

**STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION**

PUBLIC NOTICE

Pursuant to 42 C.F.R. §447.205, the Department of Human Services (DHS), Med-QUEST Division (MQD) hereby notifies the public that the MQD intends to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS).

Under Provisions of federal law, the state is required to issue public notice of proposed changes in statewide methods and standards for setting Medicaid payment rates.

The State Plan Amendment (SPA) proposes to change the current payment methodology for inpatient acute services for the Hawaii Medicaid program. Beginning with admission dates on January 1, 2022, inpatient acute services delivered through Fee-For-Service (FFS) and managed care shall be paid using the All Patient Refined Diagnosis Related Groups (APR DRGs) payment methodology. This payment methodology will encourage access to care, reward efficiency, improve transparency, and improve fairness by paying similarly across hospitals for similar care.

Background

APR DRGs are a patient classification system developed by 3M™ and used by payers and providers to classify hospital inpatient stays into clinically meaningful diagnostic groups with similar average resource requirements. APR DRGs provide a mechanism for healthcare payers to make a single case rate payment for similar services provided in a hospital inpatient stay.

APR DRGs are the most widely used DRG software, or “grouper”, by Medicaid agencies for determining payments for inpatient acute services. Due to APR DRGs’ enhanced granularity (particularly for key Medicaid service lines) and widespread adoption of across states, MQD will use the APR DRG grouper as the patient classification system for its new Medicaid inpatient prospective payment methodology.

SPA 21-0011 is expected to have minimal impact on the annual aggregate expenditures.

The SPA is posted at <https://medquest.hawaii.gov/en/about/state-plan-1115>.

The proposed change will be submitted for review to the federal government as a Medicaid SPA to be effective January 1, 2022.

For a copy of the proposed changes, please contact:

By email: emaucio@dhs.hawaii.gov (Please identify in the subject line: State Plan Amendment 21-0011)

By mail:

Department of Human Services
Med-QUEST Division
Attention: Policy and Program Development Office
P.O. Box 700190
Kapolei, Hawaii 96709

A printed copy of the proposed changes and special accommodations (i.e., interpreter, large print or taped materials) can be arranged if requested by contacting the Policy and Program Development Office at (808) 692-8058 no later than seven (7) working days before the comment period ends.

Comments should be received **within 30 days** from the time this notice is posted. Individuals may submit written comments using the following methods:

By email: emaucio@dhs.hawaii.gov (Please identify in the subject line: State Plan Amendment 21-0011)

By mail:

Department of Human Services
Med-QUEST Division
Attention: Policy and Program Development Office
P.O. Box 700190
Kapolei, Hawaii 96709

DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR

STATE OF HAWAII
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM FOR INPATIENT SERVICES

I. GENERAL PROVISIONS

A. PURPOSE

This plan establishes a reimbursement system for inpatient facilities which complies with the Code of Federal Regulations. It describes principles to be followed by Title XIX acute care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.

B. OBJECTIVE

The objective of this plan is to establish a prospective payment system that complies with the Balanced Budget Act of 1997, which requires that reimbursements be in conformity with the applicable State and Federal laws, regulations; quality and safety standards; and provide for cost reimbursement for inpatient acute care services in Critical Access Hospitals (CAH).

C. REIMBURSEMENT PRINCIPLES

1. For dates of admission on or after January 1, 2022, the Hawaii Medicaid Program shall reimburse in-state general acute hospitals and children's hospitals, for inpatient hospital services, excluding transplant services, based on prospective payment rates under an All Patient Refined Diagnosis Related Group (APR DRG) reimbursement methodology. Each claim for an inpatient hospital admission will be assigned a DRG code and a corresponding DRG relative weight based on the APR DRG classification system established. The APR DRG assignment will reflect adjustments for Health Care Acquired Conditions (HCACs) in the APR DRG software. The APR DRG payment is determined by multiplying the DRG base rate by the DRG relative weight and the applicable policy adjuster, with the applicable transfer adjustment, plus the applicable outlier payment.

A hospital will not be reimbursed separately for outpatient diagnostic services and admission-related outpatient non-diagnostic services provided to a patient within a three day window of an inpatient admission ("preadmission services"). A hospital will also not be reimbursed separately for changes to lower levels of care prior to patient discharge from the hospital ("waitlisted days"). Covered charges for preadmission services and waitlisted days will be included in the inpatient claim for outlier payment purposes (described in Section I.C.1.f).

TN No.	<u>21-0011</u>	Approval Date:	Effective Date:	<u>01/01/22</u>
Supersedes				
TN No.	<u>00-008</u>			

a. DRG Relative Weights:

The APR DRG methodology classifies inpatient admissions into categories based on similar clinical conditions and similar levels of hospital resources required for treatment. The categories are identified using APR DRGs and Severity of Illness (SOI) levels, each of which is assigned a relative weight appropriate to the relative amount of hospital resources expected to be used to treat the patient. Each claim is assigned to a DRG primarily based on the patient's diagnoses, surgical procedures performed, age, sex, birth weight, and discharge status. A claim for an inpatient hospital admission will be assigned the DRG code derived from excluding diagnosis codes associated with HCACs or other provider-preventable conditions listed in Att. 4.19-A, page 3.1, using the APR DRG grouper software logic.

The DRG relative weights will be based on the APR DRG national "hospital specific relative value" (HSRV) weights published for the associated APR DRG grouper version. MQD will use the version 37.1 APR DRG grouper and national HSRV weights for payments effective January 1, 2022.

MQD will update its APR DRG grouper version and associated national HSRV weights no less than every five years, concurrently with rebasing DRG base rates (described in the next section). When updating its APR DRG grouper version and relative weights, MQD will apply a prospective scaling adjustment to the published national HSRV weights. This scaling adjustment factor will be determined by MQD to result in the same aggregate case mix as the prior APR DRG grouper version used by MQD for payment.

The version 37.1 APR DRGs and relative weights effective January 1, 2022 are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

b. DRG Base Rates

Hospital DRG base rates are based on statewide standardized amounts, adjusted by applying the hospital's indirect medical education (IME) factor.

