

District of Columbia Medicaid Specialty Hospital Project

Frequently Asked Questions

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UPDATE:

The District of Columbia Department of Health Care Finance (DHCF) is submitting State Plan Amendments (SPAs) for three new hospital payment methods that will be effective October 1, 2014. However, until the District obtains approval of the SPAs, we do not have authority to implement the changes. Accordingly, while the changes will be effective October 1, 2014, we will implement the changes retroactively upon approval by the Centers for Medicare and Medicaid Services (CMS). DHCF will continue to pay hospital claims using current payment methodologies and current rates. Once the SPA has been approved and the new methods are activated in the Medicaid Management Information System (MMIS), all claims with discharge dates or dates of service on or after October 1, 2014 will be reprocessed with payment adjustments as necessary under the new payment methods.

For more information regarding the delay of the new payment methods, please see Transmittal #14-27 *Advice Regarding Implementation of Hospital Payment Methodologies – Update on Retroactive Implementation* at <https://www.dc-medicaid.com/dcwebportal/home>

As always, hospitals should continue to assign ICD-9 and CPT/HCPCS codes according to national coding guidelines.

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

OVERVIEW QUESTIONS

1. What is the Specialty Hospital project?

The Department of Health Care Finance (DHCF) is developing a new payment method for hospital inpatient services at certain hospitals in the fee-for-service Medicaid program. This FAQ document is intended to provide interested parties with periodic updates on the project.

2. What providers will be affected?

The new method will apply to five specialty hospitals currently paid at flat-rate per diem rates. 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.

PIW, HSC and NRH will be paid by the per-diem specialty hospital payment method. Hadley and Capitol Hill will be paid by the per-stay specialty hospital payment method.

3. What will the new payment method be?

DHCF will use 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.

Under the per diem method, each hospital will have a hospital-specific per diem base rate. Each hospital stay will be assigned an APR-DRG. A relative weight is assigned to each APR-DRG. Payment is then a component of base rate X APR-DRG relative weight X number of authorized days.

Under the per stay method, the adult LTCH hospitals have a base rate. Each hospital stay will be assigned an APR-DRG. A relative weight is assigned to each APR-DRG. Payment is then a component of the base rate X APR-DRG relative weight + any applicable outlier adjustments.

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 has met regularly with the District hospitals throughout the project. This document (the Frequently Asked Questions-FAQ) will be regularly updated and made available to interested parties.

6. How hospitals are currently paid?

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

7. What is the timeframe?

The new payment methods will be effective October 1, 2014. They will not be activated in the DC Medicaid claims processing system until CMS approves the state plan amendment. Claims will continue to be processed under the current payment method and the current rates until approval is received. After approval, these claims will be reprocessed under the new methods. Rates will be adjusted accordingly.

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?

While payments to hospitals from Medicaid managed care plans are outside the scope of this project, the DC Medicaid managed care organizations may opt to move to Medicaid's new fee-for-service payment methods.

10. What will the DRG base rate be?

The District will use hospital-specific base rates. Hospitals will be offered an interim rate that may be based on other factors; otherwise the hospital-specific base rate will be aligned with hospital costs.

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 does 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 was released October 1, 2013. Simulation modeling for the new payment method was done using V.30, which was released October 1, 2012. Final ratesetting was done using V.31.

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

No. DHCF will 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?

DC Medicaid will use Hospital-Specific Relative Value (HSRV) national relative weights as developed and maintained annually by 3M.

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 will apply high and low-cost outlier adjustments to the per-stay specialty hospitals. The per-diem specialty hospital payment will not use any outlier adjustments as payment continues throughout the approved length of stay.

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 transfers be paid?

The per diem hospitals will incorporate a new transfer payment rule. Historically, per diem reimbursement does not pay for the last day of a hospital stay (day of discharge). Under the new payment methodology, if a patient is transferred to another acute care facility, the per diem hospital will be paid for the last day of the stay, at the casemix adjusted per diem amount.

Per-diem transfers will be determined based on the patient status code found on the claim. The codes which will be eligible for the additional last day payment are listed below:

Specialty Hospital per Diem Patient Status Codes for Transfer Adjustment	
Code	Description
02	Discharged/transferred to other short term general hospital for inpatient care.
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care -- (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
04	Discharged/transferred to intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'
43	Discharged/transferred to a federal hospital (eff. 10/1/03)

Specialty Hospital per Diem Patient Status Codes for Transfer Adjustment	
Code	Description
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)
63	Discharged/transferred to a long term care hospitals. (eff. 1/2002)
64	Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare (eff. 10/2002)
65	Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).
66	Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)
70	Discharged/transferred to another type of health care institution not defined elsewhere in code list.

