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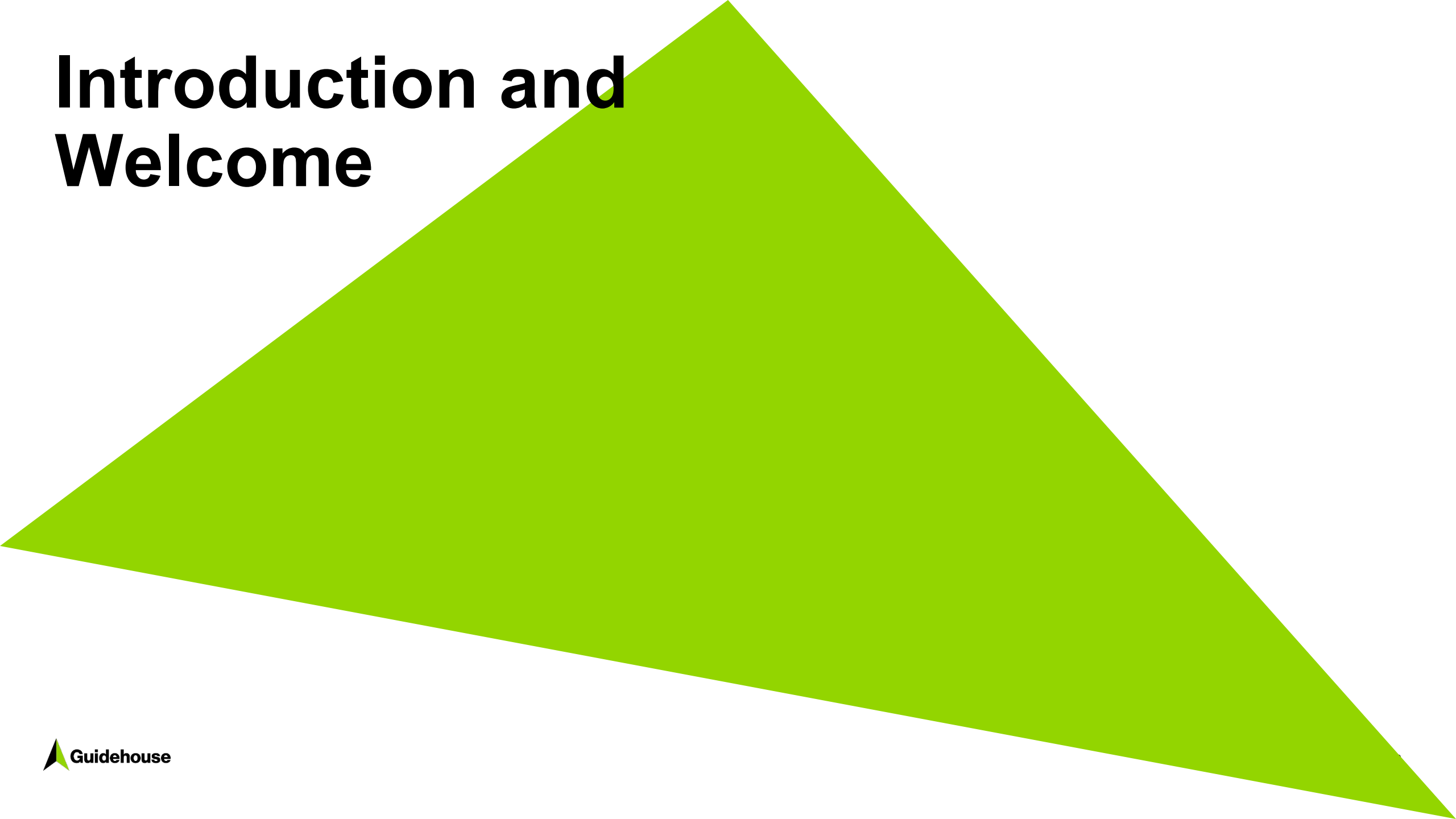
AHCCCS APR-DRG Rebase Workgroup

MARCH 2021

Agenda

- Introduction and Welcome
- Overview of Current Policy
- Hospital Payment Federal Fiscal Year (FFY) 2022 Updates
- Potential need for APR-DRG v38 CMI Normalization
- Data Summaries
- COVID-19 Considerations
- Questions

