



RI Medicaid

APR-DRG Frequently Asked Questions

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Effective July 1, 2010, the Rhode Island Executive Office of Health and Human Services (EOHHS) adopted a new Medicaid method of paying for hospital inpatient services based on All Patient Refined Diagnosis Related Groups (APR-DRGs). Our goals were to implement a new payment method that is sustainable, increases fairness, reduces administrative burden, rewards economy, and improves transparency.

This document provides questions and answers about the DRG payment method. We invite additional questions and we welcome suggestions. EOHHS continues to work with a hospital finance advisory group on questions of payment policy, implementation of changes and provider education.

Please note that details of the payment method remain subject to change, although no changes are planned at this time.

OVERVIEW QUESTIONS

1. When was the new method implemented?

The new method applies to stays with date of admission on or after July 1, 2010.

2. What change was made?

EOHHS changed its previous cost-based payment method to a new method based on All Patient Refined Diagnosis Related Groups (APR-DRGs).

3. What providers are affected?

The DRG payment method applies to acute care hospitals, including both general hospitals, specialty hospitals (e.g., psychiatric, rehabilitation), and distinct-part units, both inside Rhode Island and out of state. Payment methods are not changed for the Eleanor Slater Hospital.

4. What services are affected?

The DRG payment method applies to almost all stays. The three exceptions are:

- ***Medicare crossover stays.*** There was no change in payment calculations for stays where Medicare is the primary payer and Medicaid is the secondary payer. Note, however, that “No Part A” claims, in which a dually eligible patient either does not have Medicare Part A or has exhausted his or her Part A hospital benefit, are priced using the new DRG method. In these situations, Medicaid acts as the primary payer.
- ***Sub-acute mental health stays.*** For these stays, where approved, hospitals should continue to bill revenue code 154. Payment continues to be per diem.
- ***Pediatric patients with dual diagnoses of mental illness and intellectual or developmental disability.*** With prior authorization, services to these patients continues to be per diem if the

patient is expected to require highly specialized acute care for a period of weeks or months. Hospitals should bill revenue code 153 on the claim.

5. How much money is affected?

In FY 2013, approximately \$76 million is expected to be paid to hospitals for inpatient care. The new payment method was implemented on a budget-neutral basis, that is, total payments are expected to be about the same as they would have been under the previous payment method.

6. How did the previous payment method work?

EOHHS's previous method dated from 1971. Each year Medicaid and the hospital industry negotiated an overall percentage increase in hospital costs for serving Medicaid beneficiaries. In principle, the "Maxicap" was a starting place for hospital-specific budget agreements, but since 1993 the Maxicap percentages were usually applied across the board to each hospital. Since hospitals are paid per claim, and claims do not have cost information, interim payments were made at a percentage of charges. A settlement process then reconciled interim payments with the negotiated budgets. Adjustments were made when Medicaid utilization or the ratio of cost to charges differed from agreed-upon expectations.

7. Why change to the DRG payment method?

An important advantage is that the DRG method is more easily and appropriately sustained over time, with adaptations to promote access to quality care. Medicaid also now pays hospitals more fairly (similar pay for similar care). Transparency (how much Medicaid pays for what care) has been much improved over the previous cost-based situation. Under DRGs, the administrative burden of annual negotiations and the year-end settlement process has been eliminated. Lastly, the case-based DRG method financially incentivizes hospitals to provide cost-efficient care.

8. Does the fee-for-service change affect payments under Medicaid managed care (e.g., Rite Care and Rhody Health Partners)?

No. Although there had been discussion of a linkage between fee-for-service and managed care payment levels, the legislation as passed by the 2010 General Assembly did not contain any linkage.

PAYMENT CALCULATIONS

9. How will payment be calculated?

For over 90% of stays, payment is calculated very straightforwardly as the DRG relative weight times the DRG base price, which is known as the DRG base payment. **RI Medicaid uses the admission DRG for reimbursement.** In addition, special payment calculations are made in the following special situations.

- **Transfer adjustment.** If the patient is transferred to another acute care setting (discharge statuses 02, 05, 07) then the stay will be checked for applicability of a transfer adjustment. The DRG base payment will be divided by the nationwide average length of stay for that DRG to yield a per diem amount. The per diem amount will be multiplied by the actual length of stay plus one day (to reflect additional hospital costs associated with admission). If the calculated amount is less than the DRG base payment, then the calculated amount will be

paid. Otherwise, the DRG base payment will be paid. Unlike Medicare, EOHHS will not have a post-acute transfer policy.

