



AHCCCS Implementation of APR-DRG Payments

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New Inpatient Rate Methodology

- AHCCCS is implementing initiatives to improve patient safety and health outcomes of members, thereby reducing costs
- Current tiered per diem methodology is inconsistent with this goal as it incentivizes quantity of care
- A DRG-based payment methodology is aligned with the Agency's focus on improving patient care and shifting the focus to the quality of the services provided

New Inpatient Rate Methodology, cont.

- A DRG-based payment methodology will enhance AHCCCS' ability to implement performance review and cost-saving measures, such as:
 - Hospital acquired conditions
 - Potentially preventable readmissions
- AHCCCS is replacing its 20 year old tiered per diem methodology effective with dates of discharge on and after October 1, 2014

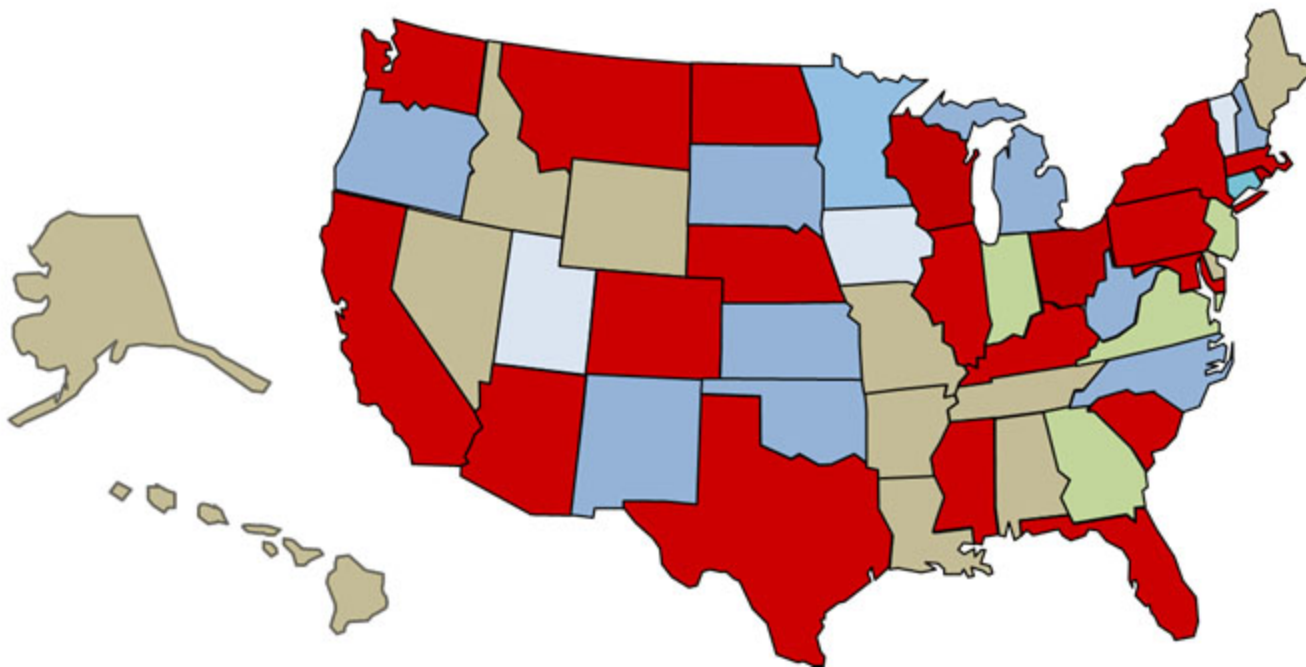
APR-DRG Model

- AHCCCS, in conjunction with a workgroup of hospital representatives (urban and rural) and AzHHA, selected 3M's All Patient Refined (APR) DRG model
- The APR-DRG grouper is considered to be a superior model over MS-DRGs for payments targeted to the Medicaid (i.e., non-aged) population
 - Over 1,200 DRGs total
 - 112 newborn DRGs (28 with 4 levels of severity each)

APR-DRG Implementation Nationwide

What Are Other State Medicaid Programs Doing?