Introduction and Welcome



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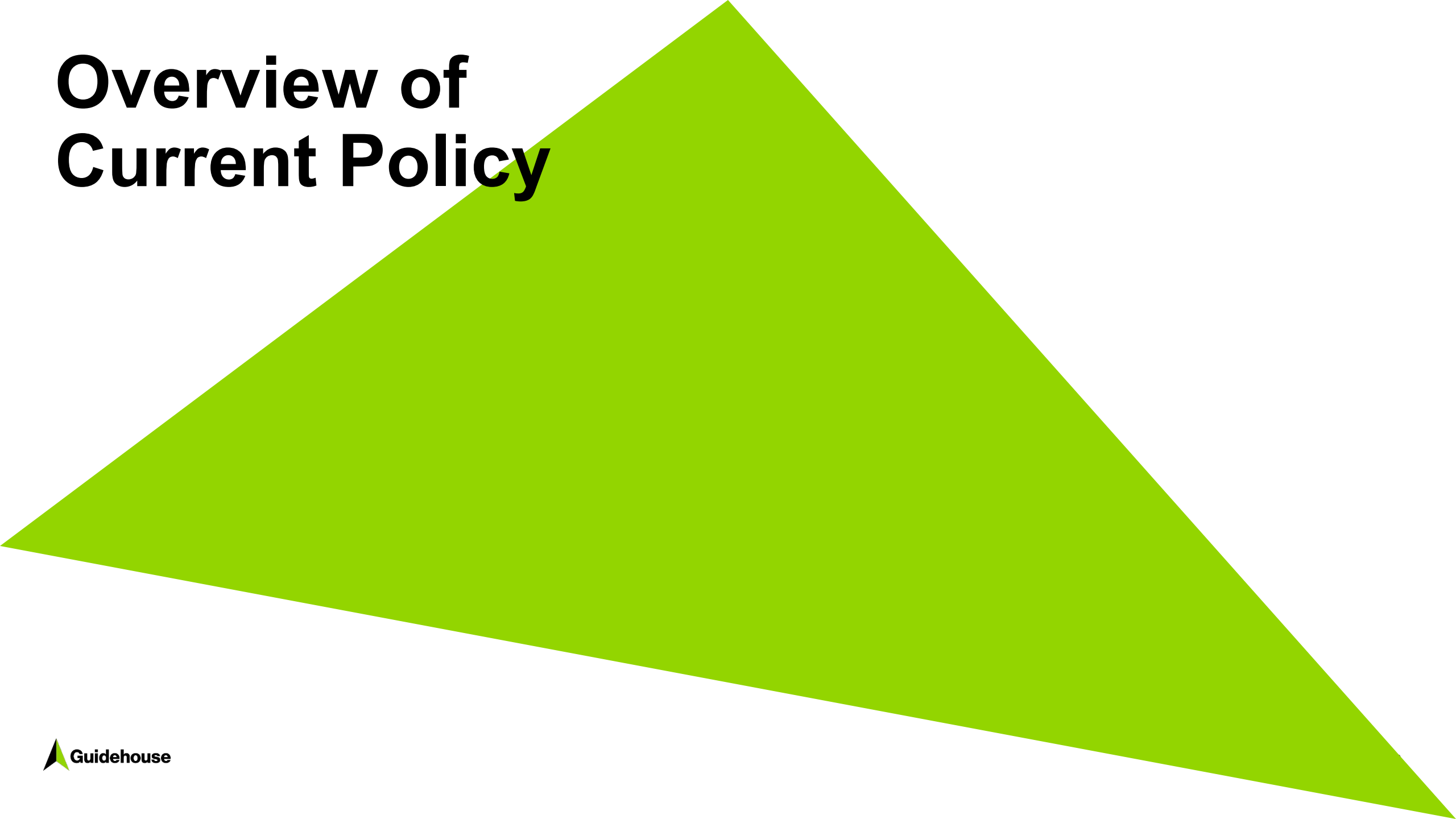
Overview of Current Policy



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OVERVIEW OF CURRENT POLICY

APR-DRG Payment System Design Payment Policies: January 2020

Policy	Decision
1. DRG Grouper	APR-DRG 3M™ (version 34)
2. DRG Relative Weights	3M™ National Weights
3. Outlier Payment Policy	Medicare – like model Using Medicare Cost-to-Charge ratios
4. Transfer Payment Policy	Reduced payment for acute-to-acute transfer (discharge status codes 02, 05, 66)
5. Partial Eligibility	Transfer-like payment reduction for Medicaid non-covered days
6. Capital Payment	N/A
7. Interim Claims	$500 per diem paid for lengths of stay greater than 30 days

OVERVIEW OF CURRENT POLICY (cont)

APR-DRG Payment System Design Payment Policies: January 2020

Policy	Decision
8. Providers carved out of DRG pricing	• Rehabilitation and LTAC hospitals not reimbursed under the DRG methodology. These facilities reimbursed under a separate per diem rate. • Freestanding psychiatric facilities not reimbursed under the DRG methodology. These facilities reimbursed under a separate per diem rate consistent with AHCCCS reimbursement policy
9. Payment for Specialty Services	• Hospitalization with transplant services are performed a recipient may first receive inpatient hospital services that are not related to the any transplant components. These services are paid under the APR-DRG methodology.
10. Hospital Base Rates	• Hospitals designated as type “Specialty” are reimbursed under the DRG methodology, under a separate DRG base rate. • All other providers are reimbursed under the same standardized base rate • The standardized base rate is wage adjusted

OVERVIEW OF CURRENT POLICY (cont)

APR-DRG Payment System Design Payment Policies: January 2020

Policy	Decision
11. Budget Goal	Budget neutral in previous rebasing, in aggregate (we start at budget neutral or value that the state determines.)
12. Targeted Policy Adjustors	• Obstetrics and Normal Newborn: : 1.550 • Neonates: 1.100 • Psychiatrics and Rehab: 1.650 • Burns: 4.000 • Pediatric, SOI 1 & 2: 1.250 • Pediatric, SOI 3 & 4: 2.300 • All other claims 1.025
13. Transitional Period	N/A for this update
14. Case Mix Normalization	Up for discussion if we should apply CMI Normalization for changing from V34 to V38

Hospital Payment FFY 2022 Updates

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FFY 2022 Updates

- FFY 2022 time period is defined as October 1, 2021 – September 30, 2022
- Model claims data extraction for rate setting purposes occurred week of January 25, 2021
  - Using dates of service in Calendar Year 2019 (January 1, 2019 – December 31, 2019)
  - Paid claims and adjudicated encounters only
  - Fee-for-service claims and managed care encounters
  - In-state and high utilization out of state providers
- Grouper versions update to APR-DRG v38
- Guidehouse performs several steps of data validation to confirm the data is usable for APR-DRG grouping and pricing purposes and will not lead to any errors in our rates.

FFY 2022 Updates (cont)

APR-DRG changes between v34 and v38 Updates – Summary of Changes Documents v35 – v38 Handouts

- DRG Changes
  - 14 new DRGs
  - 8 deleted DRGs
  - 18 revised DRGs
- Billing Requirement Changes
  - Vaginal deliveries now require billing of both a delivery procedure and a delivery outcome
  - DRG 589 (birthweight < 500 grams) now requires billing of both a birth weight and a gestational age
- National DRG Relative Weights
  - Calculated using a dataset containing only ICD-10 codes

Rate Year 2022 Updates

New DRGs since v34

New DRG	AHCCCS Policy Adjustor Under Current Policy
027 – Other open craniotomy 029 – Other percutaneous intracranial procedures 030 – Percutaneous intracranial and extracranial vascular procedures 178 – Other heart assist systems 179 – Defibrillator implants 183 – Percutaneous structural cardiac procedures 323 – Non-elective or complex hip joint replacement 324 – Elective hip joint replacement 325 – Non-elective or complex knee joint replacement 326 – Elective knee joint replacement	Adult: 1.025 Pediatric SOI 1 and 2: 1.250 Pediatric SOI 3 and 4: 2.300
539 – Cesarean section with sterilization 543 – Abortion w/ D&C, aspiration curettage, or hysterotomy 547 – Antepartum with O.R. procedure 548 – Postpartum and post abortion diagnosis with O.R. procedure	Obstetrics: 1.550

