

# Arizona Health Care Cost Containment System

DRG-Based Inpatient Hospital Payment System

DRG Workgroup

January 18, 2013



# Meeting Agenda



## Agenda

Preliminary Revised APR-DRG Model

Transition Period

Preliminary Model Results

Coding and Documentation Improvement Adjustment

Questions and Discussion

# Preliminary Revised APR-DRG Model





## Model Adjustments

- » Based on its review of the baseline model results (without service or provider adjustments), AHCCCS is evaluating a new APR-DRG model with policy adjusters for key Medicaid service lines
- » Policy adjuster model results showed that even with service line policy adjusters, additional adjustments were needed for the highest Medicaid volume providers and for non-CAH rural providers; new model reflects these adjustments

# Preliminary Revised APR-DRG Model



## Claims/Encounter Data

- » Model based on FFY 2010 Arizona Medicaid FFS claims data and MCO encounter data collected from AHCCCS (dates of service from 10/1/2009 through 9/30/2010)
  - › Includes in-state general acute providers, CAHs and select out-of-state providers
  - › Excludes Medicare dual-eligibles, federally-funded FFS claims, 638/IHS providers, closed providers, non-contract providers, transplant DRG cases and cases with “ungroupable” APR-DRG classifications
  - › Excludes freestanding psychiatric and rehabilitation provider cases, LTAC cases and Maricopa psychiatric cases with transitional stays



## Funding Pool for Modeling Purposes

- » Model funding pool used to model new DRG system based on combined reported FFY 2010 FFS claim and MCO encounter data reported payments, with adjustments for rate reductions
  - › 0.9025 factor applied to reported payments to reflect 5% rate reductions that occurred on 10/1/2010 and 10/1/2011
  - › Model funding pool does not include supplemental payments
- › New system has been modeled such that aggregate simulated payments under the new system are equal to total DRG system funding pool in the model



## Funding Pool for Modeling Purposes (Continued)

- » Model funding pool is a historical snapshot used to solve for budget neutral DRG base rates under the new system and does not represent AHCCCS' future budgeted expenditures
  - › AHCCCS payments under new system will expand and contract compared to the model funding pool due to future changes in patient volume and case mix
  - › Should a provider expand its service lines or treat an expanded Medicaid population, its payments would increase accordingly and would not be limited to the provider's aggregate modeled simulated payments

# Preliminary Revised APR-DRG Model



## Model Assumptions

- » APR-DRG version 30 model using 3M national weights (scaled by a factor of 0.755565 to result in an average Arizona case mix index of 1.0)
- » Statewide standardized DRG base rate of \$4,378.50, with labor portion adjusted by FFY 2013 Medicare wage index
  - › Standardized rate determined via iterative SAS modeling process to achieve budget neutrality under new system
- » Medicare-style outlier and transfer payment policy
  - › Outlier fixed-loss threshold of \$57,500 set to achieve approximately 6% outlier payments





## Service Line Policy Adjusters

- » Preliminary model policy adjusters applied to DRG base payments:
  - › Normal newborn DRGs: 1.40 factor
  - › Neonate DRGs: 1.15 factor
  - › Obstetric DRGs: 1.45 factor
  - › Psychiatric/Rehabilitation DRGs: 1.45 factor
  - › Other pediatric cases (age 18 and under): 1.15 factor
- » Policy adjusters set for each acute service to achieve same pay-to-cost ratio as statewide average (including allocated static payments)
- » Psychiatric/Rehabilitation policy adjuster (for non-freestanding providers) set to achieve current system spending



## Provider Adjustments

- » Model contains provider adjustments applied in addition to policy adjusters
- » High Medicaid Volume adjustment: AHCCCS identified High Medicaid Volume providers with model FFY 2010 Medicaid days and at least 400% of the provider mean Medicaid days (10,253 days) and FYE 2010 MIUR above 40%
  - › Provider-specific factors applied to 2 high volume providers' DRG base payments to keep them at least held harmless to current system
- » Non-CAH rural provider adjustment: Group adjustment factor (not provider-specific) applied to DRG base payments for non-CAH rural providers to keep the group held harmless to the current system in aggregate
  - › Providers with outlier claim payments consisting of 40% of total claim payments under the current system were not included in the determination of the non-CAH rural adjustment factor

# Transition Period





## Transition Period

- » 4-year transition period will allow hospitals time to adjust, improve efficiency, and manage cost growth
- » Proposed transitional adjustments will limit individual hospital's simulated payment change under the new system to:

**Year 1**

15% of simulated payment change amount

**Year 2**

25% of simulated payment change amount

**Year 3**

40% of simulated payment change amount

**Year 4**

Rebase using cases paid under APR-DRGs and coded under ICD-10



## Transition Period Methodology

- » Proposed transition payment adjustments would be applied to the full claim payment (DRG base payment and outlier payment combined) as last pricing step (after claim payment components have been determined)
  - › Payment transition factors based on the ratio of simulated payments with transitional payment change limits to simulated payments without transitional payment change limits

