OVERVIEW OF INPATIENT HOSPITAL APR-DRG PRICING

MARCH 2016

NAVIGANT

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OVERVIEW OF DRGS

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CHARACTERISTICS OF DRG PAYMENT

- Payment is based on patient acuity, not length of stay
- Single payment per hospital stay
- Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in a particular DRG category
- Payers determine a “relative weight” for each DRG that represents the resource requirements for a particular service in comparison to all other services
- For example:
  - If the DRG base price is $3,000 and the DRG relative weight is 0.50, then the DRG base payment is $1,500.
  - Similarly, if the DRG relative weight is 2.0, then the DRG base payment is $6,000

MS-DRG VS APR-DRG

Category	MS DRG	APR DRG
Population	Medicare 65+ population	All patients
Data requirements	Diagnoses, procedures, age, sex, discharge status	Diagnoses, procedures, age, sex, discharge status, birth weight
MDCs	Pre-MDC and 25 MDCs	Pre-MDC and 25 MDCs
Number of base DRGs	747 (745 + 2 error DRGs)	1258 (314 base DRGs x 4 subclasses + 2 error DRGs)
Diagnoses	3 Levels: • Major CC • CC • Non CC ** Note: not all base DRG have a severity designation.	4 levels for SOI and 4 levels for ROM: 1. Minor 2. Moderate 3. Major 4. Extreme ** Note: 4 levels of Severity and Risk are assigned to every DRG.

MS-DRG GROUPER

- Consideration of MS-DRGs for Medicaid Payment:
  - Designed for Classification of Medicare Patients…

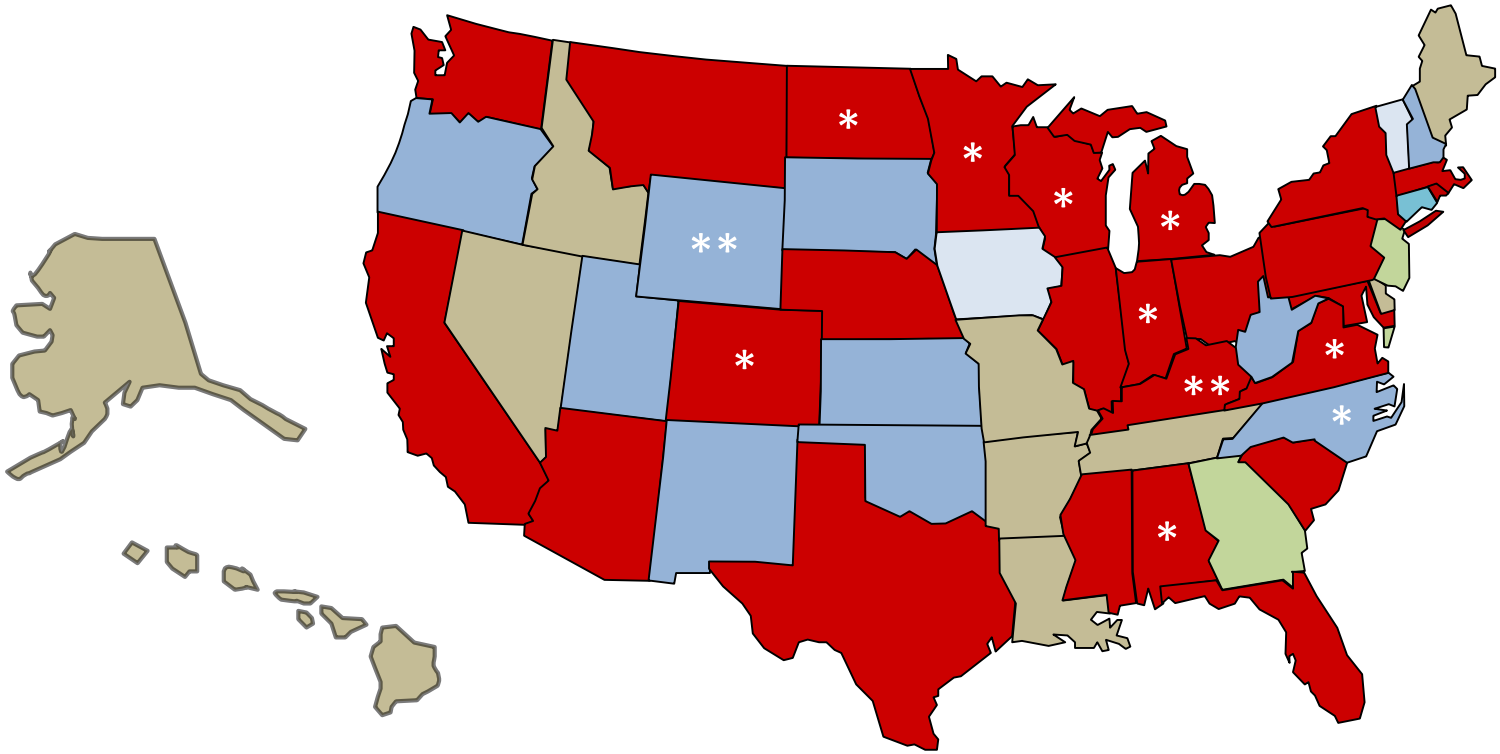
> "The MS-DRGs were specifically designed for purposes of Medicare hospital inpatient services payment… We simply do not have enough data to establish stable and reliable DRGs and relative weights to address the needs of non-Medicare payers for pediatric, newborn, and maternity patients. For this reason, 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

DRGs IN STATE MEDICAID PROGRAMS

APR-DRGs
MS-DRGs
CMS-DRGs
AP or Tricare DRGs
Per Stay/Per Diem/Cost Reimbursement/Other

* Indicates Moving Toward
** Indicates Under Consideration



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CHARACTERISTICS OF APR-DRGs

- APR-DRGs were developed by 3M Health Information Systems
- APR-DRG consists of 314 base DRGs. Each base DRG has four levels of severity:
  - Level 1: minor
  - Level 2: moderate
  - Level 3: major
  - Level 4: extreme
- There are a total of 1,256 separate codes and relative weights. The number of codes is subject to change.
- There are two additional “ungroupable” DRGs

WHAT DO THEY LOOK LIKE?