FFY 2022 Updates: Data Validation

- Accurate data is the most important aspect in ensuring accurate rates are producing in our grouping analysis.
- Data validation checks including:
  - Header level data such as:
    - Claim counts, valid Dx codes, and duplicate claims
    - Provider IDs, Recipient IDs, Missing Recipient
    - Dates of service, admit, and discharge
  - Field values and amount distribution such as:
    - Month/Year, Health Plan, Provider, Program (FFS vs. MCO)
    - Diagnosis Category, Claim Bill Type and Discharge Status, Allowed amount range
    - Age Range, Recipient, Gender
  - Ensure all grouping information is present:
    - Claims are grouped following the rules of date of claim
    - Grouping is compared to the DRG from the claim data

FFY 2022 Updates:

- Development of 2022 rates is ongoing
- FFY review items include:
  - Maintain budget neutral in aggregate
  - Inpatient outlier payment parameters (including trimpoint and thresholds)
  - Policy adjustors
  - Border status for acute care hospitals
  - Use of normalized national weights
- Target Rate Setting Timeline
  - Communicate proposed new rates and payment parameters in mid to late April 2021 workgroup meeting

Potential need for APR-DRG v38 CMI Normalization

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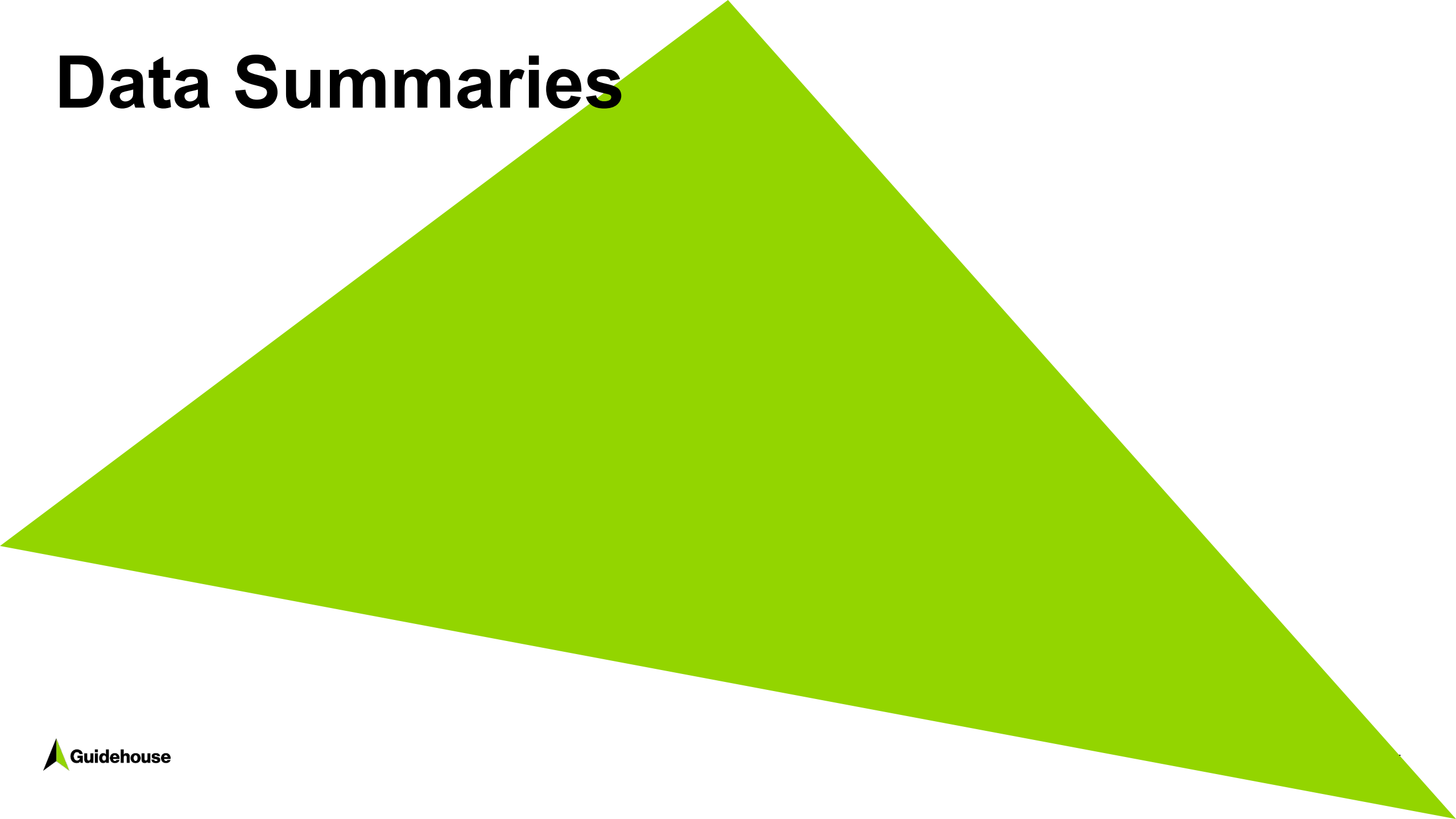
APR-DRG v38 CMI Normalization (If Necessary)

- Goal – to avoid large shifts in base rates due to substantial changes in 3M's APR-DRG 38 weights. V36 and V37 are relatively stable in each version but compared to historical values they are quite low.
- Reasons for changes in weights
  - Data set composed of ICD 10 only claims
  - Changes in hospital utilization, charges and cost in 3M dataset
  - Changes in distribution between SOI 1/2 versus 3/4
- Solution – Calculate a normalization factor that could be applied to 3M's v38 APR-DRG weights
- Example Calculation of Normalization Factor:

