



Answers to Frequently Asked Questions (FAQs) on the Proposed Inpatient All Patient Refined Diagnosis Related Group (APR DRG) Methodology



Med-QUEST Division

State of Hawaii

Department of Human Services

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State of Hawai'i Department of Human Services Med-QUEST Division
Answers to FAQs on the Proposed Inpatient APR DRG Methodology

A. General

1. What are APR DRGs?

All Patient Refined Diagnosis Related Groups (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.¹ The proliferation of APR DRGs can be attributed to a variety of factors, including having the most granularity, design for use with all patient populations, the availability of national weights for payment, and critical mass amongst state Medicaid agencies (who often adopt common approaches used nationally). Due to APR DRGs’ enhanced granularity (particularly for key Medicaid service lines) and widespread adoption of across states, Med-QUEST (MQD) proposes to use the APR DRG grouper as the patient classification system for its new Medicaid inpatient prospective payment methodology.

Under APR DRG version 37.1, as proposed by MQD, there are 1,320 APR DRGs consisting of 330 base DRGs with four severity of illness (SOI) levels each (ranging from 1-“Minor” to 4-“Extreme”), plus two “ungroupable” DRGs. Per 3M™, SOI levels relate “to the extent of physiologic decompensation or organ system loss of function experienced by the patient.”² APR DRG version 37.1 also includes 112 newborn-related APR DRGs, the most of any DRG grouper product.

2. Why is MQD adopting a new APR DRG methodology for inpatient payment?

MQD has several goals and objectives for the new APR DRG payment methodology, consistent with its QUEST Demonstration goals to promote access, efficient utilization, stabilizing costs, and transforming service delivery. These goals and objectives include the following:

- *Establish standardized payment benchmark:* For inpatient payment purposes, DRGs are a mechanism for making case rate payments for similar services provided in a hospital inpatient stay. By establishing a

¹ Based on Milliman’s review of MACPAC’s “States’ Medicaid Fee-for-Service Inpatient Hospital Payment Policies” and of state plan amendments and websites, as described in the Milliman report “Hawai’i Preliminary APR DRG Model Report” dated November 17, 2020.

² 3M, “All Patient Refined Diagnosis Related Groups (APR DRG) Methodology Overview - Software version 37.1”, April 2020.
https://apps.3mhis.com/docs/Groupers/All_Patient_Refined_DRG/Methodology_overview_GRP041/grp041_aprdrg_meth_overview.pdf

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transparent, publically available fee-for-service (FFS) fee schedule based on APR-DRGs, MQD will be better equipped to compare and evaluate reimbursement levels across inpatient services, hospitals, and Medicaid managed care organizations (MCOs).

- *Provide acuity measurement:* DRGs are used both by payers and providers to classify hospital inpatient stays into clinically meaningful diagnostic groups. This provides MQD a basis for evaluating variation in service mix, cost structures, and patient outcomes (including readmissions) across hospitals and MCOs.
- *Promote equitability across providers:* For inpatient payment purposes, DRGs are a mechanism for making a standardized case rate payment for similar services provided in a hospital inpatient stay. This provides for an equitable payment for the same type of service across the delivery system, while also providing enhanced payment for the services with the highest levels of intensity.
- *Incentivize efficient delivery of care:* By establishing case rates for each DRG, a DRG prospective payment methodology incentivizes hospitals to avoid unnecessary lengths of stay and ancillary services during an inpatient service.
- *Enable state control of expenditures:* By establishing a transparent, publically available FFS fee schedule based on APR-DRGs, MQD seeks to control the rate of inpatient expenditure increases.

3. Are hospitals required to license APR DRG software from 3M™ in order to be paid under APR DRGs?

No, hospitals will not be required to license APR DRG software, and do not need to report the APR DRG when submitting an inpatient claim for payment. MQD and any Medicaid MCOs paying under APR DRGs will be required to license APR DRGs and assign the APR DRG to inpatient claims for payment purposes. Hospitals may find it beneficial to license 3M™ APR DRG software to assign an expected APR DRG prior to receiving claim payment.

4. *Updated:* Where can I find more details on the new APR DRG methodology?

Stakeholders can refer to the Milliman report "Hawai`i Preliminary APR DRG Model Report" dated November 17, 2020 and the Milliman APR DRG presentation dated December 11, 2020.