DRG Code	DRG Description	Average Length of Stay	National Relative Weight	Casemix Relative Weight	Service Policy Adjustor	Age Policy Adjustor	Service Line Adult	Service Line Child
001-1	Liver Transplant &/or Intestinal Transplant	7.2	7.0511	9.2609	1.00	1.0	Transplant Adult	Transplant Pediatric
001-2	Liver Transplant &/or Intestinal Transplant	8.02	7.7563	10.1871	1.00	1.0	Transplant Adult	Transplant Pediatric
001-3	Liver Transplant &/or Intestinal Transplant	12.14	9.7773	12.8415	1.00	1.3	Transplant Adult	Transplant Pediatric
001-4	Liver Transplant &/or Intestinal Transplant	28.68	18.4638	24.2504	1.00	1.3	Transplant Adult	Transplant Pediatric
002-1	Heart &/or Lung Transplant	10.3	10.2533	13.4667	1.00	1.0	Transplant Adult	Transplant Pediatric
002-2	Heart &/or Lung Transplant	13.34	11.3992	14.9717	1.00	1.0	Transplant Adult	Transplant Pediatric
002-3	Heart &/or Lung Transplant	22.13	15.4854	20.3386	1.00	1.3	Transplant Adult	Transplant Pediatric
002-4	Heart &/or Lung Transplant	38.33	23.6114	31.0113	1.00	1.3	Transplant Adult	Transplant Pediatric
003-1	Bone Marrow Transplant	16.81	5.4958	7.2182	1.00	1.0	Transplant Adult	Transplant Pediatric
003-2	Bone Marrow Transplant	22.52	7.6946	10.1061	1.00	1.0	Transplant Adult	Transplant Pediatric
003-3	Bone Marrow Transplant	34.36	12.9652	17.0285	1.00	1.3	Transplant Adult	Transplant Pediatric
003-4	Bone Marrow Transplant	51.49	22.5281	29.5885	1.00	1.3	Transplant Adult	Transplant Pediatric
004-1	Tracheostomy w MV 96+ Hours w Extensive Procedure or ECMO	17.7	6.1805	8.1175	1.00	1.0	Misc Adult	Pediatric
004-2	Tracheostomy w MV 96+ Hours w Extensive Procedure or ECMO	20.45	7.9242	10.4077	1.00	1.0	Misc Adult	Pediatric
004-3	Tracheostomy w MV 96+ Hours w Extensive Procedure or ECMO	26.82	10.5130	13.8078	1.00	1.3	Misc Adult	Pediatric
004-4	Tracheostomy w MV 96+ Hours w Extensive Procedure or ECMO	38.37	15.8366	20.7998	1.00	1.3	Misc Adult	Pediatric
005-1	Tracheostomy w MV 96+ Hours w/o Extensive Procedure	19.04	5.0328	6.6101	1.00	1.0	Misc Adult	Pediatric
005-2	Tracheostomy w MV 96+ Hours w/o Extensive Procedure	18.52	6.0299	7.9197	1.00	1.0	Misc Adult	Pediatric
005-3	Tracheostomy w MV 96+ Hours w/o Extensive Procedure	23.71	7.4161	9.7403	1.00	1.3	Misc Adult	Pediatric
005-4	Tracheostomy w MV 96+ Hours w/o Extensive Procedure	31.61	11.0319	14.4893	1.00	1.3	Misc Adult	Pediatric
006-1	Pancreas Transplant	5.88	6.2759	8.2428	1.00	1.0	Transplant Adult	Transplant Pediatric
006-2	Pancreas Transplant	7.87	8.1575	10.7141	1.00	1.0	Transplant Adult	Transplant Pediatric
006-3	Pancreas Transplant	9.79	9.2530	12.1529	1.00	1.3	Transplant Adult	Transplant Pediatric
006-4	Pancreas Transplant	22.86	14.4822	19.0210	1.00	1.3	Transplant Adult	Transplant Pediatric
020-1	Craniotomy for Trauma	5.17	1.8330	2.4075	1.00	1.0	Misc Adult	Pediatric
020-2	Craniotomy for Trauma	6.36	2.5864	3.3970	1.00	1.0	Misc Adult	Pediatric
020-3	Craniotomy for Trauma	10.91	3.9146	5.1414	1.00	1.3	Misc Adult	Pediatric
020-4	Craniotomy for Trauma	20.44	7.9915	10.4961	1.00	1.3	Misc Adult	Pediatric

DETAILS REGARDING APR-DRGs

- Two basic types of APR-DRGs
  - Medical – assigned primarily based on the diagnosis codes
  - Surgical – assigned primarily based on the ICD surgical procedure codes

- 3-digit “base” APR-DRG is generally assigned based on the principal diagnosis code (medical DRGs) or the most significant surgical procedure code (surgical DRGs)

- Severity of illness is determined based on secondary diagnosis codes and less significant surgical procedures

- Documentation regarding APR-DRGs is available at

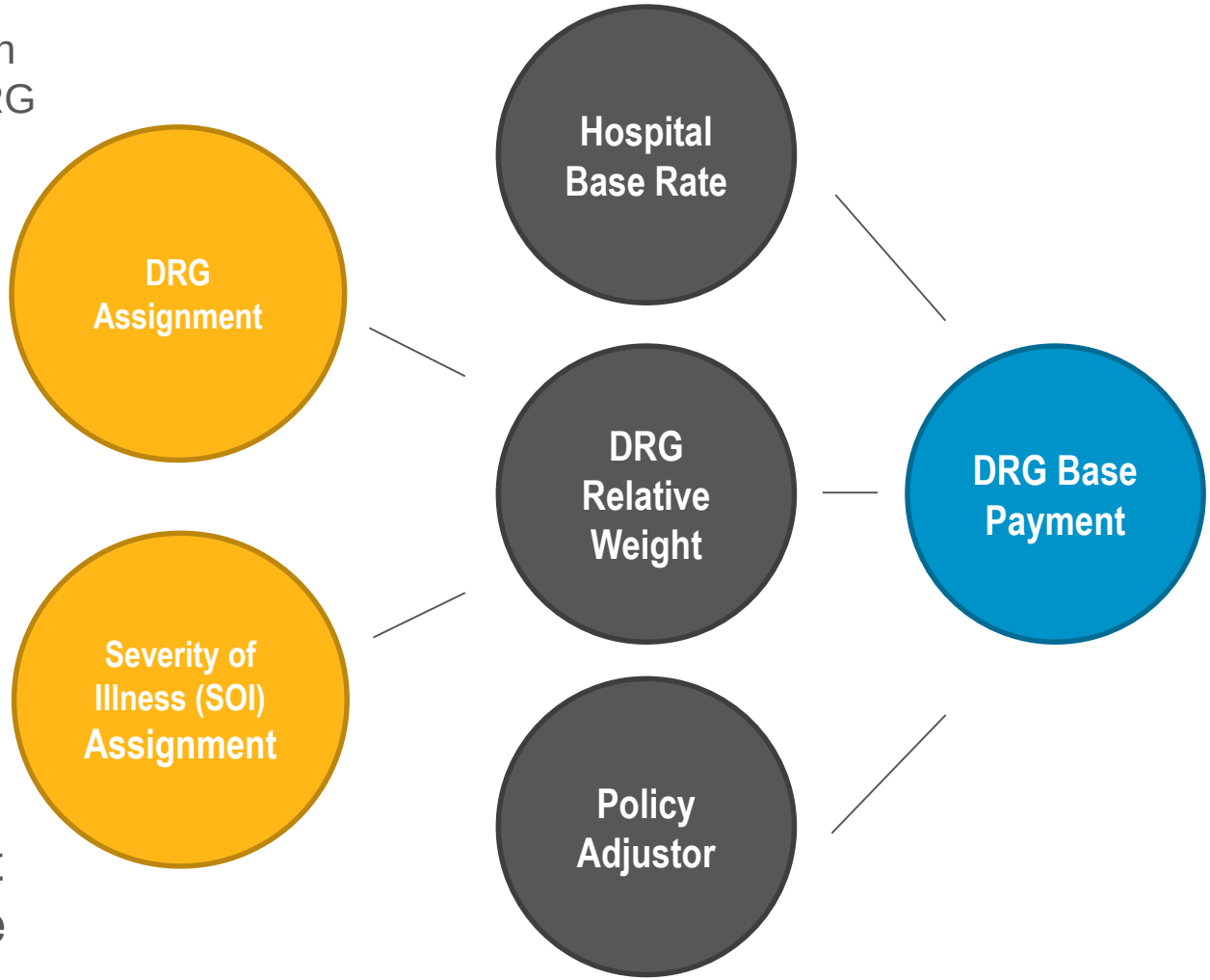
  www.aprdrgassign.com

  Please contact Solomon Williams at Solomon.Williams@medicaid.alabama.gov or Peggy Carstens at pcarstens@alaha.org to get the user ID and password for Alabama hospitals.