	Avg. APR DRG Weight Under Normalized v36	Avg. APR DRG Weight Under v37	Normalization Factor
	A	B	C = A/B
RY 2020	0.8713 (v35)	0.6485 (v36)	1.3434
RY 2021	0.8900	0.6605	1.3475
Percent Change	2.1%	1.9%	0.3%

Data Summaries



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Data Summaries

Size of dataset summary

Description	Claims	Billed Charges	AHCCCS Allowed Amount
CY 2019 paid claims	192,739	$ 10,254,546,069	$ 1,371,192,199
Exclusions			
Out of state provider	1,588	$ 130,717,248	$ 17,319,123
Paid $0	12	$ 803,002	$ -
Invalid DRG Assigned	454	$ 42,005,736	$ 6,245,870
Same day stay not priced via DRGs	7	$ 213,677	$ 26,659
Final Dataset	**190,678**	**$ 10,080,806,406**	**$ 1,347,600,547**

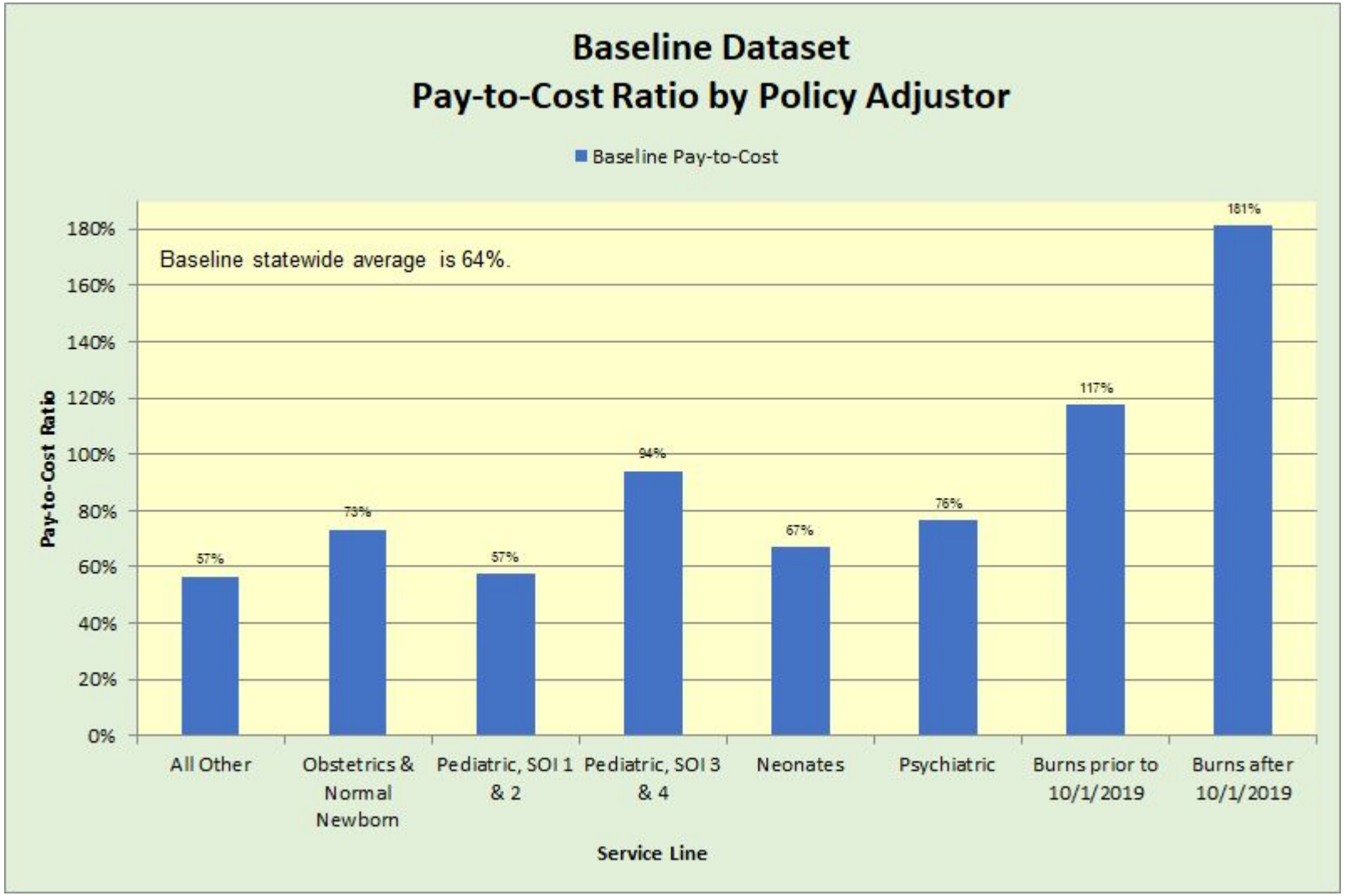
Data Summaries (cont)

Summary of current pricing by policy adjustor

Description	Policy Adjustor	Claims	Billed Charges	AHCCCS Allowed Amount	Estimated Hospital Cost	Pay-to-Cost Ratio
All Other	1.025	87,198	$ 6,835,408,313	$ 763,069,868	$ 1,348,485,161	57%
Obstetrics & Normal Newborn	1.550	77,005	$ 1,271,095,560	$ 190,995,694	$ 260,356,201	73%
Pediatric, SOI 1 & 2	1.250	10,937	$ 367,539,220	$ 56,125,990	$ 97,657,900	57%
Pediatric, SOI 3 & 4	2.300	6,592	$ 788,926,074	$ 209,198,458	$ 222,319,681	94%
Neonates	1.100	4,594	$ 643,295,831	$ 96,071,475	$ 143,430,563	67%
Psychiatric	1.650	4,103	$ 124,982,425	$ 19,273,039	$ 25,207,241	76%
Burns prior to 10/1/2019	2.700	184	$ 39,394,694	$ 9,320,591	$ 7,937,341	117%
Burns after 10/1/2019	4.000	50	$ 10,032,900	$ 3,523,221	$ 1,944,320	181%
Final Dataset		**190,663**	**$ 10,080,675,017**	**$ 1,347,578,336**	**$ 2,107,338,407**	**64%**

Note(s):
1) Estimated Hospital Cost is calculated using Medicare IPPS cost-to-charge ratios.

