Florida Agency for Health Care Administration

DRG Payment Implementation

Project Status

September 19, 2012
Presentation by MGT of America, Inc. and Navigant Consulting, Inc.

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Meeting Agenda

Agenda Topic
Introduction
Background and Project Overview
Overview of DRG Groupers
Presentation of Data Analyses and Results
Considerations for the LIP Program
Preliminary Recommendations and Decision Points

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Background and Project Overview

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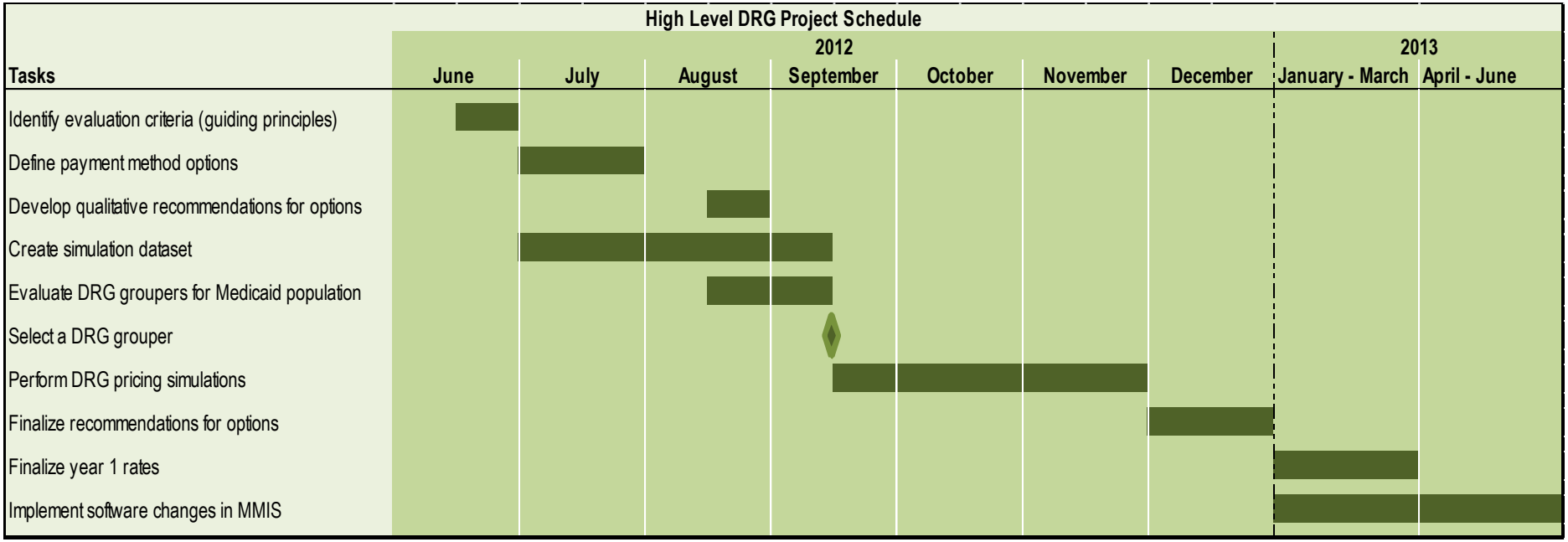
Background

- Legislation
  - Section 409.905(5)(f), Florida Statutes, as amended by House Bill 5301, 2012 session
  - Convert Medicaid fee-for-service inpatient hospital reimbursement to a prospective payment system (PPS) which categorizes stays using Diagnosis Related Groups (DRGs)
- Timing
  - Submit a Medicaid DRG plan no later than January 1, 2013
  - Implement DRG pricing by July 1, 2013

Project Timeline



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Evaluating the Options

Guiding Principles for Evaluating Options

Efficiency	Is the option aligned with incentives for providing efficient care?
Access	Does the option promote access to quality care, consistent with federal requirements?
Equity	Does the option promote equity of payment through appropriate recognition of resource intensity and other factors?
Predictability	Does the option provide predictable and transparent payment for providers and the State?
Transparency and Simplicity	Does the option enhance transparency, and contribute to an overall methodology that is easy to understand and replicate?
Quality	Does the option promote and reward high value, quality-driven healthcare services?

