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

*Frequently Asked Questions*

***Version Date: October 1, 2020***

**Updates for October 1, 2020**

Effective October 1, 2020, the District-wide base rate is $13,690 for all acute care hospitals, a 13% increase from fiscal year (FY) 2020. The base rate is set to reimburse at 98% of costs for District hospitals as a group. United Medical Center (UMC) continues to receive a 2% increase to the District-wide base rate since it is located in an Economic Development Zone (EDZ).[i]

Other changes to the inpatient All Patients Refined Diagnosis Related Groups (APR-DRG) payment methodology for FY 2021 are an increase of the pediatric mental health policy adjustor from 1.75 to 2.0, an increase in the pediatric miscellaneous policy adjustor from 1.35 to 1.75, and reductions in the obstetric policy adjustor to 1.0 and normal newborn policy adjustor to 1.2. The neonate policy adjustor remains at 1.25, and the pediatric respiratory policy adjustor remains at 1.35. In addition, the high-cost outlier threshold increased to $81,000 and the marginal cost factor decreased from 93% to 55% in order to maintain the high-cost outlier pool at no more than 5%.

FY 2021 changes to the indirect medical education (IME) portion of the base rate, direct medical education (DME) add-ons and capital add-ons are based on individual hospital FY 2019 cost report information.

**OVERVIEW QUESTIONS**

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

The Department of Health Care Finance (DHCF) developed a new method of paying for hospital inpatient services in the fee-for-service (FFS) Medicaid program using APR-DRGs effective October 1, 2014.

**2. What providers are affected?**

The APR-DRG method applies to general acute care hospitals previously paid by DRGs, including out-of-District hospitals with the exception of Maryland hospitals. Maryland hospitals will continue to be paid by their current method as required by a federal waiver. Stand-alone mental health, long-term care, and rehabilitation facilities are not included in this payment method.

**3. How were hospitals previously paid?**

The Department reimbursed FFS inpatient hospital Medicaid services using All Patient Diagnosis Related Groups (AP-DRGs) from 1998 until the new payment method using APR-DRG version 31 was implemented effective October 1, 2014. The grouper was updated in October 2016 (version 33) and October 2018 (version 35).

### 4. What services are impacted?

For affected hospitals, the new method applies to all inpatient hospital FFS claims.

### 5. Does 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.

### 6. What is the DRG base rate?

Prior to October 1, 2014, the District used a hospital-specific base rate to reimburse each hospital at 98% of their costs. Effective October 1, 2014, the department implemented a single District-wide base rate for all acute care hospitals. The District-wide base rate for FY 2016 through FY 2019 ($11,756), FY 2020 ($12,120) and FY 2021 ($13,690) were set to reimburse at 98% of costs for fee-for-service stays at 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, UMC is the only hospital located in an EDZ within the District. District government has a policy allowing the provision of a 2% favorable consideration to qualified businesses in EDZs. UMC receives a 2% increase to the District-wide base rate.

## ALL PATIENT REFINED DIAGNOSIS RELATED GROUPS (APR-DRGs)

### 7. 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 implemented is compliant with the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

### 8. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M Health Information Systems and the Children’s Hospital Association (formerly National Association of Children's Hospitals and Related Institutions (NACHRI). According to 3M, APR-DRGs are used by major payers in 30 states, including Medicaid programs in 28 states, commercial payers in 11 states and by thousands of 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 analyses done by organizations such as the Agency for Healthcare Research and Quality and the Medicare Payment Advisory Commission.

**9. Does my hospital need to buy APR-DRG software in order to get paid?**

No. The Medicaid claims processing system assigns the APR-DRG and calculates 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 https://www.3m.com/3M/en_US/health-information-systems-us/support/. DHCF and Conduent (which advises the Department) have no financial interest in APR-DRG software or in any business arrangements between hospitals and their vendors who license APR-DRGs.

**10. What version of APR-DRGs was implemented?**

The Department implemented version 31 of APR-DRGs on October 1, 2014, which was released October 1, 2013. The Department moved to version 33 of the grouper effective October 1, 2016 and to version 35 effective October 1, 2018. For FY 2021, the Department will remain on version 35 of the APR-DRG grouper and relative weights.

