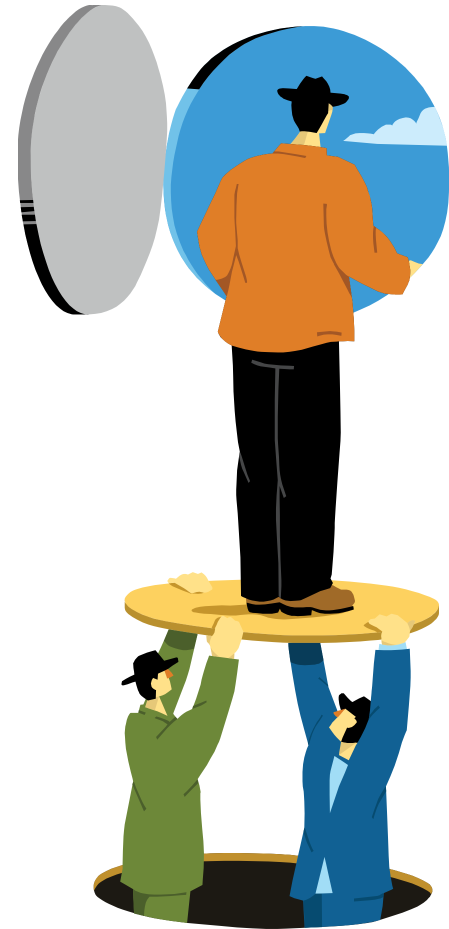
Arizona Health Care Cost Containment System

DRG-Based Inpatient Hospital Payment System

DRG Workgroup

April 25, 2013



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Meeting Agenda

Agenda
Preliminary Revised APR-DRG Model
Other Model Considerations
Coding and Documentation Improvement Adjustment
Questions and Discussion

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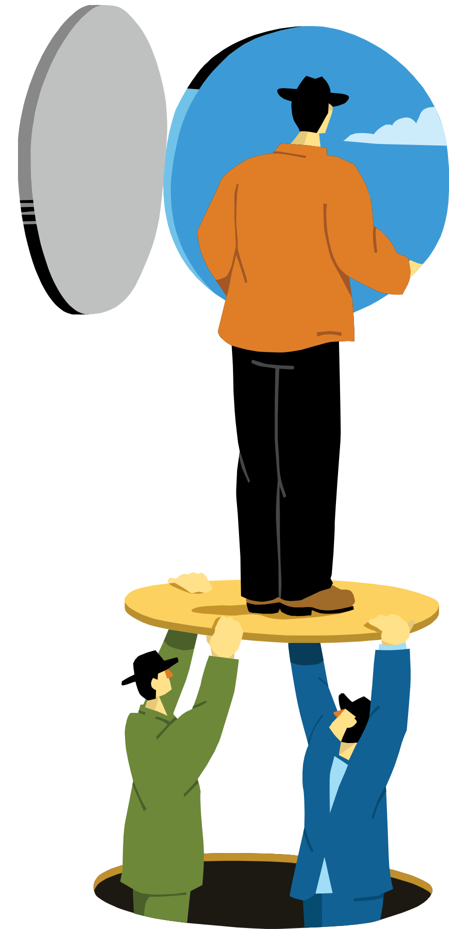
Preliminary Revised APR-DRG Model



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Preliminary Revised APR-DRG Model

Model Changes

- Changes to the APR-DRG model since the last work-group meeting:
  - 25-day limit adjustment applied to budget pool: 0.839325 adjustment factor (reflects two 5% rate reductions and a 7% reduction based the estimated impact of the 25-day limit on inpatient benefits)
  - FFY 2012 wage indices used instead of FFY 2013 factors
  - All transplant episodes removed (including pre- and post-operation services) based on AHCCCS' manual identification of each case
  - CAH group revised to include hospitals with 25 or fewer beds

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Preliminary Revised APR-DRG Model

Model Changes (Continued)

- Model outlier fixed loss threshold changed as follows:
  - Critical Access Hospital fixed loss threshold lowered to $5,000
  - All other providers' fixed loss threshold set to $65,000 to achieve approximately 6% outlier payments as percentage of total claim payments
- Year 1-3 transition period changed to 20% / 40% / 60% estimated payment change limit

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Preliminary Revised APR-DRG Model

Preliminary Model Results

- Model results in handouts do not reflect potential changes for coding and documentation improvement adjustment
- Actual provider aggregate payments under the new DRG payment system are expected to be different from these preliminary model results due to changes in Medicaid patient volume and case mix
- As with the current system, future Medicaid payments under the new system will be impacted by many factors, including but not limited to:
  - Changes in provider service lines
  - Medicaid population changes from program expansion
  - Changes in patient acuity
  - Changes in utilization

