DC Inpatient APR-DRG Payment for Acute Care Hospitals

August 2014
Provider Training

Agenda

- Headlines
- APR-DRG Overview
- Policy & Technical Updates
- DRG Pricing
- Provider Portal Changes
- For Further Information

First, the Headlines

- Payment by AP-DRG v.26 since April 2010
- Payment by APR-DRG will start with dates of discharge 10/1/14
- Hospitals:
  - Included:
    - In-district hospitals (eight)
    - out-of-district hospitals
  - Excluded:
    - Specialty - 5 hospitals (rehab, psych, LTCH)
    - Maryland hospitals- paid percentage of charges

First, the Headlines

- Technical changes APR-DRG grouper V.31, HSRV relative weights, nat. ALOS
- Policy changes
  - District-wide base rates- goal 98% of overall inpatient costs
  - Limits on IME, DME, capital
  - Economic development zone increase
  - Changes to outlier policies
    - Single threshold vs. DRG-specific
    - High-outlier calculation changes
  - Pediatric policy adjustors
  - Additional discharge codes indicating transfer
  - 3-Day window
  - Newborn birthweight

Hospitals do not need to buy APR-DRG software

APR-DRG Overview

Medicare Focuses on Medicare

"We advise those non-Medicare systems that need a more up-to-date system to choose from other systems that are currently in use in this country or to develop their own modifications… Our mission in maintaining the Medicare DRGs is to serve the Medicare population." (p. 48939)

-- *FFY 2005 Final Rule (8/11/04)*

APR-DRG Overview

DRG Algorithm: APR-DRGs

- 3M Created DRGs
  - For CMS in 1983 and has maintained them for 26 years
  - AP DRGs- Expanded CMS DRGs for use in non-Medicare population (focus: resource consumption)
- APR-DRGs- joint effort with *National Association of Children's Hospitals
  - Pediatric & NICU enhancements- Intended to be suitable for all acute care hospital patients, especially obstetrics, newborns, NICU babies, general pediatrics, and medically complex children
  - classifies patients with a similar pattern of resource intensity & into clinically meaningful patient groups (meaningful as it includes severity of illness and risk of mortality)
- Use:
  - 35 state governments using APR-DRGs for performance reporting, payment or both
  - Widely used by private companies producing hospital comparisons
  - Over 1/3 of US Hospitals license 3M APR-DRGs
- Quality assessment use for severity adjustment in research, analysis and payment
  - Understand the patients being treated, costs incurred, expected services and outcomes
  - Identify areas for improvement in efficiency, documentation, and potential quality problems

