DRG Technical Workgroup

April 16, 2014; 9:30 AM-11:00 AM

AHCCCS, 701 E Jefferson, Phoenix - Gold Salmon Rooms, 3rd Floor

**Attendees (Based upon sign-in Sheets)**

**ADHS**

Madonna Fritz, Ruth Zona

**AHCCCS**

Dan Liberator, Howard Beam

**Bridgeway**

Nancy Mauer, Cheyenne Ross

**Care1st**

David Scheer, James Solinksy, Brent Ratterree

**DDD**

Laura Reith

**DES**

David Gardner

**Health Choice**

Karl Maring

**Health Net**

Bruce James, Trista Loops

**HCA**

Kristine Van Hook, Mia Villa

**Mercy/Mercy Maricopa**

Julie Dyer

**MMIC**

Vickie Payan

**PHP**

Sharon Hunt, Vincent Menezes

**UAHP**

Kim Bolton, Dennis Thompson, Dan Parker

**UHCCP**

Michele Maclachlan, Jeff Greenspan,

**Welcome**

Lori welcomed everyone.

The policy document (AHCCCS APR-DRG Payment System Design Policies) is still in draft form but is out for final review. This document will be the major point of discussion for today’s meeting.

Also included in today’s materials is the current DRG calculator, there haven’t been a lot of changes in this version, mostly cosmetic i.e. Navigant header, etc. We will be removing the prior versions of the Calculator from the webpage in the next few weeks and only this version should be used. This is also the calculator that has gone to 3M. Shellie said it will also be up on the AHCCCS project webpage so hospitals have easier access to it.

Table layouts for the two new DRG Provider tables should go out later this week. The tables are defined and will go in a new file under the weekly Provider extracts. There will also be test versions of these files available in the next few weeks.

**AHCCCS APR-DRG Payment System Design Policies Review**

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**DRG Pricing Information Summary**

* Shelli mentioned this document starts with an overall summary on APR-DRG Pricing.
* This document addresses the majority of hospital payments, but there are some exceptions as noted.
* Please pay attention to these exceptions.
* On this first page, there are certain types of hospitals or services that will not follow DRG payments.
* Transplant services still go through contracts. Day 61 plus which today are paid under the tiered per diem rates, on 10/1/14, they will be paid under per diem rates. We will loop them into the contracts.
* Last Thursday, Shelli gave a presentation to HFMA (Healthcare Financial Management Association). She discussed the APR-DRG implementation. She said the group asked many questions especially about the plans and what you were going to do. For you, this is a default methodology and you do have to mirror exactly AHCCCS’s payment methodology and rates if you have contracts between yourselves and providers which indicate other payment arrangements. The group though was really stuck on this area and had lots of questions on this.
* **ACTION ITEM**: A copy of this presentation will be made available on the main DRG webpage.

**DRG Pricing Formulas**

* Shellie reviewed the flow chart.

**DRG Base Payment**

* Many edits were done on pages 5-8 and they tried real hard to make sure they used consistent methodology in every formula so there was no confusion. AHCCCS has its own lingo and so does Navigant so we wanted everything converted to our lingo.

*Q: Is the outlier strictly cost based now?*

*A: Shelli answered it is a cost based. Today when we calculate the outlier payment it takes the place of the entire reimbursement. There is no tiered plus outlier. Tomorrow (beginning 10/1/2014) when we go to APR-DRG that’s a big difference. You still pay the base rate then the hospital has to assume a fixed loss. There is a threshold but they assume a loss but until they hit the threshold and then they get the outlier. We made clear in the document to keep referring it to as an add on. It doesn’t replace the base payment but it is still cost based like today so it is till based on converting their charges to cost based on a CCR.*

* Numbers 1-5 show the policy adjusters which Shelli sets the analogy that they are like peer group modifiers on the application side. If it is an adult and doesn’t fall under 1-5 then the adjustment factor is 1.0 meaning there is no positive or negative (add on or subtraction).