MQD has also released a preliminary DRG calculator that includes the modeled rates and weights, and demonstrates how a single claim is priced under the

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proposed methodology. Note this tool requires the APR DRG as an input, which must be obtained separately using 3M™ APR DRG software.

MQD is also currently developing a DRG webpage that will provide reference materials going forward. In addition, MQD will provide public notice on its State Plan Amendment, and will release updates to its provider billing manual.

5. How can I submit questions/feedback on the proposed APR DRG methodology?

For questions or feedback on the proposed new APR DRG methodology, please email Eric Nouchi at MQD at enouchi@dhs.hawaii.gov.

B. APR DRG Implementation

1. When will the new APR DRG methodology be effective?

MQD proposes to include the new APR DRG payment methodology in its state plan for Medicaid FFS payment for inpatient admissions beginning **July 1, 2021** and beyond. Admissions prior to July 1, 2021 would be paid under the legacy per diem payment methodology.

*2. **Updated:** Will MQD require Medicaid MCOs to reimburse under the APR DRG methodology? If so, will the MCOs be required pay exactly under FFS rates and methodology, or can they leverage their own clinical and claim payment policies?*

Based on consideration of stakeholder feedback about potential disparities in reimbursement if not all applicable hospitals participate in the APR DRG methodology, MQD intends to implement a managed care state directed fee schedule that would require MCOs to pay under the exact FFS APR DRG payment methodology. This directed fee schedule would include all payment parameters (APR DRG grouper version, base rates, policy adjusters, relative weights, outlier parameters, etc.). MQD will field and consider proposals for exceptions to the directed fee schedule for value-based purchasing arrangements between MCOs and hospitals.

MQD is sharing model parameters with MCOs and hospitals to enable the adoption of the APR DRG methodology for managed care inpatient hospital payment purposes.

3. Which providers will be paid under the new APR DRG methodology?

MQD proposes to apply the new inpatient APR DRG methodology to in-state general acute hospitals and children's hospitals. MQD proposes to exclude Critical

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Access Hospitals, freestanding rehabilitation hospitals, freestanding psychiatric hospitals, long-term acute care hospitals, military hospitals, Veterans Association hospitals, and out-of-state hospitals from the APR DRG methodology.

4. Which services will be paid under the new APR DRG methodology?

MQD proposes to include all inpatient services at applicable hospitals under the APR DRG payment methodology, except for State of Hawaii Organ and Tissue Transplant (SHOTT) services.

5. Does the APR DRG methodology includes "waitlisted" days?

Yes, MQD proposes to include waitlisted days in the APR DRG methodology (where the patient is receiving lower level of care, but is not discharged). While there would not be a separate per diem payment for waitlisted days, MQD proposes to include the charges from these days in the DRG outlier payment calculation.

6. Does the APR DRG methodology include outpatient preadmission services?

Yes, MQD proposes to include in the APR DRG methodology outpatient diagnostic services and admission-related outpatient non-diagnostic services provided to a patient within a three day window of an inpatient admission. While there would not be a separate outpatient payment for these preadmission services, MQD proposes to include the charges from these services in the DRG outlier payment calculation.

7. Will APR DRGs impact 2021 Medicaid MCO capitation rates?

Medicaid capitation rates are developed by MQD's actuarial contactor and may be impacted by a variety of factors, including APR DRGs, MCO procurement, enrollment changes, etc. The APR DRG methodology has been modeled to be budget neutral in aggregate, so MQD does not intend to add additional funding for inpatient rate changes under APR DRGs. However, MQD proposes transitional adjustments to increase supplemental payments (described in next section), which would impact capitation rates. If capitation rates need to be adjusted for each MCO, that will be done once final policy decisions are made.

8. How will the APR DRG methodology impact the coordination of benefits with Community Care Services (CCS) for inpatient stays that have a mix of medical and psychiatric services?

MQD is considering whether to use the APR DRG assignment as the basis for identifying behavioral health inpatient services. Note that generally under APR DRGs a claim with a medical primary diagnosis and a psychiatric secondary diagnosis will receive a medical APR DRG with a higher SOI level.