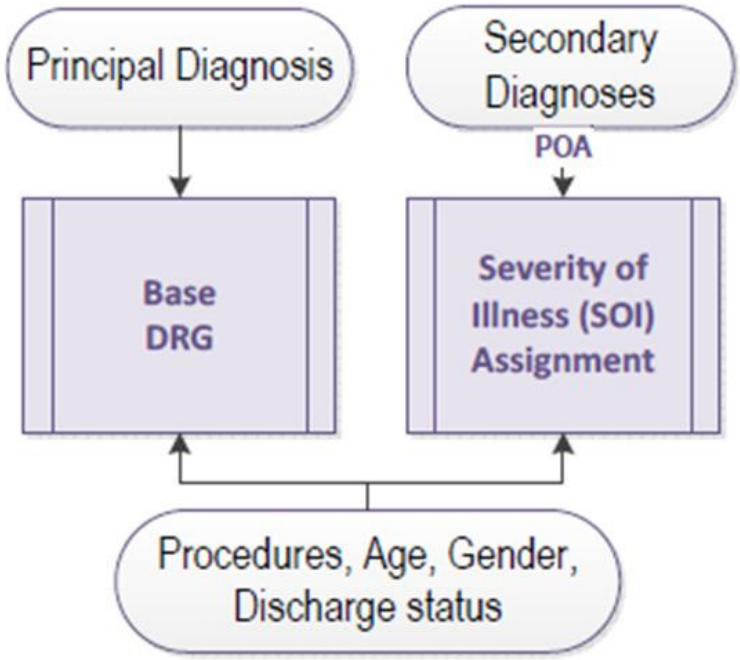
**Formerly NACHRI*

DRG Grouping

Structure of APR-DRGs

DRG 002-4

Base DRG - SOI



APR-DRG	APR-DRG Description	HSRV V.31 Relative Weight
002-1	Heart &/or lung transplant	8.1602
002-2	Heart &/or lung transplant	9.6671
002-3	Heart &/or lung transplant	12.0550
002-4	Heart &/or lung transplant	18.0801
141-1	Asthma	0.3408
141-2	Asthma	0.5015
141-3	Asthma	0.7486
141-4	Asthma	1.3503
560-1	Vaginal delivery	0.3307
560-2	Vaginal delivery	0.3855
560-3	Vaginal delivery	0.5399
560-4	Vaginal delivery	1.5061

APR-DRGs vs. AP-DRGs

Grouper Performance

Complications and Comorbidities and DRG Assignments					
A hospital has four patients, each with diverticulitis (infection of a pouch-like part of the colon) and each undergoing colon surgery. The four patients differ in the other illnesses that they have at the same time as the diverticulitis.					
	Patient 1	**Patient 2**	**Patient 3**	**Patient 4**	**Description**
Primary Proc	45.71	45.71	45.71	45.71	Multiple resection of colon
Primary Diag	562.11	562.11	562.11	562.11	Diverticulitis
Secondary Dx 1	569.41	569.41	569.41	569.41	Anal ulcer
Secondary Dx 2		560.90	560.90	560.90	Intestinal obstruction
Secondary Dx 3			422.99	422.99	Acute myocarditis
Secondary Dx 4			426.00	426.00	A-V block, complete
Secondary Dx 5				584.90	Acute renal failure
Each stay is grouped to a DRG. Patient 1 has a single, minor secondary diagnosis. The case is assigned to AP-DRG 149 and APR-DRG 221-1. Patient 2 has significant comorbidity, which results in a "higher" DRG under both groupers. Patient 3 has additional complications, resulting in higher assignments under AP-DRGs and APR-DRGs. Patient 4 is gravely ill, resulting in an increase in the APR-DRG but no change in the AP-DRG.					
	Patient 1	**Patient 2**	**Patient 3**	**Patient 4**	
AP-DRG	149	148	585	585	
APR-DRG	221-1	221-2	221-3	221-4	

Policy and Technical Updates

Policy & Technical Updates

Principles in Policy Design

Access: Encourage access thru higher payments for sicker patients.

Efficiency: Reward efficiency by allowing hospitals to retain savings from decreased LOS and decreased cost per day.

Transparency: Improve transparency and understanding by defining the "product" of a hospital in a way that makes sense to both clinical and financial managers.

Fairness: Improve fairness so that (a) different hospitals receive similar payment for similar care and (b) payments to hospitals are adjusted for significant cost factors that are outside the hospital's control.

Administrative ease: Make changes to reduce administrative burden on hospitals and Medicaid.

Data integrity: Make payment depend on data inputs that have high consistency and credibility.

Quality: Set foundation for improvement of quality and outcomes.

Policy & Technical Updates

Key Payment Values

Parameters	APR-DRG effective 10/1/14
Rates & Add-Ons	
DRG base rate	District-wide (DW) base rate (established at 98% overall cost) $10,906
Indirect medical education (IME)- added to base rate	10/1/14 - Each hospital per discharge amount limited to 75% of their IME; then 10/1/15 & thereafter- 50%.
Direct medical education (DME)	10/1/14 - hospital per discharge add-on based on Medicaid DME costs subject to limit of 200% of DW average; 10/1/15 and thereafter- limit of 150% of DW average
Capital	10/1/14 and thereafter - hospital per discharge add-on limited to 100% of the District-wide (DW) average capital cost
Economic development zone	2% increase to base rate; effects UMC
Technical Updates	
DRG version & weights	V.31 APR-DRG national weights, Hospital-Specific Relative Value (HSRV) method
3M mapper	update each Oct 1st
HAC version	3M HAC utility V.30
Outlier Policy and Transfers	
High-cost outlier threshold	One threshold for all DRGs- $65,000
High-cost marginal cost factor	80%
High-outlier pricing	Loss over the threshold is multiplied by marginal cost factor
Low-cost outlier threshold	One threshold for all DRGs- $30,000
Low-cost outlier payment	If gain is above threshold, then transfer method is used to calculate payment.
Transfer	Transfer Payment = (DRG Base Payment/National ALOS) x (LOS+1); allowed is whatever is less the DRG base payment or the transfer payment.