Data Summaries (cont)



Data Summaries (cont)

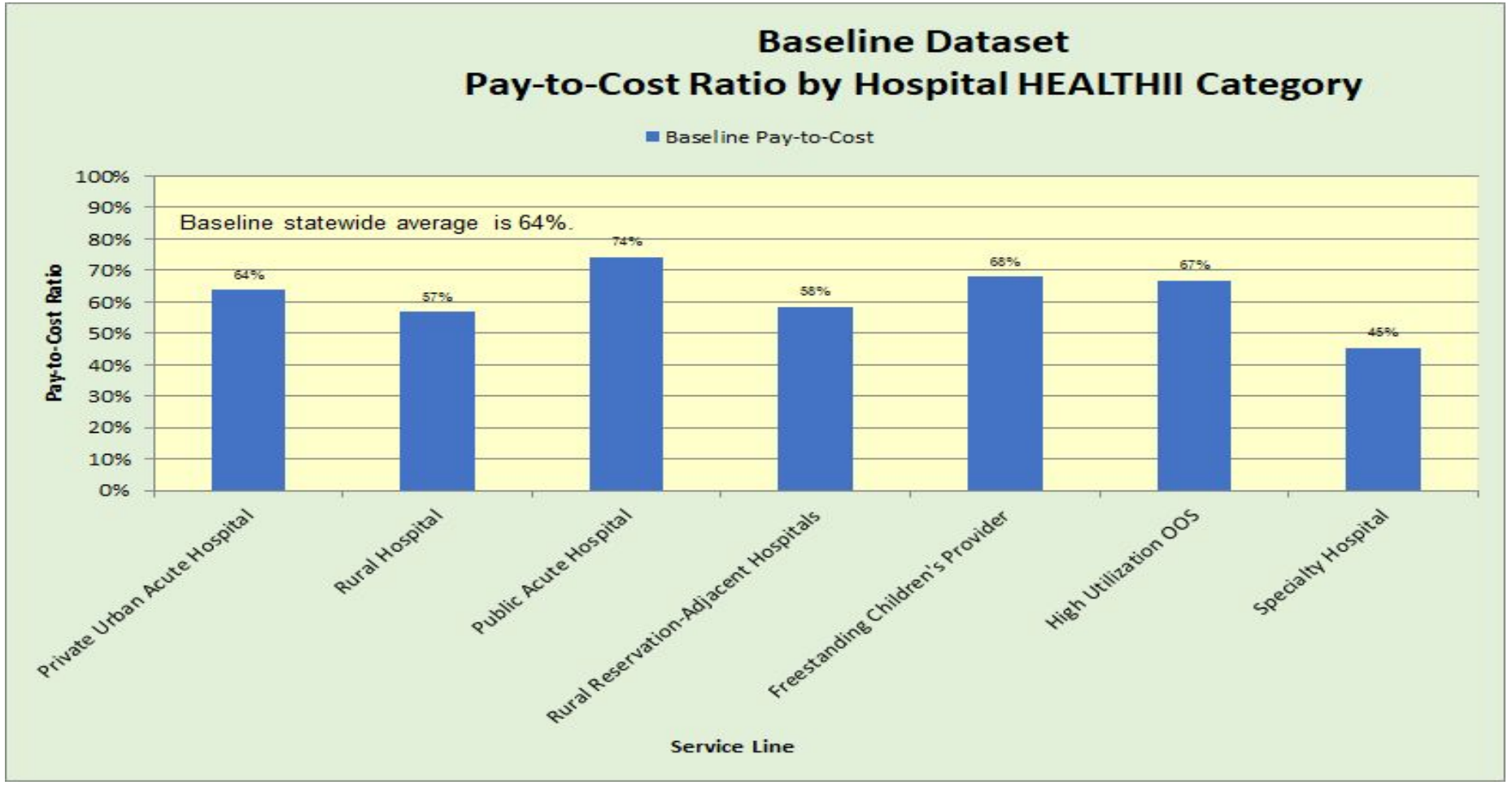
Summary of current pricing by provider (HEALTHII) category

Description	Claims	Billed Charges	AHCCCS Allowed Amount	Estimated Hospital Cost	Pay-to-Cost Ratio
Private Urban Acute Hospital	141,993	$ 7,448,924,660	$ 923,282,885	$ 1,449,300,130	64%
Rural Hospital	20,771	$ 740,430,768	$ 92,710,733	$ 163,262,831	57%
Public Acute Hospital	9,699	$ 517,746,253	$ 76,254,197	$ 102,756,804	74%
Rural Reservation-Adjacent Hosp	8,424	$ 292,152,939	$ 53,993,228	$ 92,317,802	58%
Freestanding Children's Provider	8,031	$ 853,932,429	$ 182,570,366	$ 268,560,506	68%
High Utilization OOS	1,193	$ 172,046,341	$ 14,459,849	$ 21,621,227	67%
Specialty Hospital	552	$ 55,441,627	$ 4,307,078	$ 9,519,106	45%
Final Dataset	**190,663**	**$ 10,080,675,017**	**$ 1,347,578,336**	**$ 2,107,338,406**	**64%**

Note(s):

1) Estimated Hospital Cost is calculated using Medicare IPPS cost-to-charge ratios.

