District of Columbia Medicaid
A New Inpatient Hospital Payment Method: APR-DRG

Frequently Asked Questions

Version Date: September 22, 2014

UPDATE:

The District of Columbia Department of Health Care Finance (DHCF) is submitting State Plan Amendments (SPAs) for three new hospital payment methods that will be effective October 1, 2014. However, until the District obtains approval of the SPAs, we do not have authority to implement the changes. Accordingly, while the changes will be effective October 1, 2014, we will implement the changes retroactively upon approval by the Centers for Medicare and Medicaid Services (CMS). DHCF will continue to pay hospital claims using current payment methodologies and current rates. Once the SPA has been approved and the new methods are activated in the Medicaid Management Information System (MMIS), all claims with discharge dates or dates of service on or after October 1, 2014 will be reprocessed with payment adjustments as necessary under the new payment methods.

For more information regarding the delay of the new payment methods, please see Transmittal #14-27 *Advice Regarding Implementation of Hospital Payment Methodologies – Update on Retroactive Implementation* at https://www.dc-medicaid.com/dcwebportal/home

As always, hospitals should continue to assign ICD-9 and CPT/HCPCS codes according to national coding guidelines.

<u>Please note that details of the payment method shown in this document remain subject to change before the implementation date.</u>

OVERVIEW QUESTIONS

1. **What is the APR-DRG DRG project?**

The Department of Health Care Finance (DHCF) is developing a new method of paying for hospital inpatient services in the fee-for-service Medicaid program effective October 1, 2014. This FAQ document is intended to provide interested parties with periodic updates on the project.

2. **What providers will be affected?**

The new APR-DRG method will apply to general acute care hospitals currently paid by DRGs, including out-of-district hospitals with the exception of Maryland hospitals. State of Maryland hospitals will continue to be paid by their current method as required by a federal waiver. The inpatient payment method for stand-alone mental health, long-term care, and rehabilitation facilities will be determined by the Specialty Hospital Project group.

3.   Why is the change being made?

DHCF must replace the previous method of All Patient Diagnosis Related Groups (AP-DRGs) with All Patient Refined Diagnosis Related Groups (APR-DRGs) because the AP-DRG grouper cannot be used under ICD-10. APR-DRGs are ICD-10 ready and updated annually by 3M. The implementation of APR-DRGs is not impacted by the national delay of ICD-10 implementation

4.   How will hospitals be informed about the progress of the project?

The Department has met with and will continue to meet with all District hospitals as the design process progresses. This document (the Frequently Asked Questions-FAQ) will be regularly updated and made available to interested parties.

5.   How are hospitals currently paid?

The Department has reimbursed fee-for-service (FFS) inpatient Medicaid services using AP-DRGs since 1998 (version 12). AP-DRG version 26 was implemented effective April 1, 2010.

6.   What is the timeframe?

A workgroup comprised of staff from DHCF developed the new method. The workgroup completed the policy design process and DHCF has approved all recommendations on the payment method. Final ratesetting was completed May of 2014 for rates effective October 1, 2014.

7.   What services will be impacted?

For affected hospitals, the new method and rates will apply to all inpatient hospital fee-for-service claims.

8.   Will the change affect payments from Medicaid managed care plans?

No. Medicaid managed care payments to hospitals participating in managed care organization (MCO) networks are outside the scope of this project.

9.   What will the DRG base rate be?

The district currently uses a hospital-specific base rate to reimburse each hospital at 98% of their costs. Effective October 1, 2014, the department will implement a single district-wide base rate of $10,906 for all acute care hospitals. This base rate applies to out-of-district hospitals as well. The district-wide base rate is set to reimburse at 98% of costs for District hospitals as a group. Hospital-specific payment-to-cost ratios will vary dependent on each hospital's cost-efficiency. The hospital-specific base rate consists of the District-wide base rate plus each hospital's indirect medical education (IME) payment. This rate is used to calculate DRG base payments.