Policy & Technical Updates

Key Payment Values

Parameters	APR-DRG effective 10/1/14
Policy Adjustors - Applied to the DRG Weight before Calculating Payment	
Policy adjustor - neonate	1.25
Policy adjustor - pediatric mental health	2.25
Policy adjustor - pediatric, excluding normal newborns	1.5
Pediatric age cutoff	< 21 y.o.
Interim Claims	
Day threshold	30 days
Charges threshold	$500,000 in charges
Per diem	$500 per day
Other Policy Decisions	
Transfer - discharge status codes	02,05,63, 65,66, 82, 85, 91, 93, 94
Three day window	1) Outpatient diagnostic services provided by a hospital 1-3 days prior to an inpt adm AND 2) all hosp OP services that occur same day as adm (same hospital) are not separately payable; bill as part of the inpt stay.
Newborn birth weight	Claims system uses grouper option 7 which allows both birth weight field and birth weight as coded in diagnosis to be considered and crosschecked. If no birth weight is given, then a default to normal birth weight is used.

Policy & Technical Updates

Key Payment Values

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
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		

DRG- Base Rates

- Hospital base rates includes two components
  - District-wide base rate
  - Hospital-specific Indirect Medical Education (IME)

2% increase in base rate for UMC, due to location in Economic Disadvantaged Zone

- IME:
  - All but one hospital qualifies for an IME component
  - The IME component is calculated according to Medicare rules, using Medicaid utilization, with limits phased in over the first two years

Policy & Technical Updates
Transfer Discharge Status Codes

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.

Effect of IME, DME & Capital when no Limits Applied

Effect of Disparate IME, DME, and Capital Payments on Inpatient Payment per Stay									
Example	**Base Price**	**DRG Relative Weight**	**DRG Base Payment**	**IME**	**Base Price with IME**	**Adjusted DRG Base Payment**	**DME Add-on**	**Capital Add-on**	**Final Payment**
	a	*b*	***c = a x b***	*d*	*e = a + d*	***f = e x b***	*g*	*h*	***i = f + g + h***
Hospital X	$ 7,000	1.88	$ 13,160	$ 150	$ 7,150	$ 13,442	$ 100	$ 800	$ 14,342
Hospital Y	$ 7,000	1.88	$ 13,160	$ 1,000	$ 8,000	$ 15,040	$ 1,000	$ 4,000	$ 20,040
Hospital Z	$ 7,000	1.88	$ 13,160	$ 4,000	$ 11,000	$ 20,680	$ 3,000	$ 8,000	$ 31,680

Note:

1. These numbers are fictitious and for the purpose of illustration only using the relative weight for DRG 225-3 Appendectomy. Examples do not include outlier or other adjustor policies.

Graduate Medical Education Rates and Limits

- Direct Medical Education (DME) rates and limits for FY15 have been calculated based on FY13 cost reports
  - DME costs have been inflated forward to FY15
  - 7 Hospitals receive a DME add-on
  - Per Medicaid day limit is $470.32 (200% of the District average per Medicaid day)
  - For each hospital, the per day limit is translated to a per discharge amount, based on the hospital's Medicaid days and discharges
  - FY15 and thereafter the limit will be 150% of the District average per Medicaid day

Graduate Medical Education Rates and Limits

- Indirect Medical Education (IME) component of each hospital's base rate has been calculated for FY15, based on FY13 cost reports, inflated forward to 2015
  - FY 15, each hospital is limited to 75% of their calculated IME, calculated using the Medicare algorithm
  - FY 16 and thereafter the limit will be 50% of the calculated IME

