# District of Columbia Medicaid Specialty Hospital Project

*Frequently Asked Questions*

***Version Date: October 1, 2016***

**Updates for October 1, 2016**

Effective October 1, 2016 each specialty hospital will have an adjustment to their base rate for inflation using the Medicare inflation factor. This rate increase is stipulated in the State Plan Amendment to occur in each year between rate rebasing. The rate setting process took each hospital's rate established for District FY 2016, whether a per stay base rate or a per diem base rate, and adjusted it upwards by 1.55%.

**OVERVIEW QUESTIONS**

**1. What is the Specialty Hospital project?**

The Department of Health Care Finance (DHCF) developed a new payment method for hospital inpatient services at certain hospitals 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 are affected?**

The new method applies to five specialty hospitals previously 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), Bridgepoint-Hadley and Bridgepoint-Capitol Hill.

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

**3. Why has the change been made?**

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

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

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

**5. What services are impacted?**

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

**6. 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.

**7. What is the DRG base rate?**

The District uses a hospital-specific base rate. Hospitals were offered a hospital specific transition rate for the first year; otherwise the hospital-specific base rate is aligned with hospital costs.

## ALL PATIENT REFINED DRGs (APR-DRGs)

**8. 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.

**9. 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.

**10. 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.

**11. 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.

**12. 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.

**13. 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.

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

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

**OTHER QUESTIONS**

**15. How does 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 applies high and low-cost outlier adjustments to the per-stay specialty hospitals. The per-diem specialty hospital payments do not use any outlier adjustments as payment continues throughout the approved length of stay.

**16. What changes, if any, were made to add-on payments?**

Specialty Hospital payments are hospital specific. As such, no additional add-on payments are applied.

**17. How are transfers paid?**

The per diem hospitals incorporate a transfer payment rule. Historically, per diem reimbursement did not pay for the last day of a hospital stay (day of discharge). Under the current 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 are determined based on the patient status code found on the claim. The codes which are 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). |
| 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 hospital. (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 are applied in the same manner that DRG-paid hospitals currently are. 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<br>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:<br>1. Codes in black font will trigger a transfer adjustment for DRG claims effective 10/1/14.<br>2. Discharge status codes addressing readmission were announced in MLN Matters CR 8421 released 11/19/13. | |

### 18. How does 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.

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

High-cost outliers are paid using a standard high-cost outlier method. The 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. There are no changes to the cost thresholds effective October 1, 2016.

### 20. How are low-cost outliers paid?

The "gain" on a hospital claim is 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. There are no changes to the cost thresholds effective October 1, 2016.

### 21. How are interim claims 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 is 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 is 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 engages in regular monitoring of the per diem hospitals to confirm that proper interim billing processes are followed.

The per-stay specialty hospitals must 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.

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

There are no changes to Medicare crossover claims as they were not part of the APR-DRG project.

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

All inpatient stays require preauthorization and concurrent review.

**24. Are there any changes in billing requirements?**

There are no changes to billing requirements.

**25. 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 and then shows 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).

- ***Specialty Hospital DRG Pricing Calculator.*** DHCF makes available an APR-DRG Pricing Calculator. 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 FURTHER INFORMATION**

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

## 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 over 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.