For the per stay hospitals, transfer adjustments will be applied in the same manner that DRG-paid hospitals currently are. Specifically, 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 is the DRG base payment divided by the DRG-specific average length of stay.

The effect of this calculation reduces 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. Currently, claims with a patient discharge status of 02 or 05 indicating an acute care transfer are paid using special transfer logic applied to the transferring hospital only. The Department will adjust transfer logic to include eight additional patient status codes; see Table 1 for a listing of 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
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
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.	

21. How will the new payment method 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.

22. How will high-cost outliers be paid?

High-cost outliers will be paid using a standard high-cost outlier method. 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, 2014, the marginal cost threshold is \$60,000 and marginal cost factor is 80%.

23. How will low-cost outliers be paid?

The “gain” on a hospital claim will be measured as charges times CCR minus the DRG payment. If the gain exceeds the marginal cost threshold, then the transfer policy methodology will be used to calculate the reduced payment. The marginal low-cost threshold of \$25,000 is effective October 1, 2014.

24. How will interim claims be paid?

The per-diem and per stay specialty hospital payment methods allow for the billing of interim claims. However, the rules for interim claims differ between the two.

For the per-diem specialty hospitals, the hospital will be allowed to submit an interim claim without limits to duration or cost. These claims must be submitted using the correct type of bill codes (0112 or 0113). The payment of the per diem will be based on the APR-DRG assignment and casemix adjustment to the base rate. When the patient is discharged, the hospital must supply a final interim claim (type 0114). The District will engage in regular monitoring of the per diem hospitals to confirm that proper interim billing processes are followed.

The per-stay specialty hospitals will follow the current DRG payment rules for interim claims. There has been 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 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, admit through discharge showing all charges, diagnoses and procedures for the full admit-thru-discharge period. Bill types 0114 (final interim claim) and 0115 (late charges) will be denied from DRG hospitals.

However, until the state plan amendment is approved by CMS, DHCF will continue to pay hospitals under the current payment methods. When the approval is received, claims with discharge dates on or after October 1, 2014 will be reprocessed under the new payment methods.

As stated above, under the new payment method the final interim bill type 0114 will no longer be allowed for the per-stay specialty hospitals. Conversely, these codes are allowed under the current payment method. To address the potential payment denials this may cause, the District will apply the following process during the retroactive payment period.

- Prior to the new payment method activation, the District will evaluate how many claims were paid since October 1, 2014 using type of bill 0114.
- The District will notify Capitol Hill and Hadley about these claims so that they can be prepared to immediately resubmit them after denial during the mass adjustment process.
- When the new payment method is activated, claims with type of bill 0114 will be reprocessed and denied.
- The two hospitals should submit replacement claims for these admissions using the new billing instructions, which is to submit full admit-to-discharge claims. If there were any other interim claims associated with the discharge, (TOB 0112 or 0113), those will be denied in the mass adjustment as well. This will avoid the “duplicate” billing edit when the DRG claim is submitted.

25. How will crossover claims be paid?

There are no changes to Medicare crossover claims as they are not part of the APR-DRG project. Medicaid will continue to pay the lesser of these two amounts on an inpatient crossover claim:

- a. The Medicaid allowed amount minus the Medicare paid amount
- b. The Medicare co-insurance amount plus Medicare deductible amount

26. What changes, if any, will be made to the prior authorization policy?

The Department uses prior authorization to help control inappropriate utilization of services. While there are no changes contemplated that are specifically related to the implementation of APR-DRGs, changes in the Department’s prior authorization policy are made from time to time to address new coverage policies, new technologies or to address areas of potential fraud, waste and abuse.

27. 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.

The delay of ICD-10 implementation has no effect on the District’s implementation of APR-DRGs.

28. Will there be changes in billing requirements?

No changes to billing requirements are anticipated due to the change to APR-DRGs.

29. 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).

- **Specialty Hospital DRG Pricing Calculator.** 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 are periodically held to inform the hospitals on the progress and status of the implementation of the new payment methods.

FOR FURTHER INFORMATION

DRG project questions	Sharon Augenbaum Reimbursement Analyst sharon.augenbaum@dc.gov 202.442.6082
DRG grouping calculator access and questions	Don Shearer Director, Program Operations, DHCF donald.shearer@dc.gov 202.698.2007
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 rate 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 rate 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 rate, 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.