Capital Rates and Limits

- Capital rates and limits for FY15 have been calculated based on FY13 cost reports
  - Per Medicaid day limit is $192.33
  - Four hospitals have limited capital add-on based on the ceiling
  - For each hospital, the per day limit is translated to a per discharge amount, based on the hospital's Medicaid days and discharges
  - Capital- limit capital add-ons to 100% of the District average capital payments per Medicaid patient day in FY15 and thereafter

DRG Payment Calculations

Hospital-specific base rate =

District-wide base rate + IME

DRG Base Payment =

APR-DRG HSRV Relative Weight x
Policy Adjustor x
Hospital-specific base rate

Transfer Payment or DRG Base Payment (whichever is lower)

Transfer payment = (DRG Base Payment/National ALOS) x (LOS + 1)

Note: Low-outlier uses this calculation as well.

High Outlier Calculation

Loss= DRG Base Payment- Cost (CCR x Charges) *Does Loss exceed threshold of $65,000?*

If yes, then

DRG High-outlier additional payment = (Loss - threshold) x Marginal Cost Factor (80%)

DRG Payment Calculations

Final Payment (Includes other adjustments if applicable) =

DRG Base Payment or Transfer Payment +

High-outlier payment adjustment +

Capital add-on +

DME add-on

Notes:

- IME, DME and Capital only apply to in-District hospitals.
- Other health coverage and patient share of cost is deducted.
- Interim claims paid by per diem.

DRG Pricing Examples: Straight DRG

Straight DRG				
DRG	Description	HSRV Rel. Wt.	DRG Base Price	DRG Base Payment
139-1	Oth Pneumonia	0.4202	$10,906	$4,583
139-2	Oth Pneumonia	0.6402	$10,906	$6,982
139-3	Oth Pneumonia	0.9947	$10,906	$10,848
139-4	Oth Pneumonia	1.7261	$10,906	$18,825

DRG Pricing Examples: with Policy Adjustor

Straight DRG					Pediatric Adjustor Applied	
DRG	Description	HSRV Rel. Wt.	DRG Base Price	DRG Base Payment	Pediatric Adjustor	DRG Base Payment
139-1	Oth Pneumonia	0.4202	$10,906	$4,583	1.5	$6,874
139-2	Oth Pneumonia	0.6402	$10,906	$6,982	1.5	$10,473
139-3	Oth Pneumonia	0.9947	$10,906	$10,848	1.5	$16,272
139-4	Oth Pneumonia	1.7261	$10,906	$18,825	1.5	$28,237

DRG Pricing Examples: High-outlier

Example: DRG 720-4 Septicemia with charges of $480,000		
Step	**Explanation**	**Amount**
DRG base payment	$10,906 x 2.17046	$23,671
Estimated cost	$480,000 x 21.83%	$104,784
Estimated loss	$104,784- $23,671	$81,113
Cost outlier case	$81,113 > $65,000?	Yes
Est. loss - cost outlier	$81,113 - $65,000	$16,113
Cost outlier payment	$16,113 x 80%	$12,890
DRG payment	$23,671 + $12,890	$36,561

CCR – 21.83% in this example

High Outlier Calculation

Loss= DRG Base Payment- Cost (CCR x Charges) *Does Loss exceed threshold of $65,000?*