The statewide standardized amounts are prospective and differ by hospital class, as follows:

1. Privately owned in-state general acute hospitals and children's hospitals will have a statewide standardized amount modeled to be budget neutral to base period payments in aggregate. Base period payments are based on the reported paid amounts in the SFY 2018 Medicaid inpatient managed care encounter data and fee-for-service paid claims data. The MQD modeling process to determine budget neutral standardized amounts will consider the impacts of all other APR DRG payment parameters described in this section, including policy adjusters, transfer adjustments, and outlier payments.

2. Publicly-owned in-state general acute hospitals will have a statewide standardized amount equal to 55% of the private hospital standardized amount.

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MQD will rebase its DRG base rates, including the standardized amounts and IME factors, no less than every five years, concurrently with updating the APR DRG grouper version. When rebasing, MQD will model new DRG standardized amounts modeled to be budget neutral to new base period payments in aggregate using the most recently available mature state fiscal year or calendar year of Medicaid inpatient managed care encounter data and fee-for-service paid claims data. The MQD modeling process to determine rebased DRG base rates will consider the impacts of all other APR DRG payment parameters described in this section, including policy adjusters, transfer adjustments, and outlier payments.

Hospital IME factors effective January 1, 2022 are based on the operating IME factors published by CMS in the federal fiscal year (FFY) 2021 Medicare inpatient prospective payment system (IPPS) Final Rule Impact File effective October 1, 2020. MQD will rebase the IME factors, no less than every five years, concurrently with updating the statewide standardized amounts, based on the operating IME factors published by CMS in the Medicare IPPS Final Rule Impact File effective October 1st in the federal fiscal year ending prior to the start of the effective calendar year.

New hospitals reimbursed under the APR DRG methodology will be assigned a DRG base rate with the applicable standardized amount and a hospital IME factor based on the most recently available Medicare IPPS operating IME factor published by CMS as of the hospital Medicaid provider enrollment date.

The statewide standardized amounts, IME factors, and DRG base rates for each hospital effective January 1, 2022 are posted on the MQD website at:

<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

c. Policy Adjusters

MQD will apply policy adjusters to payment amounts when claims meet certain criteria, which are based on specific APR DRG assignments or patient age parameters, to ensure access to quality care to these services. The criteria established for application of these policy adjusters include the following:

1. Neonatal DRGs
2. Well newborn DRGs
3. Maternity DRGs (normal delivery and cesarean section delivery)
4. Psychiatric and alcohol and drug abuse DRGs
5. Trauma DRGs
6. All other pediatric services (patients aged 20 and under)

All other adult services will not be subject to a policy adjuster. Policy adjusters are mutually exclusive, and there will be only a single applicable policy adjuster applied for each inpatient admission.

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MQD will rebase its policy adjusters no less than every five years, concurrently with updating the APR DRG grouper version and rebasing APR DRG base rates. When rebasing, MQD will model updated policy adjuster factors for the services described in this section, as needed, to ensure access to quality care to these services. The MQD modeling process to determine rebased policy adjuster factors will consider the impacts of all other APR DRG payment parameters described in this section, including DRG base rates, transfer adjustments, and outlier payments.

The policy adjuster factors effective January 1, 2022, by APR DRG, are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

d. DRG Base Payment

For each hospital admission, the DRG base payment equals the hospital's DRG base rate multiplied by the DRG relative weight and the service's applicable policy adjuster.

e. Transfer Adjustment

The DRG base payment may be subject to transfer adjustments as described in the following paragraphs.

A transfer adjustment to the DRG base payment applies when a patient is transferred from a hospital that is subject to DRG reimbursement to another general acute hospital or Critical Access Hospital. The transferring hospital will be reimbursed the lesser of the full DRG base payment and the DRG transfer adjusted payment. The transfer adjusted payment is equal to the full DRG base payment divided by the DRG geometric mean length of stay for the assigned DRG code, multiplied by the sum of the actual length of stay plus one day. The receiving hospital (for the same patient) will not be impacted by the transfer adjustment unless it transfers the patient to another general acute hospital or Critical Access Hospital.

The DRG geometric mean lengths of stay will be based on the APR DRG HSRV national trimmed geometric mean lengths of stay published for the associated APR DRG grouper version. MQD will use APR DRG grouper version 37.1 and associated national geometric mean lengths of stay for transfer adjustments effective January 1, 2022.

MQD will update its APR DRG national geometric mean lengths of stay no less than every five years, concurrently with updating the APR DRG grouper version.

The DRG national geometric mean lengths of stay effective January 1, 2022 are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

TN No. 21-0011

Supersedes

Approval Date:

Effective Date:

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f. Outlier Payment

Cases which are extraordinarily costly in relation to other cases within the same DRG due to the severity of illness or complicating conditions may qualify for an outlier payment in addition to the DRG base payment. A claim will qualify for an outlier payment if the claim cost exceeds the outlier threshold. The claim cost is determined by multiplying the claim covered charges by the hospital's outlier cost-to-charge ratio (CCR). The outlier threshold is equal to the DRG base payment (including transfer adjustments described previously) plus the fixed loss amount.

The outlier CCRs for all hospitals will be determined as follows:

1. For children's hospitals in Hawai'i, the outlier CCR is based on sum of the Medicare IPPS Hawai'i statewide urban default operating and capital outlier CCRs published in the Federal Register Final Rule effective October 1st in the year preceding the start of the effective calendar year. Hawai'i children's hospitals outlier CCRs effective January 1, 2022 will be based on the sum of Medicare IPPS Hawai'i statewide urban default operating and capital outlier CCRs published in the FFY 2022 Federal Register Final Rule tables effective October 1, 2021.
2. For in-state general acute hospitals in Hawai'i, the outlier CCR is based on sum of hospital-specific Medicare IPPS operating and capital outlier CCRs published in the Final Rule Impact File effective October 1st in the year preceding the start of the effective calendar year. Hawai'i general acute hospital outlier CCRs effective January 1, 2022 will be based on the sum of Medicare IPPS hospital-specific operating and capital outlier CCRs published in the FFY 2022 Final Rule Impact File effective October 1, 2021.