Other Design Considerations

Other Design Considerations	
Budget Neutrality	Funding is not unlimited – goal for design is to be budget neutral.
Adaptability	Does the option promote adaptability for future changes in utilization and the need for regular updates?
Forward Compatibility	Is the option flexible enough to support payment structures in anticipated future service models?
Policy	Is the option consistent with State and Federal policy priorities?

Overview of DRG Groupers

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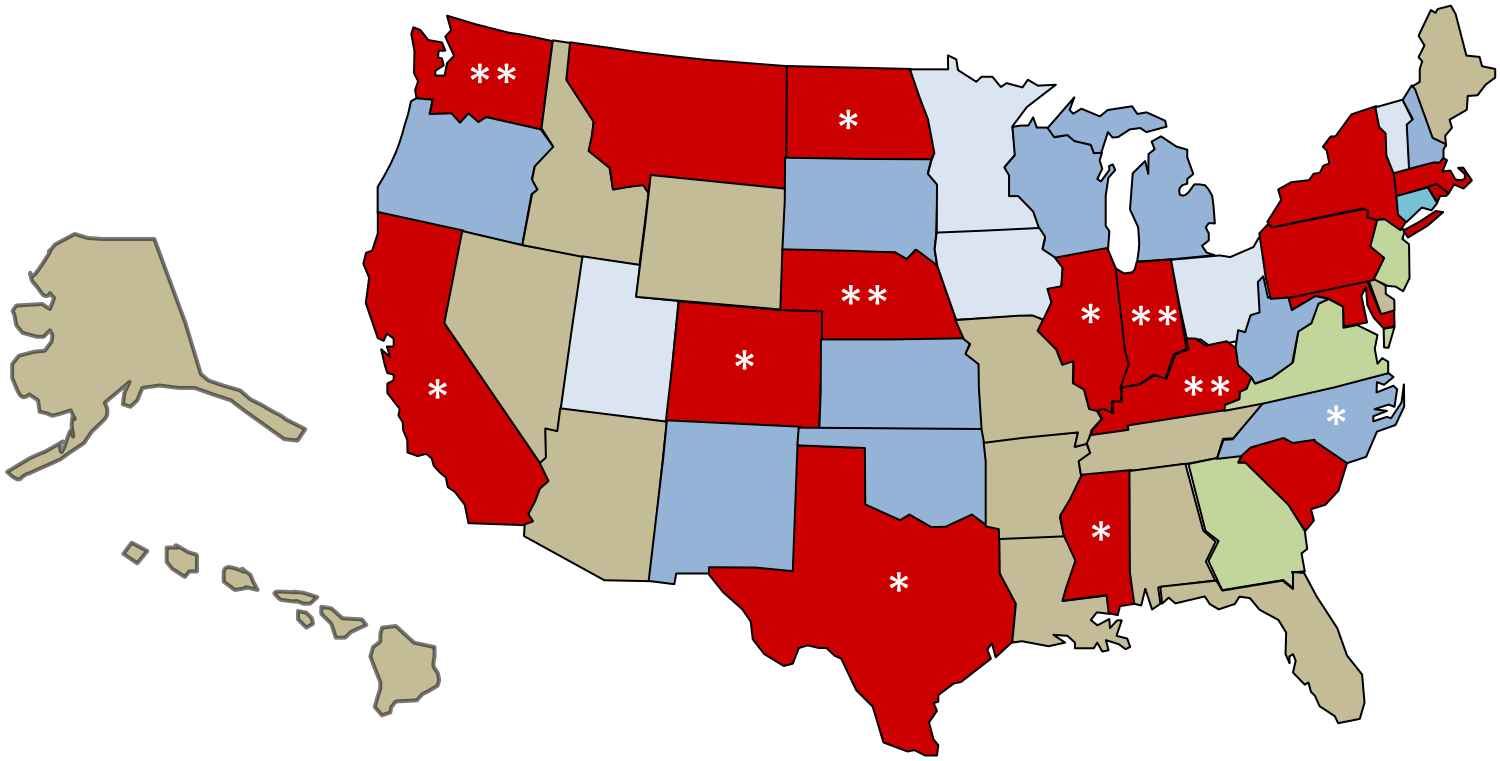
Comparison of State Medicaid Programs

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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Comparison of Most Recently Released Options