If yes, then

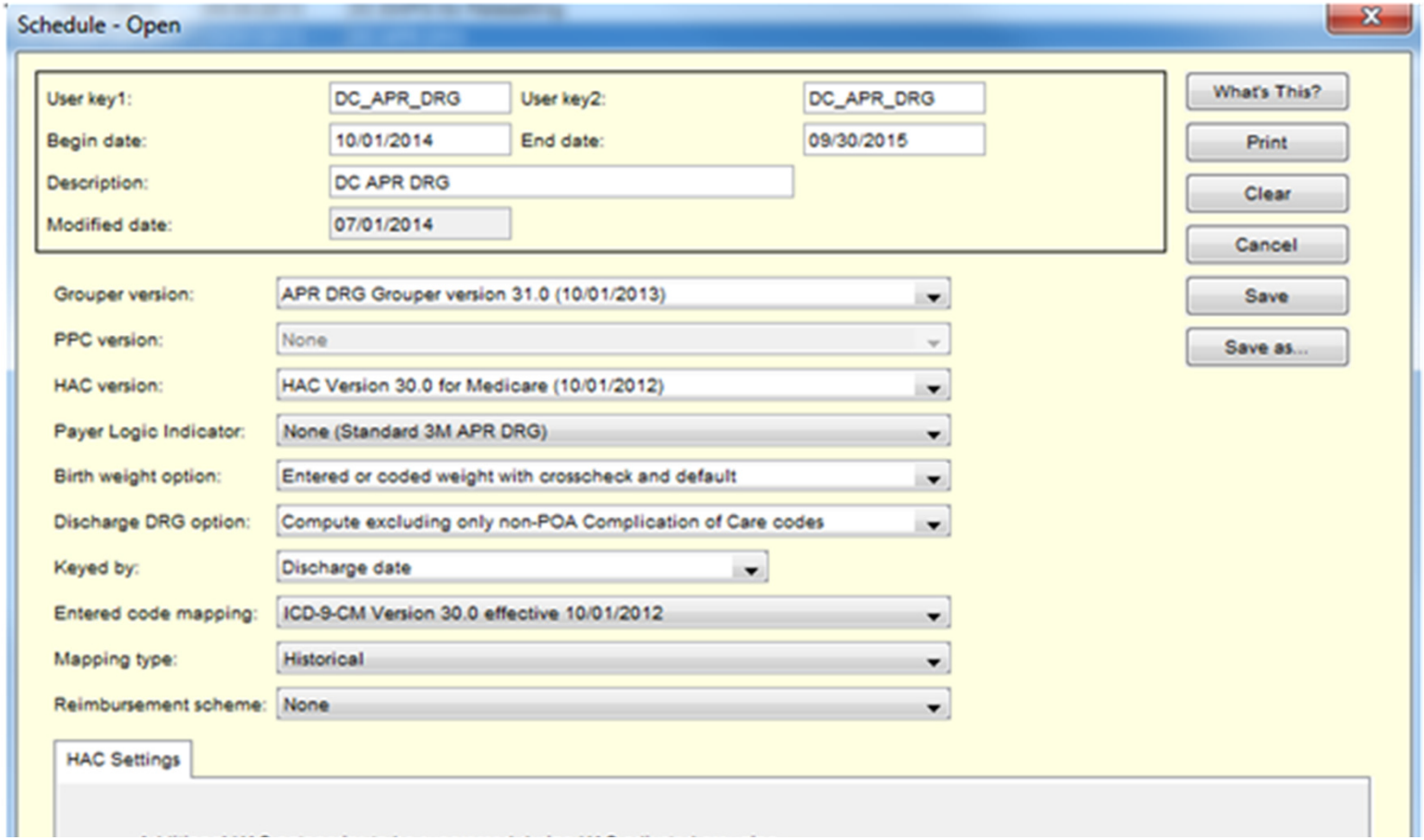
DRG High-outlier additional payment = (Loss - threshold) x Marginal Cost Factor (80%)

DRG Pricing Examples: Transfer Adjustment

Example: DRG 190-3, Heart-attack LOS= 3 days; Transferred to another general hospital		
Step	**Explanation**	**Amount**
DRG base payment	$10,906 x 1.14271	$12,462
Transfer case	Discharge status = 02	Yes
National ALOS	Look up from DRG table	5.18
Tsf adjustment	($12,462/5.18) * (3+1)	$9,623
DRG payment	$9,623 < $12,462	$9,623

