~2) Eliminate episodes without any charges or days.~~

~~3) Limit episodes to those from Michigan hospitals (provided that hospital cost report data are available).~~

~~4) Limit episodes to those with a valid patient~~

~~5) Eliminate episodes with a zero dollar Medicaid liability.~~

~~Total charges and days paid are summed by hospital.~~

~~b) The cost for each hospital is calculated by multiplying the charges for the hospital by the cost to charge ratio for the hospital.~~

~~1) Each hospital's operating cost to total charge ratio is obtained from weighted filed cost reports for fiscal years ending between September 1, 2008 and August 31, 2010. If the cost to charge ratio is greater than 1.00 then 1.00 is used. For distinct part rehabilitation units, this ratio is unique to the unit.~~

~~2) If two or more hospitals merged and are now operating as a single hospital, a cost to charge ratio is computed using the combined cost report data from all hospitals involved in the merger. Cost and charge data will be inflated to a common point in time.~~

~~The cost per day by hospital is calculated by dividing the sum of the costs by the number of days for the hospital.~~

~~c) To determine a hospital specific Per Diem base rate:~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

THIS PAGE INTENTIONALLY LEFT BLANK.

~~1) Multiply the cost per day by the applicable inflation factor. Each hospital's costs are inflated to a common point in time. Inflation factors were obtained from the Global Insight PPS-Type Hospital Market Basket Index relative to the period.~~

~~Fiscal Year Ending~~	~~Cost Inflation Factors~~	~~Weighting Factors~~
~~9/30/08~~	~~1.0555~~	~~0.40~~
~~12/31/08~~	~~1.0462~~	~~0.40~~
~~3/31/09~~	~~1.0421~~	~~0.40~~
~~6/30/09~~	~~1.0412~~	~~0.40~~
~~9/30/09~~	~~1.0413~~	~~0.60~~
~~12/31/09~~	~~1.0337~~	~~0.60~~
~~3/31/10~~	~~1.0220~~	~~0.60~~
~~6/30/10~~	~~1.0103~~	~~0.60~~
~~8/31/10~~	~~1.0000~~	~~0.60~~

~~Rates will be adjusted by an inflation factor of 1.076 for the period from August 31, 2010 to December 31, 2014.~~

~~The inflation update for the quarter in which the hospital's fiscal year ends is used.~~

~~2) Recognize area cost differences by dividing the cost per day for each hospital by an area cost adjustor factor. Hospitals are grouped by U.S. Census Core Based Statistical Area (CBSAs) as determined by the Centers for Medicare and Medicaid Services for the Medicare program for wage data. Each area cost adjustor is calculated as follows:~~

~~COST ADJUSTOR = 0.71066 X WAGE ADJUSTOR + 0.28934~~

~~The cost adjuster formula reflects Medicare estimate of labor-related costs as a portion of total hospital costs as published in the Federal Register.~~

~~3) Each area wage factor is area wage per full-time equivalent (F.T.E.) divided by the statewide average hospital wage per F.T.E. Contract labor costs are included in determining a hospital's wage costs~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

THIS PAGE INTENTIONALLY LEFT BLANK.

~~4) Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation and weighting factors. All wages are brought to a common point in time. Filed wage data is used where audited~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

THIS PAGE INTENTIONALLY LEFT BLANK.

~~data is not available. The following adjustment factors, derived from the Global Insight PPS-Type Hospital Market Basket Index relative to the period, employee cost component, are used:~~

~~Fiscal Year Ending~~	~~Wage Inflation Factors~~	~~Base Weighting Factors~~	~~Update Weighting Factors~~
~~9/30/07~~	~~1.972~~	~~0.40~~	
~~12/31/07~~	~~1.1852~~	~~0.40~~	
~~3/31/08~~	~~1.1712~~	~~0.40~~	
~~6/30/08~~	~~1.1576~~	~~0.40~~	
~~9/30/08~~	~~1.1453~~	~~0.60~~	
~~12/31/08~~	~~1.332~~	~~0.60~~	
~~3/31/09~~	~~1.1218~~	~~0.60~~	
~~6/30/09~~	~~1.1097~~	~~0.60~~	
~~9/30/10~~	~~1.0551~~		~~0.40~~
~~12/31/10~~	~~1.0447~~		~~0.40~~
~~3/31/11~~	~~1.0354~~		~~0.40~~
~~6/30/11~~	~~1.0271~~		~~0.40~~
~~9/30/11~~	~~1.0179~~		~~0.60~~
~~12/31/11~~	~~1.0111~~		~~0.60~~
~~3/31/12~~	~~1.0051~~		~~0.60~~
~~6/30/12~~	~~1.0071~~		~~0.60~~
~~8/31/12~~	~~1.000~~		~~0.60~~

