

A New Inpatient Hospital Payment Method for South Carolina Medicaid

The South Carolina Department of Health and Human Services (SCDHHS) intends to move to a new method of paying for hospital inpatient services based on All Patient Refined Diagnosis Related Groups (APR-DRGs). Our goals are to implement a new payment method that is sustainable and more appropriate to Medicaid using a modern DRG algorithm, that enables reduced payment for hospital-acquired conditions, and that simplifies the current payment method where appropriate.

This document provides questions and answers about the new payment method. We invite additional questions and we welcome suggestions.

Please note that the new payment method is under development. No decisions have been finalized.

OVERVIEW QUESTIONS

1. When will the new method be implemented?

The implementation date of the new payment method is planned for stays with a date of discharge on or after October 1, 2011.

2. What change is being made?

The Department will change its current payment method based on CMS Diagnosis Related Groups (CMS-DRGs) to a new method based on All Patient Refined Diagnosis Related Groups (APR-DRGs). In addition, some features of the current method will be simplified.

3. What providers will be affected?

The new method will apply to all inpatient hospital services provided by general acute care hospitals (including distinct-part units of general hospitals), short-term psychiatric hospitals, and long term acute care hospitals, both inside South Carolina and out of state.

Payment methods for inpatient services provided by free-standing long-term psychiatric facilities and residential treatment facilities are unaffected.

4. What services will be affected?

The new method will apply to inpatient hospital fee-for-service claims billed on paper, electronically or via the web portal, and includes the UB-04 claim type and ANSI ASC X12N 837 Institutional transaction. It will also apply to Medicare crossover claims (where Medicare is the primary payer and Medicaid is the secondary payer).

There are three exceptions:

- Administrative days
- Managed care stays (see Question 9)
- Swing bed stays

5. How much money is affected?

In the state fiscal year ending June 30, 2010, South Carolina Medicaid paid hospitals \$539 million for inpatient acute care, excluding Medicare crossovers, administrative days, managed care and swing-bed stays. "Payment" refers to the allowed amount on claims. This figure excludes supplementary disproportionate share payments and the net impact of cost settlement.

6. How does the current payment method work?

Generally, the current payment method may be summarized as cost reimbursement, with interim payments made on a DRG basis. With a few exceptions, almost all hospitals in South Carolina have been reimbursed for 100% of allowable cost, as determined through reviews and audits of cost reports submitted by the hospitals. The cost settlement process starts when a hospital submits its cost report after the end of its fiscal year.

Before cost settlement, interim payment is made on a per-stay basis using Version 24 of the CMS-DRG algorithm that Medicare used until September 30, 2007. Since the Medicare and Medicaid patient populations differ greatly, the current South Carolina Medicaid payment method includes many customized features.

7. Is there going to be a change to the cost reimbursement approach?

Almost all hospitals are currently reimbursed for 100% of allowable cost. There are currently proposals to reduce that percentage but any such proposal is unrelated to the project to replace CMS-DRGs with APR-DRGs in calculating interim payment.

Note that cost-based reimbursement would be reduced for stays that include a defined list of hospital acquired conditions (Question 15).

8. Why change to the new payment method?

The Department has four reasons:

- ***Enable continued payment to hospitals.*** Medicare no longer maintains or updates the CMS-DRG algorithm. The version currently used by South Carolina Medicaid grows more outdated every year. When the nation moves to ICD-10 diagnosis and procedure codes on October 1, 2013, South Carolina Medicaid would no longer be able to pay claims because an ICD-10 version of CMS-DRGs is not available.
- ***Use a grouper appropriate for Medicaid.*** On October 1, 2007, Medicare replaced CMS-DRGs with Medicare Severity DRGs (MS-DRGs), a completely different algorithm. CMS-DRGs did not fit the Medicaid population well, and MS-DRGs are even less accurate for the Medicaid population. Use of MS-DRGs by Medicaid would be particularly inaccurate for the newborn, pediatric and obstetric populations.
- ***Adopt a sustainable, flexible payment method.*** An important advantage is that the payment method can be more easily yet appropriately sustained over time, with adaptations to promote access to quality care. The payment method structure must be robust, readily updated, and flexible enough to accommodate future changes in payment policy and new federal requirements regarding hospital-acquired conditions.
- ***Simplify the payment method.*** The current method is overly complex and could be simplified if it were based on a DRG algorithm that is more appropriate for a Medicaid population.

9. Does the fee-for-service change affect payments under Medicaid managed care (e.g., Healthy Connections Choices)?

The Department is not requiring the managed care plans to make any changes to how they pay hospitals. However, if a contract between an MCO and a hospital references fee-for-service payment methods or levels, then there may be impacts on payments from the MCO to the hospital.

PAYMENT CALCULATIONS

10. How will payment be calculated?

The basic approach would continue as it is now: a DRG base payment would be calculated by multiplying a relative weight for the specific DRG by a hospital-specific DRG discharge rate. The difference would be that the DRG grouping system would be APR-DRGs and not CMS-DRGs. Cost outlier payments would continue to be made for stays that are exceptionally expensive for the hospital. Payments would also be reduced in some situations where the patient is transferred to another hospital, or the patient does not have Medicaid eligibility for the entire stay, or the stay is unusually low in cost for the hospital relative to the DRG.

11. What simplifications are under consideration?

Pending further analysis and final decision-making by the Department, simplifications under consideration include:

- Replacing relative weights based on South Carolina data with relative weights based on national data (since these fit the South Carolina data well)
- Discontinuation of day outlier payments
- Discontinuation of separate capital payment
- Replacement of per diem payment for some low-volume, neonatal intensive care, psychiatric and rehabilitation stays with case-based payment using DRGs.