- APR-DRGs (Using or Moving Toward Use)
- MS-DRGs (Using or Moving Toward Use)
- CMS-DRGs
- AP or Tricare DRGs
- Per Stay/Per Diem/Cost Reimbursement/Other



APR-DRG Model Benefits, cont.

MS-DRGs designed for classification of Medicare patients

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*“The MS-DRGs were specifically **designed for purposes of Medicare** hospital inpatient services payment...We do **not have comprehensive data from non-Medicare payers** to use for this purpose. The Medicare program only provides health insurance benefits for people over the age of 65 or who are disabled or suffering from end-stage renal disease. Therefore, **newborns, maternity, and pediatric patients are not well represented** in the MedPAR data that we used in the design of the MS-DRGs. We simply do not have enough data to establish stable and reliable DRGs and relative weights to address the needs of non-Medicare payers for pediatric, newborn, and maternity patients. For this reason, **we encourage those who want to use MS-DRGs for patient populations other than Medicare [to] make the relevant refinements to our system** so it better serves the needs of those patients.”*

Source: CMS, “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule,” *Federal Register* 72:162 (Aug. 22, 2007): 47158

AHCCCS Process

- AHCCCS contracted with Navigant Consulting, Inc., which has experience implementing APR-DRG models in other state Medicaid programs
- AHCCCS met with workgroup of urban and rural hospitals, including an AzHHA employee, six times from September 2012 through December 2013
- All meeting materials posted to AHCCCS website

AHCCCS Process, cont.

- AHCCCS DRG web page located at:
<http://www.azahcccs.gov/commercial/ProviderBilling/DRGBasedPayments.aspx>
- Final Rule posted at:
<http://www.azahcccs.gov/reporting/Downloads/UnpublishedRules/NOFRFinalDRG.pdf>
- Legislative authority found at
ARS §36-2903.01.G.12

APR-DRG Application

- APR-DRG will be the payment methodology for AHCCCS FFS members
- AHCCCS MCOs are not mandated to utilize AHCCCS' methodology or rates except in absence of a contract
- MCOs may enter into contracts with hospitals which specify alternative methodologies and/or rates

APR-DRG Application, cont.

- Claims for inpatient services paid by CRS and ALTCS MCOs shall be paid using APR-DRGs regardless of diagnosis (dx)
- Claims for inpatient services paid by a RBHA or TRBHA, where the primary dx upon admission is a behavioral health dx, shall be paid as prescribed by ADHS
- Claims for inpatient services paid by an integrated RBHA, where the primary dx upon admission is a physical health dx, shall be paid using APR-DRGs

APR-DRG Application, cont.

- Legislative mandates regarding certain payment terms remain in place including, but not limited to:
 - Quick pay/slow pay discounts and penalties
 - Urban Hospital Reimbursement Program for MCOs with 5% discount off AHCCCS FFS rates when no contract in place – applies to all inpatient services whether for non-emergency services or admitted from the emergency room