New hospitals reimbursed under the APR DRG methodology will be assigned an outlier CCR based on the sum of the most recently available hospital-specific Medicare IPPS operating and capital outlier CCRs published by CMS as of the hospital Medicaid provider enrollment date. If hospital-specific Medicare IPPS outlier CCRs are not available, the new hospital outlier CCR will be based on the sum of the Medicare IPPS Hawai'i statewide urban default operating and capital outlier CCRs published in the Federal Register Final Rule effective October 1st in the year preceding the start of the effective calendar year.

MQD will update the outlier CCRs annually on January 1st each year, and will not adopt any Medicare IPPS outlier CCR updates for the rest of the calendar year.

MQD outlier payment parameters, including the fixed loss amount and marginal cost factors, will be modeled prospectively to result in outlier payments equal to 10% of total inpatient APR DRG payments. The outlier fixed loss amount effective January 1, 2022 is \$58,000. The MQD modeling process to determine the outlier fixed loss amount will consider the impacts of all other APR DRG payment parameters described in this section, including DRG base payments, transfer adjustments, outlier payments, etc.

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Where a claim qualifies for an outlier payment, the outlier payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the marginal cost factor. The marginal cost factor will be based on the APR DRG severity of illness level. The marginal cost factors effective January 1, 2022 will be 75% for claims assigned Severity of Illness levels 1 and 2, and 85% claims assigned Severity of Illness levels 3 and 4.

MQD will rebase its outlier payment parameters, including the fixed loss amount and marginal cost factors periodically at its discretion, to result in outlier payments equal to 10% of total inpatient APR DRG payments. At a minimum MQD will rebase its outlier payment parameters concurrently with updating its DRG grouper version and rebasing DRG base rates. The MQD modeling process will consider the impacts of all other APR DRG payment parameters described in this section, including DRG base payments, transfer adjustments, outlier payments, etc.

Covered charges for preadmission services and waitlisted days will be included in the inpatient claim for outlier payment purposes. Claim covered charges can be subject to retrospective utilization review, and may be adjusted for items such as non-covered services (such as personal care and convenience items), medical necessity of length of stay (for non-waitlisted days), and appropriate level of care among others.

g. DRG Final Payment

The DRG final payment amount is equal to the DRG base payment amount (with applicable transfer adjustment) plus the DRG outlier payment amount.

h. Readmissions

a) A readmission to the same or different facility within twenty four (24) hours of discharge for the same spell of illness and for a similar primary diagnosis as the index admission is considered to be the same admission and must be billed as a single stay. When the readmission occurs at a different hospital from the index admission, denial or partial payment adjustments may be made for the index admission at the original hospital based on nationally recognized admission and discharge review criteria. This policy does not apply to patients who leave the original facility against medical advice.

b) Readmission to the same facility within thirty (30) days of a discharge for a similar diagnosis is subject to review by the Department based on nationally recognized admission and discharge review criteria. Based on this review, the DRG payment for a readmission within 30 days may be consolidated with the index admission DRG payment. This policy does not apply to patients who leave the facility during the original admission against medical advice, or for planned readmissions.

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2. The Hawaii Medicaid Program shall reimburse all out-of-state providers and in-state freestanding psychiatric and rehabilitation providers for inpatient hospital services based primarily on the prospective per diem payment rates developed for each facility as determined in accordance with this Plan, except for CAH. In addition, certain costs (Such as Capital Related Costs) shall be reimbursed separately. The estimated average proposed payment rate under this plan is reasonably expected to pay not more in the aggregate for inpatient hospital services than the amount that the Department reasonably estimates would be paid for those services under Medicare principles of reimbursement.
- a. A hospital -specific retrospective settlement adjustment shall be made for those providers whose Medicaid charges are less than Medicaid payments on the cost report and do not qualify as nominal charge providers under Medicare principles of reimbursement.
 - b. Prospective rates shall be derived from historical facility costs, and facilities shall be classified based on discharge volume and participation in an approved Medical Education program.
 - c. Providers that average fewer than 250 Medicaid discharges per year shall be classified as Classification I facilities and shall receive All-Inclusive Rates plus all appropriate Adjustments (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the All-Inclusive Rates.
 - d. Providers which average 250 Medicaid discharges or more per year shall be separated into two facility classifications (Classifications II and III) and shall receive payment based upon the type of services required by the patient. Psychiatric services will be paid an All-Inclusive Rate, plus all appropriate Adjustments (Section I.D.3.). Nonpsychiatric claims will be designated as requiring either surgical, medical, or maternity care and will be paid on the basis of a routine per diem rate for the service type plus an ancillary per discharge rate for the service type, plus all appropriate Adjustments, (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the per diem and per discharge rates.
 - e. The freestanding rehabilitation hospital shall be excluded from Classifications I, II, and III, shall be designated as Classification IV, and will be paid an All-Inclusive Rate, plus all appropriate Adjustments, (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the per diem and per discharge rates.

TN No. 21-0011
 Supersedes
 TN No. 94-006

Approval Date:

Effective Date: 01/01/22

- f. Claims for payment shall be submitted following discharge of a patient, except as follows:
 - i. Claims for nonpsychiatric inpatient stays which exceed the Outlier Threshold (Section I.D.34.), shall be submitted in accordance with Section IV.D.
 - ii. If a patient is hospitalized in the freestanding rehabilitation hospital for more than 30 days, the facility may submit an interim claim for payment every 30 days until discharge. The final claim for payment shall cover services rendered on all days not previously included in an interim claim.
- g. The prospective payment rates shall not be paid in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except for outlier payments and as provided in Section I.E. below.
 - i. At the point that a patient reaches the Outlier Threshold (Section I.D.34.), the facility is eligible for interim payments computed pursuant to Section IV.D.
- 3. Reimbursement for inpatient services provided by CAH facilities will be on a reasonable cost basis under Medicare principles of reimbursement without application of any Medicaid Tax Equity and Fiscal Responsibility Act (TEFRA) target amounts. Outpatient, waitlisted and acute swing to continue to be reimbursed under the current method.
- 4. Reimbursement for services related to organ transplants will be made by a contractor selected by the State. The contractor will also be responsible to coordinate and manage transplant services. Reimbursement of services related to organ transplants will be approved by the State. The negotiated care rate will not exceed Medicare or prevailing regional market rates.