Description	MS-DRGs V.29 (CMS - Maintained by 3M)	APR-DRGs V.29 (3M and NACHRI)	APS-DRGs V.29 (OptumInsight, fmr Ingenix)
Intended Population	Medicare (age 65+ or under age 65 with disability)	All patient (based on the Nationwide Inpatient Sample)	All patient (based on the Nationwide Inpatient Sample)
Overall approach and treatment of complications and comorbidities (CCs)	Intended for use in Medicare Population. Includes 335 base DRGs, initially separated by severity into "no CC", "with CC" or "with major CC". Low volume DRGs were then combined.	Structure unrelated to Medicare. Includes 314 base DRGs, each with four severity levels. There is no CC or major CC list; instead, severity depends on the number and interaction of CCs.	Structure based on MS-DRGs but adapted to be suitable for an all-patient population. Includes 407 base DRGs, each with three severity levels. Same CC and major CC list as MS-DRGs.
Number of DRGs	746	1,256	1,223
Newborn DRGs	7 DRGs, no use of birth weight	28 base DRGs, each with four levels of severity (total 112)	9 base DRGs, each with three levels of severity, based in part on birth weight (total 27)

Source: Quinn, K, Courts, C. *Sound Practices in Medicaid Payment for Hospital Care*. CHCS: November 2010, updated with current information by Navigant.

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Psychiatric DRGs	9 DRGs; most stays group to "psychoses"	24 DRGs, each with four levels of severity (total 96)	10 base DRGs, each with three levels of severity (total 30)
Payment Use by Medicaid	MI, NH, NM, OK, OR, SD, TX, WI	**AZ, CA, CO**, **IL**, MA, MD, MT, **MS, ND**, NY, PA, RI, SC, **TX** **Under consideration in numerous other states**	None
Payment use by other payers	Commercial plan use	BCBSMA, BCBSTN	Commercial plan use
Other users	Medicare, hospitals	Hospitals, AHRQ, MedPAC, JCAHO, various state "report cards"	Hospitals, AHRQ, various state "report cards"
Uses in measuring hospital quality	Used as a risk adjustor in measuring readmissions. Used to reduce payment for hospital-acquired conditions.	Used as risk adjustor in measuring mortality, readmissions, complications. Can also be used to reduce payment for hospital-acquired conditions.	Used as risk adjustor in measuring mortality and readmissions and to reduce payment for hospital-acquired conditions

Source: Quinn, K, Courts, C. *Sound Practices in Medicaid Payment for Hospital Care*. CHCS: November 2010, updated with current information by Navigant.

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MS-DRG Applicability in Medicaid

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

Statistical Comparison of APR-DRGs vs. MS-DRGs

Florida Agency for Health Care Administration DRG Cost Correlation Analysis					
			Coefficient of Determination (R^2)		
Service Line	Discharges	CCR Cost	MS-DRG	APR-DRG	Difference
Burns	1,189	$ 23,110,651.29	0.36	0.40	0.04
Circulatory Adult	82,020	$ 945,172,942.35	0.55	0.54	(0.01)
Gastroent Adult	92,838	$ 922,920,434.91	0.36	0.39	0.03
HIV	9,806	$ 148,013,653.18	0.25	0.24	(0.00)
Mental Health	44,311	$ 138,770,929.85	0.04	0.10	0.06
Misc Adult	221,004	$ 2,683,836,822.60	0.48	0.48	0.01
Misc Pediatric	111,384	$ 937,396,060.88	0.27	0.33	0.06
Neonate	33,929	$ 928,497,892.57	0.23	0.51	0.27
Obstetrics	351,914	$ 1,282,741,557.30	0.18	0.26	0.08
Rehab	5,816	$ 79,216,742.90	0.14	0.15	0.01
Resp Adult	61,673	$ 599,158,744.51	0.31	0.32	0.01
Resp Pediatric	53,149	$ 290,755,802.11	0.25	0.27	0.02
Substance Abuse	7,643	$ 32,901,445.64	0.28	0.29	0.01
Transplant	449	$ 49,814,895.67	0.27	0.31	0.04
Trauma	7,785	$ 202,160,983.00	0.52	0.48	(0.05)
All	**1,084,910**	**$ 9,264,469,558.80**	**0.38**	**0.47**	**0.09**
Note: Normal Newborn claims removed from analysis, as a significant portion are not reported in current claims system.					