MCO Implementation

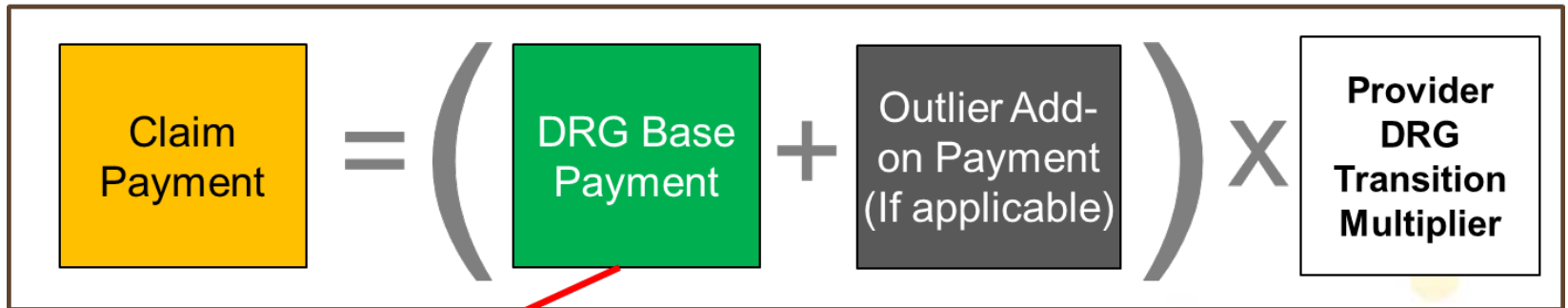
- AHCCCS convened a technical workgroup of MCO representatives specific to DRG
- MCOs have mandated reporting to AHCCCS regarding DRG implementation/progress
- MCO testing in process – must produce pre-determined DRG assignment and payment on series of claims

Implementation Mitigation Strategies

- AHCCCS is committed to ensuring no disruptions to hospital cash flow should any AHCCCS payer be delayed in implementation
- MCOs will submit mitigation plans to AHCCCS to describe strategies that will be employed should such delay occur
- PLEASE contact me directly with problems

APR-DRG Rates – Focus on Base

DRG base payment formula



Note: DRG base payment is sometimes reduced on transfer and partial eligibility claims.

Base Rate

- For majority of in-state hospitals, DRG base rates are based on a statewide standardized amount of \$5,295.40
- The labor portion of the statewide standardized amount is adjusted by each hospital's Medicare wage index
 - Wage index is a factor that represents differences the relative hospital wage level in the geographic area compared to the national average hospital wage level
 - Example base rate calculation:
 - $(\$5,295.40 \times 0.696 \text{ labor portion} \times 1.0366 \text{ wage index}) +$
 - $(\$5,295.40 \times 0.304 \text{ non-labor portion}) = \$5,430.29 \text{ DRG base rate}$

Base Rate, cont.

- For a limited group of in-state hospitals, DRG base rates are based on a standardized amount of \$3,436.08
These hospitals include:
 - Hospitals located in a city with a population greater than 1M, which on average have at least 15% of inpatient days for patients who reside outside of AZ, and at least 50% of discharges reported on the 2011 Medicare Cost Report are reimbursed by Medicare
 - Specialty hospitals including those specializing in heart and orthopedics (Rule: hospitals designated as type: hospital, subtype: short-term that have license number beginning "SH" ... posted by the ADHS Division of Licensing Services on its website for March of each year)

Relative Weights

- DRG relative weight is a factor that represents the average resource requirements for each DRG
 - DRG relative weight of 1.0 indicates average resource requirements (relative to all other inpatient services)
- APR-DRG relative weights are based on the “National Weights” calculated annually by 3M using a national dataset of 15 million inpatient claims

Example	APR-DRG	Weight
Low weight	DRG 640-1 – Normal newborn	0.0969
Average weight	DRG 225-2 – Appendectomy	1.0240
High weight	DRG 002-4 – Heart transplant	21.2277