*Q: Is it fair to say these formulas and adjusters will all be part of the 3M implementation?*

*A: Shelli replied yes. This document just explains how we get there.*

*Q: It said PEDS will be adjusted as well but it wasn’t listed there.*

*A: Shelli replied it is under the list and we did that on purpose as we wanted*

 *people to understand that it was the first 5 are not a hierarchy but the bottom*

 *one is. So it doesn’t fall into one of the other 5 and they are under age 19 you*

 *apply a 1.25 factor. If you look at the rule, it shows 1-6.*

**Covered Day Adjustment**

* There are 3 situations where you have to prorate the claim. We would prorate number 1 for FFS members only, but the two others impact you. Number 2 probably won’t happen often but had to be put into the policy.

**Final Payment Adjuster**

* The transition multiplier has two factors: the 2 year transition and the documentation and coding improvement factor.

**Admit versus Discharge Date**

* This is a big change for us and we will be paying based on the discharge date where tiered per diems are based upon the admit date. The payer of record when the member is discharged. If the member changes plans in the middle of the stay, and you are the MCO at discharge, you are paying for the stay.

**Enrollment Change during Hospital Stay**

* There is a long list of reasons why a member may change MCO’s or plans in the middle of a stay. The one you will probably see more often will be the change from Acute to Long Term Care.
* Just a reminder it will be the payer at date of discharge responsible for the stay.
* The payer at discharge is responsible for the entire stay which includes outlier however there are certain rules that we describe which will go in the billing annual about what the provider can put on the claim to you. For example, we may tell the provider you can’t put charges from the beginning of the stay if the member changed. You could put the charges from the rest of the stay. From the hospital’s perspective they are going to say my claim is going to have a harder time getting to outlier. That isn’t correct but true but the claim would go to outlier then you would be responsible.
* Providers will be instructed to only submit the claim to the payer who is responsible. In the event that you do submit a claim (longer stay and you can drop those interim bills) in between, you need to void those. If it is not interim billing, the claim should only go the payer at discharge. This will be posted to the web, is on Shelli’s presentation and it will go in the FFS billing manual..
* They will try and publish the revisions to the provider manual by July. Effective date will be 10/1.

*Q: If we get s member in the middle of the stay, the from date will be the true admit date*

 *A: Lori responded no as the admit date will be the true admit date. The from date will be the date that they become your member. They can only bill you for the days that you are responsible for them.*

***Example:*** *You go into the hospital on April 28th, switch to your plan on May 1st and then are discharged. May 5th. The admit date is April 28th, the from date is May 1st and the discharge date is May 5th. There are certain variables they can put on the claim that go from April 28th – May 5th and other variables that have to be from May 1st – May 5th.*

*Q: So those other variables that can only be on from May 1st if we believe they added the things prior to May 1st does that mean the claim is not clean?*

 *A: Lori said it doesn’t match the billing instructions so yes if they include charges or those units perhaps they can include the diagnosis and procedure codes because you need those to accurately qualify the DRG but it is clear they shouldn’t be billing you for things aren’t.*

* **Medicare Dual Eligibles**
	+ **Example:** Member is admitted on April 28th but on April 30th they exhaust they benefit, On May 1st, you become primary payer. Your second claim starts on May 1st so the from date is the day you become the primary payer (May 1st) even though the admit date is April 218th. The through date is the date of discharge.

*Q: We are not cost sharing as we get a Medicare and a Medicaid claim and they are totally separate. If we find that they crossed from dates then it would become an unclaimed claim of Medicaid’s.*

 *A: Shelli answered yes. You are cost sharing the first claim and you are the primary payer for the second claim.*

*Q: So the first claim where they have Medicare not exhausted we could cost share. The cost share would or would not be subject to DRG?*

 *A: Lori said what you are paying as a secondary is patient responsibility. So you are paying coinsurance and deductibles.*

*Q: So they get paid twice, two plans are CMS versus Medicaid versus two Medicaid payers; you are doing the rule two different ways.*

 *A: Shelli said yes.*

*Q: So for the hospital would bill that as interim billing?*

 *A: Lori said it was a situation which would allow for that.*

*Q: But the interim bill in your other situation is triggered by your bill types whereas if it is this type of situation is also interim billing that it makes the programming a little more complicated. This is why she was asking as she needs to make sure that is an exception.*

 *A: Lori said this one definitely is an exception. Lori reminded all this is very small numbers and Navigant said it was pretty small in numbers in the data analysis they had found.*

* Shelli said this is a good point as found ourselves spending weeks struggling over some of these and then we looked at the numbers and said this ridiculous since it’s so small.