~~For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.~~

- ~~The wage data for distinct part rehabilitation units is the same as for the inpatient medical/surgical area of the hospital. The cost reports do not differentiate salaries/hours by unit type.~~
- ~~If two or more hospitals merge and are now operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data will be inflated to a common point in time.~~

- ~~Remove indirect medical education (IME) costs by dividing by an adjustor for indirect education. Each hospital's IME adjustor is calculated as follows:~~

$$1+([(1+\frac{\text{Interns \& Residents}}{\text{Beds}})^{.5795}-1]\times 0.3575)$$

- ~~Distinct part rehabilitation units report this data separately. The IME adjustor is unique to the unit.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

THIS PAGE INTENTIONALLY LEFT BLANK.

~~To determine the per diem rate:~~

- ~~Calculate the statewide operating cost limit (by provider type). This is a weighted mean of all hospital' specific base prices weighted by base period days (truncated mean), multiplied by the appropriate percentage.~~
  - ~~For freestanding rehabilitation hospitals the percentages is 150%~~
  - ~~The 50th percentile is determined by calculating a standardized rate for each unit. The standardized rates for all enrolled Michigan units are sorted in ascending order. The standardized rate of the first unit after the 50% of the units listed becomes the statewide 50th percentile.~~
  - ~~For distinct part rehabilitation units the percentage is 200%~~
- ~~Calculate the statewide operating cost minimum (by provider type). This is a truncated, weighted mean of all hospitals' specific base prices weighted by base period days multiplied by 70%.~~
- ~~The per diem base rate is the lesser of:~~
  - ~~The greater of the hospital specific base price or the statewide operating cost minimum, or~~
  - ~~The statewide operating cost limit.~~

  ~~Adjust each hospital's per diem rate by the updated cost adjustor (to reflect a hospital specific per diem rate). The updated cost adjustor is calculated, to reflect the most current data available, in the same manner as the base cost adjustor, except that:~~
- ~~Medicare audited wage data for hospital fiscal years ending between September 1, 2007 and August 31, 2009 is used for the base period and September 1, 2010 and August 31, 2012 is used for the update period.~~
- ~~The wage inflation and weighting factors are derived from the employee cost component of the Global Insight PPS-Type Hospital Market Basket Index relative to the period. The same inflation and weighting factors were used here as were used for the DRG update found in Section III, B., *DRG Price*.~~
- ~~In the event that changes in federal regulations result in incompatible data between the base and update periods, adjustments are made either to the base or the update period to render the data comparable.~~

~~Calculate the final per diem rate by rounding to the nearest whole dollar.~~

~~2. Hospitals Outside of Michigan~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

~~Freestanding rehabilitation hospitals and distinct part rehabilitation units not located in Michigan are reimbursed using a per diem rate. The per diem rate is the statewide weighted average per diem (truncated mean) for this provider type.~~

~~3. New Freestanding Hospitals and Distinct Part Units~~

~~If a hospital at least doubles the number of licensed beds in its distinct part unit and the number of licensed beds in the units increases by at least 20, the entire unit is treated as a new distinct part unit for determining the per diem rate. In order for this provision to apply, the hospital must request in writing that the unit is treated as a new unit. The new unit rate will become effective on the date that the number of licensed beds doubles and the increase is at least 20 beds, or the date on which the request is received by MSA, whichever is later.~~

~~New freestanding hospitals and distinct part units are reimbursed using the statewide average (weighted by days during the base period) per diem rate for the provider type.~~

~~A hospital/unit specific per diem rate is established when new rates are calculated using data from time periods during which the new hospital/unit provided services to Medicaid patients.~~

SUBSECTIONS C AND D HAVE BEEN ELIMINATED. THE NEXT SUBSECTION IS "E. FREQUENCY OF UPDATES".

