

TRANSITION FROM AP-DRG TO APR-DRG FOR INPATIENT HOSPITALS IN NEW JERSEY

QUESTIONS AND ANSWERS

May 30, 2018

- 1. When is the implementation date for using APR-DRGs?**
 - A. Discharge dates on and after October 1, 2018.
- 2. What version of APR-DRG software will be used at implementation?**
 - A. 3M™ APR-DRG version 34.
- 3. Will training be made available to the hospitals prior to implementation?**
 - A. Training will be provided on an as requested basis
- 4. Will Medicaid managed care organizations be required to use the APR-DRG grouper?**
 - A. The Medicaid managed care organizations will not be required to use the APR-DRG grouper and do not need to make any changes due to the State's implementation of APR-DRGs.
- 5. Will Charity Care claims be impacted?**
 - A. Yes, Charity Care claims will be processed using APR-DRGs.
- 6. How does the calibration process work? Was the calibration evenly applied to all MDCs?**
 - A. 3M™ APR-DRG version 34 relative value weights served as the basis for the APR-DRG fiscal modeling. However, a calibration of the relative value weights was necessary as the application of the pre-calibrated weights using the APR-DRG grouper resulted in lower allowed amounts than was experienced under AP-DRG. Given the intent of the APR-DRG implementation (and corresponding fiscal impact modeling) was to seek cost neutrality, a calibration of the relative value weights was necessary.

The calibration is calculated by dividing the allowed amounts that were experienced under AP- DRG by the pre-calibrated allowed amounts using APR-DRGs. This single factor (1.604) was developed in aggregate across all hospitals and experience data.

The entire APR-DRG version 34 weight set was multiplied by 1.604 so as to retain the integrity of the relative weights, while meeting revenue neutrality.
- 7. What is the dollar impact of using 3M™ national benchmarks for the DRG weights and cost outlier thresholds, DRG average length of stay (ALOS) and day outlier thresholds?**
 - A. The aggregate dollar impact of the move to APR-DRG and 3M national weights was calibrated to be revenue neutral. Outlier payments were also calibrated to be

approximately the same as under AP-DRG. Alternate level of care (ALC) day payments, while small in total, increased under the change to 3M national benchmarks. Individual hospital and health system results vary depending on the distribution of APR-DRGs including severity of illness (SOI).

8. How did cost outliers change yet the threshold of \$25k remain the same?

A. The APR-DRG cost outlier thresholds are based on 3M national charge statistics and then calibrated with a .25 factor to target 3.8% of payments as outliers (to be consistent with current AP-DRG aggregate outlier payment levels). Both AP-DRG and APR-DRG utilize the same minimum threshold of \$25,000.

9. Are the ALOS and day outlier thresholds new elements to APR-DRG pricing?

A. No, these are not new elements to APR-DRG pricing; ALOS and day outlier thresholds are utilized in current AP-DRG pricing.

10. For base rates and add-on percentages, the memo stated that no there would be no change due to the transition to APR-DRGs. Does this mean there is only no change to rate structure = base rate + add-on percentage * weight?

A. There will not be a change to the rate structure due to the transition to APR-DRGs. This includes no change to the base rate or add-on percentage amounts as a part of the transition to APR-DRG.

11. Will base rates be repriced or rebased with the transition to APR-DRGs? Or will the base rates remain the same dollar amounts as with AP-DRGs but adjusted for inflation (TEFRA)?

A. There will be no change to base rates or inflation as a result of the transition to APR-DRGs.

12. Will there be a change in the criteria that determine if hospitals are eligible for the add-on percentages?

A. No.

13. What was the primary cause of the +/- at the hospital-specific level? Was it isolated to specific services?

A. The distribution of discharges by APR-DRG/SOI is the cause of variation at the hospital level. If a hospital had a distribution of DRGs exactly equal to the average distribution, the impact for that hospital would be negligible.