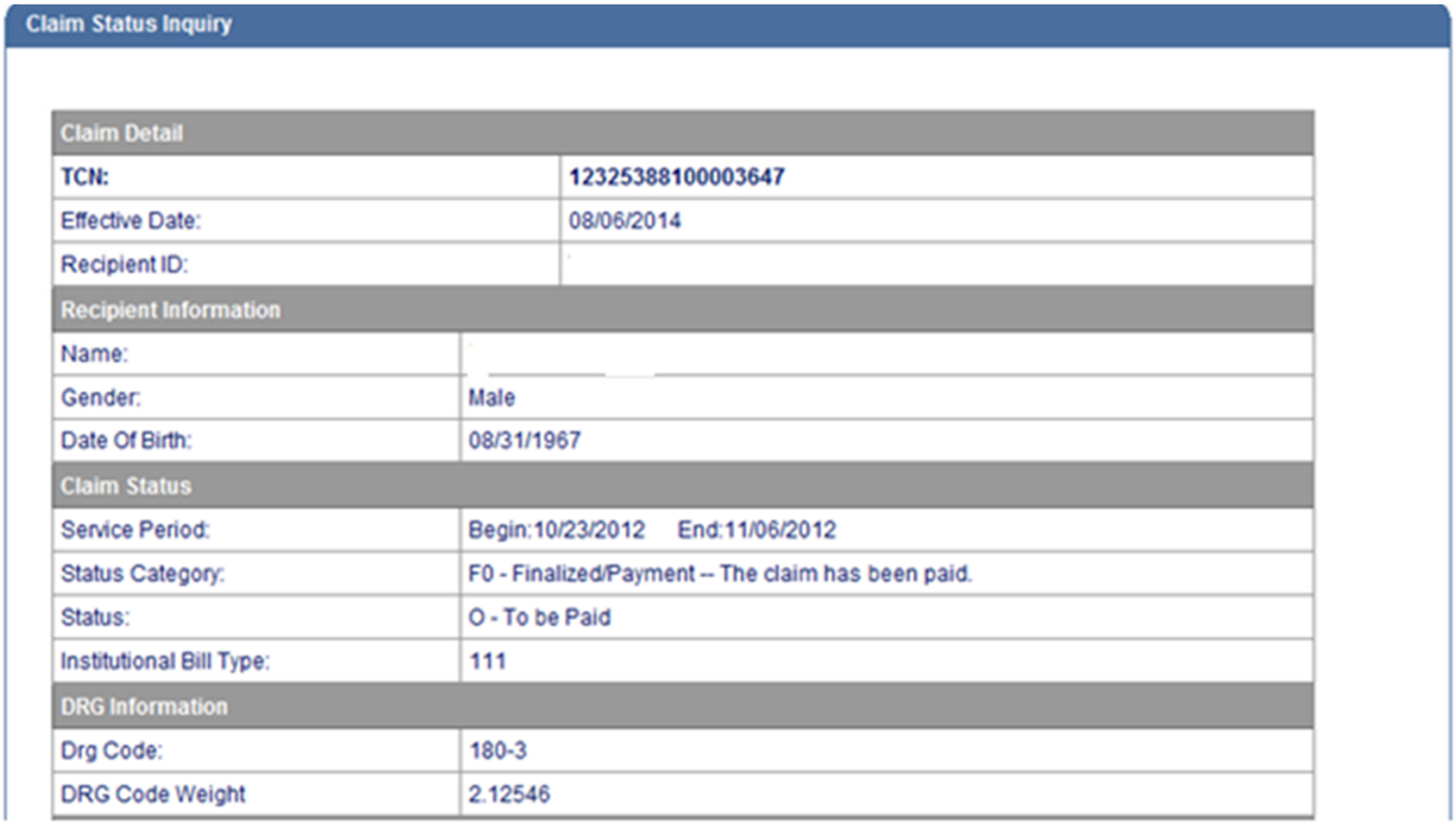
Policy & Technical Updates

Grouper Software Settings Year 1



Provider Portal

Provider Portal Slides



Claim Status Inquiry

Claim Detail	
TCN:	**12325388100003647**
Effective Date:	08/06/2014
Recipient ID:	
Recipient Information	
Name:	
Gender:	Male
Date Of Birth:	08/31/1967
Claim Status	
Service Period:	Begin:10/23/2012 End:11/06/2012
Status Category:	F0 - Finalized/Payment -- The claim has been paid.
Status:	O - To be Paid
Institutional Bill Type:	111
DRG Information	
Drg Code:	180-3
DRG Code Weight	2.12546