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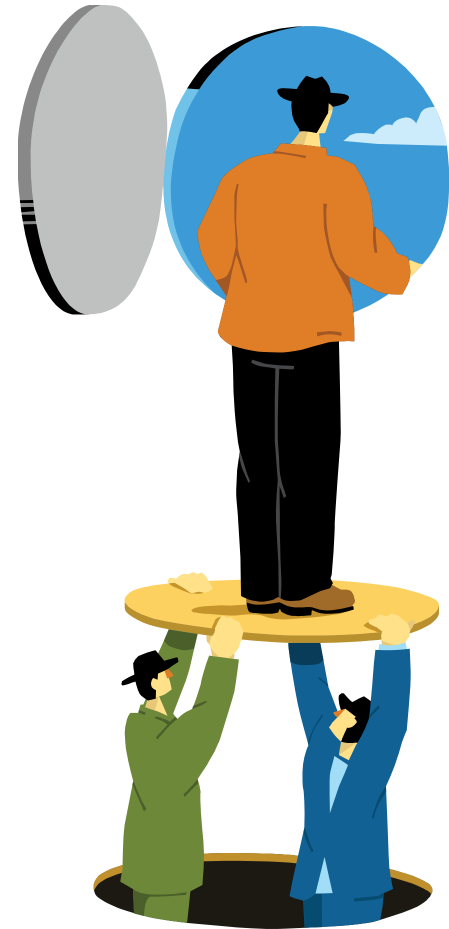
Other Model Considerations



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Other Model Considerations

Hemophilia Blood Clotting Factors

- Identified 52 detail lines in FFY 2011 claims/encounter data with blood clotting factor-related HCPCS codes per Medicare designation:
  - J-codes J7185-95 and J7198
- FFY 2011 blood clotting factor charges were $7.9 million
  - Charges ranged from $2k to $1.5 million
  - 5 detail lines with more than $500k in charges

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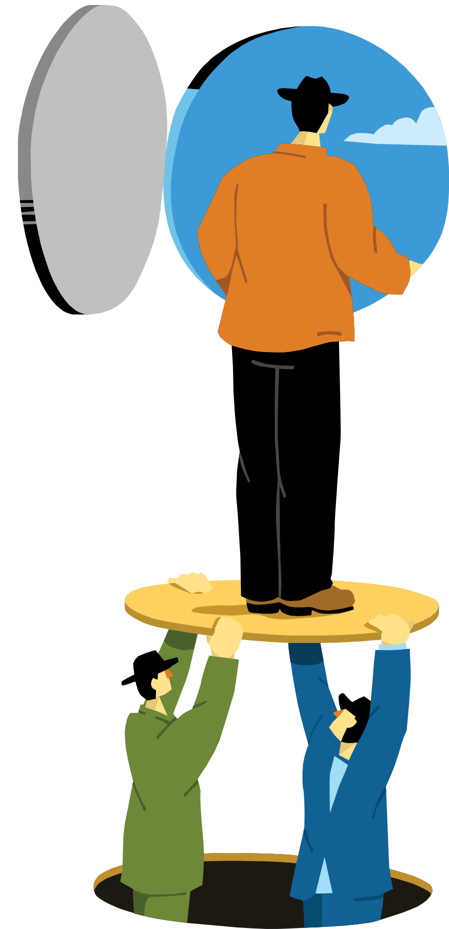
Other Model Considerations

Implants and New Technologies

- APR-DRG nationals weights include historical average use of implants and new technologies

- Changes in costs related to implants and new technologies can be reflected in the APR-DRG system by adopting the latest APR-DRG version and updating the relative weights

Coding and Documentation Improvement Adjustment



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Coding and Documentation Improvement Adjustment

Why is an Adjustment Necessary?

- Coding and documentation improvements are necessary, and as such are expected to be made by providers as an appropriate response to the coding requirements under the APR-DRG model.
- Because the same level of coding rigor was not required for payment purposes under the legacy per diem model, AHCCCS expects that case mix will increase as a result of improvements to claim coding once the system is implemented – beyond actual increases in acuity.
- As such, AHCCCS expects that actual payments, in the aggregate, will exceed payments that have been estimated as part of the simulation modeling process.
- To maintain budget neutrality, it will be necessary to incorporate and adjustment or other transitional strategy.