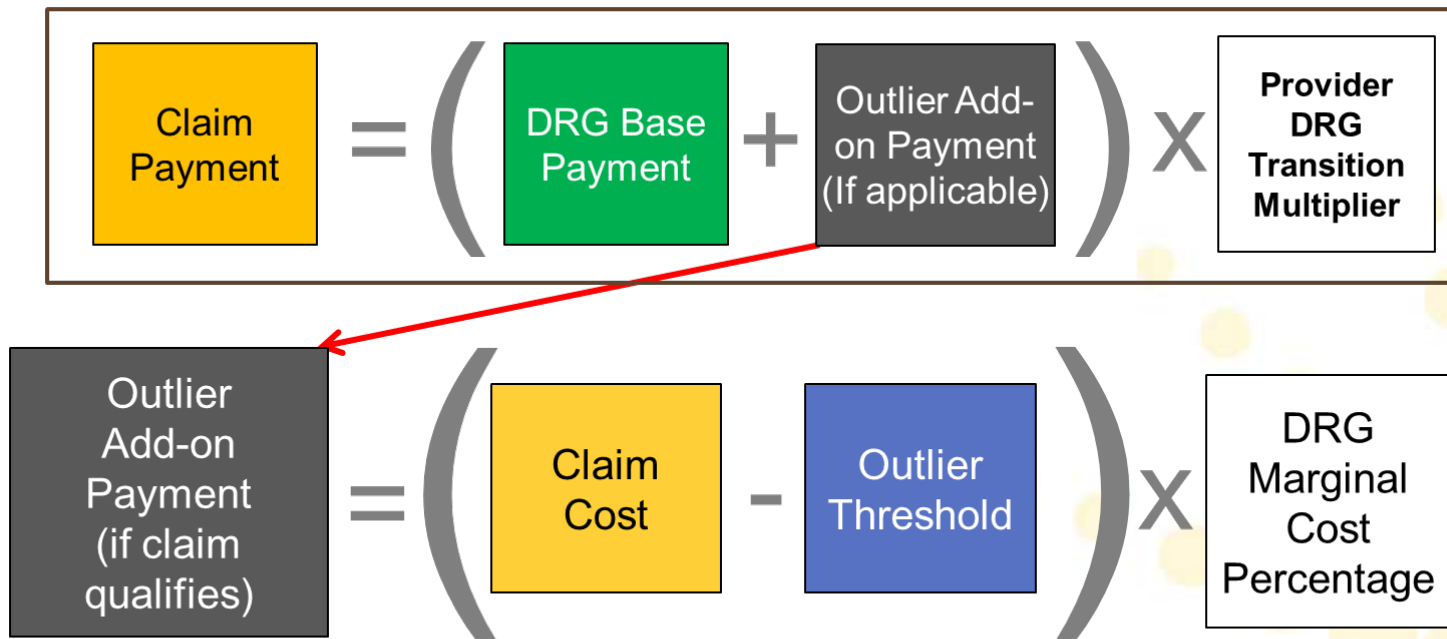
Policy Adjustors

Key Medicaid providers/services targeted for enhanced payment to ensure access to care – applied to DRG base payments

- Provider Policy Adjustor:
 - Hold harmless applied to high volume provider who meets specific Medicaid volume criteria and is projected to incur a loss under APR-DRG: 1.055 factor
- Service Policy Adjustors:
 - Normal newborn DRGs: 1.55 factor
 - Neonate DRGs: 1.10 factor
 - Obstetric DRGs: 1.55 factor
 - Psychiatric/Rehabilitation DRGs: 1.65 factor
 - Other pediatric cases (age 18 and under): 1.25 factor

APR-DRG Rates – Focus on Outlier

Outlier add-on payment formula



Note: Outlier payments are only applied if claim cost is greater than the outlier threshold.

Outlier Add-On Payment

For extraordinary cases where the claim cost exceeds the outlier threshold for a DRG

Outlier threshold = base DRG payment + fixed loss threshold

- Provider must incur a “fixed loss” on the claim for costs exceeding the base DRG payment
- Fixed Loss Amount is \$5,000 for CAH; \$65,000 for all other providers

Outlier add-on payment equals the cost exceeding the outlier threshold multiplied by the DRG marginal cost percentage

- DRG marginal cost percentage is 90% for burn DRGs and 80% for all other DRGs

APR-DRG Rates – Focus on Transition

Transition adjustment factor formula

$$\text{Claim Payment} = \left(\text{DRG Base Payment} + \text{Outlier Add-on Payment (If applicable)} \right) \times \text{Provider DRG Transition Multiplier}$$

$$\text{Provider DRG Transition Multiplier} = \text{Transition Impact Factor} \times \text{Documentation and Coding Improvement Factor}$$

Note: Outlier payments are only applied if claim cost is greater than the outlier threshold.