ASSIGNING A DRG CODE AND PRICE TO A CLAIM?

Many factors are included in the determination of the DRG Base Payment.

- Principal Diagnosis
- Secondary Diagnoses
- POA Indicators
- Surgical Procedures
- Patient Age
- Patient Gender
- Discharge Status



It is the hospital's responsibility to ensure that the coding used is accurate and defensible.

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CODING UNDER APR-DRG

Coding requirements are significantly different for APR-DRGs, even when compared to the requirements under the current Medicare MS-DRG model.

Patient Record		Version 1 Coding	Version 2 Coding
DX 1 – V3000 – Live newborn		Include	Include
DX 2 – 745.4 – Ventricle septal defect		Include	Include
DX 3 – V290 – Observation		Exclude	Include
DX 4 – 745.5 – Ostium secoundum type arial septal defect		Exclude	Include
DX 5 – 774.6 – Unspecified fetal and neonatal jaundice		Exclude	Include
MS-DRG	Same DRG assignment: 389, Full Term Neonate w/Major Problems		
APR-DRG	Different DRG assignments: 640, Neonate Birthwt > 2499G, Normal Newborn or Neonate w Other Problem	SOI = 2 RW = .1871	SOI = 3 RW = .4847

Base Payment Version 1: ($7,000 * 0.1871 = **$1,309.70**)

Base Payment Version 2: ($7,000 * 0.4847 = **$3,392.90**)

BILLING CHANGES

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BILLING CHANGES

- All deliveries (recipient is the mother) and all births (recipient is the newborn) must be billed on separate claims, even when the newborn is healthy and is in the hospital for a short period of time. APR-DRG payment is calculated separately for the delivery and the birth.
- Birth weight billed as a number of grams must be included for all newborns whose age at date of admission is less than or equal to 28 days.
  - Birth weight is billed as a value amount along with value code “54”
- Interim claims:
  - Interim claims must be a minimum of 30 days in length to allow for payment
  - Second, third, fourth, etc … interim claims must be billed as adjustments to the original interim claim and include dates of service from date of admission through current billing date
  - Each interim claim will be paid under normal DRG pricing rules

BILLING CHANGES

- Present On Admission (POA) indicators will be validated in all diagnosis codes that are not exempt from POA
- If a recipient is dually eligible for Medicare and Medicaid and his/her Medicare Part A benefits are fully consumed during a hospital stay, then the hospital can submit a regular Medicaid claim (not a Medicare crossover claim) Occurrence Code “A3” included along with the date in which Medicare Part A benefits were exhausted. Medicaid will calculate a full DRG payment, then prorate it downward based on the number of days payable by Medicaid (i.e. the number of days after Medicare Part A benefits exhausted).

ALABAMA MEDICAID APR-DRG PAYMENT METHOD DESIGN

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KEY APR-DRG DECISIONS

Design Consideration	Options/Comments
DRG Grouper	• APR-DRGs are best fit and most popular DRG solution for a Medicaid population • Other options, MS-DRG, Tricare, APS-DRGs
DRG Relative Weights	• Adopt national weights • Adopt national weights re-centered to AL Medicaid population • Calculate state-specific weights
Hospital Base Rates	• Statewide standardized amount • Peer group • Hospital specific

Targeted Policy Adjustors	• None
	• Potential adjustors for:
	  ○ Targeted service lines
	  ○ Specific age groups (generally pediatrics)
	  ○ Targeted hospitals

KEY APR-DRG DECISIONS

Design Consideration	Options/Comments
Outlier Payment Policy	• None • Adopt “Medicare-like” model – fixed loss threshold and marginal cost percentage
Inlier Payment Policy	• None • Charge cap • Low-cost outlier policy • Short stay outlier policy
Transfer Payment Policy	• None • Acute-to-acute transfers – applicable discharge statuses • Post acute transfers

Partial Eligibility (a.k.a. Non-Covered Days)	• Use lower of DRG and per diem payment
	  ○ Loss of Medicaid eligibility during hospital stay
	  ○ Stay longer than limit for undocumented alien
	  • 2 days for vaginal delivery
	  • 4 days for C-section
	  • 3 days for all other services

KEY APR-DRG DECISIONS

Design Consideration	Options/Comments
Budget Goal	• Budget neutral • Set by State or set by historic experience • Budget neutral for all inpatient services, or individually by hospital
Transitional Period	• None ○ October 1, 2016 • If transitional period, then: a) Timeframe, b) Method of integration
Payment for Administrative Days	• None • Per diem or add-on payment
Anchor Date	• Date of admission • Date of discharge
Documentation and Coding Improvement Adjustment	• None • Adjust for expected increase in “paid” case mix due to improved documentation and coding of claims • 6% for Children’s of Alabama • 2% for all other hospitals

KEY APR-DRG DECISIONS

Design Consideration	Options/Comments

Interim Claims	• No
	• Yes
	  ○ ≥30 days
	  ○ Paid via DRG
	  ○ Additional interim claims submitted as adjustments to original claim with dates of service back to admission date

Payment for Specialty Providers (Psychiatric, Rehabilitation, LTAC, Other)	• Include in DRG payment method • Exclude from DRG method ○ Free-standing Psych • Hybrid method, such as per diem adjusted for acuity
Payment for Specialty Services (Psychiatric, Rehabilitation, Transplant, Clotting Factors, Administrative Days, Other)	• Include in DRG payment method • Exclude from DRG payment method ○ Transplants • Pay in addition to DRG payment

KEY APR-DRG DECISIONS

Design Consideration	Options/Comments
Per-Claim Add-On Payments	• None • Supplemental Payment
Hospital Acquired Conditions	• None • Hospital Acquired Conditions (HACs) payment reduction using APR-DRG software
Mid-stay enrollment change (FFS to RCO; RCO to FFS; or RCO to RCO)	• The payer with which the recipient is enrolled on date of admission will be responsible for reimbursement for the entire hospital stay • The payer with which the recipient is enrolled on date of discharge will be responsible for reimbursement for the entire hospital stay
Billing rule changes	• None • Described in previous section

PEER GROUPS

- Payments under APR-DRG in Alabama uses four peer groups
- Peer groups represent similar provider “buckets” based upon patient mix, service offerings and hospital type
- Each peer group has a unique base payment rate under APR-DRG

Peer Group
Children’s Hospital of Alabama
USA Women’s and Children’s
Academic Teaching Hospitals • University of Alabama Hospital • USA Medical Center
All Other Hospitals

POLICY ADJUSTORS

- Alabama Medicaid Agency uses service line adjustors to modify payments for certain services performed in an inpatient setting
- Service lines selected for an adjustment “factor” align with the mission of the Medicaid program and key service offerings for the patient population
- Each APR-DRG is assigned to a service line
- The default service line adjustment factor is 1.0

Service Line	Factor
Normal Newborn	1.3
Obstetrics	1.3
Neonatal	1.3
Mental Health – Adult*	2.0
Mental Health – Pediatric	1.5

*Adult ≥ 18 years of age

FREQUENTLY ASKED QUESTIONS

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FREQUENTLY ASKED QUESTIONS

Q – Can an example of my claims, grouped and priced under APR-DRG be provided?

A – Yes.

