District of Columbia Medicaid Specialty Hospital Project

Frequently Asked Questions

OVERVIEW QUESTIONS

1. What is the Specialty Hospital project?

The Department of Health Care Finance (DHCF) is developing a new method of paying for hospital inpatient services at certain hospitals in the fee-for-service Medicaid program. This project is in the initial stages. This FAQ document is intended to provide interested parties with periodic updates on the project. **Please note that no decisions have been finalized about how the new payment method will work.**

2. What will the new payment method be?

DHCF will be utilizing APR-DRGs to adjust payment to select specialty hospitals. Some hospitals will continue to be paid on a per diem basis and others on a per stay basis. In both cases the actual payment will be adjusted for the severity of the member, based on the APR-DRG assigned to their hospital stay.

3. What providers will be affected?

The new method will apply to five acute care specialty hospitals currently paid by at a flat-rate per diem. These hospitals include Psychiatric Institute of Washington (PIW), The Hospital for Sick Children (HSC), National Rehabilitation Hospital (NRH), Specialty Hospital- Hadley and Specialty Hospital-Capitol Hill.

4. Why is the change being made?

DHCF desires to replace the current flat-rate per diem with a prospective payment method that more closely aligns payment with patient need.

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

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

6. How are hospitals currently paid?

The Department reimburses the five hospitals with a hospital specific per diem.

7. What is the timeframe?

A workgroup of staff from DHCF is developing the new method. The workgroup is scheduled to finish its policy design work February of 2014 at which point DHCF will review all recommendations and make final decisions on the structure of the payment method. The target date to implement payment by APR-DRG is October 1, 2014.

8. What services will be impacted?

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

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

Payments to hospitals that are participating in managed care organizations' (MCO) networks are outside the scope of this project. Hospitals which are non-participating with MCOs must be paid at the District rate and method by MCOs.

10. What will the DRG base price be?

The district will use a hospital-specific base price.

ALL PATIENT REFINED DRGs (APR-DRGs)

11. 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. The Department will implement V.31 which is ICD-10 ready.

12. 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, the State of Maryland, Montana Medicaid, New York Medicaid, Pennsylvania Medicaid, Rhode Island Medicaid, Colorado Medicaid, North Dakota Medicaid, South Carolina Medicaid, Mississippi Medicaid, and Wellmark, the BlueCross BlueShield plan in Iowa.

13. In order to be paid would my hospital need to buy APR-DRG software?

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.

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

The Department intends to implement V.31 of APR-DRGs, which will be released October 1, 2013. Simulation modeling for the new payment method will be done using V.30, which was released October 1, 2012. Final ratesetting will be done using V.31. Usually, a period of nine months is taken to evaluate a new release prior to implementation.

15. 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 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 would 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.

16. Would the hospital have to submit the APR-DRG on the UB-04 paper form or the 837I electronic transaction?

No. DHCF would assign the APR-DRG based on the diagnoses, procedures, patient age, and patient discharge status, all as submitted by the hospital on the claim.

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

The two options are to use relative weights calculated from the Nationwide Inpatient Sample or relative weights calculated from District data. DC Medicaid will use national relative weights.

OTHER QUESTIONS

18. How will the Department ensure that adequate payment is made for very expensive or long lengths of stay often seen at the Specialty hospitals?

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. Outlier adjustments typically affect 1% to 2% of all stays. The Department is considering outlier policies appropriate to the per stay and the per diem payment methods being considered for each of the specialty hospitals.

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

Specialty Hospital payments will be hospital specific. As such, no additional add-on payments are anticipated.

20. 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.

21. 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 decisions that have not yet been made, most importantly whether there are policy-based adjustments to certain care categories, whether there will be changes to how DRG base prices are determined, and whether there is a transitional period before the new payment rates are fully implemented.

22. Will there be changes in billing requirements?

No changes to billing requirements are anticipated due to the change to APR-DRG. However, since this change coincides with ICD-10 implementation, ICD-10-CM and ICD-10-PCS codes must be used for discharges on and after 10/1/14.

23. 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 <Need contact here> (see "For Further Information" below).

- ***Specialty Hospital 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

DRG project questions	Ganayswaran Nathan Deputy Director Medicaid Finance Ganayswaran.nathan@dc.gov 202.442.8980
Technical questions re DRG payment, relative weights, outlier calculations etc.	Jeff Gray Project Director, Xerox jeff.gray2@xerox.com 414.258.1655

APPENDIX of DRG BACKGROUND

1. How do DRG payment methods work?

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 Specialty Hospital payment this base payment can either reflect the base per diem, or the base payment for the entire stay. For example, if the DRG relative weight is 1.25 and the DRG base per diem price is $1,000 then the payment rate for that DRG is $1,250 per diem.

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.

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

For approximately 90% of stays, payment is typically made using a "straight DRG" calculation—that is, payment equals the DRG relative weight times the DRG base price, as described above. In special situations, payment may also include other adjustments, e.g.

- ***Transfer pricing adjustment.*** Payment may be reduced for some stays where the patient is transferred to another acute care hospital.

- ***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. Outlier adjustments typically affect 1% to 2% of all stays.

- ***Third party liability.*** The calculations described above determine the allowed amount. From the allowed amount, payers typically deduct amounts for which a third party (e.g., workers' compensation, other insurance) is liable as well as copayments or other amounts owed by the patient. In a Medicaid program, these amounts are typically minor.