In addition, United Medical Center is the only hospital identified as being located in an Economic Development Zone within the District. District government has a policy of providing a 2% favorable consideration to qualified businesses in Economic Development Zones. UMC will receive an increase to the District-wide base rate by 2%.

Claims with dates of discharge on or after October 1, 2014, which are processed and paid under current rates before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including the new district-wide base rate, outlier policies, policy adjustors, IME, DME, capital payments, and three-day window policy once SPA approval is obtained.

ALL PATIENT REFINED DRGs (APR-DRGs)

10. Why were APR-DRGs chosen?

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal, pediatric, and obstetric care. Furthermore, they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.

APR-DRGs are regularly maintained by its developers, 3M, and the version that the Department will implement is ICD-10 ready.

11. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M Health Information Systems and the Children's Hospital Association (formerly NACHRI). According to 3M, APR-DRGs have been licensed by over 20 state and federal agencies and by 1,600 hospitals. APR-DRGs have been used to adjust for risk in analyzing hospital performance; examples are state "report cards" such as www.floridahealthfinder.gov and analysis done by organizations such as the Agency for Healthcare Research and Quality and the Medicare Payment Advisory Commission.

APR-DRGs are also in use or planned for use in calculating payment by California Medi-Cal, Colorado Medicaid, Florida Medicaid, the State of Maryland, Mississippi Medicaid, Montana Medicaid, New York Medicaid, North Dakota Medicaid, Ohio Medicaid, Pennsylvania Medicaid, Rhode Island Medicaid, South Carolina Medicaid, Texas Medicaid, and Wellmark, the BlueCross BlueShield plan in Iowa.

12. Would my hospital need to buy APR-DRG software in order to get paid?

No. The Medicaid claims processing system will assign the APR-DRG and calculate payment without any need for the hospital to put the DRG on the claim.

For hospitals interested in learning more about APR-DRGs, information is available at www.3m.com/us/healthcare/his/products/coding/refined_drg.html. DHCF and Xerox (which is advising the Department) have no financial interest in APR-DRG software or in any business arrangements between hospitals and their vendors who license APR-DRGs.

13. What version of APR-DRGs will be implemented?

The Department intends to implement V.31 of APR-DRGs effective October 1, 2014, which was released October 1, 2013. Simulation modeling for the new payment method was performed using V.30 (released October 1, 2012); Final ratesetting was accomplished using V.31.

Claims with dates of discharge on or after October 1, 2014, which are processed and paid under current rates before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including the new district-wide base rate, outlier policies, policy adjustors, IME, DME, capital payments, and three-day window policy once SPA approval is obtained.

14. What is the APR-DRG format?

Initially, each stay is assigned to one of 314 base APR-DRGs. Then, one of four levels of severity (minor, moderate, major or extreme) specific to the base APR-DRG is assigned. Severity depends on the number, nature and interaction of complications and comorbidities. For example, APR-DRG 139-1 is pneumonia, severity 1 minor, while APR-DRG 139-2 is pneumonia, severity 2 moderate.

For hospitals that choose to acquire APR-DRG software, staff should note that the software outputs the base APR-DRG and the severity of illness as two different fields. The Department will concatenate these fields for purposes of calculating payment. The APR-DRG is therefore four bytes (ignoring the hyphen), in contrast to the three-byte AP-DRG field.

15. Will the hospital have to submit the APR-DRG on the UB-04 paper form or the 837I electronic transaction? How will the DRG be assigned?

No. DHCF has acquired the 3M ™ All Patient Refined Diagnosis Related Groups (APR-DRGs), Version 31, and will use it to assign DRGs to claims.

16. Where do the APR-DRG relative weights come from?

Relative weights are calculated from the Nationwide Inpatient Sample by 3M or relative weights could be calculated from District data. DC Medicaid will use Hospital-Specific Relative Value (HSRV) national relative weights as developed and maintained annually by 3M.