- DRG Code and DRG Code Weight are new additions
- Line Item information is unchanged

For Further Information

FAQ- On DHCF website

DRG Grouping Calculator- 3M has made available; please contact Don Shearer for access

DRG Pricing Calculator- contains list of DRGs, relative weights, and will price a claim

DRG Pricing Calculator Instructions- Step by step instructions to use the DRG calculator

Training Presentation

DC Medicaid DRG Pricing Calculator

Note: This calculator does not reflect final decisions on the structure of the DC general, acute care hospitals fee-for-service DRG payment method that will be implemented October 1, 2014. Specialty hospital stays are subject to unique payment methods.

Indicates information to be input by the user (cells E7-E18). Look for an estimate of final payment in Cells E66 and E69.

Indicates payment policy parameters set by Medicaid (cells E20-E28). Check Tab 3- DRG Base Rate Addons for hospital-specific base rates and addons to use in calculator.

Information	Data	Comments or Formula
INFORMATION FROM THE HOSPITAL-- TO BE INPUT BY THE USER		
Total charges	$19,232.00	UB-04 Form Locator 47
Cost-to-charge (CCR) ratio (Hospital-specific)	21.83%	Used to estimate the hospital's cost of this stay
Length of stay	2	Used for transfer pricing adjustment
Discharge status = 02, 05, 63, 65, 66, 82, 85, 91, 93, 94	No	Used for transfer pricing adjustment
Patient age (in years)	2	Used for age adjustor
Other health coverage	$0.00	UB-04 Form Locator 54 for payments by third parties
Patient share of cost	$0.00	Includes spend-down or copayment
Is discharge status equal to 30?	No	Indicates an interim claim
DRG base rate (Hospital-specific including IME)	$13,336.76	Used for DRG base payment--see 3-DRG base Rate Addons
Capital add-on payment (Hospital-specific)	$1,053.81	Capital payment applies to in-District hospitals; See 3-DRG base rate addon tabs.
DME add-on payment (Hospital-specific)	$1,388.56	DME applies to in-District hospitals; See 3-DRG base rate addons tab.
APR-DRG	759-2	Assigned via separate APR-DRG grouping software
PAYMENT POLICY PARAMETERS SET BY MEDICAID--SUBJECT TO CHANGE		
High-cost outlier threshold	$65,000	Used for high-cost outlier adjustments
Low-cost outlier threshold	$30,000	Used for low-cost outlier adjustments
Marginal cost percentage	80%	Used for high-cost outlier adjustments
Interim claim threshold- days	30	Threshold defining interim claims in days
Interim claim threshold- dollars	$500,000	Threshold defining interim claims in dollars
Interim per diem amount	$500	Per diem for pricing interim claims
Pediatric mental health adjustor	2.25	Applied to pediatric mental health DRGs defined in the tab 4-DRG table
Neonate adjustor	1.25	Applied to neonate DRGs defined in the tab 4-DRG table
Pediatric adjustor (excludes ped MH, neonate, newborns)	1.50	Applied to ped misc & ped resp stays (excludes norm newborn), see tab 4
APR-DRG INFORMATION		
APR-DRG description	EATING DISORDERS	Look up from DRG table
Casemix relative weight--unadjusted	0.69607	Look up from DRG table
Pediatric Medicaid Care Category	Pediatric mental health	Look up pediatric or neonate MCC from DRG table or n/a
Pediatric or Neonate Policy adjustor used (if applicable)	2.25	Assign policy adjustor value depending on pediatric or neonate MCC
Payment relative weight	1.56616	Casemix relative weight (E31) times policy adjustor (E33)
National average length of stay for this APR-DRG	12.97	Look up from DRG table

For Further Information

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