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Coding and Documentation Improvement Adjustment

Illustration of Potential Impacts to Paid Casemix from Coding and Documentation Improvement

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Coding and Documentation Improvement Adjustment

Data Element	Under CMS-DRGs	Under APR-DRGs
Principle Diagnosis	Drives DRG assignment	Drives DRG assignment and may impact SOI
Other Diagnoses	Key diagnoses impact	Every diagnosis may impact
Patient age	Some impact	Significant impact
Birth weight	No impact	Significant impact
"Simple" procedures	No impact	Impacts in some cases
Coding	Inclusion of key diagnoses and procedures can ensure correct CMS-DRG assignment without being a "complete representation" of all care the patient received	Any diagnosis and procedure and/or combinations of diagnoses and procedures can impact APR-DRG assignment – Coding should be "all inclusive"

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Coding and Documentation Improvement Adjustment

Patient Record	Version 1 Coding	Version 2 Coding
DX 1 – V3000 – Live newborn	Include	Include
DX 2 – 745.4 – Ventricle septal defect	Include	Include
DX 3 – V290 – Observation	Exclude	Include
DX 4 – 745.5 – Ostium secoundum type arial septal defect	Exclude	Include
DX 5 – 774.6 – Unspecified fetal and neonatal jaundice	Exclude	Include
Same MS-DRG Assignment - Full Term Neonate w/Major Problems		
Different APR-DRG Assignments – 640 - Neonate Birthwt > 2499G, Normal Newborn or Neonate w Other Problem	SOI = 2 RW = .1886	SOI = 3 RW = .5087

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Coding and Documentation Improvement Adjustment

Examples of Actual Case Mix Increases from DRG Grouper Change

- In October 2007, CMS in its Medicare Inpatient Prospective Payment System (IPPS) replaced its CMS-DRG grouper with the MS-DRG grouper
  - CMS subsequently estimated that the extent of case mix increase from coding improvements above real case mix for FFY 2008-2009 was **5.8%**
  - Medicare inpatient Documentation and Coding Adjustment preemptively reduces rates; **2.0%** FFY 2012 and **1.9%** in FFY 2013
- In July 2010, the Pennsylvania Department of Public Welfare (DPW) in its Medicaid IPPS replaced its CMS-DRG grouper with the APR-DRG grouper
  - DPW subsequently estimated that total case mix increases for SFY 2011 was **12.1%**

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Coding and Documentation Improvement Adjustment

Overview of Options:

- Option 1: Prospectively reduce either base rates or relative weights to reduce future payments to offset anticipated increases in payments to result from CDI – generally follow the approach that was taken by CMS when it implemented the MS-DRG payment system for Medicare services.
- Option 2: Retroactively adjust either base rates or relative weights to offset actual increases in payments resulting from DCI.
- Option 3: Establish a hybrid strategy that combines elements of Options 1 and 2, above.

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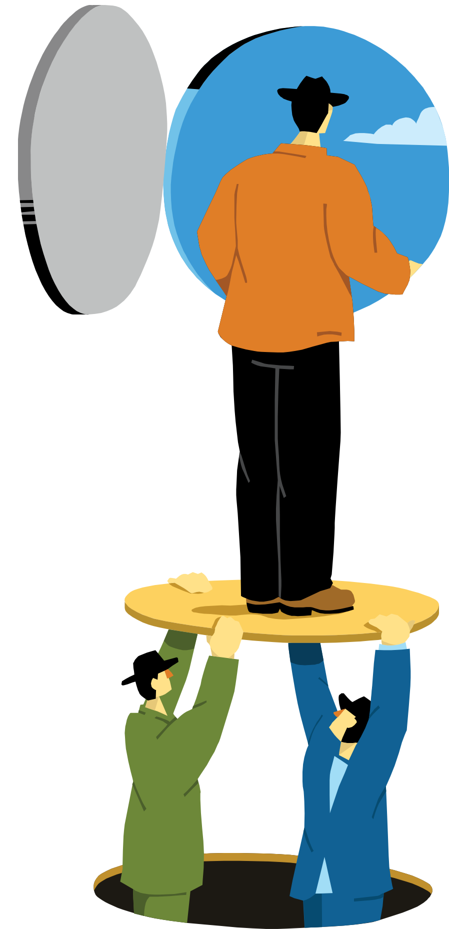
Questions and Discussion



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Questions and Discussion

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DRG Project Website:
http://www.azahcccs.gov/commercial/ProviderBilling/DRGBasedPayments.aspx

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