- Claims used to develop APR-DRGs will be provided to their corresponding provider - State Fiscal Year 2014 (10/01/2013 – 09/30/2014).
- In addition, a second extract of claims processed after Oct. 1, 2015. (i.e. ICD-10 implementation) through March will be provided.
- Finally, starting in April and each month leading up October 1, 2016 (when APR-DRGs go live) an extract of all claims processed that month will be provided.
- Claims will be provided in Excel format for users to review. Excel workbooks will contain all steps in calculating APR-DRG payment but not the formulas. Just the numeric values.
- Claim extracts are for illustrative purposes only to reflect how the claim as submitted would group and price under APR-DRG and do not reflect actual payment

FREQUENTLY ASKED QUESTIONS

Q – Is Risk of Mortality (ROM) used in the calculation of DRG?

A – No. Risk of mortality values are not used in the calculation of DRG payments.

Q – Does the DRG code need to be entered on claims?

A – No, hospitals do not need to include the DRG code on their submitted claims. The DRG code and severity of illness (SOI) will be assigned by the Alabama Medicaid Management Information System (AMMIS) during the claims adjudication process.

Q – Will the Alabama Medicaid remittance advice (RA) include DRG values?

A – Yes the APR-DRG code, including severity of illness will be included on the paper remittance advice and on the electronic 835.

ALABAMA MEDICAID DRG PRICING FORMULA

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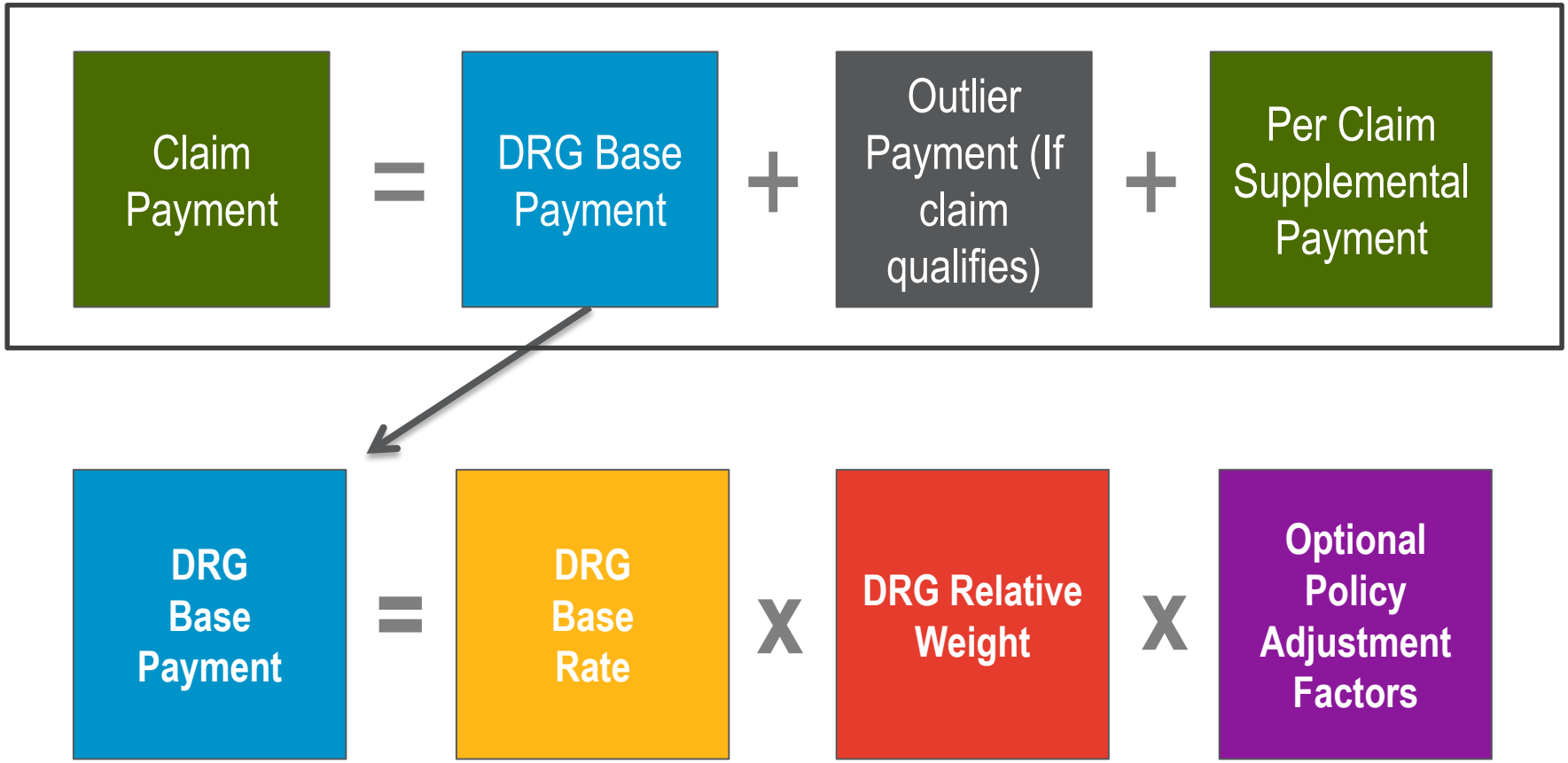
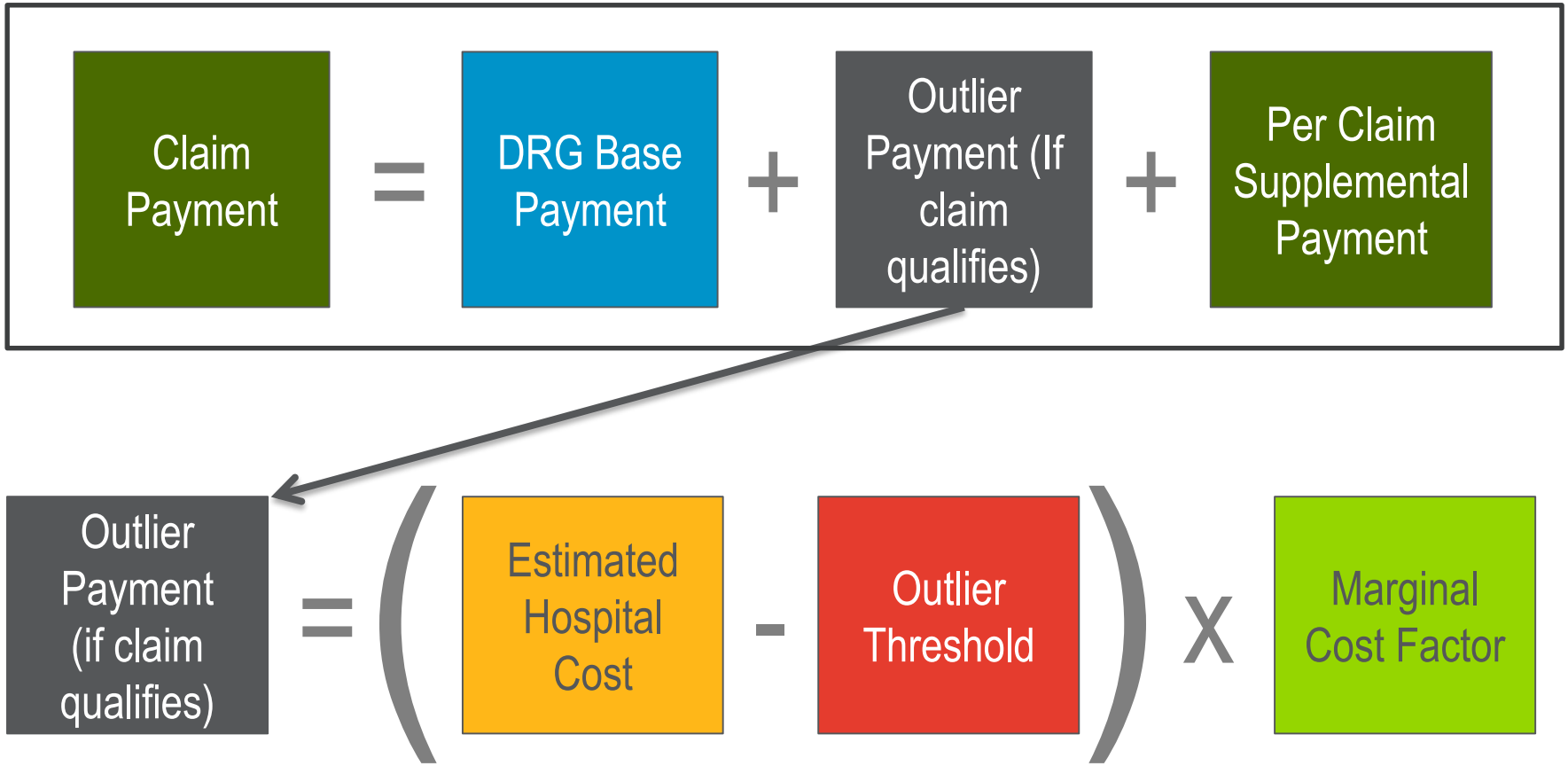
DRG BASE PAYMENT