Data Summaries (cont)



Data Summaries (cont)

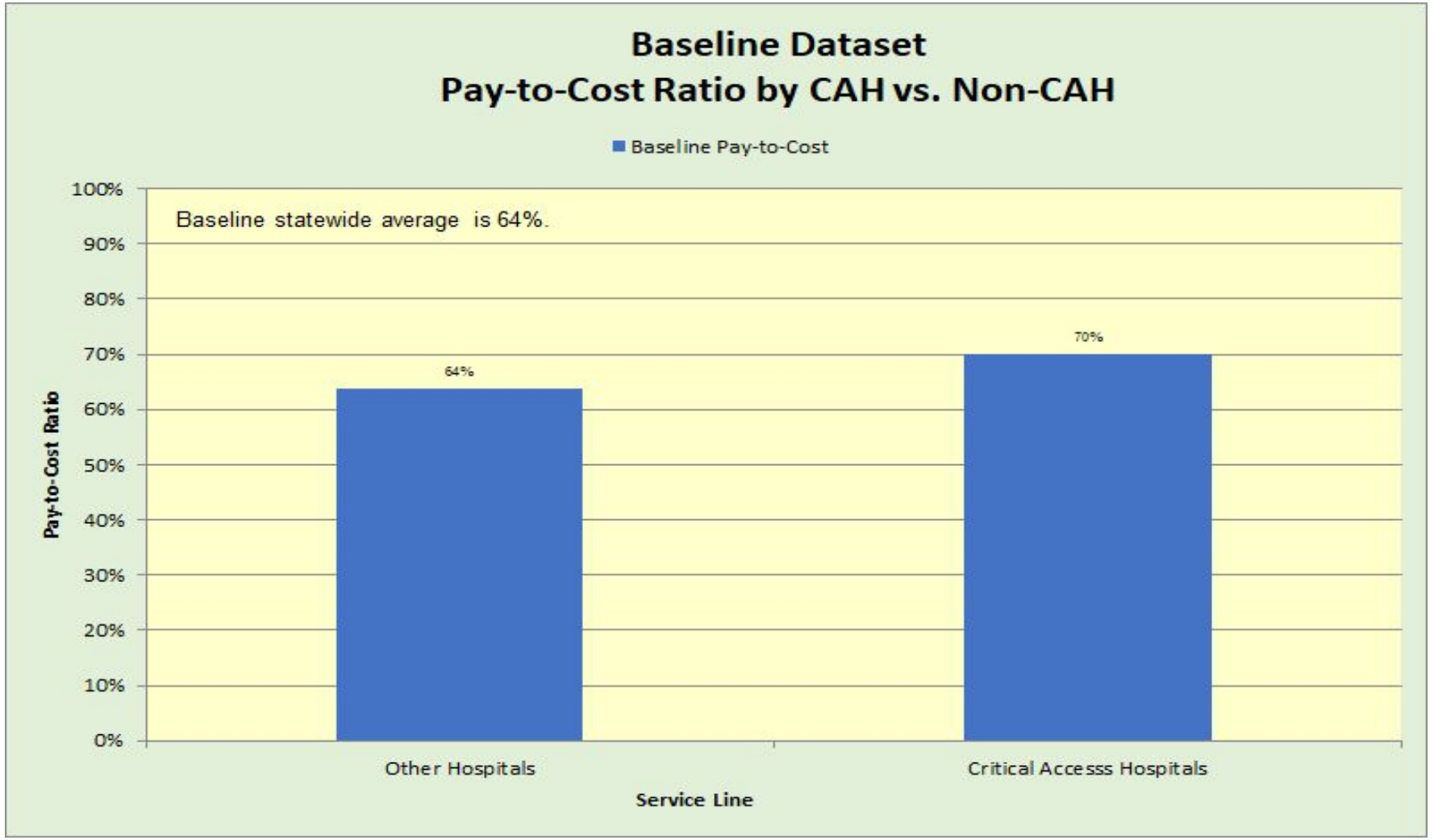
Summary of current pricing by CAH versus non-CAH

Description	Claims	Billed Charges	AHCCCS Allowed Amount	Estimated Hospital Cost	Pay-to-Cost Ratio
Other Hospitals	187,676	$ 10,016,495,420	$ 1,334,991,601	$ 2,089,390,481	64%
Critical Accesss Hospitals	2,987	$ 64,179,597	$ 12,586,735	$ 17,947,926	70%
Final Dataset	**190,663**	**$ 10,080,675,017**	**$ 1,347,578,336**	**$ 2,107,338,407**	**64%**

Note(s):

1) Estimated Hospital Cost is calculated using Medicare IPPS cost-to-charge ratios.

Data Summaries (cont)



Data Summaries (cont)