TN No. 21-0011
Supersedes
TN No. 94-006

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01/01/22

Citation: 42 CFR 434, 438 and 447; and Social Security Act 1902(a)(4), 1901 (a)(4), 1902 (a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions.

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902 (a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions.

The State identifies the following Other Provider-Preventable Conditions for non-payment under section 4.19-A.

Hospital-Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions.

The State identifies the following Other Provider-Preventable Conditions for non-payment under section 4.19-A.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below of the plan:

Adjustment of inpatient hospital reimbursement to account for non-payment of HCACs and OPPCs.

In accordance with 42 CFR 447.26(c), no reduction in payment for a Provider Preventable Condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment that patient by that provider. Reductions in provider payment are limited to the extent that the State can reasonably isolate for non-payment, the portion of the payment directly related to treatment for, and related to, the PPC that would otherwise result in an increase in payment.

Hospitals will use the Present on Admission indicator to identify whether an identified HCAC or OPPC was present on admission or hospital acquired. For hospitals reimburse on a per diem basis, such claims will be reviewed to determine whether the HCAC or OPPC resulted in a longer length of stay or increased acuity that can be directly and independently attributable to the HCAC or OPPC. For hospitals reimbursed on an APR DRG basis, the APR DRG and SOI level assignment will be based on the Medicare HCAC adjusted classifications under the APR DRG software logic, and payment will not include additional payment for the HCAC or OPPC that was not present on admission.

Lastly, in accordance with 42 CFR 447.26(c)(5), non-payment for OPPCs shall not prevent access to medically necessary covered services for Medicaid recipients.

D. The following definitions shall apply for the purpose of APR-DRG payment methodology.

1. All Patient Refined Diagnosis Related Groups (APR DRGs): Base APR-DRG classifications assigned to inpatient claims based on a variety of factors (including patient diagnosis and surgical procedures, among others) using the APR-DRG Health Information Systems software.

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Supersedes			
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2. DRG geometric mean lengths of stay (GMLOS): factor that represents the GMLOS for each combination of APR DRG and SOI level used for transfer adjustments, based on APR DRG national HSRV trimmed GMLOS amounts published for the APR DRG grouper version used for payment.
3. DRG Relative Weights: factor that represents the average resource requirements and level of acuity for each combination of APR DRG and SOI level used for base DRG payments, based on APR DRG national HSRV weights published for the APR DRG grouper version used for payment.
4. DRG Base Rates: Based on statewide standardized amounts adjusted by applying the hospital's IME factor, used for base DRG payments.
5. DRG Base Payments: For each hospital admission, the DRG base payment equals the hospital's DRG base rate multiplied by the HAC-adjusted DRG relative weight and the service's applicable policy adjuster.
6. Health Care Acquired Condition (HCAC)-Adjusted DRG: APR DRG and SOI assignment derived from excluding diagnosis codes associated with HCACs or other provider-preventable conditions listed in Att. 4.19-A, page 3.1.
7. Indirect Medical Education (IME) factors: based on hospital-specific operating IME factors in the Medicare inpatient prospective payment system (IPPS) published by CMS, used to adjust DRG base rates.
8. Outlier cost: Estimated claim cost for outlier payment purposes, based on claim covered charges multiplied by the hospital outlier CCR.
9. Outlier cost-to-charge ratio (CCR): Based on the Medicare IPPS combined operating and capital outlier CCRs for outlier payment purposes.
10. Outlier threshold: Based on the base DRG payment plus the fixed loss amount, for purposes of determining if a claim qualifies for an outlier payment.
11. Outlier marginal cost factor: Factor based on SOI level that is applied to the claim outlier cost exceeding the outlier threshold, for outlier payment purposes.
12. Outlier Payment: Claim payment add-on, in addition to the base DRG payment, for extraordinarily high cost cases where the claim outlier cost exceeds the claim outlier threshold.
13. Policy Adjusters: Adjusters to base DRG payments when claims meet certain criteria, which are based on specific APR DRG assignments or patient age parameters, to ensure access to quality care to these services.
14. Severity of Illness (SOI) level: SOI level 1 through 4 assigned to inpatient claims based on comorbid conditions and the severity of the underlying illness, using the APR-DRG Health Information Systems software.
15. Transfer Adjustment: Adjustment to the DRG base payment when a patient is transferred from a hospital that is subject to DRG reimbursement to another general acute hospital or Critical Access Hospital, equal to the full DRG base payment divided by the DRG geometric mean length of stay for the assigned DRG code, multiplied by the sum of the actual length of stay plus one day (not to exceed the full DRG base payment).

TN No. 21-0011

Supersedes

TN No. 12-006

Approval Date:

Effective Date: 01/01/2022

(Rev. 05/07/2021)

E. DEFINITIONS APPLICABLE TO THE PROSPECTIVE RATE SYSTEM

The following definitions to include Attachment 4.19-A Sections II.-VI. or pgs. 5-39 are not applicable to the APR-DRG payment methodology.