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9. **Updated:** *How will billing requirements change under APR DRGs?*

APR DRGs require more complete documentation and coding of the medical record in the inpatient claim in order for a hospital to receive the appropriate APR DRG classification for payment (compared to the current per diem methodology). The following information is critical for the appropriate APR DRG assignment and payment under APR DRGs:

- Member information (birthdate, sex, etc.)
- Service date range
- ICD-10 diagnosis codes (with Present on Admission codes) and procedure codes (with procedure dates)
- Birth weight (value code 54)
- Patient discharge status
- Billed charges

In addition, MQD will require providers to report the following for informational purposes:

- The Occurrence Span Code for waitlisted days (for example, 74 for ICF level of care and 75 for SNF level of care)
- ICD-10 diagnosis codes for problems related to housing and economic circumstances (for example, Z59)

The above examples are not intended to be a comprehensive list of required information. MQD will update its hospital billing manual and issue new guidance to MCOs where there are changes identified in encounter submission requirements. MQD will also be providing information to hospitals and MCOs on APR DRG grouper version specifications and which data inputs will be used for grouping and pricing.

C. APR DRG Methodology

1. *What are the APR DRG relative weights based on?*

MQD proposes APR DRG version 37.1 relative weights based on the 3M™ national "hospital specific relative value" (HSRV) weights. MQD proposes to use APR DRG classifications and relative weights assigned for payment based on the Hospital Acquired Condition (HAC) adjusted DRG. HAC adjustments to the APR DRG occur in the patient classification algorithm when select secondary diagnosis codes not present on admission are suppressed from the APR DRG

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assignment. This adjustment may result in a lower weighted APR DRG / SOI level in certain instances.

2. How are APR DRG base rates calculated?

MQD proposes hospital DRG base rates based on statewide standardized amounts, adjusted by applying the hospital's indirect medical education (IME) factor. The proposed statewide standardized amounts are prospective and differ by hospital class, as follows:

- **For privately owned hospitals**, MQD proposes a statewide standardized amount of **\$11,578.24**, 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.
- **For publicly-owned hospitals**, MQD proposes a statewide standardized amount of **\$6,368.03**, equal to 55% of the private hospital standardized amount (modeled to be approximately budget neutral).

The MQD modeling process to determine budget neutral standardized amounts considered the impacts of all other APR DRG payment parameters described in this section, including policy adjusters, transfer adjustments, and outlier payments.

The proposed Hospital IME factors 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. Kapiolani's IME factor is based on the intern-to-bed ratio reported in its FYE 2019 Medicare cost report.

3. Will MQD make special considerations for payment for key Medicaid service lines?

MQD proposes to apply policy 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. The criteria established for application of these policy adjusters include the following:

- Neonatal DRGs – **1.55** factor
- Well newborn DRGs – **1.15** factor
- Maternity delivery DRGs – **1.15** factor
- Psychiatric and alcohol and drug abuse DRGs – **1.15** factor
- Trauma DRGs – **1.15** factor
- All other pediatric services (patients aged 20 and under) – **1.15** factor

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The proposed policy adjusters (except for neonatal DRGs) were modeled to result in estimated pay-to-cost ratios consistent with the statewide average. The neonatal DRG policy adjuster was modeled to mitigate negative impacts for this key Medicaid service line, while maintaining reimbursement levels at enhanced levels.

MQD proposes for all other adult services to apply a policy adjuster factor of 1.0 (essentially no adjustment). Policy adjusters are mutually exclusive, and there will be only a single applicable policy adjuster applied for each inpatient admission. If comparing proposed policy adjuster factors to other states, the comparison must consider the other state's full context, including differences in DRG base rates, the scale of relative weights, use of legacy supplemental payment funding, using of provider tax funding, or other drivers of the state's policy adjuster factors.

4. Will MQD make outlier payments for high cost claims?

MQD proposes Medicare-style outlier payments, in addition to the base DRG payment, for extraordinarily high cost claims. A claim would 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 below) plus the fixed loss amount of **\$58,000**.

For qualifying claims, the outlier payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the applicable marginal cost factor. The marginal cost factor would be **75%** for claims assigned SOI levels 1 and 2, and **85%** for claims assigned SOI levels 3 and 4.

Outlier payment parameters have been modeled such that the simulated total outlier payments represent approximately 10% of total simulated payments under the APR DRG payment system.

5. Is there a payment system for transfer claims?

MQD proposes a Medicare-style transfer payment adjustment for transfer-out cases to another general acute hospital or critical access hospital. The transferring hospital would 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 APR DRG geometric mean length of stay, multiplied by the sum of the actual length of stay plus one day. The receiving hospital (for the same patient) would not be impacted by the transfer adjustment unless it transfers the patient to another general acute hospital or Critical Access Hospital.