OTHER QUESTIONS

17. What other payment policies are typically included in DRG payment methods?

For approximately 96% of stays, it is likely that payment will be made using a "straight DRG" calculation—that is, payment will equal the DRG relative weight times the DRG base price. In special situations, payment may also include other adjustments, for example:

- *Transfer pricing adjustment.* Payment may be reduced when the patient is transferred to another acute care hospital. Please see Question #18.

- *Cost outlier adjustment.* Medicare and other DRG payers typically make additional "outlier" payments on stays that are exceptionally expensive for a hospital. Some payers also have a payment reduction if a stay is exceptionally profitable for a hospital. Nationally, outlier adjustments typically affect 1% to 2% of all stays and a higher percentage of all DRG payments.

The Department will change from DRG-specific outlier thresholds to a single threshold for high-side outliers of $65,000 and a single threshold for low-side outliers of $30,000 effective October 1, 2014. Please see Questions #19 and #20.

- *Policy Adjustors.* Policy adjustors can be used to explicitly increase or decrease DRG weights for certain care categories in order to meet policy goals. The Medicaid program may choose to focus its scarce funds in the clinical areas where Medicaid funding makes the most difference to beneficiary access focused on operating pay-to-cost ratios. Policy adjustors should be few in number, apply to entire Medicaid Care Categories (MCC), and be initiated for compelling policy reasons, e.g., to enable access for care where Medicaid payment levels can have substantial impact.

DHCF has evaluated the impact of various MCCs specific to pediatrics (less than 21 years old). Final ratesetting occurred in May of 2014 and the Department has decided to implement three policy adjustors effective for October 1, 2014, to promote access for pediatric stays: 2.25 for pediatric mental health; 1.25 for neonates; 1.5 for all other pediatric stays, excluding newborns.

The calculation formula is: casemix relative weight x policy adjustor = payment relative weight

- *Third Party Liability and patient cost-sharing.* DRG payment policies determine the allowed amount. From this value, payers typically deduct other health coverage payments (e.g., workers' compensation) as well as the patient's share of cost. No changes are planned to current policies or procedures on third party liability or share of cost.

Claims with dates of discharge on or after October 1, 2014, which are processed and paid under current rates before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including the new district-wide base rate, outlier policies, policy adjustors, IME, DME, capital payments, and three-day window policy once SPA approval is obtained.

18.   How will transfers be paid?

DC Medicaid follows the Medicare model for transfers to another acute care hospital. For these stays, the transferring hospital would be paid the lesser of:

- The DRG base payment

- A per diem amount times the actual length of stay plus one day (to recognize the up-front costs of admission). The per diem amount is the DRG base payment divided by the DRG-specific average length of stay.

This policy aims to reduce the DRG base payment if the actual length of stay at the transferring hospital is less than overall average length of stay minus one day. The receiving hospital is paid the full DRG payment. Currently, claims with a patient discharge status of 02 or 05, indicating an acute care transfer, are paid using this transfer logic applied to the transferring hospital only. The Department will adjust transfer logic to include eight additional patient discharge status codes; see Table 1 for a listing of codes.

Claims with dates of discharge on or after October 1, 2014, which are processed and paid under current rates before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including

the new district-wide base rate, outlier policies, policy adjustors, IME, DME, capital payments, and three-day window policy once SPA approval is obtained.

Table 1 Changes in Discharge Status Codes that Affect Transfers	
Discharge Status Codes	**New Readmission Discharge Values that Parallel Current Discharge Status Codes**
02: Discharged/transferred to a short-term hospital for inpatient care	82: Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
05: Discharged/transferred to a designated cancer center or children's hospital	85: Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
63: Discharged/transferred to a long-term care hospital	91: Discharged/transferred to a Medicare certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission
65: Discharged transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	93: Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
66: Discharged/transferred to a critical access hospital	94: Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission
Notes:	
1. Codes in black font will trigger a transfer adjustment for DRG claims effective 10/1/14.	
2. Discharge status codes addressing readmission were announced in MLN Matters CR 8421 released 11/19/13.	

