

## Case Study

# Modernizing Hospital Payment Methods for DC Medicaid



### The Challenge

In 2013, DC Medicaid decided that the payment methods used to reimburse hospitals that served its members were outdated and inefficient. The reasons were as varied as the methods:

- Inpatient acute care services were reimbursed using AP-DRG, which was being phased out and no longer supported by 3M.
- Inpatient specialty care was paid retrospectively. This involved reviewing cost reports, paying an interim rate and then settling for actual costs after an audit. It was an administrative headache and prevented hospitals from receiving final payment until years after service dates, making revenue forecasting difficult.
- Outpatient acute care payment relied on a patchwork method of parts of other programs that had been used since the 1980s. It was not only difficult for all stakeholders involved to understand and implement; it also underpaid for services.

These approaches provided little clarity for program stakeholders and caused imbalances in hospital payment levels, with some services being underpaid or overpaid. It was hard for program managers to understand what was being purchased; hospitals had limited insights into how they would be paid in the future.

The program needed more transparency for hospital payments. Modernized approaches would be more efficient to manage and provide predictable reporting to simplify budget planning. They would also ensure more appropriate payments and increase access to services, improving healthcare for providers and members.

## Hospitals can now more effectively establish their business plans, work more efficiently and be more responsive to Medicaid members.

“After the payment reform projects, hospitals now receive payments that are more closely aligned with the acuity of the patient.”

Claudia Schlosberg, J.D.  
Senior Deputy Director/  
Medicaid Director  
District of Columbia  
Department of Health  
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### The Solution

At this time, Conduent had already worked with the program for several years managing the District’s MMIS and Pharmacy Benefit Management program. Our history of collaboration, longstanding relationship and years of experience with varying types of diagnostic related groupings (DRGs) and DRG payment implementations made us a natural partner to update the systems.

The teams implemented All Patients Refined Diagnosis Related Groups (APR-DRGs) for inpatient services and Enhanced Ambulatory Patient Groups (EAPGs) for outpatient services. APR-DRGs were also implemented to bring casemix adjustment and prospective payment to five specialty hospitals. APR-DRGs are the most appropriate casemix tool for Medicaid populations, as they are designed for all patient populations and can be used by any payer. EAPGs add transparency because they are acuity-adjusted. Instead of paying a flat rate for all member visits, higher amounts are paid for sicker patients that require more services, with lower amounts for less sick patients.

Because all three payment methods would be updated concurrently, DC Medicaid created efficiencies by setting the same effective date for all of them. This would ensure they were complete in preparation for the impending switch to ICD-10. The ICD-10 connection provided extra benefits: Conduent was already helping DC Medicaid with the transition, so the payment updates were added to the existing contract. This work was then considered a system enhancement, qualifying the program to receive federal matching funds.

### The Results

The APR-DRG and EAPG implementations addressed multiple challenges for DC Medicaid. Hospitals can now be paid more fairly, based on the acuity of the patients they serve. DC Medicaid also has more granular information about what care and services patients receive and what care needs exist in the DC Medicaid population.

Over the long term, the payment method updates bring more transparency into the program’s annual rate-setting process. We developed formalized processes for hospital inpatient, outpatient and specialty care reimbursements, enabling DC Medicaid to better communicate to hospitals what the rates will be for the upcoming year. As a result, hospitals can now more effectively establish their business plans, work more efficiently and be more responsive to Medicaid members.

Standardization has also reduced program costs. The old payment methods required some claims to be filled out manually with specialized information. Now, hospitals can simply bill Medicaid for services as they would any other payer. With less manual handling and fewer resources required to process the claims, the program operates more efficiently and can direct more resources toward improving member health. And as hospitals are paid more appropriately, they can operate and address member needs more effectively, as well as maintain access to care for members.