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

OUTLIER PAYMENT



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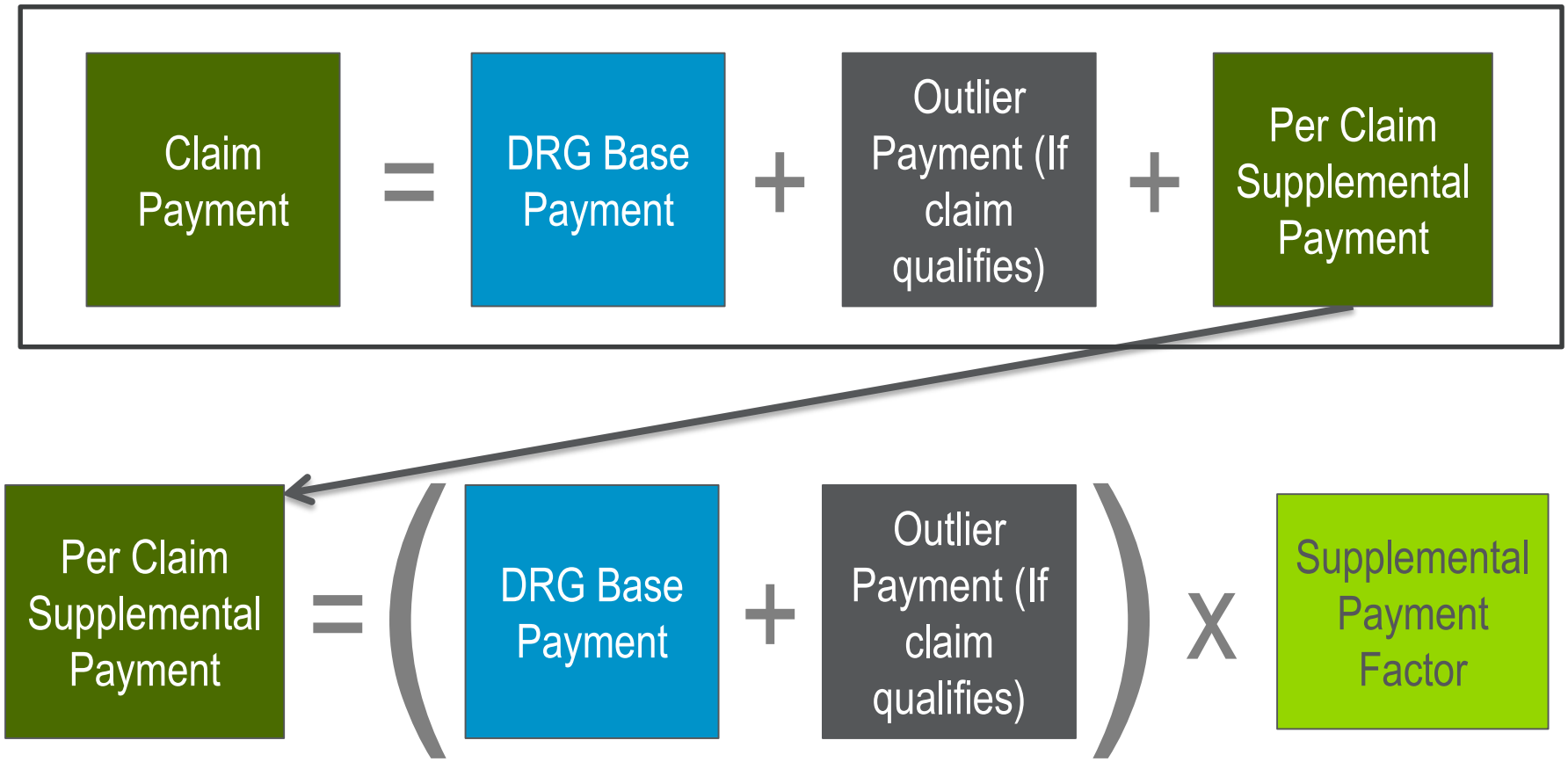
SUPPLEMENTAL PAYMENT



Note: Supplemental Payment Factor is the same value for all hospitals.