1. "Acuity Level A" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively lower than Acuity Level C. Prior to October 1, 1990, that level of care was appropriately obtained from an ICF.
2. "Acuity Level C" means that the Department has applied its standards of medical necessity and determined that the Resident requires level of medical care from a Nursing Facility relatively higher than Acuity Level A. Prior to October 1, 1990, that level of care was appropriately obtained from an SNF.
3. "Adjustments" mean all adjustments to the Basic Per Diem, Basic Per Discharge and All-Inclusive Rates and/or the Capital Payments that are defined in this Plan and that are appropriate for a particular Provider. Those adjustments may include the ROE/GET Adjustment, the Medical Education Adjustment, and/or the Severity and Case Mix Adjustment.
4. "All-Inclusive Rates" means the separate per diem rates that are paid to Classification I and IV facilities for psychiatric and nonpsychiatric cases, and the per diem rates that are paid to Classification II and III facilities for psychiatric cases only. The All-Inclusive Rates are calculated to include reimbursement for both routine and ancillary costs.
5. "Ancillary Services" means diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges, and they include such services as laboratory, radiology, surgical services, etc.
6. "Basic Year" means the State fiscal year used for initial calculation and recalculation of prospective payment rates. The Base Year shall be the most recent State fiscal year or years for which complete, finally-settled financial data is available. Base Year data shall be supplemented with finally-settled financial data is available. Base Year data shall be supplemented with finally-settled cost data from previous years, if it is determined that extraordinary costs occurred in the most recent finally-settled cost report.

 TN No. 21-0011

Supersedes

Approval Date:

Effective Date: 01/01/2022TN No. 12-006

~~[(rev. 11/6/00)]~~

STATE OF HAWAII
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM FOR INPATIENT SERVICES

I. GENERAL PROVISIONS

A. PURPOSE

This plan establishes a reimbursement system for ~~[acute care]~~ inpatient facilities which complies with the Code of Federal Regulations. It describes principles to be followed by Title XIX acute care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.

B. OBJECTIVE

The objective of this plan is to establish a prospective payment system that complies with the Balanced Budget Act of 1997, which requires that reimbursements be in conformity with the applicable State and Federal laws, regulations; quality and safety standards; and provide for cost reimbursement for inpatient acute care services in Critical Access Hospitals (CAH).

C. REIMBURSEMENT PRINCIPLES

1. For dates of admission on or after January 1, 2022, ~~[The]~~the Hawaii Medicaid Program shall reimburse in-state general acute hospitals and children's hospitals ~~[Providers]~~for inpatient ~~[institutional]~~hospital services, excluding transplant services, based ~~[primarily]~~on ~~[the]~~prospective payment rates under an All Patient Refined Diagnosis Related Group (APR DRG) reimbursement methodology. ~~[developed for each facility as determined in accordance with this Plan, except for CAH. In addition, certain costs (Such as Capital Related Costs) shall be reimbursed separately.]~~Each claim for an inpatient hospital admission will be assigned a DRG code and a corresponding DRG relative weight based on the APR DRG classification system established. The APR DRG assignment will reflect adjustments for Health Care Acquired Conditions (HCACs) in the APR DRG software. The APR DRG payment is determined by multiplying the DRG base rate by the DRG relative weight and the applicable policy adjuster, with the applicable transfer adjustment, plus the applicable outlier payment.

A hospital will not be reimbursed separately for outpatient diagnostic services and admission-related outpatient non-diagnostic services provided to a patient within a three day window of an inpatient admission ("preadmission services"). A hospital will also not be reimbursed separately for changes to lower levels of care prior to patient discharge from the hospital ("waitlisted days"). Covered charges for preadmission services and waitlisted days will be included in the inpatient claim for outlier payment purposes (described in Section I.C.1.f).

~~[The estimated average proposed payment rate under this plan is reasonably expected to pay not more in the aggregate for inpatient hospital services than the amount that the Department reasonably estimates would be paid for those services under Medicare principles of reimbursement.]~~

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a. DRG Relative Weights:

The APR DRG methodology classifies inpatient admissions into categories based on similar clinical conditions and similar levels of hospital resources required for treatment. The categories are identified using APR DRGs and Severity of Illness (SOI) levels, each of which is assigned a relative weight appropriate to the relative amount of hospital resources expected to be used to treat the patient. Each claim is assigned to a DRG primarily based on the patient's diagnoses, surgical procedures performed, age, sex, birth weight, and discharge status. A claim for an inpatient hospital admission will be assigned the DRG code derived from excluding diagnosis codes associated with HCACs or other provider-preventable conditions listed in Att. 4.19-A, page 3.1, using the APR DRG grouper software logic.

The DRG relative weights will be based on the APR DRG national "hospital specific relative value" (HSRV) weights published for the associated APR DRG grouper version. MQD will use the version 37.1 APR DRG grouper and national HSRV weights for payments effective January 1, 2022.

MQD will update its APR DRG grouper version and associated national HSRV weights no less than every five years, concurrently with rebasing DRG base rates (described in the next section). When updating its APR DRG grouper version and relative weights, MQD will apply a prospective scaling adjustment to the published national HSRV weights. This scaling adjustment factor will be determined by MQD to result in the same aggregate case mix as the prior APR DRG grouper version used by MQD for payment.

The version 37.1 APR DRGs and relative weights effective January 1, 2022 are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

b. DRG Base Rates

Hospital DRG base rates are based on statewide standardized amounts, adjusted by applying the hospital's indirect medical education (IME) factor.

The statewide standardized amounts are prospective and differ by hospital class, as follows:

1. Privately owned in-state general acute hospitals and children's hospitals will have a statewide standardized amount modeled to be budget neutral to base period payments in aggregate. Base period payments are based on the reported paid amounts in the SFY 2018 Medicaid inpatient managed care encounter data and fee-for-service paid claims data. The MQD modeling process to determine budget neutral standardized amounts will consider the impacts of all other APR DRG payment parameters described in this section, including policy adjusters, transfer adjustments, and outlier payments.

2. Publicly-owned in-state general acute hospitals will have a statewide standardized amount equal to 55% of the private hospital standardized amount.

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MQD will rebase its DRG base rates, including the standardized amounts and IME factors, no less than every five years, concurrently with updating the APR DRG grouper version. When rebasing, MQD will model new DRG standardized amounts modeled to be budget neutral to new base period payments in aggregate using the most recently available mature state fiscal year or calendar year of Medicaid inpatient managed care encounter data and fee-for-service paid claims data. The MQD modeling process to determine rebased DRG base rates will consider the impacts of all other APR DRG payment parameters described in this section, including policy adjusters, transfer adjustments, and outlier payments.