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Examples

= ([Est Hosp Loss] - [Outlier Thrshld]) * [Marg Cost Factor]

= [Hosp Base Rt] * [DRG Rel Wt] * [Policy Adj Factor]

DRG	Hospital Base Rate	DRG Relative Weight	Policy Adjustment Factor	DRG Base Payment	Estimated Hospital Cost	Estimated Hospital Loss	Outlier Payment	Final DRG Payment
123-4	$5,000	0.40	1.00	$2,000	$2,500	$500	$0	**$2,000**
432-1	$5,000	2.25	1.25	$14,063	$12,000	$0	$0	**$14,063**
678-4	$5,000	9.50	1.00	$47,500	$80,000	$32,500	$5,250	**$52,750**

= [Est Hosp Cost] - [DRG Base Pymt]

= [DRG Base Pymt] + [Outlier Pymt]

Notes:
- Examples for illustration purposes only
- Assuming outlier cost threshold equal to $25,000
- Assuming outlier mariginal cost percentage equal to 70%

Data Analyses

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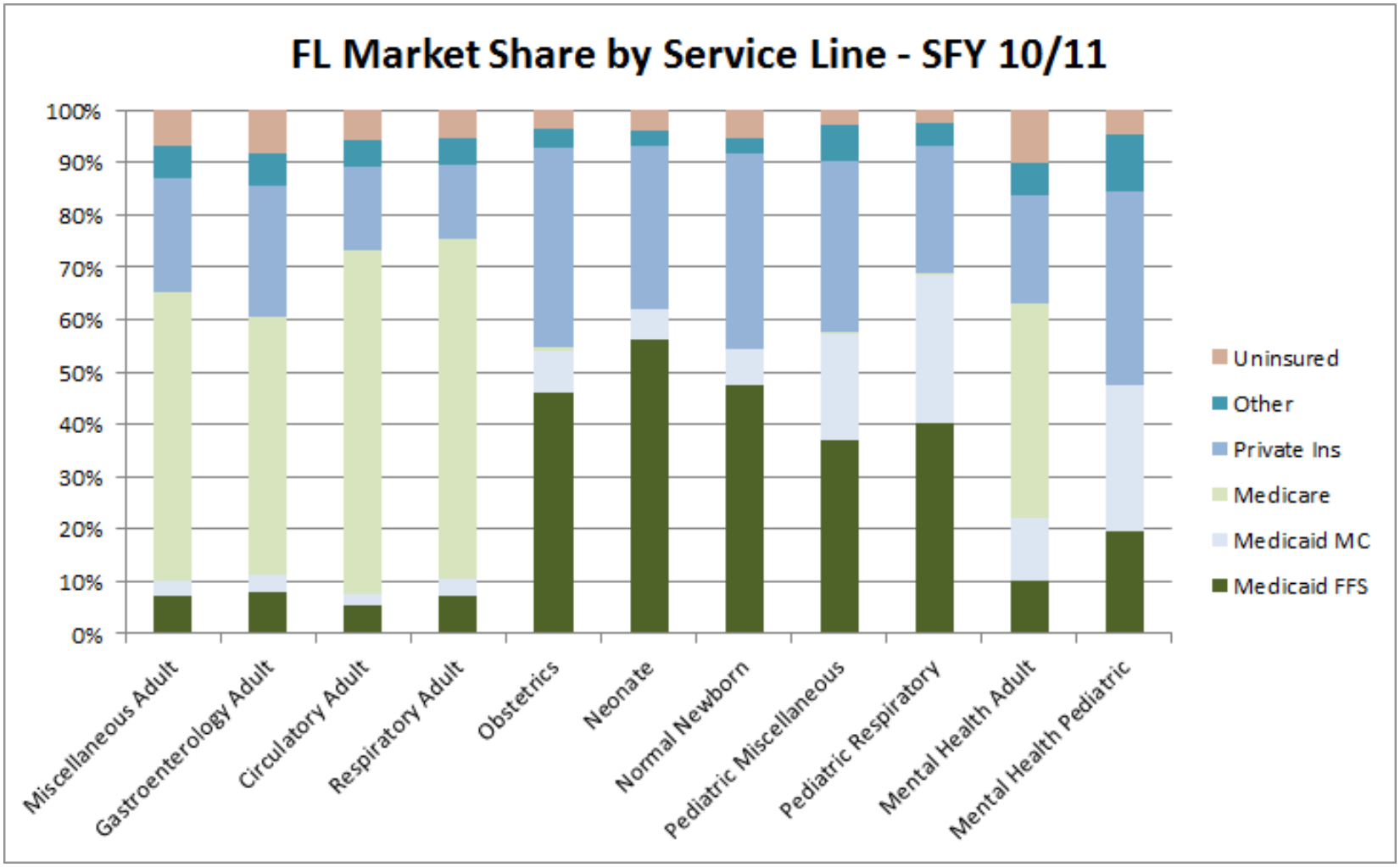
Florida Market Share by Service Line



