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

Frequently Asked Questions

Version Date: October 1, 2016

Updates for October 1, 2016

Effective October 1, 2016 the District-wide base rate is $11,756 for all acute care hospitals which is unchanged from FY16. The District-wide base rate is set to reimburse at 98% of costs for District hospitals as a group. United Medical Center will receive an increase to the District-wide base rate by 2% since it is located in an Economic Development Zone.

Effective October 1, 2016, the District will move from version 31 of the APR-DRG grouper to version 33. Version 33 of the Hospital-Specific Relative Value (HSRV) national relative weights will be adjusted slightly to accommodate the increased casemix impact of ICD-10 coding.

Other changes to the inpatient APR-DRG payment methodology for FY17 are: the marginal cost percentage on high cost outliers is increased from 80% to 95%, and the threshold for low cost outliers is reduced from $30,000 to $20,000.

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 Medicaid program using APR-DRGs effective October 1, 2014. This FAQ document is intended to provide interested parties with periodic updates on the project.

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. 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 has been determined by the Specialty Hospital Project group.

3. How were hospitals previously paid?

The Department 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. The new APR-DRG V .31 method was implemented effective October 1, 2014.

4. What services are impacted?

For affected hospitals, the new method applies to all inpatient hospital fee-for-service 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. As of October 1, 2014, the department implemented a single District-wide base rate for all acute care hospitals. The District-wide base rates for for FY 2016 and FY 2017 ($11,756 for both years) were 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 received an increase to the District-wide base rate of 2%.

ALL PATIENT REFINED DRGs (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 ICD-10 ready.

8. 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.

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 www.3m.com/us/healthcare/his/products/coding/refined_drg.html. DHCF and Xerox (which advised 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 V.31 of APR-DRGs on October 1, 2014, which was released October 1, 2013. The Department will move to V.33 of the grouper effective October 1, 2016.

11. 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 concatenates 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.

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 will use the HSRV relative weights that have been recentered to accommodate increased casemix levels which are a result of the transition to ICD-10 coding.

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% to 2% of all stays and a higher percentage of all DRG payments. For FY 2017 the high-cost outlier threshold is $65,000; the low-cost outlier threshold will change from $30,000 to $20,000. The marginal cost percentage on high-cost outliers is increased for FY17 from 80% to 95%. 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 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 utilizes three policy adjustors to promote access for pediatric stays (patients less than 21 years old). For FY 2016 and FY 2017, the values for the three policy adjustors are: 2.0 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. 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

- 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. 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 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 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
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.	

16. How are high-cost outliers paid?

Effective October 1, 2014, high-cost outliers are 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. Previously, outliers were 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, 2016, the marginal cost threshold is $65,000 and marginal cost factor is 95%.

17. How are low-cost outliers paid?

Effective October 1, 2014, DRG-specific thresholds are no longer used in favor of a single marginal cost threshold to determine whether a claim qualifies for low-cost outlier treatment. The "gain" on these claims is measured as charges times CCR minus the DRG payment. If the gain exceeds the marginal cost threshold, then the transfer policy methodology is used to calculate the reduced payment. The marginal low-cost threshold of $20,000 is effective October 1, 2016.

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 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.

20. How are crossover claims paid?

There are no changes to Medicare crossover claims as they were not part of 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. Some hospitals requested that efficiency be rewarded in the reimbursement process by redirecting hospital-specific add-on payment funds 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. Below are the final decisions regarding phased-in limits to Capital, DME, and IME payments for DRG hospitals which were effective with the implementation of APR-DRGs on October 1, 2014:

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

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

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

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?

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 include a District-wide base rate (see question #6), limits on IME and add-ons (see question #22), specific pediatric policy adjusters and changes to outlier policies (see question #14). In August 2016, hospitals were given their FY15 claims data with charges inflated by 3.3% (based on two years of Medicare's IPPS inflation factor), then repriced using these new policies to allow them to evaluate the impact.

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

The implementation of ICD-10 nationwide was delayed. DC Medicaid implemented V.31 of APR-DRG on October 1, 2014, which accepts both ICD-9 and ICD-10 codes. When ICD-10-CM/PCS was implemented nationwide, the claims processing system accepted ICD-10 diagnosis and procedure codes and utilized ICD-10 codes for internal processing. Hospitals should follow national guidelines in submitting ICD-10 codes.

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 to 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-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. 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 and password, contact Sharon Augenbaum (see "For Further Information" below).

- ***DRG Pricing Calculator.*** DHCF has made 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:

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