Transition Factor

- Temporary provider-specific factor that limits payment gain/loss based on Navigant payment simulation model
 - Year 1 (FFY 2015) factor limits gain/loss to 33% of full estimated gain/loss
 - Year 2 (FFY 2016) factor limits gain/loss to 66% of full estimated gain/loss
- FFY 2017 no transition factor is applied and full gain/loss is realized
- FFY 2018 rebase anticipated

Transition Factor, cont.

Provider-specific factor based on the ratio of:

- Modeled payments under the new system with transitional limits;
- Modeled payments under the new system without transitional limits Example:

Example Hospital	Current System Payments	New System Modeled Payments Before Transitional Limits	Estimated Payment Change From Current System (Before Transition)	Year 1 Payment Change Limit Percentage	Year 1 New System Modeled Payments With Transitional Limits	Year 1 DRG Transition Policy Factor
	A	B	C=B-A	D	E=A+(C*D)	F=E/B
#1	\$4,500,000	\$5,000,000	\$500,000	33%	\$4,665,000	93.30%
#2	\$10,500,000	\$10,000,000	(\$500,000)	33%	\$10,335,000	103.35%

Documentation & Coding Improvement Factor

- Because diagnosis coding rigor is not required for payment under per diem rates, case mix increase as a result of DCI coding – beyond actual increases in acuity – is anticipated
- To maintain budget neutrality, it is necessary to incorporate an adjustment to offset increases in case mix after implementation
- DCI factor is a statewide factor that is a preemptive adjustment for an expected 3 percent increase in DRG case mix over “real” case mix increases as a result of improved coding
 - 0.9739 factor in Year 1
 - Adjustments in future periods may depend on actual trends

AHCCCS Payment Policy Decisions

- AHCCCS payment policies related to APR-DRGs will be published in various documents:
 - Some are in Rule
 - Most will be in AHCCCS' Fee-For-Service Provider Manual (anything specific to Managed Care Organizations – MCOs – will be excluded)
 - All will be included in AHCCCS' new document: APR-DRG Payment System Design: Payment Policies –posted on website

Payment Policy Highlights

- APR-DRG payments based on date of discharge
- The day of discharge is never paid unless the member expires on date of discharge
- All same-day inpatient admit/discharge, admit/transfer claims will be paid using OPFS, including maternity and nursery
- APR-DRG payments shall be sole reimbursement for all inpatient services
 - Services provided in the ER, observation, or other outpatient department that are directly followed by inpatient admission to the same hospital are not paid separately
 - No other services or supplies will be carved out or separately reimbursed

Payment Policy Highlights, cont.

- Transfers
 - Transferring hospital will be paid a prorated payment
 - Base payment will be divided by National Average LOS
 - Quotient will be multiplied by actual LOS + 1
 - Transfer pricing applies to the following discharge status codes:
 - 02: Discharged/transferred to a short-term general hospital for inpatient care
 - 05: Discharged/transferred to a designated cancer center or children's hospital
 - 66: Discharged/transferred to a critical access hospital

Payment Policy Highlights, cont.

- Recipient may change payers during a single hospital stay, while still Medicaid eligible throughout entire stay
- This may occur under a variety of scenarios including
 - Enrollment change from FFS to MCO
 - Enrollment change from MCO to FFS
 - Enrollment change between MCOs within same program
 - Enrollment change between MCOs in different programs (e.g. from an Acute MCO to an ALTCS MCO)
- Services paid via APR-DRG will be paid by the payer with which the recipient is enrolled at the date of discharge

Payment Policy Highlights, cont.