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Florida Market Share by Service Line

Stays	Medicaid Fee for Service	Medicaid Managed Care	Medicare	Private Ins	Other	Unins	Total
Miscellaneous Adult	67,529	28,632	523,721	206,508	59,280	65,845	**951,515**
Gastroenterology Adult	25,415	10,218	158,303	79,649	19,537	27,167	**320,289**
Circulatory Adult	21,671	9,159	262,417	64,358	20,369	23,429	**401,403**
Respiratory Adult	16,239	7,282	145,077	31,450	11,424	12,439	**223,911**
Obstetrics	106,436	18,160	1,411	88,534	8,030	8,377	**230,948**
Neonate	15,448	1,571	13	8,623	840	1,038	**27,533**
Normal Newborn	87,826	12,272	93	69,164	5,660	9,663	**184,678**
Pediatric Miscellaneous	30,363	16,780	266	27,191	5,516	2,399	**82,515**
Pediatric Respiratory	12,817	8,992	24	7,723	1,467	752	**31,775**
Mental Health Adult	9,171	10,849	36,791	18,621	5,550	9,152	**90,134**
Mental Health Pediatric	1,958	2,751	7	3,704	1,059	475	**9,954**
Total	**394,873**	**126,666**	**1,128,123**	**605,525**	**138,732**	**160,736**	**2,554,655**

Notes:

1) Source is Florida all-payer dataset, state fiscal year 2010/2011

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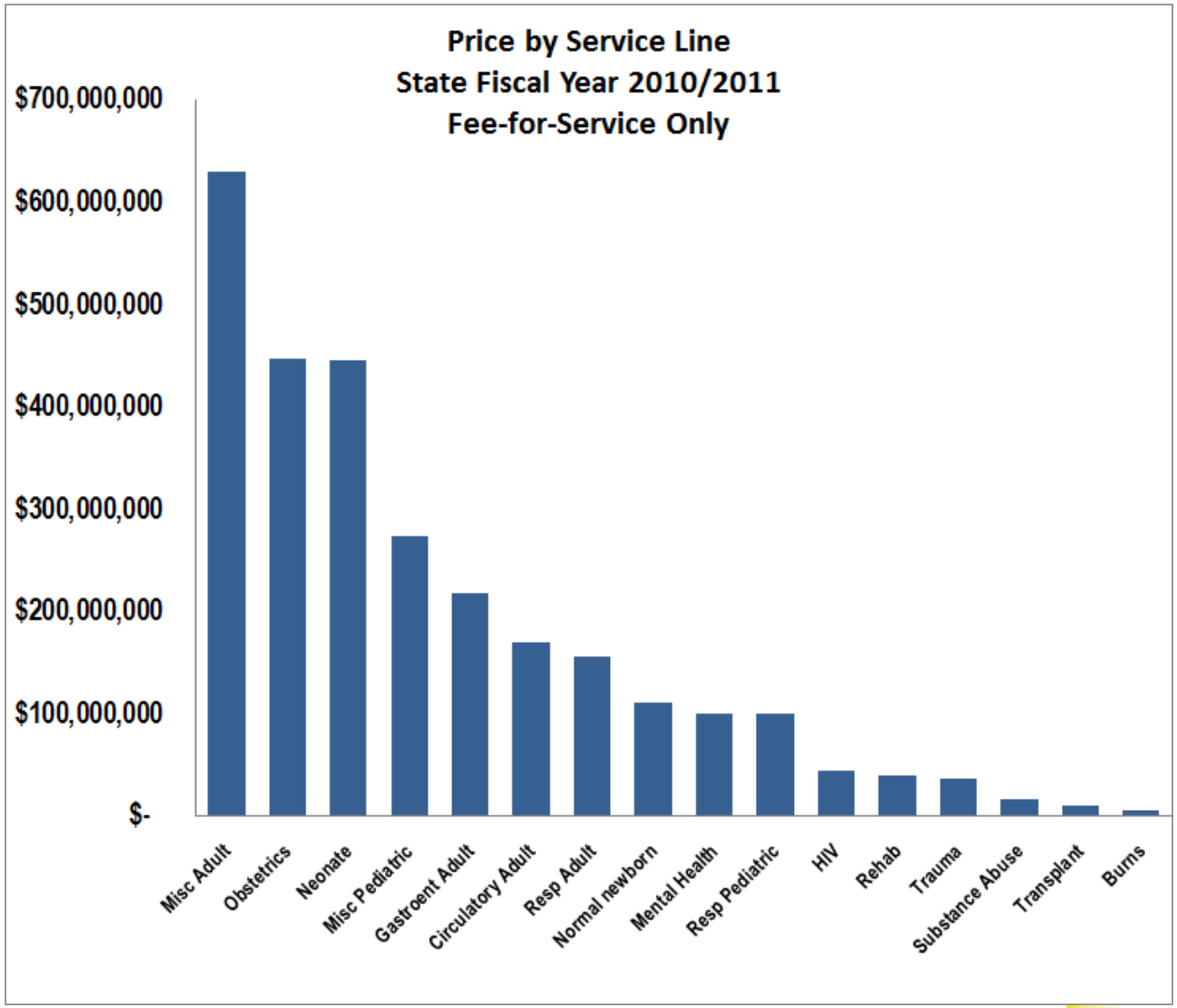
Historical Payments by Service Line