**11. What is the APR-DRG format?**

Initially, each stay is assigned to one of 328 base APR-DRGs (version 35). 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 separate fields. The Department concatenates these fields for purposes of calculating payment. The APR-DRG is therefore four bytes (ignoring the hyphen), in contrast to the three-byte APR-DRG field.

**12. Does 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) software, and uses it to assign DRGs to claims.

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

The DC Medicaid weights are based on the Hospital-Specific Relative Value (HSRV) national relative weights as developed and maintained annually by 3M. Effective October 1, 2016, DC Medicaid slightly adjusted these weights downward to accommodate the increased casemix impact of ICD-10 coding. These adjusted weights were also used for FY 2018 payment because there was no grouper change for October 1, 2017. However, FY 2021 rates are based upon version 35 of the HSRV national weights with no adjustments.

## OTHER QUESTIONS

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

For approximately 95% 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 #15.

- ***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- 2% of all stays and a higher percentage of all DRG payments. For FY 2021 the high-cost outlier threshold is $81,000; the low-cost outlier threshold is $40,000. The marginal cost percentage on high-cost outliers is 55%. Please see Questions #16 and #17.

- ***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. 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. Medicaid Care Category (MCC) is a categorization algorithm based on APR-DRGs developed by Conduent for hospital inpatient analyses. MCCs are intended to result in a manageable list of categories that are aligned with both the policy areas of a typical Medicaid program and the internal organization of a typical hospital.

  DHCF utilizes five policy adjustors to promote access for newborn and pediatric (patients less than 21 years old) stays. The obstetric policy adjustor was removed in FY 2021 due to the significant increase in the base rate. For FY 2021 the policy adjustor are: 1.20 for normal newborns, 1.25 for neonates, 2.00 for pediatric mental health, 1.75 for pediatric miscellaneous stays, and 1.35 for pediatric respiratory stays. The policy adjustor values are based on the relative payment levels (pay-to-cost ratios) by MCC in the initial ratesetting simulations; higher policy adjustor values do not necessarily equate to higher payments between MCCs.

  For version 35 of the grouper, DHCF determined that the following DRGs are related to sick infants and are not normal newborns. Therefore these DRGs were mapped from the newborn MCC to the neonate MCC in FY 2019 and continuing through FY 2021.

| APR-DRG | APR-DRG Description |
|---|---|
| 626-3 | Neonate BWT 2000-2499G, normal newborn or neonate w other problem |
| 626-4 | Neonate BWT 2000-2499G, normal newborn or neonate w other problem |
| 640-4 | Neonate Birthwt >2499G, normal newborn or neonate w other problem |

  The calculation formula for policy adjustors 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. There are no changes to current policies or procedures on third party liability or share of cost.

## 15. How are transfers paid?

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

- The DRG base payment; or

- 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 the overall average length of stay plus one day. The receiving hospital is paid the full DRG payment. Previously, claims with a patient discharge status of 02 or 05, indicating an acute care transfer, were paid using this transfer logic applied to the transferring hospital only. Effective October 1, 2014, the Department adjusted transfer logic to include eight additional patient discharge status codes; see Table 1 for a listing of codes.

**Table 1**
**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 Medicare certified long-term care hospital (LTCH) 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 |

## 16. How are high-cost outliers paid?

High-cost outliers are paid using a standard high-cost outlier threshold that is not DRG-specific in order to determine whether a claim qualifies for high-cost outlier treatment. The calculation 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 cost-to-charge ratio (CCR) is multiplied by charges to calculate the estimated cost of the stay. The difference between the cost of the stay and the 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. In FY 2021, the high-cost threshold increases to $81,000 and the marginal cost factor is decreased from 93% to 55% beginning October 1, 2020. These changes are required to maintain an overall high-cost outlier pool of 5%.