- **Cost outlier payments.** For exceptionally expensive physical health cases, a cost outlier payment will be added. The cost of the stay will be estimated by multiplying charges on the claim by the hospital-specific ratio of cost to charges. The hospital's estimated loss will be calculated as the estimated cost minus the DRG base payment. If the estimated loss exceeds the cost outlier threshold, then a cost outlier payment will be made. The payment will equal the estimated loss times a marginal cost percentage of 60%.
- **Day outlier payments.** For exceptionally expensive mental health cases, a day outlier payment will be added. For every covered day that exceeds the day outlier threshold, the hospital will receive a per diem outlier payment. The threshold is 20 days and the day outlier payment \$850. Payment for outlier days will be subject to prior authorization.
- **Prorated eligibility.** In situations where the patient has Medicaid eligibility for fewer days than the length of stay, payment will be prorated. That is, the DRG payment (DRG base payment plus outlier payment) will be divided by the national average length of stay to yield a per diem amount. The hospital will receive the lower of the DRG payment or the per diem amount times the number of covered days. See Question 26.
- **Interim claims.** If a stay exceeds 29 days, a hospital can choose to receive an interim payment based on submission of an interim claim. The interim payment will be a flat per diem rate times the number of covered days for the claim. When the patient is discharged, the hospital will adjust or void the interim claims and submit a single admit-thru-discharge claim that will be paid by DRG. The availability of interim payments, which is unusual among DRG payers, is intended to promote access to care for patients whose care requires exceptionally long lengths of stay. Submission of interim claims will be voluntary. See Question 25.

10. Will the lesser-of adjustment be in effect?

Yes. The lesser-of logic will be re-implemented effective July 1, 2012. This means that Medicaid will pay the lesser of either total billed charges on the claim or the calculated DRG payment (before third-party or patient cost-sharing calculations).

11. How will the DRG base price be set and updated?

On July 1, 2010, the default DRG base price was \$10,031. For a one-year transitional period, three hospitals had higher, hospital-specific base prices.

For July 1, 2011, Medicaid moved to a single state-wide base rate of \$10,566. This included a one-year temporary reduction of 1.8%. For July 1, 2012, the 1.8% reduction is restored to the base rate as well as a market basket increase of 2.7%. The resulting base rate for July 1, 2012 is \$11,046.

EOHHS will review the DRG payment method and the DRG base price annually, making adjustments as appropriate in consideration of such elements as trends in hospital input costs, patterns in hospital coding and beneficiary access to care.

12. Are there separate payments for capital?

No. Capital costs are factored into the DRG base price.

13. Were any changes made to disproportionate-share hospital (DSH) payments?

Payment policies and calculation formulas for supplementary DSH payments are not affected by the implementation of the DRG payment method.

ALL PATIENT REFINED DRGS

14. Why were APR-DRGs chosen? Why not the same DRG system as Medicare uses?

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal and pediatric care, and because they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use. 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.

MS-DRGs—the algorithm now used by Medicare—were designed for a Medicare population using only Medicare claims. In Medicare, fewer than 1% of stays are for obstetrics, pediatrics, and newborn care. In the RY 2011 Rhode Island fee-for-service inpatient dataset, these categories represented about 25% of stays.

15. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M Health Information Systems and the National Association of Children’s Hospitals and Related Institutions (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 the “America’s Best Hospitals” list by *U.S. News & World Report*, 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 the State of Maryland, Montana Medicaid, New York Medicaid, Pennsylvania Medicaid, North Dakota Medicaid, Texas Medicaid, California Medicaid and Wellmark, the BlueCross BlueShield plan in Iowa.

16. What was done to verify that APR-DRGs are appropriate for the Rhode Island Medicaid population?

Xerox Government Healthcare Solutions conducted an analysis of alternative DRG algorithms. Using the statistical tests that are standard in payment method development, the contractor found that APR-DRGs consistently fit the Rhode Island data very well, although not as well for mental health services as for physical health services. For this reason, the proposed new method includes special provisions for mental health payment.

Results from the evaluation have been published in *Health Affairs* and are available at <http://content.healthaffairs.org/cgi/content/full/27/1/269>.

17. To be paid, does my hospital need to buy APR-DRG software?

No. The Medicaid claims processing system assigns the 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, [see here](#).

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

Effective July 1, 2012, Medicaid updated the APR-DRG grouper to version 29. APR-DRG grouper version 27 was in effect from July 1, 2010 through June 30, 2011. APR-DRG grouper version 28 was in effect from July 1, 2011 through June 30, 2012.

CODING AND BILLING

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

No. The claims processing system assigns the APR-DRG based on the diagnoses, procedures, patient age, and patient discharge status, all as submitted by the hospital on the claim. The UB-04 field for PPS Code (Form Locator 71) is not read by the Medicaid claims processing system. The PPS Code field is used when a payer does not assign the DRG and therefore needs to be advised by the hospital of the DRG; this situation does not apply to Medicaid.

20. How does the new payment method affect medical coding requirements?

Assignment of the APR-DRG and calculation of payment use the standard information already on the hospital claim. APR-DRG assignment depends chiefly on the diagnosis fields and the ICD-9-CM procedure fields. Hospitals are advised to ensure that these fields are coded completely, accurately and defensibly. Hospitals may want to review their inpatient coding and make any necessary improvements as soon as possible.

21. How many diagnoses and procedures are used in DRG assignment?

The Rhode Island Medicaid claims processing system accepts the principal diagnosis, up to 12 secondary diagnoses, and up to 13 ICD-9-CM procedures. Claims submitted after 10/1/2015 should include diagnoses as listed in ICD 10.