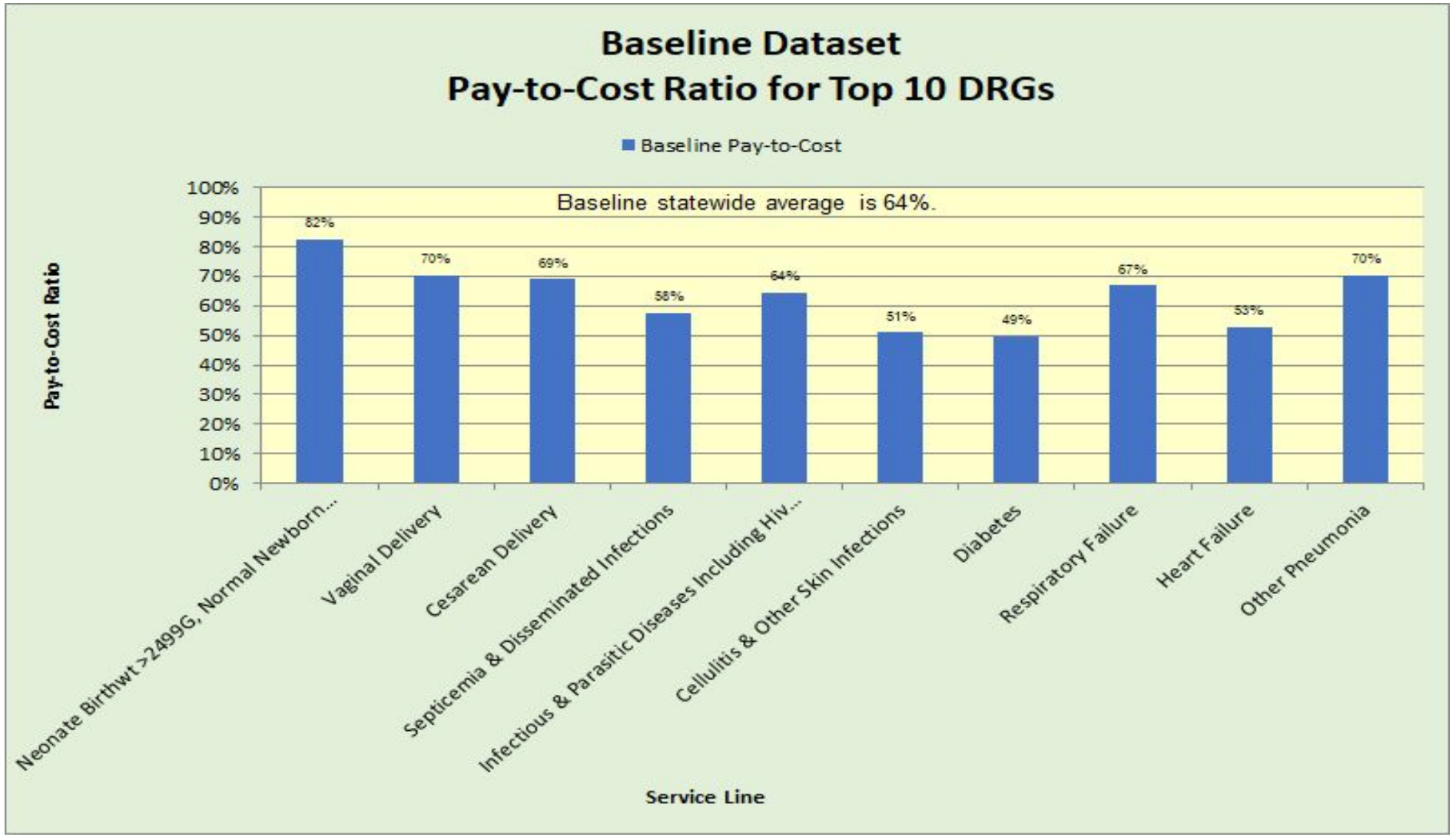
Summary of top 10 DRGs by volume

DRG Code	Description	Claims	Billed Charges	AHCCCS Allowed Amount	Estimated Hospital Cost	Pay-to-Cost Ratio
640	Neonate Birthwt >2499G, Normal Newborn Or Neonate W Other Problem	34,707	$ 210,529,949	$ 35,816,583	$ 43,520,787	82%
560	Vaginal Delivery	26,349	$ 532,295,353	$ 76,902,769	$ 109,584,596	70%
540	Cesarean Delivery	10,002	$ 382,093,936	$ 53,214,601	$ 77,207,761	69%
720	Septicemia & Disseminated Infections	8,552	$ 607,324,222	$ 69,898,537	$ 121,537,222	58%
710	Infectious & Parasitic Diseases Including Hiv W O.R. Procedure	2,999	$ 515,934,307	$ 66,305,003	$ 103,123,104	64%
383	Cellulitis & Other Skin Infections	2,872	$ 96,587,350	$ 10,157,130	$ 19,928,001	51%
420	Diabetes	2,858	$ 108,380,093	$ 11,202,127	$ 22,659,472	49%
133	Respiratory Failure	2,730	$ 140,071,547	$ 22,176,051	$ 33,169,257	67%
194	Heart Failure	2,484	$ 128,345,504	$ 13,472,009	$ 25,535,194	53%
139	Other Pneumonia	2,292	$ 88,634,485	$ 13,261,694	$ 18,905,246	70%
Final Dataset		**95,845**	**$ 2,810,196,746**	**$ 372,406,504**	**$ 575,170,641**	**65%**

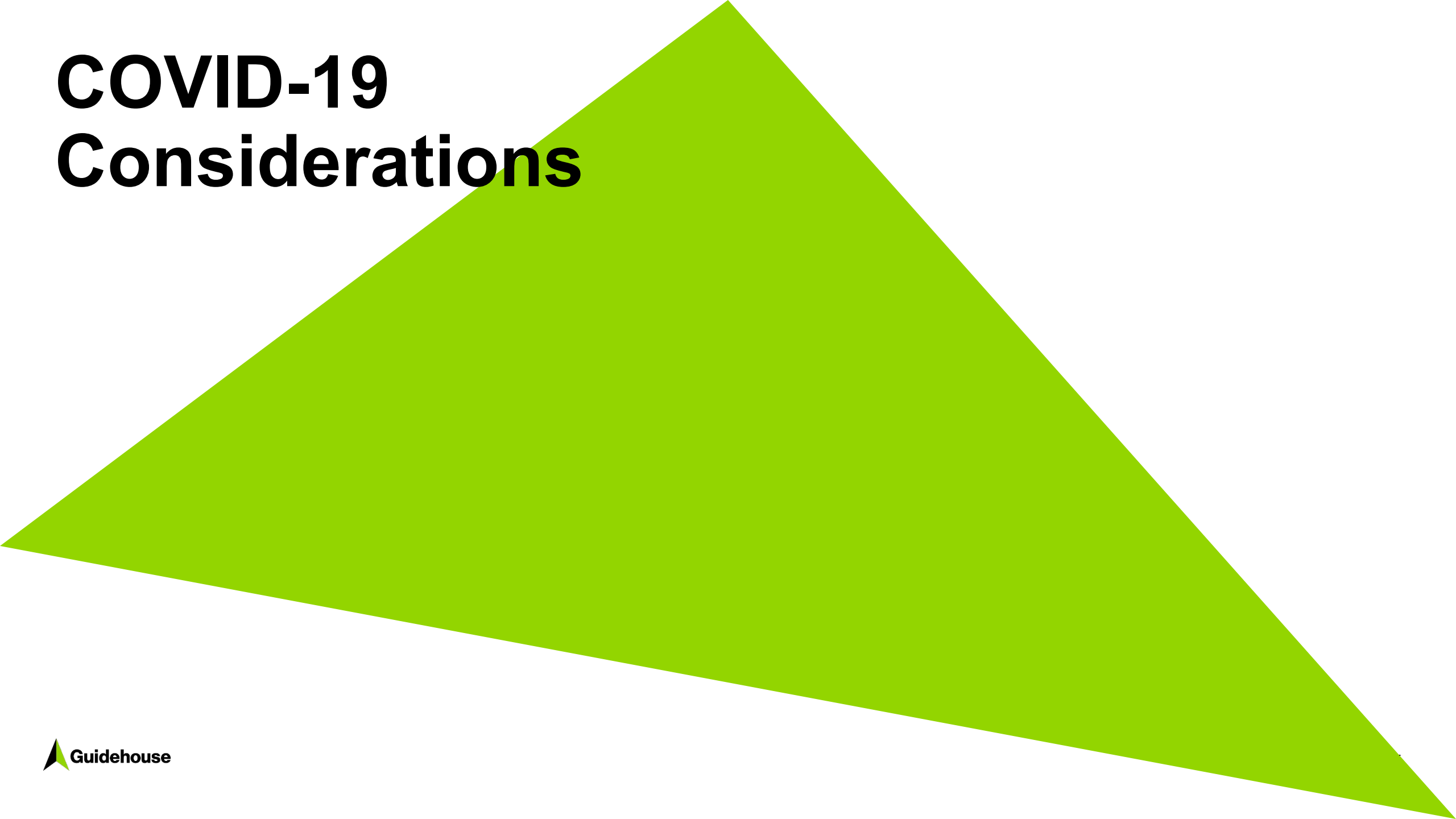
Note(s):