**Administrative Days**

* We decided that for our population it was a necessary requirement to pay administrative days particular for FFS with our native American population. We know it’s a big issue with ALTCS as well.
	+ **Example**: These days could occur at the beginning of a stay say for a pregnant woman who is in the hospital because she’s a high risk and lives too far away from the hospital. Or the person could be at the end of the stay like a ALTCS member who doesn’t have a safe discharge.
* Administrative days must be prior authorized, and they will be paid under a negotiated per diem rate. We chose not to dictate the rate because our own FFS department did not want us to dictate a rate. They need to have flexibility to negotiate that rate.
	+ Lori mentioned this is one area we are proposing an encounter reporting requirement associated with it so we know when you pay admin days. Some of the questions Lori did receive are about how this will be constructed. Lori will solicit feedback on ways to do this.

*Q: So we are not requiring the noted use of ADMN as a component of the reported PA # on encounters at this point?*

 *A: Lori responded at this point she wants to take the feedback we are getting and make sure everyone is comfortable with that. She received at least two concerns very specific to that.*

* Shelli said they will have to submit a separate claim for the admin portion of the stay separate from the DRG portion. You pay the portion that meets medical criteria for an inpatient stay under a complete and full DRG. The admin days are under a separate payment under a separate negotiation.

*Q: So that negotiated rate would be negotiated by each health plan unique to that provider?*

 *A: Shelli answered exactly and we tell you the discharge status code to use whether it is the beginning or the end of the stay.*

*Q: So the discharge code of 70 at the end of the admin stay or could occur at the end of the beginning of a stay.*

 *A: Shelli answered yes.*

* + **Example**: The ALTCS member doesn’t have a safe place to go so they aren’t being discharged so they stay on the admin so they put a 70 to indicate they weren’t sent home but for our purposes 70 means they are going to admin days.
* Shelli said that Lori may be able to work with the national body that works on these codes to long term establish one that is very specific to this situation. Lori has already started writing this up and lobby for some support for some other states.

**Interim Claims**

* This is also very unique to our population and some of our safety net hospitals who wouldn’t be able to wait until the end of a stay for a payment.
	+ **Example**: The member was with you the entire stay so you as the payer will void all the interims and then submit the final claim. Lori said it is predicated by the hospitals and if there are three interim bills they should replace one as the full stay and void the other two. If they don’t do this and you get that final bill you can deny it back to them and make them do it right or void the three interim claims and pay the new full claim. Lori said they will make the instructions clear to the provider. They will not get their final DRG reimbursement until all the interims are voided.
	+ **Example**: If they are in the hospital for 29 days, they are allowed to submit an interim bill.

**Multiple Medicaid Payers**

* + **Example**: A member is with Health Choice at the start of the stay and then with Health Net at the end of the stay. The member was in the hospital for a long time and Health Choice was paying interim bills. Health Choice would recoup the interim payments when they are notified that the member changed plans. Assume Health Net also got interim bills because the stay continued for this member and Health Net then the hospital has to void those interim claims from Health Net before Health Net can pay the final DRG.

**Transfer Policy**

* Very similar with what Medicare does.
* We potentially prorate (prorate but never to exceed the full DRG) the claim to the transferring hospital.
* The calculator will do this automatically.
* We add plus one because most hospital stays have a disproportionate amount of serviced sand cost at the start of a stay. Otherwise you are penalizing the transferring hospital.

**Recipient Gains Medicaid Eligibility after Admission & Recipient Loses Medicaid Eligibility after Admission**

* The only big difference is the addition of the plus 1 day which is in the formula under “Recipient Loses Medicaid Eligibility after Admission.