E. Frequency of UPDATES ~~Recalibration~~

The STATE WILL UPDATE AREA WAGE INDEX, COST TO CHARGE RATIO, RELATIVE WEIGHTS, APR-DRG GROUPER, DRG RATES, AND PER DIEM RATES ON AN ANNUAL BASIS. ~~Department will recalibrate hospital prices and ratios according to the following schedule:~~

~~1) Relative weights will be recalibrated annually.~~

~~2) DRG prices will be rebased every three years and updated annually.~~

~~3) Per Diem rates will be rebased every two years and updated annually.~~

~~4) Inpatient operating cost to charge ratios will be recalculated with each DRG/Per Diem rebasing.~~

F. Mergers

1. General Hospitals

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

In the event of a merger between two or more hospitals ~~between DRG rebasing periods~~, the DRG rate for the surviving hospital will be computed as follows:

A. THE STATEWIDE RATE WILL BE ADJUSTED BY APPLICABLE AREA WAGE INDEX.
B. THE COST TO CHARGE RATIOS OF THE HOSPITALS WILL BE COMBINED TO CREATE A NEW COST TO CHARGE RATIO.

~~a. Cost to charge ratio, indirect medical education, and wage data will be inflated to a common point in time (for the surviving entity).~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

~~b. No changes will be made to the relative weights.~~

~~c. The DRG rate will be computed with the same methodology as described in the section covering the computation of the DRG rates, with the following exceptions:~~

~~1) No change will be made to the statewide cost limit.~~

~~2) No change will be made to the statewide average used to compute the update base wage adjustor.~~

~~3) No change will be made with respect to the statewide average used to compute the update wage adjustor.~~

~~d. As part of recalibration or rebasing, all data will be combined prior to adjusting the invoice file, as discussed in the section covering the recalibration/rebasing.~~

2. **LTACHs,** Freestanding Psychiatric and Rehabilitation Hospitals/Distinct Part Psychiatric and Rehabilitation Units

In the event of a merger between two or more hospitals ~~between per diem rebasing periods~~, the resulting per diem rate for the surviving hospital will be computed as follows:

A. THE STATEWIDE RATE WILL BE ADJUSTED BY APPLICABLE AREA WAGE INDEX.
B. THE COST TO CHARGE RATIO OF THE HOSPITALS WILL BE COMBINED TO CREATE A NEW COST TO CHARGE RATIO.

~~a. Cost to charge ratio, indirect medical education (IME), and wage data will be inflated to a common point in time (for the surviving entity).~~

~~b. The per diem rate will be computed using the same methodology as described in the section covering the computation of the DRG rates, with the following exceptions:~~

~~1) No change will be made to the statewide operating cost limit.~~

~~2) No change will be made to the statewide operating cost minimum.~~

~~3) No change will be made to the statewide average used to compute the base wage adjustor.~~

~~4) No change will be made to the statewide average used to compute the update wage adjustor.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

~~b. As part of recalibration or rebasing, all data will be combined prior to adjusting the invoice file, as discussed in the section covering the recalibration/rebasing.~~

G. Other Reimbursement Methods

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

1. Sub-Acute Ventilator-dependent Care

   Payment for services provided to patients in sub-acute ventilator-dependent units (SVDUCU) is made using a negotiated prospective per diem rate that includes capital and direct medical education costs.

   The per diem rate is based on cost estimates for the upcoming year. The negotiated per diem rate is not to exceed the average outlier per diem rate that would be paid for outlier days between DRG **004X** ~~541~~ and DRG **005X** ~~542~~. The payment rate for patients in subacute ventilator-dependent care units is an all-inclusive facility rate. No additional reimbursement is made for capital or direct medical education costs. These units are not eligible for indigent volume adjustor or indirect medical education adjustor payments.

2. Michigan State-Owned Hospitals

   Reimbursement to Michigan state-owned hospitals is allowable costs under Medicare principles of reimbursement as freestanding psychiatric hospitals exempt from the prospective payment system.

H. Disproportionate Share

Minimum Eligibility Criteria

Indigent volume data is taken from each hospital's cost report and from supplemental forms that each hospital must file with its cost report. Data from the most recent available filed cost report are used to calculate a disproportionate share adjustor. New adjustors are calculated and become effective concurrently with annual inflation updates. Separate indigent volume data is collected for and applied to distinct part psychiatric units.

Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's total inpatient charges. Indigent charges are the annual charges for services rendered to patients eligible for payments under the Medicaid, CSHCS and the Adult Benefits Waiver plus uncompensated care charges. Uncompensated care is limited by Medicare standards and is offset by any recoveries.

Each hospital must have a Medicaid utilization rate of at least 1%. Medicaid utilization is measured as:

$$\frac{\text{Medicaid Inpatient Days (Whole Hospital including Subproviders)}}{\text{Total Hospital Days (Whole Hospital including Subproviders)}}$$

Individual inpatient hospital claims will be paid without DSH adjustments. Inpatient DSH payments will be made annually in a single distribution based on charges converted to cost