- Providers shall submit a claim to the appropriate payer
- Unique to changing payer scenarios, providers shall submit a claim to the payer with the “From” date of service equal to the first day for which the recipient was enrolled with that payer in order to avoid denial based on eligibility/ enrollment edits
 - The “From” date of service for the payer responsible on the Date of Discharge will be later than the Date of Admission
- The “Through” date of service should be the date of discharge

Payment Policy Highlights, cont.

- Also unique to changing payer scenarios:
 - The claim may include all surgical procedures applicable for the hospital stay (admit through discharge), even if these procedures were performed prior to the recipient's enrollment with the payer responsible for payment
 - The claim should only include revenue codes, service units, and charges applicable to services performed during the covered days included on the claim (e.g. days between the "From" and "Through" dates)

Payment Policy Highlights, cont.

- Recipients of the Federal Emergency Services Program (FES) are limited to hospital services that meet the Federal definition of emergency service
- For each FES claim, AHCCCS will determine number of days that meet emergency definition
- Claims will be prorated to pay emergency services only based on the number of AHCCCS covered days, when emergency days are less than full stay
- Proration factor = $[\text{AHCCCS Covered Days} + 1] / \text{DRG National Average Length of Stay}$

Payment Policy Highlights, cont.

- When a recipient exhausts Medicare Part A benefits during a single hospital stay, providers must submit a separate claim for the Medicaid covered portion of the stay
- Providers shall submit a claim with the “From” date of service equal to the first day Medicaid is the primary payer (i.e. the day after Medicare benefits have been exhausted)
- The “Through” date of service should be the date of discharge

Payment Policy Highlights, cont.

- Unique to Medicare Part A benefits being exhausted:
 - The claim shall only include charges associated with the Medicaid portion of the stay (i.e. the “From” date of service through the “Through” date of service reported on the claim)
 - All diagnosis codes may be included on the claim
 - The claim should only include those revenue codes, surgical procedures, service units, and charges for services those ICD surgical procedures performed between the “From” and “Through” dates of service
- A full DRG payment will be paid for the Medicaid claim

Payment Policy Highlights, cont.

- Administrative days may be covered for recipients occupying a bed who do not meet criteria for an acute inpatient stay
 - Administrative days must be prior authorized by AHCCCS
 - Administrative days will be paid a negotiated per diem rate
 - Payment for administrative days will be separate from APR-DRG reimbursement for acute care services and providers must bill such days on a separate claim
 - Hospitals shall use patient discharge status 70 (Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in this Code List)

Payment Policy Highlights, cont.

- For stays > than 29 days, interim billing will be permitted in 30 day increments
 - Interim bills will be reimbursed at \$500 per day
 - Interim bills must be voided and a final replacement admission through discharge bill must be submitted at discharge encompassing all days billed as interim and covered by Medicaid
 - Interim payments will be recouped and the final bill paid at APR-DRG
 - Post-payment audits may be performed to ensure providers submit the final bill per these guidelines

Payment Policy Highlights, cont.

- A recipient may be ineligible for Medicaid upon admission, however, may become eligible during the hospital stay
- Providers will be paid for Medicaid covered days of the hospital stay
 - The DRG payment will be prorated based on the number of AHCCCS covered days
- Only claims with dates of service where the recipient is enrolled with the payer will be accepted

Payment Policy Highlights, cont.

- Unique to recipients who gain eligibility after admission:
 - Claims should include the “From” date of service as the first date the recipient is eligible for Medicaid
 - The “Through” date of service will be the date of discharge
 - The number of AHCCCS covered days will be calculated as the “Through” date of service less the “From” date of service
- The proration factor = $\text{AHCCCS Covered Days} / \text{DRG National Average Length of Stay}$

Payment Policy Highlights, cont.