1) Estimated Hospital Cost is calculated using Medicare IPPS cost-to-charge ratios.

Data Summaries (cont)



COVID-19 Considerations



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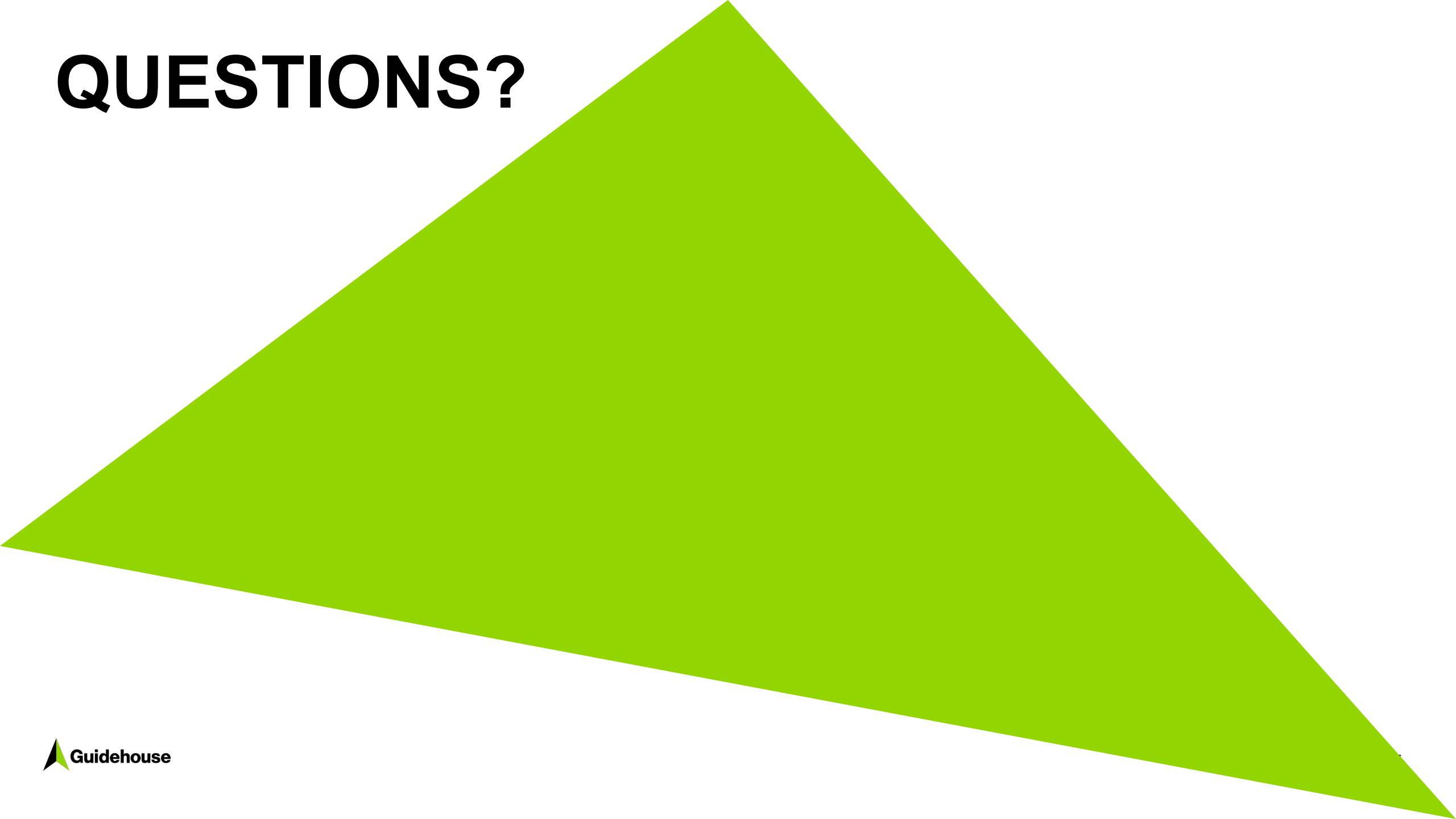
COVID-19 Considerations

- Current COVID-19 Impact
  - 3M included the new COVID-19 ICD-10 code, U07.1, into the April 1, 2020 release
  - 3M HIS APR v37 logic update to include new vaping code and COVID-19 diagnosis code effective April 1 2020
  - Working on summary of COVID-19 Coding and Grouping for HCPCS/CPT Codes, APR-DRG Mapping, and ICD-10 Diagnosis Code(s)
- AHCCCS will review how COVID-19 will impact future rate setting
  - Current rate development for FFY 2022 will not be impacted because the base data (CY 2019) does not include COVID-19 cases
  - Will review impact of reduced utilization and COVID-19 cases for future rate years

QUESTIONS?



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Questions

- Please send any questions by email to
  - Kenna Garman at kenna.garman@azahcccs.gov
  - Wendy Ecker at wendy.ecker@azahcccs.gov

- Please submit all email questions by March 31, 2021