**Same Day Admit and Discharge**

For same day admit discharge you do pay the OPFS rate currently except for maternity or nursery claims as you do a lesser of. Tomorrow (beginning 10/1/14) under DRG’s we are going to no longer do that lesser of. Maternity and nursery claims and all Same Day Admit and Discharge claims are going to be paid under the OPFS rates. Only exception is claims with same day admit date of death which would be reimbursed for a full DRG.

**Specialty Hospitals**

* You will be provided with the short list of hospitals.
* These hospitals are getting paid under a APR-DRG methodology but they are getting paid under a different base rate which will also be provided to you and incorporated into the tools and tables.
* Specialty is a group of six hospitals defined as hospitals on the ADHS Facility list with a license beginning with SH. These could change over time if hospitals change their licensing. They are generally spinal and orthopedic hospitals.

**Rehabilitation and LTAC Hospitals & Psychiatric Hospitals**

* These are the exceptions to APR- DRG.
* They will be paid under per diem rates which AHCCCS will set. We are changing our lingo to specialty per diem rate.

*Q: Will these providers have different values populated in the existing AHCCCS reference tables?*

 *A: Lori said it was a new provider type you have to recognize and know that the new provider type pays per diems. The provider type is listed in the second paragraph. Those providers won’t go into this provider type until 10/1. AHCCCS will automatically convert them.*

* There is also outlier for this Provider Type and outlier will work the way it does under tiered per diem and does become the full payment. It is not an add on.
* For freestanding psych hospitals, ADHS may choose to adopt the APR-DRG methodology in the future and at that time include the RHBA’s but that would be down the road.

*Q: On Rehab and LTAC, if we contract differently with them, we can follow our payment*

 *A: Shelli said absolutely. You still have the ability to contract different rates, methodology, and payment policies unless you don’t have a contract. And then this becomes the default*

**Inpatient Claims for Recipients with Medicare Part B Only**

* There was some confusion in workgroup on cost sharing so this explains it in detail**. It is not a change from what should currently be occurring.**

**Non-Covered Charges**

* When the claim hits outlier, you continue to do the same thing if it’s a non-covered Medicaid service you could cut back those charges.

**Transplants**

* We are hoping to look at those rates before 10/1 as they are very stale. For DRG we made a budget neutral implementation with transplant data carved out. .

**Negotiated Settlements**

* Nothing new or different here.

**Detox/Behavioral Health versus Physical Health Diagnosis**

* + ***Example:*** *Patient slits wrists, goes to hospital, but there is an underlying behavioral issue that caused this. If they get admitted from the ER, you look at the primary diagnosis code. Was it medical in nature or an underlying behavioral issue? The primary diagnosis drives who pays the bill and what methodology will be used. If the primary diagnosis is a physical health reason the hospital should only bill the AHCCCS MCO Acute or ALTCS. If Acute, you submit claim to MCO and you get reimbursed under the DRG methodology or whatever the contract says. If the primary diagnosis for admission is behavioral the nit goes to the TRBA RBHA for them to pay under the ADHS psych per diem rates.*
* Lori mentioned we have a separate workgroup going through that behavioral health financial policy and making sure that it is consistent and correct in all factors.

*Q: So you are taking them out of the psych unit and they are getting medical services in a different unit like intensive care.*

 *A: Lori asked have they been doing a discharge. To the extent they are doing a discharge and readmit that is still permissible because it is a distinct part. This is somewhat predicated by the structure of the facility. Some don’t have distinct parts like beds while others do.*

**HCAC & POA**

* Federal law says we must not pay for certain health care required conditions if they occur in the hospital.
* Things will become easier under APR-DRG because the pricing software has this built in.
* Lori said we’ll be going back through the billing requirements to make sure they are clear and consistent with these policy decisions so that hospitals are not only aware of what they have to report but how we are evaluating that information.

**Same Day Admit and Date of Death**

* Nothing new or different here.