MQD does not propose to include in its transfer payment methodology the post-acute settings included in the Medicare IPPS transfer payment policy. After APR DRG implementation, MQD will monitor the prevalence of short lengths of stay in

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cases where the patient is transferred to a post-acute setting, and will evaluate whether transfer payment policy charges are warranted.

6. Will reimbursement be reduced for short stays, or capped at billed charges?

MQD does not propose to reduce the APR DRG payment for short stays, or cap payment at billed changes, with the exception of transfer-out cases described previously.

*7. **Updated:** Will MQD have a readmissions policy under APR DRGs?*

Currently MQD's FFS inpatient readmission policy, as defined in its State Plan Amendment 4.19-A, is as follows:

- a) A readmission to the same or different facility within twenty four (24) hours of discharge for the same spell of illness and for the same general diagnosis as the original admission is considered to be the same admission and must be billed as a single stay. When two different facilities are involved, denial or partial payments may be made for the original admission, if the Department determines that the services should have been provided during the initial inpatient stay. 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. Denial or partial payment of either the original stay or readmission may be made if the Department determines that the services should have been provided during the initial inpatient stay. This policy does not apply to patients who leave the facility during the original admission against medical advice.*

MQD proposes to update item B above to specify that the DRG payment for a readmission within 30 days may be consolidated with the index admission DRG payment, based on review subject to administrative guidelines. These guidelines would be based on nationally recognized admission and discharge review criteria (likely to be defined in the provider billing manual or separate policy document). This would enable plans to conduct retrospective reviews to validate readmissions, and to have a consistent approach across FFS and managed care.

MQD does not propose to include planned readmissions in the consolidated DRG payment policy.

8. Will providers be able to bill on an interim basis under APR DRGs?

Yes, MQD does not plan to change its current interim billing policy. Note that providers would be required to update the diagnosis codes and procedure codes, as appropriate, as they submit each interim claim.

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9. *New:* Will billed charges be subject to retrospective utilization review?

Yes, inpatient claim billed charges can be subject to retrospective utilization review. Billed charges 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), appropriate level of care, etc.

D. Transition and Future Updates

1. *Will MQD make transitional adjustments to mitigate impacts under APR DRGs?*

To help mitigate impacts under APR DRGs, MQD proposes transitional adjustments to SFY 2022 supplemental payments. Currently private hospital Access inpatient payments and public hospital directed inpatient payments are based on each hospital's Medicaid managed care "shortfall". For private hospitals, the Medicaid shortfall is based on the gap between estimated payments under Medicare and Medicaid managed care payments, and for public hospitals the Medicaid shortfall is based on the gap between estimated costs and Medicaid managed care payments.

MQD proposes to update the Medicaid shortfall calculation to account for APR DRG model estimated impacts. This would result in higher Access/directed payments for hospitals with estimated losses under APR DRGs, and lower Access/directed payments for hospitals with estimated gains under APR DRGs.

MQD also proposes material increases to the quality payment pool, which is currently \$42.1 million. Note that supplemental payment changes are subject to final MQD policy decisions, stakeholder discussions, and approval by the state legislature and CMS

2. *Updated:* How often will MQD update the APR DRG methodology?

MQD proposes to "rebase" its APR DRG methodology no less frequently than every 5 years. "Rebasing" includes updating the APR DRG grouper version, weights, average lengths of stay, DRG base rates, and policy adjuster factors. When updating the APR DRG grouper version and weights, MQD proposes to make scaling adjustments to the new version of weights to result in aggregate modeled case mix equal to the prior version of weights to maintain budget neutrality.

MQD proposes annual updates to outlier payment parameters, including outlier CCRs, the fixed loss amount, and marginal cost factors, so that aggregate outlier payments are approximately 10% of aggregate inpatient payments, as originally modeled.

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Caveats

The preliminary APR DRG model described in these answers to FAQs reflects preliminary payment policy options under consideration by MQD. Final policy decisions for a new FFS APR DRG methodology have not been made by MQD; as such, the preliminary model is subject to change based on stakeholder feedback, MQD final policy decisions, and the CMS approval process. In addition, final APR DRG payment parameters adopted by MCOs may differ from the FFS methodology implemented by MQD.

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