19. How will high-cost outliers be paid?

High-cost outliers will be paid in a similar fashion to the current method; however, there are changes effective October 1, 2014. At that time, high-cost outliers will be paid using a standard high-cost outlier threshold that is no longer DRG-specific in order to determine whether a claim qualifies for high-cost outlier treatment. The change from DRG-specific thresholds to a single threshold necessitates a change in the outlier payment calculation. Currently, outliers are paid at 80% of excess costs. (Excess costs are costs that exceed the DRG cost outlier threshold.) The new method is as follows. First, it is determined whether a loss has occurred. If that loss reaches the outlier threshold, the stay qualifies for a high-cost outlier payment. The hospital CCR is multiplied by charges to calculate the estimated cost of the stay. The difference between the cost of stay and DRG payment determines the estimated loss on the stay. If the estimated loss exceeds the outlier threshold the stay qualifies for an outlier payment. The second step is to calculate the outlier payment as the estimated loss minus the threshold, times the marginal cost factor. Effective October 1, 2014, the marginal cost threshold is $65,000 and marginal cost factor is 80%.

Claims with dates of discharge on or after October 1, 2014, which are processed and paid under current rates before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including the new district-wide base rate, outlier policies, policy adjustors, IME, DME, capital payments, and three-day window policy once SPA approval is obtained.

20. How will low-cost outliers be paid?

Low-cost outliers will be paid in a similar fashion to the current method using the transfer policy algorithm; however, there is one change that will be effective October 1, 2014. DRG-specific thresholds will no longer be used in favor of a single low-cost threshold to determine whether a claim qualifies for

low-cost outlier treatment. The "gain" on these claims will be measured as charges times CCR minus the DRG payment. If the gain exceeds the low-cost threshold, then the transfer policy methodology will be used to calculate the reduced payment. The low-cost threshold of $30,000 is effective October 1, 2014.

Claims with dates of discharge on or after October 1, 2014, which are processed and paid under current rates before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including the new district-wide base rate, outlier policies, policy adjustors, IME, DME, capital payments, and three-day window policy once SPA approval is obtained.

21. How would the hospital indicate a situation of partial eligibility?

The District only pays Medicaid claims for eligible days. Claims should not be submitted with ineligible days. The claims payment system will deny a claim for an inpatient stay if ineligible days are submitted. Hospitals should only bill for the portion of a stay that is covered.

22. How will interim claims be paid?

There is no change to the current interim claim policy. Interim claims will continue to be accepted from in-District DRG hospitals for stays that exceed a threshold of 30 days or $500,000 in charges. The hospital can submit an interim claim (type of bill 112 or 113) and be paid an interim per diem amount ($500) times the number of days. When the patient is discharged, the hospital voids the previous interim claims and submits one claim, admit through discharge showing all charges, diagnoses and procedures for the full admit-thru-discharge period. Bill types 114 (final interim claim) and 115 (late charges) will be denied from DRG hospitals.

23. How will crossover claims be paid?

There are no changes to Medicare crossover claims as they are not part of the APR-DRG project.

24. What changes, if any, will be made to the prior authorization policy?

All inpatient stays require preauthorization and concurrent review.

25. What changes, if any, will be made to add-on payments?

DC Medicaid makes add-on payments to hospitals, e.g., for medical education and capital. Capital and direct medical education (DME) are currently paid as per-discharge add-ons while indirect medical education (IME) is added to each hospital's base rate. Some hospitals have requested that efficiency be rewarded in the reimbursement process by redirecting hospital-specific add-on payments toward the district-wide base rate. Out-of-District hospitals do not receive Capital, DME and IME payments.

In January 2014, the District shared the plan to phase in the implementation of changes to add-on payments and IME in the DRG reimbursement model for fee-for-service Medicaid beneficiaries. These are the final decisions regarding phased-in limits to Capital, DME, and IME payments for DRG hospitals which will be effective on October 1, 2014:

- IME – In FY15, the District will limit IME to 75% of the amount calculated using the Medicare algorithm. In FY16 and thereafter, the limit will be 50% of the amount calculated using the Medicare algorithm.