22. Does EOHHS require submission of the present-on-admission (POA) indicator?

Yes. Except for exempt providers and some diagnoses, the POA indicator is required effective July 1, 2012.

23. Are there changes in prior authorization policy?

In general, prior authorization continues to be required on all inpatient stays. The exceptions will continue to be deliveries and normal newborns in Rhode Island hospitals and stays where a third party is the primary payer.

Authorization of length of stay will no longer be required, with three exceptions. Those are mental health days that exceed the day outlier threshold (20 days) and days for the dually diagnosed patients and sub-acute mental health stays mentioned in Question 4.

24. Are outpatient services related to the inpatient stay bundled?

Yes. A “related” service is defined as any outpatient service provided by the admitting hospital, or by another provider under arrangement with the admitting hospital, that is provided on the same calendar day as the admission or on the calendar day before the admission. This definition is intended to strike the appropriate balance between simplicity and precision in defining related outpatient services.

25. Were there any changes to interim claims and late-charge claims?

Interim claims are only accepted for time periods of at least 30 days. The claims processing system no longer accepts claims for late charges (type of bill 115). Instead, hospitals should adjust the earlier claim, as they currently do for Medicare and other payers.

26. How do I indicate a situation in which a patient has partial eligibility for fee-for-service Medicaid?

In some cases, the fee-for-service Medicaid program is financially responsible for fewer days than the entire length of stay. During the stay, the beneficiary either gains or loses Medicaid eligibility or moves between fee-for-service Medicaid and Medicaid managed care. In either situation, the claims processing system currently denies the claim because the span from the first to the last date of service includes ineligible days. The hospital then resubmits the claim with dates of service that match the eligibility span, and the claim is paid.

Under the DRG payment method, the dates of service on the claim must continue to match the eligibility span for fee-for-service Medicaid. A more recent requirement is that hospitals must bill occurrence code A2 or A3 to indicate that the beneficiary was ineligible for some part of the stay.

- ***If the patient gains fee-for-service Medicaid eligibility during the stay,*** bill occurrence code A2 (effective date for Medicaid coverage). Code A2 should be billed in the first occurrence code field.
- ***If the patient loses fee-for-service Medicaid eligibility during the stay,*** bill occurrence code A3 (benefits exhausted). Because the beneficiary was still an inpatient on the last date of coverage, the claim would show discharge status 30, but the presence of occurrence code A3 will lead the claims processing system to treat the claim as a complete stay for payment purposes. Code A3 should be billed in the first occurrence code field.

In these situations, the hospital will either receive full DRG payment or the DRG payment will be prorated, depending on whether the beneficiary’s eligible days were more or less than the average length of stay for the DRG. See Question 9.

27. Is the APR-DRG on the remittance advice?

Yes, the APR-DRG number is on the 835 electronic remittance advice. Because EOHHS is transitioning toward electronic transactions, there are no plans to modify the current paper RA form.

OTHER QUESTIONS

28. Do hospitals still have to submit year-end settlement reports?

No. Medicare cost reports will only be used to set ratios of cost to charges for purpose of calculating cost outlier payments.

29. Are payments subject to adjustment after cost reports have been submitted?

No. Payments based on DRG are final.

30. Does the new payment method have any impact on the provider tax calculations?

No.

31. What other changes, if any, are effective for July 1, 2012?

Other than the DRG base rate increase, the update to the DRG grouper version from v28 to v29 and the re-implementation of the lesser-of adjustment, all other payment policy parameters including policy adjustors and outlier thresholds are unchanged. Please see the DRG calculator referred to in Question 32.

32. What does Medicaid do to involve and inform hospitals during the development and continuation of the DRG payment method?

- **Consultative meetings.** Representatives from Rhode Island Medicaid, HP and Xerox continue to meet with hospital finance staff to discuss upcoming changes related to the DRG payment method, results from analyses and any related concerns.
- **Training sessions.** Training sessions related to the initial DRG implementation were held September 9, 2009, and February 2, 2010.
- **FAQ document.** This document will be updated as appropriate and posted to the Provider Services page at www.dhs.ri.gov. Choose “Provider Types” then under “Hospital Services” choose “Inpatient Facility.”
- **DRG Calculator.** An Excel spreadsheet is available that hospitals can use to calculate expected payment. The DRG calculator has been updated with changes effective July 1, 2012. The spreadsheet does not assign the APR-DRG but it does show how a given APR- DRG will be priced in different circumstances. Please note that a spreadsheet model cannot exactly replicate the complexities of the claims processing system. The DRG calculator has been posted to the EOHHS website, please see previous bullet for instructions. Like the FAQ, the DRG calculator will be updated and posted as appropriate.

33. Who can I contact for more information?

- **Questions about billing and claims processing.** Customer Service Help Desk at (401) 784-8100 for local and long-distance calls or 1-800-964-6211 for in-state toll calls.

Revision History

Version	Date	Reason for Revisions	Sections
1.0	July 26, 2012	New Inpatient Payment Process	All
1.1	May 17, 2019	Reviewed for accuracy	All