- A recipient may be eligible for Medicaid upon admission but may lose eligibility for Medicaid prior to being discharged
- Providers will be paid for Medicaid covered days of the hospital stay
 - The DRG payment will be prorated based on the number of AHCCCS covered days
- Only claims with dates of service where the recipient is an eligible member will be accepted

Payment Policy Highlights, cont.

- Unique to recipients who lose eligibility before discharge:
 - Claims should include the “From” date of service as the date of admission
 - The “Through” date of service should be reported as the last date the recipient is enrolled with the Medicaid payer
 - The number of AHCCCS covered days will be calculated as the “Through” date of service less the date of admission
- The proration factor = $[\text{AHCCCS Covered Days} + 1 \text{ Day}] / \text{DRG National Average Length of Stay}$

Payment Policy Highlights, cont.

- AHCCCS will utilize DRG assignment to determine payment reductions in cases of health care acquired conditions (HCAC)
- A present on admission (POA) indicator will continue to be required on all inpatient claims as the HCAC payment reduction policy only applies if the HCAC condition(s) were acquired in the hospital after admission
- Under the APR-DRG methodology, two DRGs will be assigned to every claim (“pre-HCAC” and “post-HCAC”)
- The DRG with the lower relative weight will be used to price the claim

Payment Policy Highlights, cont.

- Potentially preventable readmissions will not be paid, as follows:
 - Readmissions within 72 hours to the same hospital with the same base DRG assignment will be pended to medical review
 - If the readmission is determined to have been preventable, payment will be disallowed
- If upon the medical review it is determined the hospital would not have been able to prevent the readmission, the claim will be paid under APR-DRG methodology
- If prior authorized, the readmission claim will be considered to have already gone through medical

Payment Policy Highlights, cont.

- For claims submitted for newborns, providers will need to include the birth weight of the newborn on all claims in which the age of the newborn is 14 days or less, as follows:
 - Report in a value amount field with associated value code = 54
 - Report in number of grams
- Hospitals need not report an APR-DRG group on a claim

Exceptions to APR-DRG Payments

- APR-DRG will not apply to certain hospital types:
 - Claims from a free-standing rehabilitation facility
 - Claims from a free-standing long term acute care facility
 - Claims for both paid a per diem rate with outlier provision
 - Claims from a free-standing psychiatric facility
 - These claims paid a per diem rate established by ADHS
 - Claims from an Indian Health Service facility or tribally operated 638 facility
 - These claims paid at the OMB rate
 - Claims for transplant services under AHCCCS contract

Stay Informed

- All updates posted to website:
<http://www.azahcccs.gov/commercial/ProviderBilling/DRGBasedPayments.aspx>
- Subscribe to the AHCCCS List Serve at
<http://listserv.azahcccs.gov/cgi-bin/wa.exe?A0=APRDRG-L>
Select “join” on the right side of the page
- Questions and comments can be e-mailed to:
DRG@AZAHCCCS.gov

Stay Informed, cont.

- AzHHA is collaborating with AHCCCS to educate hospitals about decisions regarding the procurement of 3M's APR-DRG software
- AzHHA has agreed to provide information to hospitals that are not members of the Association
- Contact Jim Haynes at AzHHA (jhaynes@azhha.org) for more information

Please Note...

- More detail on all items included in this presentation, and other issues not addressed, can be found on the AHCCCS website
- In general, AHCCCS Rule prevails in the event of any discrepancy and, for policies not covered in Rule, AHCCCS policy documents prevail in the event of any discrepancy with other presentations (including this one) or documents

ICD -10 Latest Developments

- AHCCCS is implementing 3Ms Version 31 of the APR-DRG software
- Version 31 has both ICD-9 and ICD-10 code sets
- AHCCCS will implement the ICD-9 code set
- Version 31 code set currently uses the ICD-9 code set for 10/1/13 to 9/30/14
- AHCCCS will update to the ICD-9 code set for 10/1/14 to 9/30/15 when available
- AHCCCS is closely monitoring 3Ms ICD-10 decisions

Questions?