- DME - In FY15, the District will limit DME to 200% of the District average DME payments per Medicaid patient day for teaching hospitals. That limit will move to 150% of the average for FY16 and thereafter.

- Capital - In FY15 and thereafter, capital add-ons will be limited to 100% of the District average capital payments per Medicaid patient day.

Claims with dates of discharge on or after October 1, 2014, which are processed and paid under current rates before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including the new district-wide base rate, outlier policies, policy adjustors, IME, DME, capital payments, and three-day window policy once SPA approval is obtained.

26. How will this affect the overall payment level?

The change to APR-DRGs is a change in payment *method*, not payment *level*. The overall payment level will continue to be determined each year through the budget process.

27. How will the change affect funding to each hospital?

Due to the major change in the payment method and policies, changes in hospital payments are expected. Ultimately, payment is based upon a hospital's casemix for their Medicaid admissions. Changes includes a district-wide base rate (see question #9), limits on IME and add-ons (see question #25), specific pediatric policy adjusters and changes to outlier policies (see question #17). In August 2014, hospitals were given their FY13 claims data with charges inflated 4.1% based on two years of Medicare's IPPS inflation factor, then repriced using these new policies to allow them to evaluate the impact.

Please note that due to the delay in SPA approval, claims will pay as they have been under the current method and rates until SPA approval is obtained. Once SPA approval is obtained, claims with dates of discharge on or after October 1, 2014, which are processed and paid before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including the new district-wide base rate, outlier policies, policy adjustors, IME, DME, capital payments, and three-day window policy once SPA approval is obtained. Hospitals should be aware that this reprocessing will happen and will affect payments.

28. How will ICD-10-CM/PCS affect the DRG payment method?

The implementation of ICD-10 has been delayed. DC Medicaid will implement V.31 of APR-DRG effective October 1, 2014, which accepts both ICD-9 and ICD-10 codes. When ICD-10-CM/PCS is implemented nationwide, the claims processing system will accept ICD-10 diagnosis and procedure codes and will utilize ICD-10 codes for internal processing. Hospitals should follow national guidelines in submitting ICD-10 codes.

29. Will there be changes in billing requirements?

For most claims, there are no changes to inpatient billing requirements. Under DRG payment, complete recording of all appropriate diagnoses and procedure codes is critical to appropriate DRG assignment. Please see question #30 for information on recording birth weight on a newborn claim. Please see question #31 related to billing outpatient services provided within a three day window of an inpatient stay.

30. How will birth weight be submitted on the claim?

For dates of discharge after April 1, 2010, providers were no longer required to record birth weight on newborn claims, but to code birth weight using the ICD-9 code instead. The capability still exists for hospitals to submit birth weight in a separate field called the value code-amount field, which is treated as a birth weight when the corresponding value code (code of 54) is entered indicating birth weight. Effective October 1, 2014, hospitals can submit birth weight on claims in either way- either within the diagnosis code or the value code field. DC Medicaid will adjust the APR-DRG grouper setting to allow birth weight to be read in both ways. However, hospitals are encouraged to submit the birth weight in the value-code field as this is more specific.

Claims with dates of discharge on or after October 1, 2014, which are processed and paid under current rates before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including the availability of birth weight in the value code field which could affect DRG assignment.

31. When should outpatient services be billed as part of an inpatient claim?

Hospital outpatient diagnostic services provided one to three days prior to an inpatient admission at the same hospital are not separately payable and should be billed as part of the inpatient stay. Diagnostic services are defined by revenue code, see table 2 below. All hospital outpatient services (regardless of revenue code) that occur on the same day as an inpatient admission at the same hospital are also considered part of the inpatient stay and as such are not separately payable.

The three-day window policy will be enforced retroactively after CMS approval of the SPAs. Hospitals should comply with this policy on claims with dates of service or discharge dates on or after October 1, 2014. It is expected and acceptable that dates of service on an inpatient claim submitted for dates of discharge on or after October 1, 2014, may be prior to the admission date. This differs from current policy.

