A New Inpatient Hospital Payment Method for Mississippi Medicaid

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The Mississippi Division of Medicaid has moved to a new method of paying for hospital inpatient services. Our goal is to improve access to care, increase fairness to hospitals, reward efficiency, improve purchasing clarity, and reduce administrative burden for both the Division and the hospitals.

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

The New Inpatient Hospital Payment Method

1. When was the new method implemented?

The Division implemented the new method for admit dates on and after October 1, 2012.

2. What changed?

The Mississippi Division of Medicaid changed the method it uses to pay hospitals for inpatient care. Under the new method, hospitals are paid per stay based on All Patient Refined Diagnosis Related Groups (APR-DRGs).

3. What providers and services were affected?

The new method applies to inpatient care in all acute care hospitals, including general hospitals, freestanding psychiatric hospitals and freestanding rehabilitation hospitals. The following services provided by acute care hospitals were not affected: outpatient care, Medicare crossover claims, and swing bed services. Psychiatric residential treatment facilities, Indian Health Services hospitals and nursing facilities were among the providers not affected by the new method.

4. How much money was affected?

In the fiscal year that ended June 30, 2011, the Division of Medicaid paid acute care hospitals $643 million for inpatient care. This figure excludes supplementary payments (DSH and UPL) and payments for care received by Medicaid patients for whom Medicare was the primary payer, which are made using a separate crossover payment policy.

5. Why was a change made to the new payment method?

The Division had five reasons.

- **Improve access to care.** Under the new method, the Medicaid payment for a particular inpatient stay is closely tied to the acuity, or casemix, of the inpatient stay. Hospitals that take sicker patients receive higher payment, which improves access to care for the sickest patients.

- **Increase fairness to hospitals.** Under the previous method, two hospitals were often paid very different amounts for the care of very similar patients. Under the new method, all hospitals are paid similarly for similar patients.

- **Reward efficiency.** Under the previous method, hospitals that became more efficient and decreased cost were penalized with lower payment. Under the new method, hospitals receive a flat rate for each stay of a given casemix level. If they improve efficiency, they keep the savings.

- **Improve purchasing clarity.** The new method allows the Division clearer insight into the services being covered. Each stay is assigned to a single DRG with a single payment. DRGs are organized so that each DRG contains stays that are similar both clinically and in terms of hospital resources used.

- **Reduce administrative burden.** Under the previous method, delays and adjustments to cost reports and payment rates bedeviled financial planning for both the hospitals and the Division. Several years could elapse after discharge before payment was finalized. Under DRG payment, a hospital receives final payment for a stay shortly after it submits a claim. As well, the previous method depended on the Division receiving audited hospital cost reports from Medicare contractors. Medicare contractors focus their audits on areas of the cost report that affect Medicare payment, not on areas such as neonatal care and pediatrics that are of great importance to Medicaid.

6. Was there an independent review of this proposal?

Yes. In 2009, the Performance Evaluation and Expenditure Review (PEER) Committee of the Mississippi Legislature reviewed the proposed new method. Its report (www.peer.state.ms.us/530.html) said:

> "PEER believes that the ACS-recommended APR-DRG payment method better accomplishes the management objectives and goals for a new payment method than the present method or the Medicare DRG method. The APR-DRG payment method would be a sustainable, rational method that better addresses the client service cost care payment requirements for the state Medicaid population while improving client access to hospitals, rewarding hospital efficiency for reducing state costs through more efficient client treatment, increasing fairness to hospitals for payments for client care, improving the purchasing clarity of client hospital services, and reducing the administrative burden for final payments on the hospitals and the DOM."

Components of the New Payment Method

7. Overall, how does the new payment method work?

The operation of the new method is very similar to DRG-based payment methods currently in use by Medicare and two-thirds of the nation's other Medicaid programs. Every inpatient stay is assigned to a single DRG that reflects the difficulty of that case. For example, a patient with an uncomplicated pneumonia is assigned to APR-DRG 139-1 and a pneumonia patient with multiple comorbidities is assigned to APR-DRG 139-4. For each stay, the DRG base payment equals:

RELATIVE WEIGHT FOR THAT DRG X BASE PRICE = DRG BASE PAYMENT

For example, DRG 139-1 has a relative weight of 0.3886 and DRG 139-4 has a relative weight of 1.7342.

The base price for October 1, 2012, is $6,223. The base payment for these DRGs is:

DRG 139-1: 0.3886 x $6,223 = $ 2,418.26

DRG 139-4: 1.7342 x $ 6,223 = $10,791.93

Hospitals are therefore paid more for more difficult cases and less for less difficult cases. At the same time, payment does not depend on the hospital's charges or costs, so the hospital has an incentive to improve efficiency.

