Florida Agency for Health Care Administration

DRG Payment Implementation

Project Status

November 14, 2012
Presentation by MGT of America, Inc. and Navigant Consulting, Inc.

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Meeting Agenda

Agenda
Activity in DRG Project to Date
Preliminary Design Decisions
Characteristics of Latest Simulation
Timing of Final Rates for State Fiscal Year 2013/2014

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DRG Design not Yet Finalized

All decisions, parameters, and results listed in this presentation are preliminary. Final decisions have not been made.

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Activity in DRG Project to Date

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Activity in DRG Project to Date

- DRG Governance Committee has met 4 times
- 3 public meetings held, and fourth scheduled for Thursday 11/15
- Simulation dataset finalized
- 7 Pricing simulations have been run
- Preliminary decisions made on nearly every design consideration
- Draft requirements document for changes to Florida Medicaid Management Information System created

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Preliminary Design Decisions

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Preliminary Design Decisions

Design Consideration	Preliminary Decision
DRG Grouper	• APR-DRGs (version 30, released 10/1/2012)
DRG Relative Weights	• National weights re-centered to 1.0 for Florida Medicaid
Hospital Base Rates	• One standardized amounts • 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 • Two add-ons per claim, one for automatic IGTs another for self-funded IGTs

Preliminary Recommendations

Design Consideration	Preliminary Decision

Targeted Policy Adjustors	• Service adjustor for obstetrics
	• Provider adjustors for:
	  o Rural hospitals
	  o Free-standing LTAC hospitals
	  o Free-standing rehab hospitals
	  o High Medicaid and high outlier hospitals

Outlier Payment Policy	• Adopt “Medicare-like” stop-loss model • Include a single threshold amount • Leaning towards no provider gain outlier policy
Transfer Payment Policy	• Adopt “Medicare-like” model for acute transfers • Discharge statuses applicable to acute transfer policy = 02, 05, 65, 66 • Do not include a post-acute transfer policy

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Preliminary Recommendations

Design Consideration	Preliminary Decision
Charge Cap	• Leaning towards including a charge cap instead of a hospital gain outlier adjustment
Interim Claims	• Do not allow
Adjustment for Expected Coding and Documentation Improvements	• Necessary • Further discussions needed to define details
Transition Period	• None
Non-Covered Days o 45 Day Benefit Limit o Undocumented non-citizens	• Prorate payment based on number of covered days versus total length of stay

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Preliminary Recommendations

Design Consideration	Preliminary Recommendation
Partial Eligibility	• Prorate payment based on number of eligible days versus total length of stay
Prior Authorizations	• Remove length of stay limitations for admissions that will be reimbursed under the DRG method • Only exception will be recipients who have reached 45 day benefit limit and recipients who are undocumented non-citizens
Payment for Specialty Services (Psychiatric, Rehabilitation, Other)	• Psychiatric, rehabilitation, and long term care stays included in DRG payment • Stays at state psychiatric facilities excluded from DRG payment • Transplants currently paid via global fee excluded from DRG payment • Newborn hearing test paid in addition to DRG payment

Characteristics of Latest Simulation

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Policy / Design Decisions

- Separate provider policy adjustors as follows:
  - Rural hospitals - set to 85% of cost
  - LTACs - set to 60% of cost
  - Rehab hospitals - set to 60% of cost
  - High Medicaid utilization high outlier adjustor – set to 86% of cost
- Service adjustor for obstetrics – goal of 85% of cost
- IGT payments are casemix adjusted by provider
- A low-side outlier policy is in place and is symmetrical with the high side outlier (considering changing to a charge cap in future simulations)
- Outlier threshold is $27,425
- Outlier marginal cost percentage is 80%

Casemix Adjusting Payments of IGT Funds - Example

- Example provider receiving $5M from IGT funds during the year
- Example provider's overall casemix is 0.6
- Example provider has 2,500 stays in a year

