Arizona Health Care Cost Containment System

DRG-Based Inpatient Hospital Payment System

DRG Workgroup

April 25, 2013
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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
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
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
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
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
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.
Illustration of Potential Impacts to Paid Casemix from Coding and Documentation Improvement

- Higher
- Lower

- System Implementation
- Bump from CDI
- Rate of Increase Without APR-DRG Implementation
- Rate of Paid Casemix Increases Return to Pre-Implementation Levels
## Coding and Documentation Improvement Adjustment

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

<table>
<thead>
<tr>
<th>Patient Record</th>
<th>Version 1 Coding</th>
<th>Version 2 Coding</th>
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<tbody>
<tr>
<td>DX 1 – V3000 – Live newborn</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>DX 2 – 745.4 – Ventricle septal defect</td>
<td>Include</td>
<td>Include</td>
</tr>
<tr>
<td>DX 3 – V290 – Observation</td>
<td>Exclude</td>
<td>Include</td>
</tr>
<tr>
<td>DX 4 – 745.5 – Ostium secoundum type arial septal defect</td>
<td>Exclude</td>
<td>Include</td>
</tr>
<tr>
<td>DX 5 – 774.6 – Unspecified fetal and neonatal jaundice</td>
<td>Exclude</td>
<td>Include</td>
</tr>
<tr>
<td>Same MS-DRG Assignment - Full Term Neonate w/Major Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Different APR-DRG Assignments – 640 - Neonate Birthwt &gt; 2499G, Normal Newborn or Neonate w Other Problem</td>
<td>SOI = 2 RW = .1886</td>
<td>SOI = 3 RW = .5087</td>
</tr>
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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%
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.
Questions and Discussion
Questions and comments may be addressed to Jean Ellen Schulik at JeanEllen.Schulik@azahcccs.gov (602) 417-4335

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