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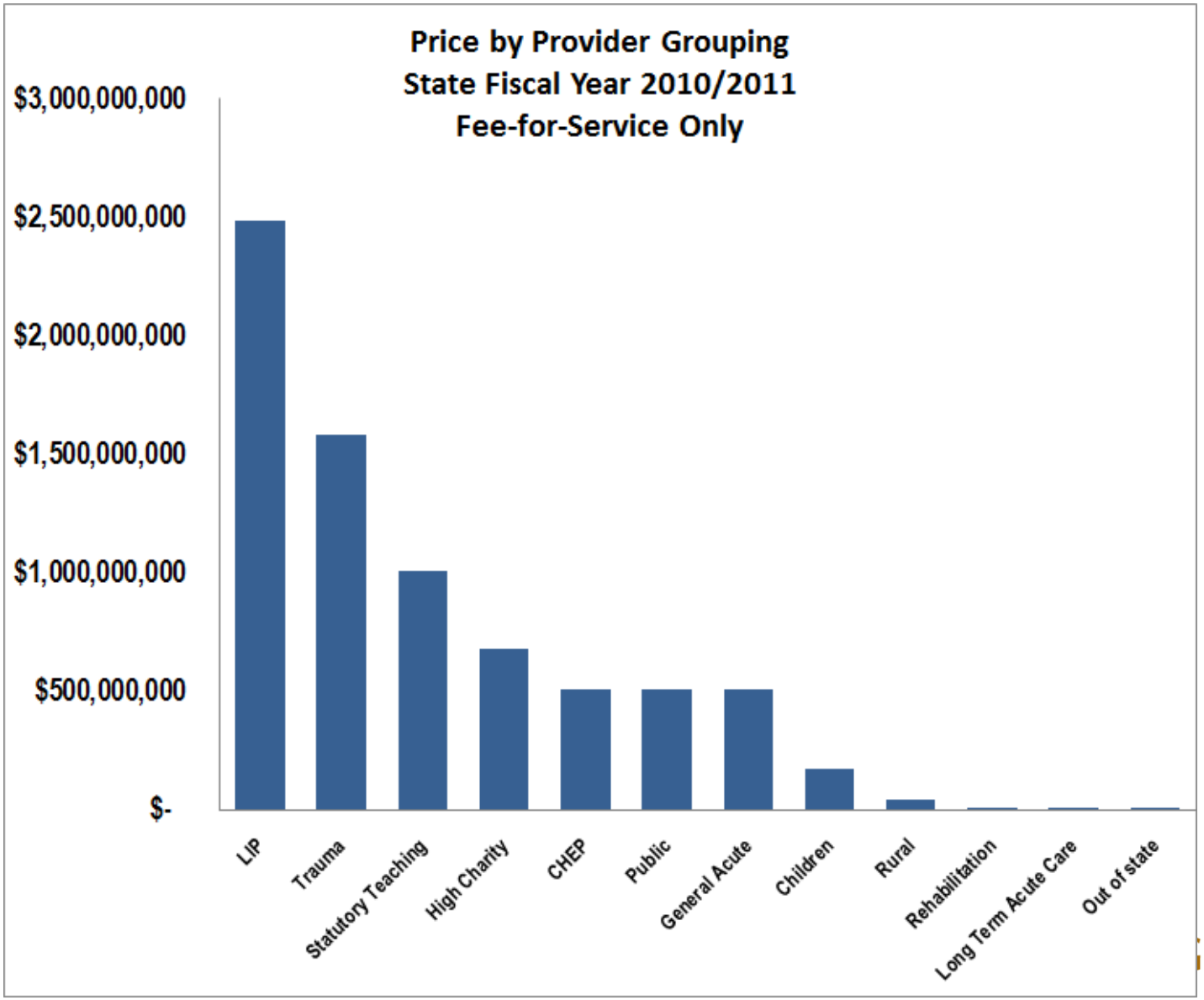
Historical Payments by Provider Category