8. Where do the DRG relative weights come from?

The Division of Medicaid uses APR-DRG relative weights calculated from the Nationwide Inpatient Sample. An analysis found very close correlation between the national weights and a set of weights calculated specifically from Mississippi Medicaid fee-for-service data. The national weights are updated annually by 3M Health Information Systems.

9. Where can I find a list of weights and rates?

The list of relative weights and payment rates are available on the Provider Relations website at http://msmedicaid.acs-inc.com and the Division of Medicaid website at http://www.medicaid.ms.gov. There are weights and rates for 1,256 DRGs. In addition, there are two error DRGs, for a total of 1,258 groups.

10. How are hospitals protected against the cost of exceptionally expensive cases?

About 5% of payments are made as "outlier" payments. There are two types of outlier payments.

- For mental health cases, where exceptionally expensive cases tend to be associated with long lengths of stay, hospitals are paid $450 for each day that exceeds the DRG Long Stay Threshold, which is 19 days. This per-diem amount is called the DRG day outlier amount.

- For all other cases, hospitals receive "DRG cost outlier payments" for stays where the estimated loss, or the difference between the hospital's estimated cost (charges for that stay times the hospital-specific inpatient cost-to-charge ratio) and the DRG base payment, exceeds $30,000, the DRG Outlier Threshold. The hospital's DRG cost outlier payment equals the hospital's estimated loss minus the DRG Outlier Threshold, times the marginal cost percentage. The cost outlier payment policy is patterned after Medicare's cost outlier policy.

11. What changes were made to disproportionate-share hospital (DSH) payments, upper payment limit (UPL) payments, medical education payments and payments for capital?

The DRG-based payment method is a separate topic from DSH and UPL payment policy. We note, however, that the current UPL formula means that some hospitals that see a decrease in claim payments under DRGs may see an offsetting increase in UPL payments, and vice versa.

Payments for medical education, which were previously included in the per diem claim payment, are made on the claim, as a flat amount per stay.

Under DRG-based payment, there is no separate payment for capital. Previous payments for capital are rolled into the DRG payment.

12. What other factors affect payments for individual cases?

As is common in DRG payment methods, there are special calculations for patients who are transferred to other acute care settings and for situations in which the patient has Medicaid coverage for only part of the stay (e.g., loss of eligibility).

The Division pays the same rates to all hospitals, without labor-market adjustments such as Medicare has. This decision promotes access to hospital care in rural areas, since the typical effect of labor-market adjustments is to reduce payments in rural areas.

13. What is Medicaid's transfer policy?

DRG payers typically reduce payment if a transfer to an acute care setting means that the length of stay at the transferring hospital is unusually low. The typical approach is to follow the Medicare model, that is, to calculate the DRG base payment check if the discharge status qualifies as a transfer to another acute care setting and, if so, calculate a transfer-adjusted base payment. The actual DRG base payment is then the DRG base payment or the transfer-adjusted amount, whichever is lower. The formula for the transfer-adjusted base payment is:

TSF-ADJUSTED BASE PAYMENT = (DRG BASE PAYMENT) X (ACTUAL LOS + 1) / OVERALL AVERAGE LOS

Although Medicare also has a post-acute transfer policy, Medicaid does not have a post-acute transfer policy. The difference in approaches reflects the difference in patient populations.

Overall Payment Levels

14. How does the new payment method affect overall funding to hospitals?

The Division started calculating payment rates on October 1, 2012, that are budget-neutral to the period October 2010 to March 2011 (on an annualized basis). Fiscal pressures facing the Medicaid program precluded an inflation adjustment for the 18-month interval. However, the Division expects DRG payment to incentivize efficiency improvements by hospitals. Any savings from these improvements improves hospital profitability.

The calculation of the October 1 rates included adjustments for expected improvement in diagnosis and procedure coding on claims (Question 25) and for the change in definition in the three-day window (Question 26).

15. How has payments to individual hospitals been affected?

For some hospitals, payments have risen while for other hospitals they have fallen. When a simulation was done of the new payment method using six months of data from October 2010 to March 2011, payments rose by more than 10% for 29 hospitals, rose by less than 10% for 25 hospitals, declined by more than 10% for 26 hospitals and declined by less than 10% for 17 hospitals. (The numbers refer to Mississippi hospitals, excluding out-of-state hospitals.)