Hospital IME factors effective January 1, 2022 are based on the operating IME factors published by CMS in the federal fiscal year (FFY) 2021 Medicare inpatient prospective payment system (IPPS) Final Rule Impact File effective October 1, 2020. MQD will rebase the IME factors, no less than every five years, concurrently with updating the statewide standardized amounts, based on the operating IME factors published by CMS in the Medicare IPPS Final Rule Impact File effective October 1st in the federal fiscal year ending prior to the start of the effective calendar year.

New hospitals reimbursed under the APR DRG methodology will be assigned a DRG base rate with the applicable standardized amount and a hospital IME factor based on the most recently available Medicare IPPS operating IME factor published by CMS as of the hospital Medicaid provider enrollment date.

The statewide standardized amounts, IME factors, and DRG base rates for each hospital effective January 1, 2022 are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

c. Policy Adjusters

MQD will apply policy adjusters to payment amounts when claims meet certain criteria, which are based on specific APR DRG assignments or patient age parameters, to ensure access to quality care to these services. The criteria established for application of these policy adjusters include the following:

1. Neonatal DRGs
2. Well newborn DRGs
3. Maternity DRGs (normal delivery and cesarean section delivery)
4. Psychiatric and alcohol and drug abuse DRGs
5. Trauma DRGs
6. All other pediatric services (patients aged 20 and under)

All other adult services will not be subject to a policy adjuster. Policy adjusters are mutually exclusive, and there will be only a single applicable policy adjuster applied for each inpatient admission.

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MQD will rebase its policy adjusters no less than every five years, concurrently with updating the APR DRG grouper version and rebasing APR DRG base rates. When rebasing, MQD will model updated policy adjuster factors for the services described in this section, as needed, to ensure access to quality care to these services. The MQD modeling process to determine rebased policy adjuster factors will consider the impacts of all other APR DRG payment parameters described in this section, including DRG base rates, transfer adjustments, and outlier payments.

The policy adjuster factors effective January 1, 2022, by APR DRG, are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

d. DRG Base Payment

For each hospital admission, the DRG base payment equals the hospital’s DRG base rate multiplied by the DRG relative weight and the service’s applicable policy adjuster.

e. Transfer Adjustment

The DRG base payment may be subject to transfer adjustments as described in the following paragraphs.

A transfer adjustment to the DRG base payment applies when a patient is transferred from a hospital that is subject to DRG reimbursement to another general acute hospital or Critical Access Hospital. The transferring hospital will be reimbursed the lesser of the full DRG base payment and the DRG transfer adjusted payment. The transfer adjusted payment is equal to the full DRG base payment divided by the DRG geometric mean length of stay for the assigned DRG code, multiplied by the sum of the actual length of stay plus one day. The receiving hospital (for the same patient) will not be impacted by the transfer adjustment unless it transfers the patient to another general acute hospital or Critical Access Hospital.

The DRG geometric mean lengths of stay will be based on the APR DRG HSRV national trimmed geometric mean lengths of stay published for the associated APR DRG grouper version. MQD will use APR DRG grouper version 37.1 and associated national geometric mean lengths of stay for transfer adjustments effective January 1, 2022.

MQD will update its APR DRG national geometric mean lengths of stay no less than every five years, concurrently with updating the APR DRG grouper version.

The DRG national geometric mean lengths of stay effective January 1, 2022 are posted on the MQD website at:
<https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html>

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f. Outlier Payment

Cases which are extraordinarily costly in relation to other cases within the same DRG due to the severity of illness or complicating conditions may qualify for an outlier payment in addition to the DRG base payment. A claim will qualify for an outlier payment if the claim cost exceeds the outlier threshold. The claim cost is determined by multiplying the claim covered charges by the hospital's outlier cost-to-charge ratio (CCR). The outlier threshold is equal to the DRG base payment (including transfer adjustments described previously) plus the fixed loss amount.

The outlier CCRs for all hospitals will be determined as follows:

1. For children's hospitals in Hawai`i, the outlier CCR is based on sum of the Medicare IPPS Hawai`i statewide urban default operating and capital outlier CCRs published in the Federal Register Final Rule effective October 1st in the year preceding the start of the effective calendar year. Hawai`i children's hospitals outlier CCRs effective January 1, 2022 will be based on the sum of Medicare IPPS Hawai`i statewide urban default operating and capital outlier CCRs published in the FFY 2022 Federal Register Final Rule tables effective October 1, 2021.
2. For in-state general acute hospitals in Hawai`i, the outlier CCR is based on sum of hospital-specific Medicare IPPS operating and capital outlier CCRs published in the Final Rule Impact File effective October 1st in the year preceding the start of the effective calendar year. Hawai`i general acute hospital outlier CCRs effective January 1, 2022 will be based on the sum of Medicare IPPS hospital-specific operating and capital outlier CCRs published in the FFY 2022 Final Rule Impact File effective October 1, 2021.

New hospitals reimbursed under the APR DRG methodology will be assigned an outlier CCR based on the sum of the most recently available hospital-specific Medicare IPPS operating and capital outlier CCRs published by CMS as of the hospital Medicaid provider enrollment date. If hospital-specific Medicare IPPS outlier CCRs are not available, the new hospital outlier CCR will be based on the sum of the Medicare IPPS Hawai`i statewide urban default operating and capital outlier CCRs published in the Federal Register Final Rule effective October 1st in the year preceding the start of the effective calendar year.

MQD will update the outlier CCRs annually on January 1st each year, and will not adopt any Medicare IPPS outlier CCR updates for the rest of the calendar year.

MQD outlier payment parameters, including the fixed loss amount and marginal cost factors, will be modeled prospectively to result in outlier payments equal to 10% of total inpatient APR DRG payments. The outlier fixed loss amount effective January 1, 2022 is \$58,000. The MQD modeling process to determine the outlier fixed loss amount will consider the impacts of all other APR DRG payment parameters described in this section, including DRG base payments, transfer adjustments, outlier payments, etc.