Considerations for LIP Program

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Considerations for LIP Program

- System will be designed to be budget neutral in the aggregate, but it is expected that payments to individual hospitals will change –
- Increases and decreases will impact upper payment limit "gap" by class of hospital, which may change the level of funding that can be federally matched under the LIP program
  - ✓ Hospital classes for purposes of UPL determination are (1) state owned, (2) non-state government owned and (3) privately owned
  - ✓ Total payments to a class, in the aggregate, may not exceed a reasonable estimate of what Medicare would have paid for the same services

Considerations for LIP Program

- It will be necessary to determine new UPLs under the new DRG-based payment system
  - ✓ It may be necessary to redirect LIP funding to hospitals to maintain compliance with federal UPL rules in order to maintain federal match for the program
- Similarly, individual hospital limits (OBRA limits, or DSH limits) must also be considered
  - ✓ It may be necessary to redirect LIP funding to hospitals to maintain compliance with federal OBRA/DSH payment limits

Preliminary Recommendations

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Preliminary Recommendations

Design Consideration	Preliminary Recommendation
DRG Grouper	• APR-DRGs
DRG Relative Weights	• Adopt national weights
Hospital Base Rates	• Two standardized amounts – one for rural hospitals, the second for all other hospitals • Adjust standardized base rate using Medicare wage indices • Base rates used to distribute funds from general revenue and Public Medical Assistance Trust Fund
Per-Claim Add-On Payments	• Used to distribute the IGT funds paid on a per-claim basis today

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Preliminary Recommendations

Design Consideration	Preliminary Recommendation
Targeted Policy Adjustors	• Recommendations are more valuable based on results of payment simulations • Consider service and/or age adjustors for services where Medicaid has the greatest influence
Outlier Payment Policy	• Adopt “Medicare-like” stop-loss model • Include a single threshold amount • Incorporate symmetrical “high-resource” and “low-resource” outlier policies
Transfer Payment Policy	• Adopt “Medicare-like” model for acute transfers • Do not include a post-acute transfer policy
Partial Eligibility	• Include, with calculations similar to those used in the transfer policy

Preliminary Recommendations

Design Consideration	Preliminary Recommendation
Charge Cap	• Exclude and use hospital gain outlier adjustment instead
Interim Claims	• Do not allow
Adjustment for Expected Coding and Documentation Improvements	• Necessary • Further discussions needed to define details
Transition Period	• Will likely be necessary • Payment simulations needed before defining details
Payment Adjustments for Differing Provider Cost Structures	• Handled through per-claim add-on payments funded by IGTs • Only exception is rural hospitals who may be given a different standardized hospital base rate

Preliminary Recommendations

Design Consideration	Preliminary Recommendation
45 Day Benefit Limit	• Apply the limit for new admissions • Do not adjust payment for limits reached during an inpatient stay
Prior Authorizations	• Remove length of stay limitations for admissions that will be reimbursed under the DRG method (excludes psychiatric and rehabilitation stays)
Payment for Specialty Services (Psychiatric, Rehabilitation, Other)	• Pay psychiatric and rehabilitation services via a per diem method when performed in free-standing facilities and distinct part units • Adjust per diem based on patient acuity measured via DRGs • Pay the same per diem for each day of psychiatric stays – no graduated payments

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Discussion & Questions

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