**AHCCCS**

**APR-DRG Payment System Design**

**Payment Policies**

**Preliminary Draft**

**January 23, 2014**

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**1. DRG Pricing Information Summary**

Effective October 1, 2014, AHCCCS will determine Medicaid reimbursement for most acute care hospital inpatient services using a Diagnosis Related Group (DRG) payment methodology. Specifically, All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems will be used to categorize each inpatient stay. Each inpatient hospital claim will be assigned an APR-DRG code and each DRG code is assigned a relative weight which is intended to indicate the average relative amount of hospital resources required to treat patients within that DRG category. The DRG relative weight is a key factor in determining payment to the hospital.

DRG payment will be applied to all inpatient claims from acute care hospitals except the following:

* Claims from a free-standing rehabilitation facility
* Claims from a free-standing long term acute care facility
* Claims from a free-standing psychiatric facility
* Claims from an Indian Health Service facility or tribally operated 638 facility
* Claims paid by Tribal/Regional Behavioral Health Authorities (T/RBHAs) for behavioral health services
* Claims for administrative days only
* Claims for transplant services
* Claims in which admit and discharge are on the same day and the discharge status does not indicate member expired
* Claim is an interim bill

Payment under DRG pricing will be comprised of a DRG base payment and a DRG outlier payment. Total payment will equal the sum of these two. DRG base payment is generally set to a hospital DRG base price times the DRG relative weight. In addition, a few payment factors referred to as “policy adjustors” will be applied under specific scenarios to affect the DRG base payment. The DRG outlier payment will be cost-based and calculated based on a fixed-loss threshold.

The following are examples of the payment policy adjustors applied to the DRG base payment under specific scenarios,

* Provider specific policy adjustor
* Service specific policy adjustor
* Age adjustor

**2. DRG Pricing Formulas**

DRG Base Payment

Initial DRG Base Payment will be calculated as:

*Initial DRG Base Payment = [Wage adjusted provider DRG base rate]*

*\* [Post-Healthcare Acquired Condition DRG relative weight]*

*\* [Provider policy adjustor]*

*\* [Maximum of (DRG service adjustor) and (DRG age adjustor)}*

If the patient discharge status code is in the following list of codes for which the DRG transfer policy applies:

*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*

Then the Transfer DRG Base Payment will be calculated as:

*Transfer DRG Base Payment = [Initial DRG Base Payment]*

*/ [DRG national average length of stay]*

*\* [Medicaid covered days + 1]*

If the patient discharge status code is in the list of codes for which the DRG transfer policy applies, then:

*Full Stay DRG Base Payment = lesser of [Initial DRG Base Payment]*

*and [Transfer DRG Base Payment]*

Otherwise,

*Full Stay DRG Base Payment = [Initial DRG Base Payment]*

DRG Outlier Payment

Not all claims will qualify for a DRG Outlier Payment. For those that do, the DRG Outlier Payment will be an add-on payment which is added to the Full Stay DRG Base Payment to determine final payment for the claim.

To determine if a claim will qualify for an outlier payment, first the Claim Cost must be calculated. The Claim Cost will be calculated as:

*Claim Cost = {[Claim total submitted charges] – [Claim non-covered charges]}*

*\* Hospital Cost to Charge Ratio*

The Claim Cost must then be compared to the outlier threshold. The Outlier Threshold is calculated as:

*Outlier Threshold = Full Stay DRG Base Payment + Fixed Loss Amount*

The Fixed Loss Amount is $5,000 for CAH/small rural providers and $65,000 for all other providers.

If the Claim Cost exceeds the Outlier Threshold, then the claim qualifies for a DRG Outlier Payment; else if the Claim Cost does not exceed the Outlier Threshold, the claim receives $0 DRG Outlier Payment.

For claims that qualify for a DRG Outlier Payment, the Full-Stay DRG Outlier Payment will be calculated as:

*Full-Stay DRG Outlier Payment = [Claim Cost – Outlier Threshold]*

*\* DRG Marginal Cost Percentage*

The DRG Marginal Cost Percentage is 90% for burn DRGs and 80% for all other DRGs.

Covered Day Adjustment

There are scenarios for which payment will be reduced because not all days of the inpatient stay are payable. Some examples are:

* Recipient is enrolled in the Federal Emergency Services Program (FES)
* Recipient gains Medicaid eligibility after admission into the hospital
* Recipient losses Medicaid eligibility after admission and before discharge

For each of these scenarios, a payment reduction factor will be calculated in order to prorate the payment based on covered days. If the factor is greater than 1, it will be reduced down to 1 so that the covered day adjustment never has the effect of increasing payment greater than the full DRG payment. The factor will be applied to both the DRG base payment and the outlier payment.

The formulas for calculating the unadjusted non-covered day (NCD) reduction factor are:

If recipient enrolled in the FES program:

*Covered Day Reduction Factor unadjusted = {[Medicaid covered days] + 1}*

*/ [Length of Stay from First Day of Service to Last Day of Service]*

Else If recipient gains Medicaid eligibility after admission then:

*Covered Day Reduction Factor unadjusted = [Medicaid covered days]*

*/ [Length of Stay from Admit Through Discharge]*

Else If recipient losses Medicaid eligibility prior to discharge then:

*Covered Day Reduction Factor unadjusted = {[Medicaid covered days] + 1}*

*/ [DRG national average Length of Stay]*

The final covered day reduction factor is calculated as:

*If [Covered Day Reduction Factor unadjusted] > 1.0 Then*

*Covered Day Reduction Factor final = 1.0*

*Else*

*Covered Day Reduction Factor final = [Covered Day Reduction Factor unadjusted]*

The final non-covered day reduction factor gets applied to both the full stay DRG base payment and the full stay DRG outlier payment using the following formulas:

*Covered Day adjusted DRG base Payment = [Full stay DRG base payment]*

*\* [Covered Day Reduction Factor final]*

*Covered Day adjusted DRG outlier Payment = [Full stay DRG outlier payment]*

*\* [Covered Day Reduction Factor final]*

Note: The adjustment factors are applied separately to the DRG base payment and the outlier payment so that the percentage of total payment coming from outliers can be tracked.

Final Payment Adjustment

For FFY 2015, 2016, and 2017 of DRG pricing, there will be a provider-specific payment adjustment applied to every claim paid via the DRG pricing method. This payment adjustment will be made using a numeric multiplier that will be applied to both the DRG base payment and the DRG outlier payment. The multiplier will be loaded into a provider specific DRG pricing table.

This multiplier will be a combination of two payment adjustments – one for the DRG transition policy and the second for anticipated improvement in documentation and coding.

By applying this adjustment as the last step in the DRG pricing logic, final payment will be calculated as:

*Final DRG Base Payment = [Covered day adjusted DRG base payment]*

*\* [Provider DRG transition multiplier]*

*Final DRG Outlier Payment = [Covered day adjusted outlier payment]*

*\* [Provider DRG transition multiplier]*