We emphasize that these changes are still under active discussion. Any changes would be budget-neutral overall. For example, if separate payments for capital were discontinued then the savings would be used to increase DRG base payments. In any event, almost all hospitals ultimately are reimbursed based on allowable cost.

12. How will the DRG discharge rates be set and updated?

Payment based on APR-DRGs will continue to reflect hospital-specific discharge rates, as has been true under CMS-DRGs. The Department will continue to review and recalculate the DRG discharge rates each year so that interim payments will approximate final payments for each hospital.

13. What changes, if any, will be made to disproportionate-share hospital (DSH) payments?

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

14. What changes, if any, will be made to medical education payments?

Payment policies and calculation formulas for direct and indirect medical education payments are not expected to be affected by the implementation of the APR-DRG payment method.

15. How will payment be affected if a hospital-acquired condition is present on the claim?

Medicaid programs nationwide are required by federal law to demonstrate that they are not paying for “hospital acquired conditions,” which are defined very specifically by the Medicare program. In South Carolina, only 0.2% of Medicaid stays include a HAC as defined by Medicare. The DRG software will ignore secondary diagnoses that meet the HAC definition. Adjustments will also be made during the cost settlement process so that hospital costs associated with HACs are not reimbursed by the Department. Using the current Medicare HAC list, this provision is expected to reduce reimbursed costs by less than one-tenth of 1%. Note that these figures could change with future changes in Medicare HAC policy.

A proposed regulation recently released by the Centers for Medicare and Medicaid Services would also allow states to define HACs (or “provider preventable conditions”) that the state could add to the Medicare list. At this time, South Carolina has no specific plans to add conditions.

In addition, the proposed regulation also extends the nonpayment policy to Medicaid contracts. Medicaid programs will be required to prohibit payment of HACs under their managed care contracts.

ALL PATIENT REFINED DRGs

16. 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.

CMS-DRGs—the algorithm currently used by South Carolina Medicaid and previously used by Medicare—were not chosen because CMS no longer maintains or supports their clinical logic.

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 SFY 2010 South Carolina fee-for-service inpatient dataset, these categories represented two-thirds of all stays.

17. 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, Rhode Island Medicaid, Colorado Medicaid, North Dakota Medicaid, and Wellmark, the BlueCross BlueShield plan in Iowa.

18. 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. The South Carolina Medicaid program and ACS Government Healthcare Solutions (which is advising the Department) have no financial interest in APR-DRG software or any business arrangements between hospitals and their vendors who license APR-DRGs.

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

The Department intends to use V.28 of APR-DRGs, which was released October 1, 2010. All simulation calculations for the new payment method are being done using V.28. Although 3M will release V.29 on October 1, 2011, this version will not be available with sufficient lead time to allow all the calculations to be re-done. The Department will use code mapper software that maps any new ICD-9-CM diagnosis and procedure codes back to code values that are appropriate for APR-DRGs V.28.

20. What does the four-digit APR-DRG represent?

As mentioned earlier, each stay is assigned first to one of 314 base APR-DRGs. Then, each stay is assigned to one of four levels of severity of illness or SOI (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.

An APR-DRG is a four-byte field while a CMS-DRG is a three-byte field. The APR-DRG is in the format 123-4, where the first three bytes indicate the base APR-DRG. The fourth byte indicates the severity of illness for a given DRG. For example, APR-DRG 139-1 is pneumonia, severity 1, while APR-DRG 139-2 is pneumonia, severity 2.

CODING AND BILLING

21. 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 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. 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, for example, the hospital needs to advise a commercial insurer of the DRG for a stay. This situation does not apply to South Carolina Medicaid.

22. How will the new payment method affect medical coding requirements?

Hospitals need not make any changes. 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. However, any such review is entirely the hospital's decision.

23. Will the Department require submission of the present-on-admission (POA) indicator?

Yes. The Department will continue to require hospitals to submit the POA indicator and the claims processing system will continue to edit POA indicator information. The POA indicator is used to identify hospital-acquired conditions.

24. Will there be changes in prior authorization policy?

No changes in prior authorization are being made as part of this project.

25. Any changes to interim claims and late-charge claims?

No changes in current billing practices are anticipated for interim claims and late-charge claims. South Carolina does not accept interim claims (bill types 112, 113, 114) or late charges (bill type 115) except in exceptional circumstances, as specified in the hospital provider manual.

26. Will the APR-DRG be shown in the remittance advice?

Yes, the APR-DRG will be displayed.

OTHER QUESTIONS

27. Will there be an adjustment for documentation and coding?

It is possible that the implementation of payment by APR-DRG will result in more complete coding by hospitals. More refined DRGs increase the need for improved documentation and coding. For Medicare, the number of DRG groups increased from 538 to 745 when MS-DRGs were implemented. For South Carolina Medicaid, the number of DRG groups will increase to 1,256 when APR-DRGs are implemented.

Improved documentation and coding may lead to an increase in average measured casemix. Although increased coding may have minimal effect since the expectation is that the payment will be cost-based through the settlement process, it is likely that the interim payment would result in higher payment. At this time, the Department is considering a “documentation and coding adjustment” to offset any such increase.

28. What will Medicaid do to involve and inform hospitals during the development of the new payment method?

- **FAQ.** Updates of this document will be available to hospitals.
- **DRG Calculator.** An Excel spreadsheet will be available that hospitals can use to calculate expected payment. 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.
- **Hospital meetings.** Meetings with the South Carolina Hospital Association, hospital representatives and other interested parties are currently being planned by the Department and the hospital association. The meeting dates will be announced in the very near future.

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