**Out-of-State Hospitals**

* They will also receive DRG payments.
* We have 5 hospitals that are high AHCCCS utilizing border facilities. These facilities are setting their pricing identical to instate hospitals. Not only are they getting the same base rate, they are getting a hospital specific CCR for their outliers.
* There is no transition multiplier as it is hospital specific multiplier.
* There will be a two year transition. In year one there will only actually allow the payment to be 33/66 of the final payment. In year three you are at a 100%.
* Navigant produced modeling of what we believe payments could look like under AP-DRG versus what payments look like under per diem using a 2011 base of business. Assuming no changes which doesn’t ever happen.

*Q: When we saw a demo of the product the 3M representative was sharing with us that we would actually have to go in and for the specific Arizona provider policy adjuster we would actually program that into the rate schedule.*

 *A: Lori said that wasn’t the impression they got from him. They believe 3M will be doing everything but will follow up with them.*

**Slow Pay Penalties and Quick Pay Discounts**

* Shelli said she reminded the hospitals these laws still apply.
* Lori said the new provider type C4 is also subject to this.

**Readmission Policy**

* This is Arizona specific.
* We are working on the specific criteria for identifying preventable readmissions. There are some drafts but Lori will see if there is a more up to date version.
* We will be watching readmission rates and in the future if we are not happy with the results then we’ll decide if there will be payment reductions or other actions.

*Q: What is a member is admitted they don’t qualify under this policy.*

 *A: Shelli said you pay the claim.*

*Q: What if it is unpreventable?*

 *A: This is the criteria for AHCCCS policy of what falls under our readmission policy. If you want to make it stricter or less strict you can do that under contract.*

*Q: Let’s say the clinician authorizes the member needs to admitted but we have a backend process that says this was really preventable. The authorization is in place though.*

 *A: Lori said we need to revisit that because an authorization is not a guarantee of payment. This is our first foray in having a policy around readmissions because frankly what happens now is you end up paying them.*

*Q: If the policy were to say something like following national guidelines or some industry standard the claim is later determined to have been a preventable admit by the hospital then that claim can be denied because the authorization is in place, its going through the process and later determined using some national or industry standards that this should have been preventable and the claim could be denied or recouped at that time.*

 *A: Shelli said we’ll take that back. Lori said it will be some softening on #3.*

*Q: What if it is a stage procedure? The person is required to come back as inpatient for follow up stay.*

 *A: Lori said this is where you authorize it.*

* Lori said we talked about introducing this and getting it out there and then move forward to enforce it. We will look at softening # 3 and then solicit feedback.
* Shelli said we will need to look in the rule because if we put these criteria in the rule we will not be able to change until we do a rule change which takes nine months.

**Reinsurance**

* There are changes under the DRG policy.
* Hospitals will no longer split the claim.

**Non-Covered Services**

* Robotic assists are not covered.

**Newborn Birth Weight Reporting**

* The birth weight must now be on the claim as on July 1, 2014 when appropriate. Enforcement will begin 10/1/2014.

**Hemophilia HCPCS / NDC Reporting**

* No edits but report it if you have it.

Please review very carefully especially the formulas. All of these materials will be posted and the matrices of questions will be sent. The two DRG provider table layouts will be out on the share info. The final version has been sent to 3M. believes we will get a lot more questions from the hospitals either from her PowerPoint or since they will be starting their education campaign to help the hospitals becomes educated on the 3M tools. First meeting with the hospitals is May 19th and 3M will be attending this meeting.

Next meeting will be in the next few weeks or as needed.

***ACTION ITEM:***Provider Table (row 71) - Ben will clarify provider type.

*Q: Someone asked about entering the provider table information.*

*A: Lori responded anything that is hospital specific comes off of what is essentially the PR050. Ben mentioned that in the comments when it refers to the provider table, it really means we are referring to the worksheets in the Excel file.*

**Next Workgroup Session**

Lori may try and schedule a meeting next week. This will be contingent on whether or not we get that Policy Document as she would like to start walking through the policy document.

Lori will send the Rule out tomorrow as soon as she is notified it is posted.