Example Hospital	Current System Payments	New System Simulated Payments Before Transitional Limits	Estimated Payment Change From Current System (Before Transition)	Year 1 Payment Change Limit Percentage	Year 1 New System Simulated Payments With Transitional Limits	Year 1 Payment Transition Factor
	A	B	C=B-A	D	E=A+(C*D)	F=E/B
#1	\$4,500,000	\$5,000,000	\$500,000	15%	\$4,575,000	91.5%
#2	\$10,500,000	\$10,000,000	(\$500,000)	15%	\$10,425,000	104.3%

# Preliminary Model Results





## Preliminary Model Results for Discussion Purposes Only

- » Note that at this time, *no final decisions* have been made or proposed by AHCCCS
- » These preliminary analyses have been prepared by Navigant for *discussion purposes only*, and do not necessarily reflect recommendations by AHCCCS or Navigant
- » Model results in handouts do not reflect :
  - › Potential changes for coding and documentation improvement strategy
  - › Recognition of impacts of 25-day benefit limit



## Preliminary Model Results (Continued)

- » 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



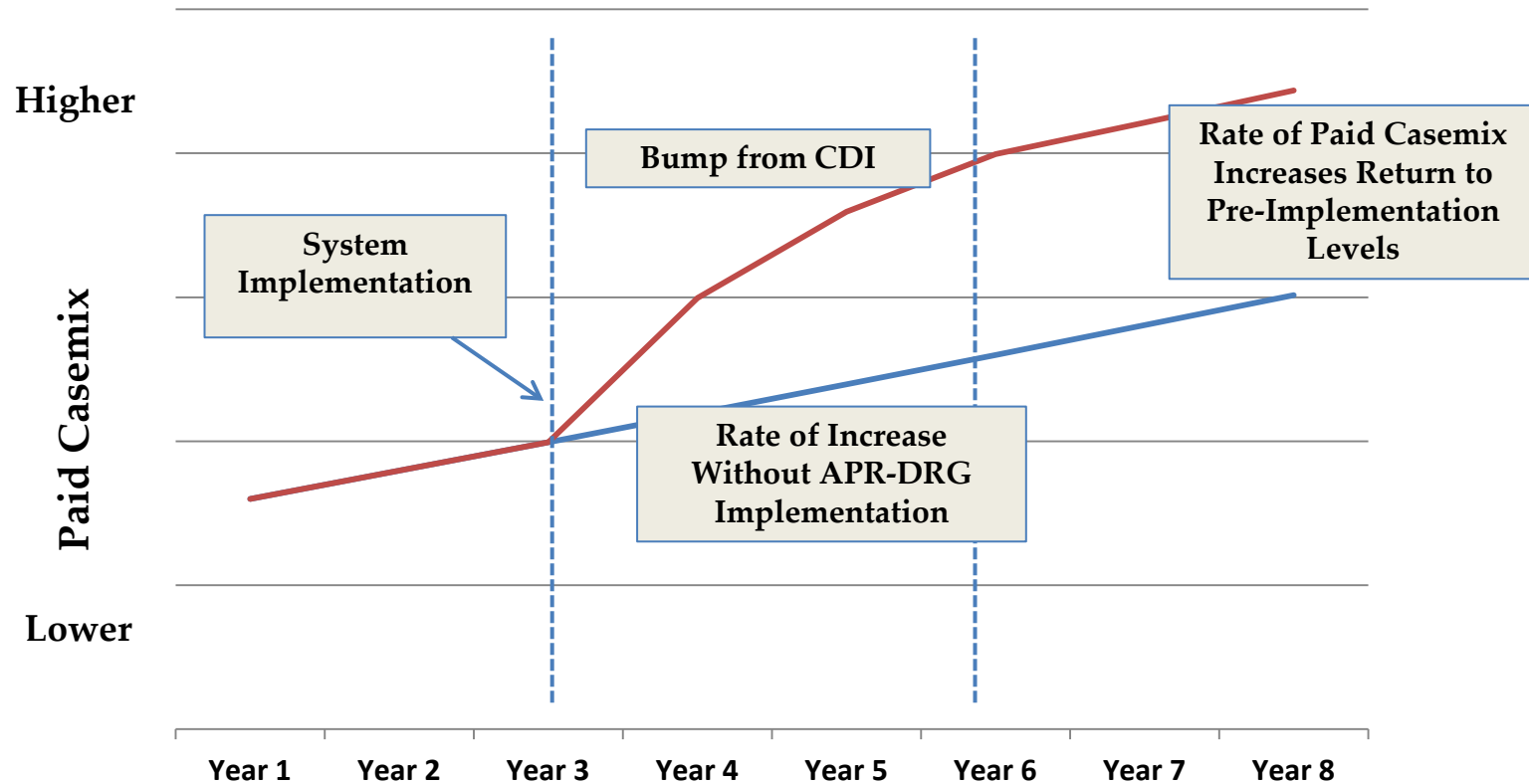
# Coding Documentation and Improvement Adjustment



# Coding and Documentation Improvement Adjustment



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



# Questions and Discussion



# Questions and Discussion



Questions and comments may be addressed to

Jean Ellen Schulik at

[JeanEllen.Schulik@azahcccs.gov](mailto:JeanEllen.Schulik@azahcccs.gov)

(602) 417-4335

DRG Project Website:

<http://www.azahcccs.gov/commercial/ProviderBilling/>

[DRGBasedPayments.aspx](http://www.azahcccs.gov/commercial/ProviderBilling/DRGBasedPayments.aspx)