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Where a claim qualifies for an outlier payment, the outlier payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the marginal cost factor. The marginal cost factor will be based on the APR DRG severity of illness level. The marginal cost factors effective January 1, 2022 will be 75% for claims assigned Severity of Illness levels 1 and 2, and 85% claims assigned Severity of Illness levels 3 and 4.

MQD will rebase its outlier payment parameters, including the fixed loss amount and marginal cost factors periodically at its discretion, to result in outlier payments equal to 10% of total inpatient APR DRG payments. At a minimum MQD will rebase its outlier payment parameters concurrently with updating its DRG grouper version and rebasing DRG base rates. The MQD modeling process will consider the impacts of all other APR DRG payment parameters described in this section, including DRG base payments, transfer adjustments, outlier payments, etc.

Covered charges for preadmission services and waitlisted days will be included in the inpatient claim for outlier payment purposes. Claim covered charges can be subject to retrospective utilization review, and may be adjusted for items such as non-covered services (such as personal care and convenience items), medical necessity of length of stay (for non-waitlisted days), and appropriate level of care among others.

g. DRG Final Payment

The DRG final payment amount is equal to the DRG base payment amount (with applicable transfer adjustment) plus the DRG outlier payment amount.

h. Readmissions

a) A readmission to the same or different facility within twenty four (24) hours of discharge for the same spell of illness and for a similar primary diagnosis as the index admission is considered to be the same admission and must be billed as a single stay. When the readmission occurs at a different hospital from the index admission, denial or partial payment adjustments may be made for the index admission at the original hospital based on nationally recognized admission and discharge review criteria. This policy does not apply to patients who leave the original facility against medical advice.

b) Readmission to the same facility within thirty (30) days of a discharge for a similar diagnosis is subject to review by the Department based on nationally recognized admission and discharge review criteria. Based on this review, the DRG payment for a readmission within 30 days may be consolidated with the index admission DRG payment. This policy does not apply to patients who leave the facility during the original admission against medical advice, or for planned readmissions.

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[~~rev. 7/22/96~~]

- 2. The Hawaii Medicaid Program shall reimburse all out-of-state providers and in-state freestanding psychiatric and rehabilitation providers for inpatient hospital services based primarily on the prospective per diem payment rates developed for each facility as determined in accordance with this Plan, except for CAH. In addition, certain costs (Such as Capital Related Costs) shall be reimbursed separately. The estimated average proposed payment rate under this plan is reasonably expected to pay not more in the aggregate for inpatient hospital services than the amount that the Department reasonably estimates would be paid for those services under Medicare principles of reimbursement.
 - a. A hospital -specific retrospective settlement adjustment shall be made for those providers whose Medicaid charges are less than Medicaid payments on the cost report and do not qualify as nominal charge providers under Medicare principles of reimbursement.
 - b. Prospective rates shall be derived from historical facility costs, and facilities shall be classified based on discharge volume and participation in an approved Medical Education program.
 - c. Providers that average fewer than 250 Medicaid discharges per year shall be classified as Classification I facilities and shall receive All-Inclusive Rates plus all appropriate Adjustments (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the All-Inclusive Rates.
 - d. Providers which average 250 Medicaid discharges or more per year shall be separated into two facility classifications (Classifications II and III) and shall receive payment based upon the type of services required by the patient. Psychiatric services will be paid ~~[on the basis of]~~ an All-Inclusive Rate, plus all appropriate Adjustments (Section I.D.3.). Nonpsychiatric claims will be designated as requiring either surgical, medical, or maternity care and will be paid on the basis of a routine per diem rate for the service type plus an ancillary per discharge rate for the service type, plus all appropriate Adjustments, (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the per diem and per discharge rates.
 - e. The freestanding rehabilitation hospital shall be excluded from Classifications I, II, and III, ~~shall be~~ designated as Classification IV, and ~~[shall receive payment based on]~~ will be paid an All-Inclusive Rate, plus all appropriate Adjustments, (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the per diem and per discharge rates.

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 Supersedes
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Approval Date:

Effective Date:

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f. Claims for payment shall be submitted following discharge of a patient, except as follows:

i. Claims for nonpsychiatric inpatient stays which exceed the Outlier Threshold (Section I.D.34.), shall be submitted in accordance with Section IV.D.

ii. If a patient is hospitalized in the freestanding rehabilitation hospital for more than 30 days, the facility may submit an interim claim for payment every 30 days until discharge. The final claim for payment shall cover services rendered on all [~~these~~]days not previously included in an interim claim.

g. The prospective payment rates shall not be paid in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except for outlier payments and as provided in Section I.E. below.

i. At the point that a patient reaches the Outlier Threshold (Section I.D.34.), the facility is eligible for interim payments computed pursuant to Section IV. D.

3. Reimbursement for inpatient services provided by CAH facilities will be on a reasonable cost basis under Medicare principles of reimbursement without application of any Medicaid Tax Equity and Fiscal Responsibility Act (TEFRA) target amounts. Outpatient, waitlisted and acute swing to continue to be reimbursed under the current method.

4. Reimbursement for services related to organ transplants will be made by a contractor selected by the State. The contractor will also be responsible to coordinate and manage transplant services. Reimbursement of services related to organ transplants will be approved by the State. The negotiated care rate will not exceed Medicare or prevailing regional market rates.

Citation: 42 CFR 434, 438 and 447; and Social Security Act 1902(a)(4), 1901 (a)(4), 1902 (a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions.

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902 (a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions.

The State identifies the following Other Provider-Preventable Conditions for non-payment under section 4.19-A.

Hospital-Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions.

The State identifies the following Other Provider-Preventable Conditions for non-payment under section 4.19-A.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below of the plan:

Adjustment of inpatient hospital reimbursement to account for non-payment of HCACs and OPPCs.

In accordance with 42 CFR 447.26(c), no reduction in payment for a Provider Preventable Condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment that patient by that provider. Reductions in provider payment are limited to the extent that the State can reasonably isolate for non-payment, the portion of the payment directly related to treatment for, and related to, the PPC that would otherwise result in an increase in payment.