These changes reflect both the new payment method (where payment depends on a hospital's casemix) and the previous payment method (where payment depended on a hospital's cost and on the cost of similarly sized hospitals). Now, an increase in a hospital's casemix index leads directly to increases in payment. Moreover, if a hospital decreases its costs then those savings flow directly to the hospital's bottom line.

16. Does the new method apply even to small hospitals? Medicare exempts critical access hospitals from its DRG-based payment method.

The new method applies to all hospitals. The simulation using October 2010-March 2011 data showed that of 40 Mississippi hospitals with fewer than 50 beds, 24 would see an increase in payments, with 14 of those hospitals seeing an increase of more than 10%. Small hospitals are protected against exceptionally expensive cases by the outlier features and by the fact that they often transfer complex cases to larger hospitals.

17. How are mental health stays paid?

A mental health stay is one that groups to one of the 72 APR-DRGs for treatment of psychiatric and substance abuse conditions. Both general and freestanding hospitals are paid using the same set of 72 payment rates, with higher payments for more complex stays regardless of setting. The payment rates equal the relative weight for each DRG times a policy adjustor times the DRG base price. The policy adjustor recognizes the importance of Medicaid funding in ensuring continued access to acute mental health care in Mississippi. Policy adjustors are used for pediatric (under 21 years old) and adult stays. Under the new payment method, the payment-to-cost ratio for mental health cases is higher than for any other care category.

Exceptionally long mental health stays—those that exceed 19 days—are eligible for day outlier payments for each day that exceeds the threshold.

18. How will payments change in the future?

The Division plans to do an annual review of what change, if any, in the DRG base price would be appropriate. The combination of the base price, the number of stays, the average casemix per stay, the impacts of the mental health policy adjustor, rehab policy adjustor, obstetrics policy adjustor and transplant policy adjustor will determine the overall level of payments. We will also update the APR-DRG grouping algorithm to include new ICD-9-CM diagnosis and procedure codes.

In the first year of DRG payment, as the Division and the hospitals gain experience with the new method, it is possible that the Division will change the base price if it becomes clear that the initial value was set too low or too high. If at all possible, any changes would be made on a go-forward basis. We intend to avoid making retroactive adjustments.

19. How will ICD-10 affect the use of APR-DRGs?

At the national level, ICD-10 implementation is now scheduled for October 1, 2014. 3M Health Information Systems will release an ICD-10 version of the APR-DRG algorithm.

All Patient Refined Diagnosis Related Groups

20. Why were APR-DRGs chosen? Why not Medicare DRGs?

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

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 Mississippi Medicaid fee-for-service population, these categories represent almost 75% of all stays.

21. What was done to verify that APR-DRGs are appropriate for the Mississippi Medicaid population?

The Division hired Xerox State Healthcare, the Division's current fiscal agent, to conduct a thorough assessment of the options. Using the statistical tests that are standard in payment method development, the contractor found that APR-DRGs consistently fit the Mississippi data very well, and better than the alternatives. The results were described in "New Directions in Medicaid Payment for Hospital Care," published in the January/February 2008 issue of Health Affairs. For neonatal care, the results were similar to those found in an evaluation of national data described in "Structure and Performance of Different DRG Systems for Neonatal Medicine," published in the January 1999 issue of *Pediatrics.*

22. 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 are in current use or planned for use by Medicaid programs in California, Illinois, Maryland, Montana, New York, North Dakota, Pennsylvania, Rhode Island, South Carolina and Texas. APR-DRGs are also commonly used to adjust for casemix in analyzing hospital performance, for example at www.FloridaHealthFinder.gov and www.health.utah.gov.

23. Does my hospital need to buy APR-DRG software to be paid by Medicaid?

No. The Medicaid claims processing system assigns the APR-DRG and calculates payment without any need for the hospital to put the APR-DRG on the claim. (This was how the simulations were done using existing data.) More information about APR-DRGs is available at

http://solutions.3m.com/wps/portal/3M/en_US/Health-Information-Systems.

24. What version of APR-DRGs is implemented?

APR-DRG versions are released each October 1. On October 1, 2012, Medicaid implemented APR-DRG Version 29, which was effective October 1, 2011. This is the same version that has been used in developing the new payment method. The Division will update to Version 30 on July 1, 2013.

Impacts on Coding, Billing and Other Hospital Operations

25. How did the new payment method affect medical coding requirements?

Assignment of the APR-DRG and calculation of payment use the standard information already on the hospital claim. APR-DRG assignment depends chiefly on the diagnosis fields and the ICD-9-CM procedure fields, so hospitals are advised to ensure that these fields are coded completely, accurately and defensibly.

As do other DRG payers, the Division reviews claims from hospitals whose claims show a marked increase in average casemix following implementation of DRGs.

