

District of Columbia Medicaid

A New Inpatient Hospital Payment Method: APR-DRG

Frequently Asked Questions

Version Date: January 24, 2014

Please note that details of the payment method shown in this document remain subject to change before the implementation date of October 1, 2014.

Changes have been made since the August 23, 2013 version.

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 in-patient 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) as an aspect of the ICD-10 project implementation on October 1, 2014. APR-DRGs are ICD-10 ready and updated annually by 3M. The AP-DRG grouper cannot be used after 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 of staff from DHCF is developing the new method. The workgroup finished its policy design work and DHCF has approved all recommendations on the structure of the payment method. The target date to implement payment by APR-DRG is October 1, 2014. Final ratesetting will occur in the spring and summer of 2014.

7. What services will be impacted?

For affected hospitals, the new method 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 that are participating in managed care organizations' (MCO) networks are outside the scope of this project.

9. What will the DRG base price be?

The district currently uses a hospital-specific base price reimbursing each hospital at 98% of their costs. As of October 1, 2014, the department will implement a single district-wide base price for all acute care hospitals. The district-wide base rate will be 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.

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, and because they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.

APR-DRGs are being 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, which was released October 1, 2013. Simulation modeling for the new payment method was performed using V.30 (released October 1, 2012). Final ratesetting will be done using V.31.

14. What is the APR-DRG format?

Each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned to one of four levels of severity (minor, moderate, major or extreme) that are specific to the base APR-DRG. 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 will acquire the 3M™ All Patient Refined Diagnosis Related Groups (APR-DRGs), Version 31, and will use it to assign the DRGs to claims.

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

The two options are to use relative weights calculated from the Nationwide Inpatient Sample by 3M or relative weights 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 and a single threshold for low-side outliers. Please see Questions #19 and #20.
- **Third Party Liability and patient cost-sharing.** DRG payment policies determine the allowed amount. From the allowed amount, payers typically deduct payments from other health coverage (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.

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 would be the DRG base payment divided by the DRG-specific average length of stay.

The effect would be 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 would receive the full DRG payment. DC Medicaid will define a transfer as UB-04 discharge status values 02, 05, 65, and 66. As of October 1, 2014, transfer codes 65 and 66 will be implemented and trigger transfer pricing in addition to transfer codes 02 and 05.

Transfer codes are:

- 02-Discharged/transferred to a short-term general hospital for inpatient care.
- 05-Discharged/transferred to another type of institution.
- 65- Discharged/transferred to a psychiatric hospital or distinct part unit of a psychiatric hospital
- 66- Discharged/transferred to a Critical Access Hospital (CAH)

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. 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 how the outlier payment is calculated. Currently, outliers are paid at 80% of excess costs. (Excess costs are costs that exceed the DRG cost outlier threshold.) Instead, the loss to the hospital will be calculated based on the product of charges and cost to charge ratio (CCR) subtracted from the DRG payment, then multiplied by the marginal cost factor to determine the additional outlier payment. The marginal cost threshold and marginal cost factor will be set during ratesetting in 2014.

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 marginal cost threshold, in order to determine whether a claim qualifies for low cost outlier treatment. The “gain” on these claims will be measured (charges times CCR minus the DRG payment) and if the gain exceeds the marginal cost threshold, then the transfer policy methodology to calculate the reduced payment will be used. The marginal cost threshold will be set during ratesetting in 2014.

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 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?

Changes to prior authorization requirements are being discussed.

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 price.

In January 2014, the District shared the plan to phase in the implementation of changes to add-on payments 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 with the implementation of APR-DRGs on October 1, 2014:

- IME - IME limits will be phased in over two years. The District will limit IME to 75% of the amount calculated using the Medicare algorithm in FY15. 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.

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?

Because there will be a major change in the payment method, we do expect hospitals to see changes in payments. The impacts will depend on ratesetting decisions that have not yet been made and, most importantly, whether there are policy-based adjustments to certain categories of care. A policy adjustor for pediatrics is under consideration.

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

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. Because a HIPAA-approved version of ICD-10-CM/PCS will not be available from CMS until July 2014, the earliest version of APR-DRGs that can contain this approved list for DRG assignment is V.32. Since, DC Medicaid will implement and be in production with V.31 on October 1, 2014, we will use a bridge created by 3M to map from ICD-10 to ICD-9 in order to assign APR-DRG codes. When DC Medicaid upgrades to V.32 of APR-DRG the bridge will no longer be needed and APR-DRGs can be assigned using the HIPAA-approved ICD-10-CM/PCS codes.

29. Will there be changes in billing requirements?

No changes to billing requirements are anticipated. Under DRG payment, complete recording of all appropriate diagnoses and procedure codes is critical to appropriate DRG assignment.

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. The capability still exists for hospitals to submit the 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 10/1/14, hospitals can submit birthweight 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 the grouper to read birth weight in both ways. Hospitals are encouraged to submit the birthweight in the value-code field as this is more specific.

31. 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 and then shows 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.** Once decisions have been made about the structure of the APR-DRG payment method, DHCF plans to make 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.
- **Hospital information sessions.** Hospital information sessions will be held during the spring and summer of 2014.

FOR FURTHER INFORMATION

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

APPENDIX of DRG BACKGROUND

1. How do DRG payment methods work?

APR-DRG payment will work very similarly 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 price to arrive at the DRG base payment. For example, if the DRG relative weight is 0.50 and the DRG base price 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 better information about services provided.