- Average per discharge IGT add-on payment equals,

  $5M / 2,500 = $2,000

- For a claim with casemix equal to 0.75,

  Per-claim IGT Pymt = $2,000 * (0.75 / 0.6)
  = $2,500

- Separate claim with casemix equal to 0.3,

  Per-claim IGT Pymt = $2,000 * (0.3 / 0.6)
  = $1,000

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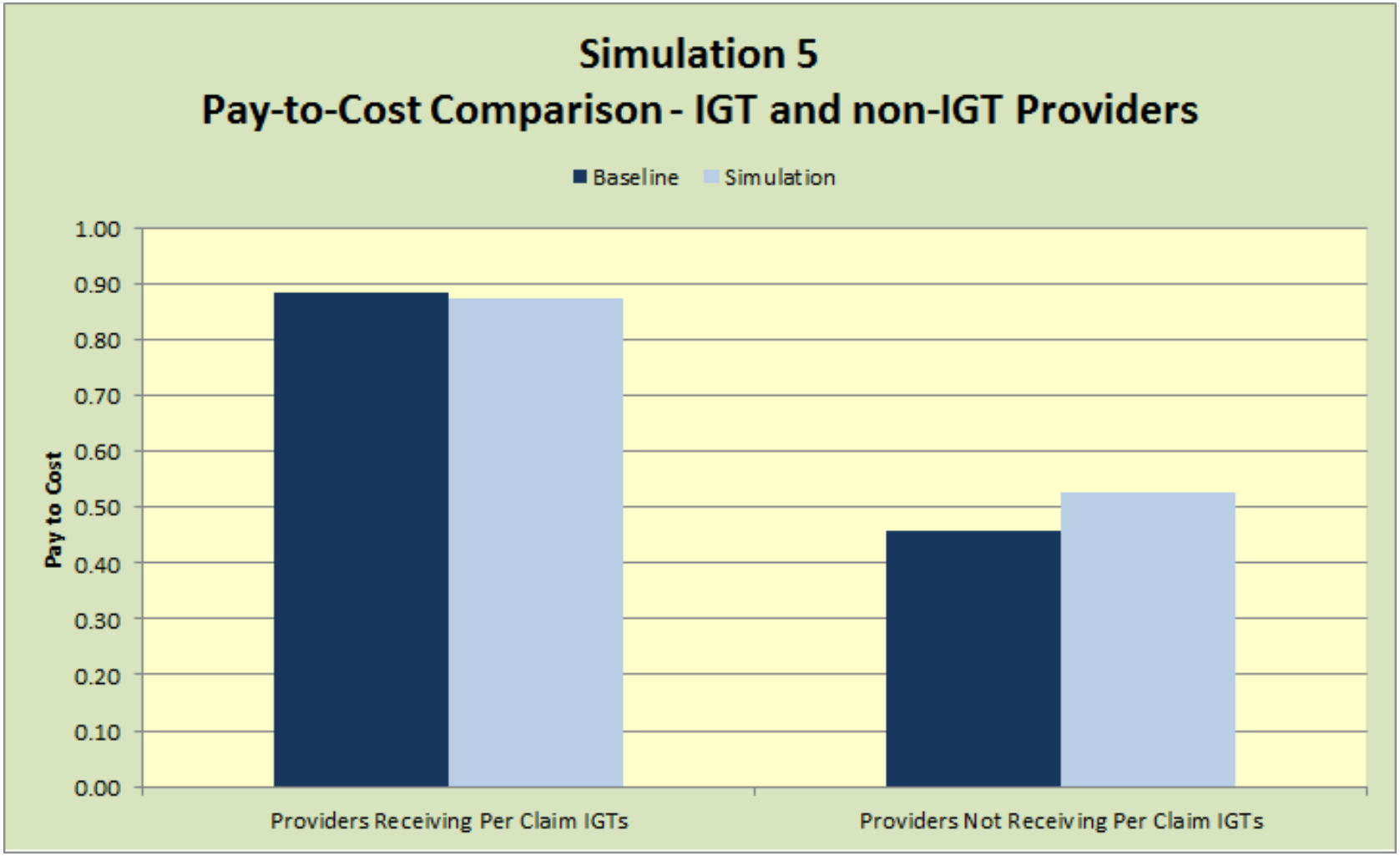
Pay-to-Cost Comparison – IGT vs. non-IGT Providers



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Timing of Final Rates for State Fiscal Year 2013/2014

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Timing of Final Rates for State Fiscal Year 2013/2014

- Goal is completion by January 1, 2013
- Adjustments to dataset:
  - Apply rate changes and IGT funding level changes (either those from SFY 12/13 or those predicted for 13/14
  - Apply inflation factor to charges from SFY 10/11 to 13/14 (used in calculation of estimated cost)
  - Apply most current AHCA cost-to-charge ratios
  - Apply FFY 2013 Medicare wage indices

Questions and Discussion

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