26. Does Medicaid use an "outpatient window" like Medicare does?

Yes. Medicaid changed its definition of the "outpatient window" with the intention of mirroring Medicare. This window refers to outpatient services immediately preceding the admission that are considered to be part of the inpatient stay. Hospitals are already very familiar with the Medicare window, which is described at www.trailblazerhealth.com/Publications/Job%20Aid/three-dayrule.pdf. As is true in Medicare, hospitals can indicate that outpatient services are unrelated to the inpatient stay through the appropriate use of condition code 51 on the outpatient claim.

Although Medicaid's intention was to mirror the Medicare three-day window definition, please note that if there are any differences then the Medicaid approach will prevail.

27. What is the policy for interim claims?

Hospitals are not required to submit interim claims under any circumstances.

However, the Division (unlike many DRG payers) will make interim payments if a hospital chooses to submit an interim claim during an exceptionally long stay. This policy is intended to encourage access for patients who may need weeks or months of acute care.

If a stay exceeds 30 days then the hospital can submit an interim claim and will be paid an interim per diem amount ($450) times the number of days. After the patient is discharged, the interim claims will be voided or adjusted and a single payment will be made to cover the entire stay. If the hospital has submitted one interim claim, it will adjust that claim. If the hospital has submitted more than one interim claim, it will adjust one of the interim claims and void the others. The procedures for submitting adjustments and voids to Mississippi Medicaid have not changed.

Bill types 114 (interim claim—final bill) and 115 (late charges) will be denied. Instead, hospitals should submit a single claim (either bill type 111 or an adjustment) covering all services provided during the stay.

28. How are hospitals paid for newborns?

Hospitals bill each newborn on his, or her, own claim. (Before October 1, well babies were billed on their mother's claim.) As do other DRG payers, Medicaid makes separate payments for the mother and the baby depending on the DRG that is assigned to each patient's stay.

29. What if the patient is not Medicaid-eligible during the entire length of stay?

For various reasons, a patient may not be eligible for Medicaid for the entire length of stay. Previously, the claims-processing system denied any claim that included non-covered days.

Under the new payment method, if a patient is not eligible for the entire length of stay, the claims processing system prices the entire stay using DRG-based logic (including outlier provisions as appropriate) and then prorates the payment. The prorated payment is the DRG payment divided by the nationwide average length of stay for that DRG times the Medicaid covered days, with double payment for the first day to reflect increased hospital costs on the first day.

The Medicaid payment is considered payment in full only for those days that were covered by Medicaid. For non-covered days, hospitals may seek payment from patients as they do now.

30. Is the present-on-admission indicator be used?

Yes. Hospitals should submit valid values of the POA indicator.

31. How are hospital inpatient payments affected if a health-care acquired condition (HCAC) is present on the claim?

Federal law prohibits payment for HCACs; claims with HCACs are identified through post-payment review and payment reductions are made as appropriate.

32. Was there a change to the 30-day service limit?

House Bill 421 allowed the Division to remove the 30-day service limit. Inpatient claims processed using APR-DRG methodology are not subject to a 30-day service limit. An adjustment has been made to the overall DRG base price so that there is no net impact on Medicaid spending. We expect this change to improve fairness to hospitals and patients that were previously affected by the 30-day limit.

The Division has also discontinued three other annual limits, namely those for psychiatric inpatient days, blood units and physician services to inpatients. The Division believes that these limits were no longer necessary to control expenditures when payment is made by DRG.

33. How are claims paid when a dually eligible Medicare/Medicaid beneficiary exhausts his or her Medicare days?

If Medicare days are exhausted prior to the admission previously being billed, the entire stay should be billed to Medicaid with the Medicare exhausted days reflected as an occurrence code and date. If Medicare days are exhausted during the stay, then two claims should be submitted to Medicaid. For the days where Medicare is the primary payer, Medicaid pays the coinsurance and deductible. For the days where Medicaid is the primary payer, Medicaid prices the claim by DRG like any other claim. On the second claim, the fact that Medicare days have been exhausted must be shown as an occurrence code and date.

34. How many diagnosis and procedure codes will Medicaid use to assign the APR-DRG?

The Envision claims processing system and the APR-DRG grouper accepts as many as 24 secondary diagnosis codes and 24 secondary procedure codes in addition to the principal diagnosis and principal procedure. The UB-04 paper claim form enables the hospital to show a principal diagnosis, 17 secondary diagnoses, the principal procedure, and 5 secondary procedures.

35. What date of admission should be used if the patient has been in observation or other outpatient status prior to admission?