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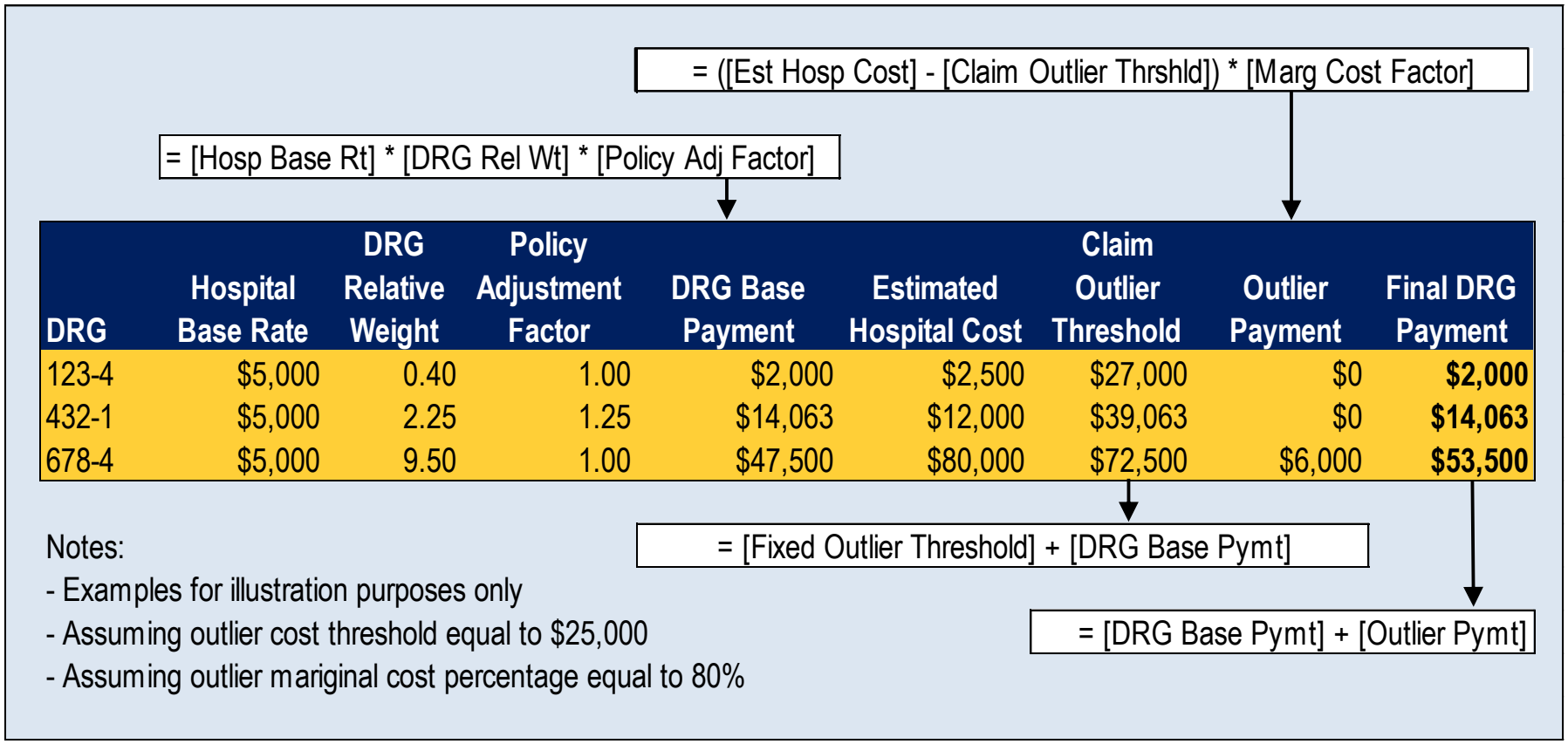
EXAMPLES



DRG	Hospital Base Rate	DRG Relative Weight	Policy Adjustment Factor	DRG Base Payment	Estimated Hospital Cost	Claim Outlier Threshold	Outlier Payment	Final DRG Payment
123-4	$5,000	0.40	1.00	$2,000	$2,500	$27,000	$0	**$2,000**
432-1	$5,000	2.25	1.25	$14,063	$12,000	$39,063	$0	**$14,063**
678-4	$5,000	9.50	1.00	$47,500	$80,000	$72,500	$6,000	**$53,500**

Notes:
- Examples for illustration purposes only
- Assuming outlier cost threshold equal to $25,000
- Assuming outlier mariginal cost percentage equal to 80%

* These examples exclude per-claim supplemental payments.

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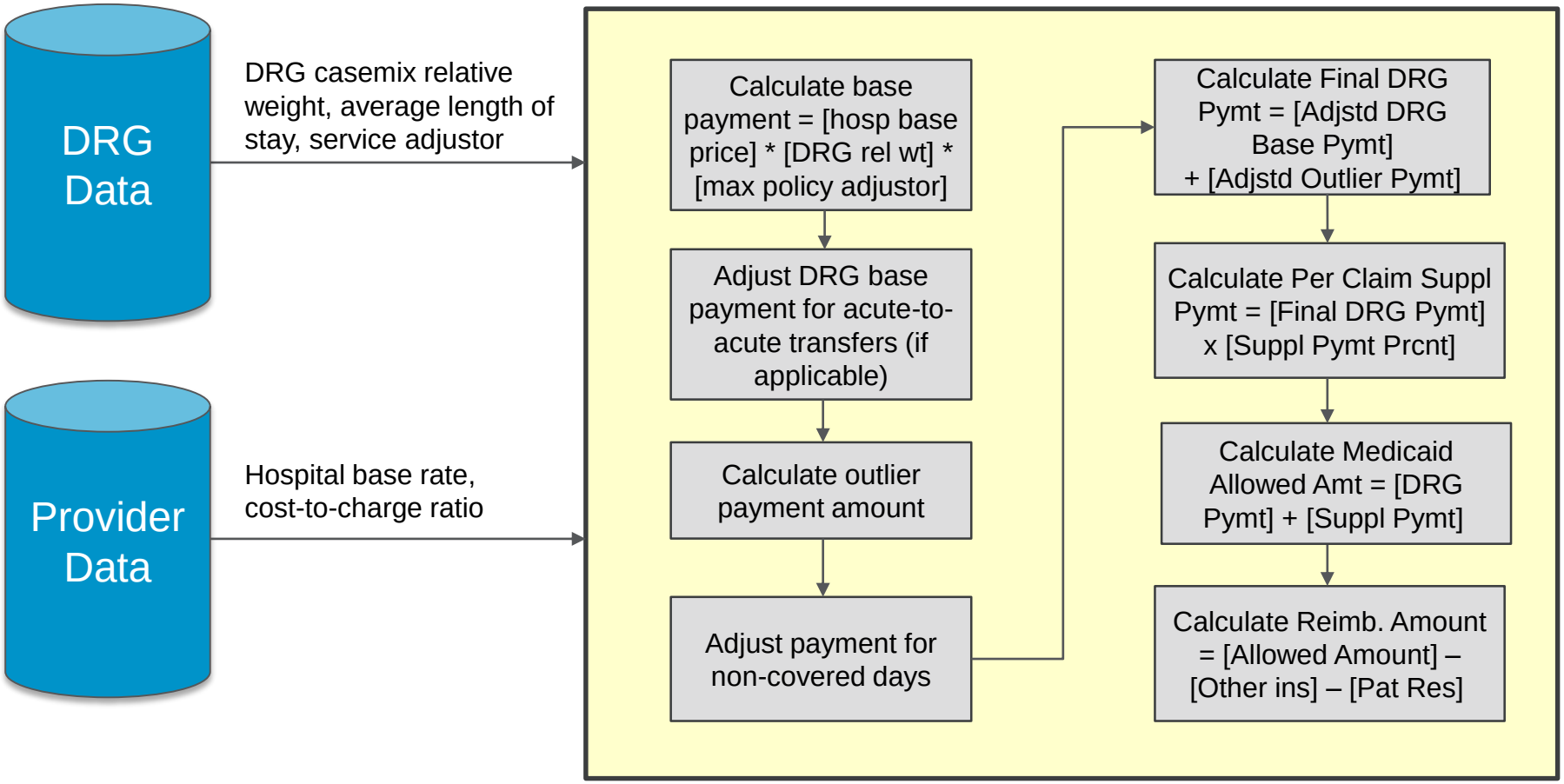
PRICING CALCULATION FLOW



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PRICING EXAMPLES

BASIC EXAMPLE

Claim / Encounter Information	Value
Submitted Charges	$84,000
Length of Stay (Admit through Discharge)	3
Medicaid Covered Days	3
Transfer	No
Patient Age	55
DRG (knee joint replacement)	302-2

Outlier Add-on Payment	Value
Hospital Specific CCR	0.25
Claim Cost (CCR x Charges)	$21,000
Fixed Loss Threshold	$25,000
Claim Outlier Threshold	$33,163
Hospital Cost Above Threshold	$0
Marginal Cost Percentage	80%
Unadjusted Outlier Add-on Payment	$0