Hospitals will use the Present on Admission indicator to identify whether an identified HCAC or OPPC was present on admission or hospital acquired. For hospitals reimburse on a per diem basis, such claims will be reviewed to determine whether the HCAC or OPPC resulted in a longer length of stay or increased acuity that can be directly and independently attributable to the HCAC or OPPC. For hospitals reimbursed ~~on a~~ on an APR DRG~~s~~ basis, the APR DRG and SOI level assignment will be based on the Medicare HCAC adjusted classifications under the APR DRG software logic, and payment will not include additional payment for the HCAC or OPPC that was not present on admission.

Lastly, in accordance with 42 CFR 447.26(c)(5), non-payment for OPPCs shall not prevent access to medically necessary covered services for Medicaid recipients.

D. The following definitions shall apply for the purpose of APR-DRG payment methodology.

1. All Patient Refined Diagnosis Related Groups (APR DRGs): Base APR-DRG classifications assigned to inpatient claims based on a variety of factors (including patient diagnosis and surgical procedures, among others) using the APR-DRG Health Information Systems software.

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Supersedes

Approval Date:

Effective Date: 01/01/2022

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2. DRG geometric mean lengths of stay (GMLOS): factor that represents the GMLOS for each combination of APR DRG and SOI level used for transfer adjustments, based on APR DRG national HSRV trimmed GMLOS amounts published for the APR DRG grouper version used for payment.
3. DRG Relative Weights: factor that represents the average resource requirements and level of acuity for each combination of APR DRG and SOI level used for base DRG payments, based on APR DRG national HSRV weights published for the APR DRG grouper version used for payment.
4. DRG Base Rates: Based on statewide standardized amounts adjusted by applying the hospital's IME factor, used for base DRG payments.
5. DRG Base Payments: For each hospital admission, the DRG base payment equals the hospital's DRG base rate multiplied by the HAC-adjusted DRG relative weight and the service's applicable policy adjuster.
6. Health Care Acquired Condition (HCAC)-Adjusted DRG: APR DRG and SOI assignment derived from excluding diagnosis codes associated with HCACs or other provider-preventable conditions listed in Att. 4.19-A, page 3.1.
7. Indirect Medical Education (IME) factors: based on hospital-specific operating IME factors in the Medicare inpatient prospective payment system (IPPS) published by CMS, used to adjust DRG base rates.
8. Outlier cost: Estimated claim cost for outlier payment purposes, based on claim covered charges multiplied by the hospital outlier CCR.
9. Outlier cost-to-charge ratio (CCR): Based on the Medicare IPPS combined operating and capital outlier CCRs for outlier payment purposes.
10. Outlier threshold: Based on the base DRG payment plus the fixed loss amount, for purposes of determining if a claim qualifies for an outlier payment.
11. Outlier marginal cost factor: Factor based on SOI level that is applied to the claim outlier cost exceeding the outlier threshold, for outlier payment purposes.
12. Outlier Payment: Claim payment add-on, in addition to the base DRG payment, for extraordinarily high cost cases where the claim outlier cost exceeds the claim outlier threshold.
13. Policy Adjusters: Adjusters to base DRG payments when claims meet certain criteria, which are based on specific APR DRG assignments or patient age parameters, to ensure access to quality care to these services.
14. Severity of Illness (SOI) level: SOI level 1 through 4 assigned to inpatient claims based on comorbid conditions and the severity of the underlying illness, using the APR-DRG Health Information Systems software.
15. Transfer Adjustment: Adjustment to the DRG base payment when a patient is transferred from a hospital that is subject to DRG reimbursement to another general acute hospital or Critical Access Hospital, equal to the full DRG base payment divided by the DRG geometric mean length of stay for the assigned DRG code, multiplied by the sum of the actual length of stay plus one day (not to exceed the full DRG base payment).

TN No. 21-0011

Supersedes

Approval Date:

Effective Date: 01/01/2022

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(Rev. 05/07/2021 ~~Rev. 05/21/00~~)

E. ~~[D.]~~DEFINITIONS APPLICABLE TO THE PROSPECTIVE RATE SYSTEM

The following definitions to include Attachment 4.19-A Sections II.-VI. or pgs. 5-39 are not applicable to the APR-DRG payment methodology. ~~[shall apply for purpose of calculating prospective payment rates and adjustment for acute inpatient services.]~~

1. "Acuity Level A" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively lower than Acuity Level C. Prior to October 1, 1990, that level of care was appropriately obtained from an ICF.
2. "Acuity Level C" means that the Department has applied its standards of medical necessity and determined that the Resident requires level of medical care from a Nursing Facility relatively higher than Acuity Level A. Prior to October 1, 1990, that level of care was appropriately obtained from an SNF.
3. "Adjustments" mean all adjustments to the Basic Per Diem, Basic Per Discharge and All-Inclusive Rates and/or the Capital Payments that are defined in this Plan and that are appropriate for a particular Provider. Those adjustments may include the ROE/GET Adjustment, the Medical Education Adjustment, and/or the Severity and Case Mix Adjustment.
4. "All-Inclusive Rates" means the separate per diem rates that are paid to Classification I and IV facilities for psychiatric and nonpsychiatric cases, and the per diem rates that are paid to Classification II and III facilities for psychiatric cases only. The All-Inclusive Rates are calculated to include reimbursement for both routine and ancillary costs.
5. "Ancillary Services" means diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges, and they include such services as laboratory, radiology, surgical services, etc.
6. "Basic Year" means the State fiscal year used for initial calculation and recalculation of prospective payment rates. The Base Year shall be the most recent State fiscal year or years for which complete, finally-settled financial data is available. Base Year data shall be supplemented with finally-settled financial data is available. Base Year data shall be supplemented with finally-settled cost data from previous years, if it is determined that extraordinary costs occurred in the most recent finally-settled cost report]

TN No. 21-0011
 Supersedes
 TN No. 12-006

Approval Date:

Effective Date: 01/01/2022