Previously, when a patient had been in outpatient observation status and was then admitted to inpatient status, the Division instructed the hospital to use the first day of outpatient observation status as the inpatient admission date. Under the new payment method, this instruction has changed. The date of the inpatient admission will be the date the patient enters inpatient status as indicated by the physician's order. We believe this reduces administrative burden on hospitals.

Authorization of Services

36. What changed in the treatment authorization requirements?

Requirements for treatment authorization on the admission did not change. Requirements for continued stay review (i.e., the length of stay) were significantly simplified. Only stays that exceed 19 days require continued stay review. That is, only about 2% of all stays require authorization of the medical necessity of the length of stay. This change reflects the fact that for almost all stays, payment is per stay based on the patient's diagnoses and procedures, regardless of the length of stay. The exceptions are that mental health stays that exceed 19 days receive day outlier payments and that physical health stays that qualify as cost outlier stays receive cost outlier payments. Cost outlier status does not depend on length of stay as such, but in practice cost outlier stays tend to be long stays—hence the requirement for concurrent review on stays that exceed 19 days.

Please see Table 1.

Table 1
Summary of Treatment Authorization Changes

	TAN--Admission		TAN--Continued Stay Review	
	Previous Policy	**Effective Oct. 1, 2012**	**Previous Policy**	**Effective Oct. 1, 2012**
Deliveries	Yes, by reporting	Yes, by reporting	Only after 3 days (vaginal) or 5 days (cesarean)	Only after 19 days
"Well baby" = newborn LOS less than or equal to 5 days	No	No	Not applicable	Not applicable
"Sick baby" = Newborn LOS more than 5 days	Yes	Yes—Should be obtained before Day 6	All days	Only after 19 days
All other stays	Yes	Yes	All days	Only after 19 days

Notes:
1) LOS = length of stay. A newborn is identified by the presence of admit type = 4 on the claim
2) Newborns who are well babies or newborn sick babies who become ill and are discharged on or before Day 5 will not require a TAN. Only newborns who remain sick and continue to require inpatient care on or after Day 6 will require a TAN.
3) LOS is used to differentiate well babies and sick babies only for purposes of TAN authorization. Payment for the baby's stay will depend on the assigned APR-DRG. There are 116 newborn APR-DRGs that reflect the baby's birthweight, diagnoses and procedures.

37. How is length of stay calculated?

The length of stay equals the last day of service minus the first day of service, with two exceptions. First, if the patient is admitted and discharged on the same day, then the length of stay is one day. Second, if the patient is still a patient (discharge status 30) on the last day of service, then the last day also counts in the length of stay. For example:

Monday → Wednesday with discharge status 30 = 3 days

Monday → Wednesday with any other discharge status = 2 days

Monday → Tuesday = 1 day

Monday → Monday = 1 day

38. In some cases, a hospital moves a patient from a medical/surgical unit to a rehabilitation unit or psychiatric unit within the same hospital. Does this count as one stay or two for purposes of calculating DRG payment?

If both stays are authorized as having met the criteria for medical necessity of the admission, then the hospital can discharge the patient from the medical/surgical unit and admit him or her to the rehabilitation or psychiatric unit. Two claims are submitted, each with its own treatment authorization number (TAN), and two DRG payments are made.

39. Is Medicaid authorization required for dually eligible beneficiaries when Medicare is the primary payer?

No.

Other Questions and Next Steps

40. Do hospitals still have to submit cost reports?

Yes. Cost reports are used in calculating supplemental payments. The Division also uses cost reports as a data source in the annual review of the DRG base price.

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

No, except for limited circumstances. Payments based on DRG are generally final. A major benefit of the new payment method is that payments are not subject to adjustment two to three years after the date of service. Cost outlier payments may be subject to adjustment in cases of suspected fraud and/or abuse.

42. What does Medicaid do to educate hospitals about the new payment method?

Training materials are available on both the Provider Relations website at http://msmedicaid.acs-inc.com and the Division of Medicaid website at http://medicaid.ms.gov. These materials include this FAQ document and an interactive DRG pricing calculator in spreadsheet form.

43. Who can I contact for more information?

- **Technical questions about APR-DRGs, outliers, etc.** Kevin Quinn, Vice President, Payment Method Development, Xerox State Healthcare LLC, kevin.quinn@xerox.com, 406-457-9550.

- **Questions about Division policy.** Margaret King, Chief Financial Officer, Division of Medicaid, margaret.king@medicaid.ms.gov, 601-359-6155, or Karen Thomas, Accounting/Auditing Division Director, karen.thomas@medicaid.ms.gov, 601-359-5186.