Claims with dates of discharge on or after October 1, 2014, which are processed and paid under current rates before SPA approval will be reprocessed using the new APR-DRG V.31 payment method, including the new district-wide base rate, outlier policies, policy adjustors, IME, DME, capital payments, and three-day window policy once SPA approval is obtained.

Table 2: Diagnostic Revenue Codes Included in the Three Day Window			
Diagnostic Revenue Codes	Revenue Code Description	Diagnostic Revenue Codes	Revenue Code Description
0254 - 0255	Pharmacy	0400 - 0409	Other imaging
0341, 0343	Nuclear medicine	0460 - 0469	Pulmonary function
0371 - 0372	Anesthesia	0530 - 0539	Osteopathic services
0471	Diagnostic audiology	0610 - 0619	Magnetic resonance tech

Table 2: Diagnostic Revenue Codes Included in the Three Day Window			
Diagnostic Revenue Codes	Revenue Code Description	Diagnostic Revenue Codes	Revenue Code Description
0482 - 0483	Cardiology	0621 - 0624	Med/surgical supplies
0918	Behavioral health services	0730 - 0739	EKG/ECG
0300 - 0319	Laboratory	0740	EEG
0320 - 0329	Diagnostic radiology	0920 - 0929	Other dx services
0350 - 0359	CT Scan		

32. Where can I go for more information?

• *FAQ*. Updates of this document will be available on the DHCF website.

• *DRG Grouping Calculator.* 3M Health Information Systems has agreed to provide all District hospitals with access to an APR-DRG Grouping Calculator at no charge. The calculator is a webpage that enables the user to enter diagnoses, procedures and other claims data followed by the step-by-step assignment of the APR-DRG to a single claim. For the webpage address and password, contact Don Shearer (see "For Further Information" below).

• *DRG Pricing Calculator.* DHCF has made an APR-DRG Pricing Calculator available. It will not assign the APR-DRG, but it will show how a given APR-DRG will be priced in different circumstances. The calculator will include a complete list of APR-DRGs and related information for pricing.

• *Hospital information sessions.* Hospital information sessions were held during spring and summer of 2014.

FOR FURTHER INFORMATION

DRG project questions	Don Shearer Director, Program Operations, DHCF 202-698-2007 donald.shearer@dc.gov
Technical questions regarding DRG payment, relative weights, outlier calculations etc.	Dawn Weimar Project Director, Xerox dawn.weimar@xerox.com 262-365-3592

APPENDIX of DRG BACKGROUND

1. How do DRG payment methods work?

APR-DRG payment is similar to the current AP-DRG method. In general, every complete inpatient stay is assigned to a single diagnosis related group using a computerized algorithm that takes into account the patient's principal diagnoses, age, gender, major procedures performed, and discharge status. Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that DRG relative to the hospital resources needed to take care of the average patient. For example, if a DRG has a relative weight of 0.50 then that patient is expected to be about half as expensive as the average patient.

The DRG relative weight is multiplied by a DRG base rate to arrive at the DRG base payment. For example, if the DRG relative weight is 0.50 and the DRG base rate is $8,000 then the payment rate for that DRG is $4,000.

2. Who uses DRG payment?

The District of Columbia has used DRG payment for fifteen years. The Medicare program implemented payment by DRG on October 1, 1983. About two-thirds of state Medicaid programs use DRGs, as do many commercial payers and various other countries. Many hospitals in the U.S. use DRGs for internal management purposes.

3. What are the characteristics of DRG payment?

• DRG payment defines "the product of a hospital," thereby enabling greater understanding of the services being provided and purchased.

• Because payment does not depend on hospital-specific costs or charges, this method rewards hospitals for improving efficiency.

• Because DRGs for sicker patients have higher payment rates, this method encourages access to care across the full range of patient conditions.

• DRG payment rewards hospitals that provide complete and detailed diagnosis and procedure codes on claims, thereby giving payers and data analysts more comprehensive information about services provided.