Base Payment Information	Value
DRG Relative Weight	1.6326
DRG Base Rate	$5,000
Applicable Policy Adjustor	1.00
Unadjusted DRG Base Payment	$8,163

Final Allowed Amount	Value
Covered Day Reduction Factor	1.00
Final Base DRG Payment	$8,163
Final Outlier Add-on Payment	$0.00
Supplemental Payment Factor	0.12360
Supplemental Payment	$1,009
Final Allowed Amount	**$9,172**

Note: The Final Reimbursement Amount to providers is subject to other insurance payments

POLICY ADJUSTOR EXAMPLE

Claim / Encounter Information	Value
Submitted Charges	$34,000
Length of Stay (Admit through Discharge)	3
Medicaid Covered Days	3
Transfer	No
Patient Age	16
DRG (Bipolar Disorder)	753-2

Outlier Add-on Payment	Value
Hospital Specific CCR	0.25
Claim Cost (CCR x Charges)	$8,500
Fixed Loss Threshold	$25,000
Claim Outlier Threshold	$28,992
Hospital Cost Above Threshold	$0
Marginal Cost Percentage	80%
Unadjusted Outlier Add-on Payment	$0

Base Payment Information	Value
DRG Relative Weight	0.5323
DRG Base Rate	$5,000
Applicable Policy Adjustor	1.50
Unadjusted DRG Base Payment	$3,992

Final Allowed Amount	Value
Covered Day Reduction Factor	1.00
Final Base DRG Payment	$3,992
Final Outlier Add-on Payment	$0.00
Supplemental Payment Factor	0.12360
Supplemental Payment	$493
Final Allowed Amount	**$4,485**

Note: The Final Reimbursement Amount to providers is subject to other insurance payments

OUTLIER PAYMENT POLICY

- Alabama Medicaid Agency adopted a “Medicare-like,” cost-based approach for outlier payments
- To be eligible for an outlier payment, an individual claim must exceed a fixed-loss threshold amount of $25,000
- An 80% marginal cost factor is applied to excess costs above the DRG base payment plus fixed-loss threshold

Outlier Payment =

([Est. Hosp Cost] – [DRG Payment + Fixed-Loss Threshold]) × Marginal Cost Factor

Outlier Payment =

([Est. Hosp Cost] – [DRG Payment + $25,000]) × 0.80

OUTLIER EXAMPLE

Claim / Encounter Information	Value
Submitted Charges	$350,000
Length of Stay (Admit through Discharge)	10
Medicaid Covered Days	10
Transfer	No
Patient Age	55
DRG (knee joint replacement)	302-2

Base Payment Information	Value
DRG Relative Weight	1.6326
DRG Base Rate	$5,000
Applicable Policy Adjustor	1.00
Unadjusted DRG Base Payment	$8,163

Outlier Add-on Payment	Value
Hospital Specific CCR	0.25
Claim Cost (CCR x Charges)	$87,500
Fixed Loss Threshold	$25,000
Claim Outlier Threshold	$33,163
Hospital Loss Above Threshold	$54,337
Marginal Cost Percentage	80%
Unadjusted Outlier Add-on Payment	$43,470

Final Allowed Amount	Value
Covered Day Reduction Factor	1.00
Final Base DRG Payment	$8,163
Final Outlier Add-on Payment	$43,470
Supplemental Payment Factor	0.12360
Supplemental Payment	$6,382
Final Allowed Amount	**$58,015**

Note: The Final Reimbursement Amount to providers is subject to other insurance payments

TRANSFER EXAMPLE - FORMULA

- Alabama Medicaid Agency adopted the Medicare acute-to-acute transfer model
- Transfer payment adjustment applies to the transferring hospital
- The receiving hospital gets full DRG payment (unless they also transfer the patient)
- Transfer policy calculates a “Transfer Base Payment” and selects lessor of full DRG Base Payment and Transfer Base Payment.
- One day is added to cover additional costs for admission, diagnosis and stabilization on first day of stay at transferring hospital
- Transfer Base Payment = (DRG Base Pymt) ÷ (DRG ALOS)
  x (Actual Len of Stay + 1)
- The following discharge status codes trigger the transfer payment policy:
  02, 05, 65, 66, 82, 85, 93, 94

TRANSFER EXAMPLE

Claim / Encounter Information	Value
Submitted Charges	$25,000
Length of Stay (Admit through Discharge)	1
Medicaid Covered Days	1
Transfer	Yes
Patient Age	0
DRG (Neo Bwt 1250-1499G w Maj Problem)	607-3

Transfer Payment	Value
DRG National Avg Length of Stay	44.31
Transfer Per Diem (DRG Base Pay ÷ National Avg LOS)	$987
Transfer Base Payment	$1,974
Lessor of DRG and Transfer Pymt	$1,974

Outlier Add-on Payment	Value
Hospital Loss Above Threshold	$0
Unadjusted Outlier Add-on Payment	$0

Base Payment Information	Value
DRG Relative Weight	6.7296
DRG Base Rate	$5,000
Applicable Policy Adjustor	1.30
Unadjusted DRG Base Payment	$43,742

Final Allowed Amount	Value
Covered Day Reduction Factor	1.00
Final Base DRG Payment	$1,974
Final Outlier Add-on Payment	$0
Supplemental Payment Factor	0.12360
Supplemental Payment	$244
Final Allowed Amount	**$2,218**

Note: The Final Reimbursement Amount to providers is subject to other insurance payments

COVERED DAY ADJUSTMENT

- Potential Reasons for a Covered Day Adjustment:
  - Medicare dual eligibles in which the recipient's Medicare Part A coverage is exhausted during the stay
  - Medically needy recipients, who gain Medicaid eligibility during the middle of a hospital stay
  - Undocumented immigrant whose length of stay is longer than the number of payable days

- Adjustment method in Alabama Medicaid: Per Diem Reduction Factor based upon length of stay (LOS)

  - Lesser of:

(Covered LOS) / (DRG Avg LOS) *OR* 1.0

COVERED DAY EXAMPLE – PER DIEM METHOD

Claim / Encounter Information	Value
Submitted Charges	$350,000
Length of Stay (Admit through Discharge)	10
Medicaid Covered Days	2
Transfer	No
Patient Age	55
DRG (knee joint replacement)	302-2