**17. How are low-cost outliers paid?**

A single marginal cost threshold is used to determine whether a claim qualifies for low-cost outlier payment. The "gain" on these claims is measured as charges times CCR minus the DRG payment. If the gain exceeds the low cost threshold, then the transfer policy methodology is used to calculate the reduced payment. There marginal low cost threshold increased to $40,000 as of October 1, 2020.

**18. How does 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.

**19. How are interim claims paid?**

Interim claims are 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 0112 or 0113) 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 showing all charges, diagnoses and procedures for the full admit through discharge period. Bill types 0114 (final interim claim) and 0115 (late charges) will be denied from DRG hospitals.

**20. How are crossover claims paid?**

There are no changes to Medicare crossover claims related to the APR-DRG project.

**21. Are there any changes to the prior authorization policy?**

All inpatient stays require preauthorization and concurrent review.

**22. Are there any changes 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 paid as per-discharge add-ons while indirect medical education (IME) is added to each hospital's base rate. Out-of-District hospitals do not receive capital, DME and IME payments.

Below are the limits to capital, DME, and IME payments for DRG hospitals which are effective on October 1, 2020:

- Capital – the limit is 100% of the District average capital cost per Medicaid patient day.
- DME – the limit is 150% of the average DME cost per Medicaid patient day.
- IME – the limit is 50% of the amount calculated using the Medicare algorithm.

**23. How does this affect the overall payment level?**

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

**24. How does the change affect funding to each hospital?**

Every year when the District sets rates for the upcoming fiscal year (which begins in October), hospitals are sent rate letters which contain the new rates and are given their own claims data which was used to simulate those rates. This allows each hospital to evaluate the impact of the new rates at a claim level. Rate letters with claims are usually sent out before October.

**25. How did ICD-10-CM/PCS affect the DRG payment method?**

The implementation of ICD-10 coding on October 1, 2015 resulted in a casemix increase and therefore a payment increase on FY 2016 claims. For FY 2017, APR-DRG relative weights were adjusted downward by 4% to accommodate this increase. The use of the adjusted weights continued in FY 2018 but were eliminated for FY 2019 with the implementation of version 35 of the grouper. There are no adjustments to DRG national weights for FY 2021.

**26. Are there 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 for appropriate DRG assignment. Please see question #27 for information on recording birth weight on a newborn claim. Please see question #28 related to billing outpatient services provided within a three day window of an inpatient stay.

**27. How should 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-10 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. As of 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 adjusted 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.

**28. 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. Additionally, all hospital outpatient services that occur on the same day as an inpatient admission at the same hospital are considered part of the inpatient stay and are not separately payable.

**29. Where can I go for more information?**

- ***FAQ***. Updates of this document are available on the DHCF website.

- ***DRG Grouping Calculator.*** 3M Health Information Systems 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, contact Sharon Augenbaum (see "For Further Information" below).

- ***DRG Pricing Calculator.*** DHCF makes an APR-DRG Pricing Calculator available on their website. It does not assign the APR-DRG, but it does show how a given APR-DRG will be priced in different circumstances. The calculator includes a complete list of APR-DRGs and related information for pricing.

**FOR FURTHER INFORMATION CONTACT:**

Sharon Augenbaum, Reimbursement Analyst
Office of Rates, Reimbursement and Financial Analysis
Department of Health Care Finance
Tel: 202-442-6082
Email: Sharon.augenbaum@dc.gov

[i] In its website, District government defines the DZE designation as follows: "Enterprise Zones and Economic Development Zones are both areas in the District designated by law to provide special initiatives that stimulate economic growth and job development. Programs include taxable and tax-exempt revenue bonds to finance the acquisition, construction and renovation of a wide array of capital projects owned by private enterprises and nonprofit institutions; wage credits and additional expensing allowance; a zero federal capital-gains tax rate on certain investments; and tax-exempt bond financing. Businesses that are located within either of these zones and have received a "DZE" certification from DSLBD will also be eligible for two preference points and a two-percent price reduction for proposals and bids. Select an icon to the left to see the boundaries of either zone and print the maps to help you choose your business location." Downloaded 9/23/13 from http://lsdbe.dslbd.dc.gov/public/ezl/.