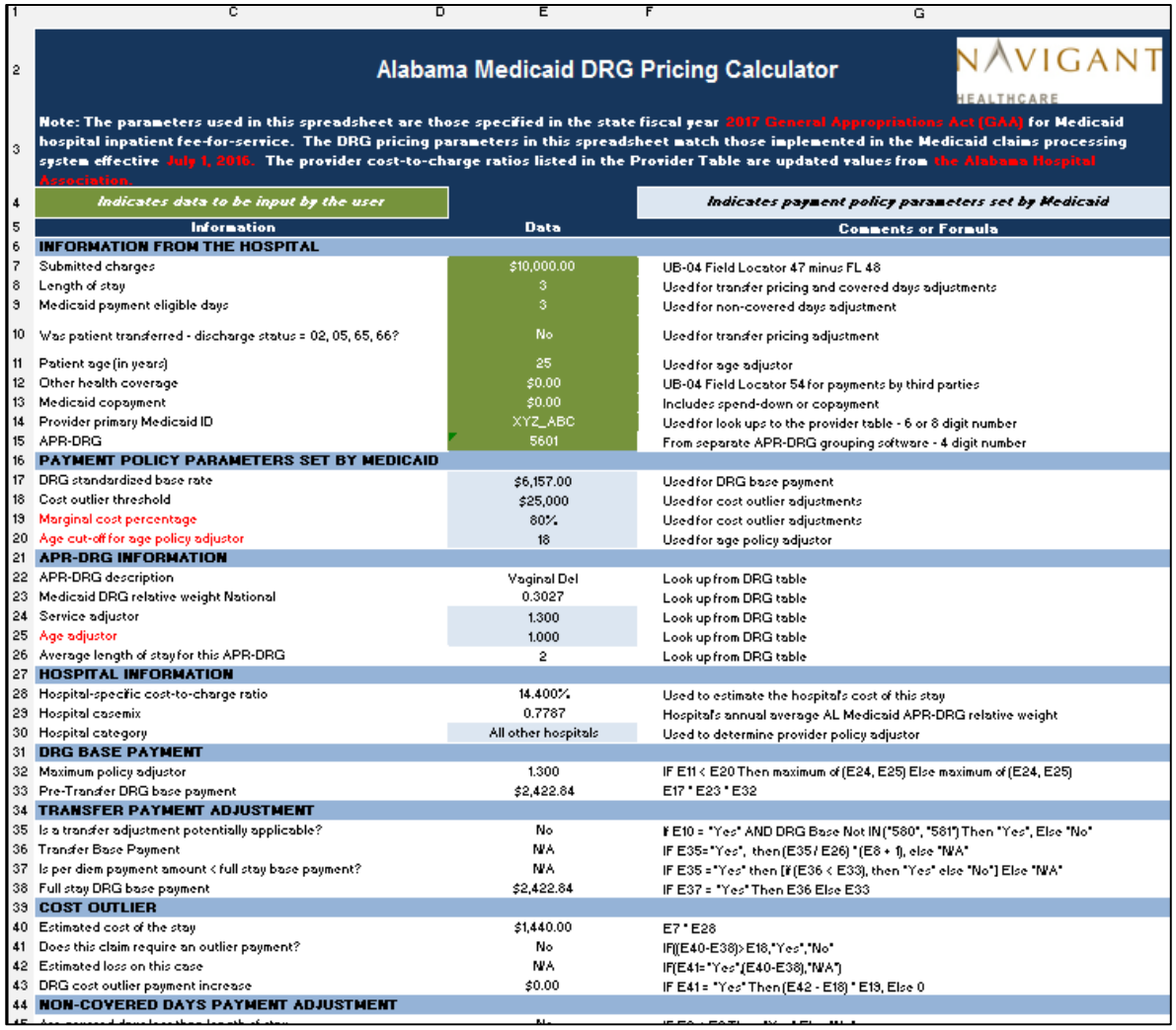
Outlier Add-on Payment	Value
Hospital Specific CCR	0.25
Claim Cost (CCR x Charges)	$87,500
Fixed Loss Threshold	$25,000
Claim Outlier Threshold	$33,163
Hospital Loss Above Threshold	$54,337
Marginal Cost Percentage	80%
Unadjusted Outlier Add-on Payment	$43,470

Base Payment Information	Value
DRG Relative Weight	1.6326
DRG Base Rate	$5,000
Applicable Policy Adjustor	1.00
Unadjusted DRG Base Payment	$8,163

Final Allowed Amount	Value
DRG National Avg Length of Stay	3.30
Covered Day Reduction Factor[1]	0.6061
Final Base DRG Payment	$4,948
Final Outlier Add-on Payment	$26,347
Supplemental Payment Factor	0.12360
Supplemental Payment	$3,868
Final Allowed Amount	**$35,163**

Notes: [1] Factor is set to 1 if covered length of stay is greater than DRG average length of stay.
The Final Reimbursement Amount to providers is subject to other insurance payments.

DRG CALCULATOR



Alabama Medicaid DRG Pricing Calculator

NAVIGANT HEALTHCARE

Note: The parameters used in this spreadsheet are those specified in the state fiscal year 2017 General Appropriations Act (GAA) for Medicaid hospital inpatient fee-for-service. The DRG pricing parameters in this spreadsheet match those implemented in the Medicaid claims processing system effective July 1, 2016. The provider cost-to-charge ratios listed in the Provider Table are updated values from the Alabama Hospital Association.

Indicates data to be input by the user | *Indicates payment policy parameters set by Medicaid*

Information	Data	Comments or Formula
INFORMATION FROM THE HOSPITAL		
Submitted charges	$10,000.00	UB-04 Field Locator 47 minus FL 48
Length of stay	3	Used for transfer pricing and covered days adjustments
Medicaid payment eligible days	3	Used for non-covered days adjustment
Was patient transferred - discharge status = 02, 05, 65, 66?	No	Used for transfer pricing adjustment
Patient age (in years)	25	Used for age adjustor
Other health coverage	$0.00	UB-04 Field Locator 54 for payments by third parties
Medicaid copayment	$0.00	Includes spend-down or copayment
Provider primary Medicaid ID	XYZ_ABC	Used for look ups to the provider table - 6 or 8 digit number
APR-DRG	5601	From separate APR-DRG grouping software - 4 digit number
PAYMENT POLICY PARAMETERS SET BY MEDICAID		
DRG standardized base rate	$6,157.00	Used for DRG base payment
Cost outlier threshold	$25,000	Used for cost outlier adjustments
Marginal cost percentage	80%	Used for cost outlier adjustments
Age cut-off for age policy adjustor	18	Used for age policy adjustor
APR-DRG INFORMATION		
APR-DRG description	Vaginal Del	Look up from DRG table
Medicaid DRG relative weight National	0.3027	Look up from DRG table
Service adjustor	1.300	Look up from DRG table
Age adjustor	1.000	Look up from DRG table
Average length of stay for this APR-DRG	2	Look up from DRG table
HOSPITAL INFORMATION		
Hospital-specific cost-to-charge ratio	14.400%	Used to estimate the hospital's cost of this stay
Hospital casemix	0.7787	Hospital's annual average AL Medicaid APR-DRG relative weight
Hospital category	All other hospitals	Used to determine provider policy adjustor
DRG BASE PAYMENT		
Maximum policy adjustor	1.300	IF E11 < E20 Then maximum of (E24, E25) Else maximum of (E24, E25)
Pre-Transfer DRG base payment	$2,422.84	E17 * E23 * E32
TRANSFER PAYMENT ADJUSTMENT		
Is a transfer adjustment potentially applicable?	No	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"
Transfer Base Payment	N/A	IF E35="Yes", then (E35 / E26) * (E8 + 1), else "N/A"
Is per diem payment amount < full stay base payment?	N/A	IF E35 = "Yes" then [If (E36 < E33), then "Yes" else "No"] Else "N/A"
Full stay DRG base payment	$2,422.84	IF E37 = "Yes" Then E36 Else E33
COST OUTLIER		
Estimated cost of the stay	$1,440.00	E7 * E28
Does this claim require an outlier payment?	No	IF((E40-E38)>E18,"Yes","No"
Estimated loss on this case	N/A	IF(E41="Yes",(E40-E38),"N/A")
DRG cost outlier payment increase	$0.00	IF E41 = "Yes" Then (E42 - E18) * E19, Else 0
NON-COVERED DAYS PAYMENT ADJUSTMENT		

MORE INFORMATION

RCOData@Medicaid.Alabama.Gov

http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.6_Hospital_Services.aspx

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