Florida Agency for Health Care Administration

DRG Update for LIP Council

January 9, 2013
Presentation by MGT of America, Inc. and Navigant Consulting, Inc.

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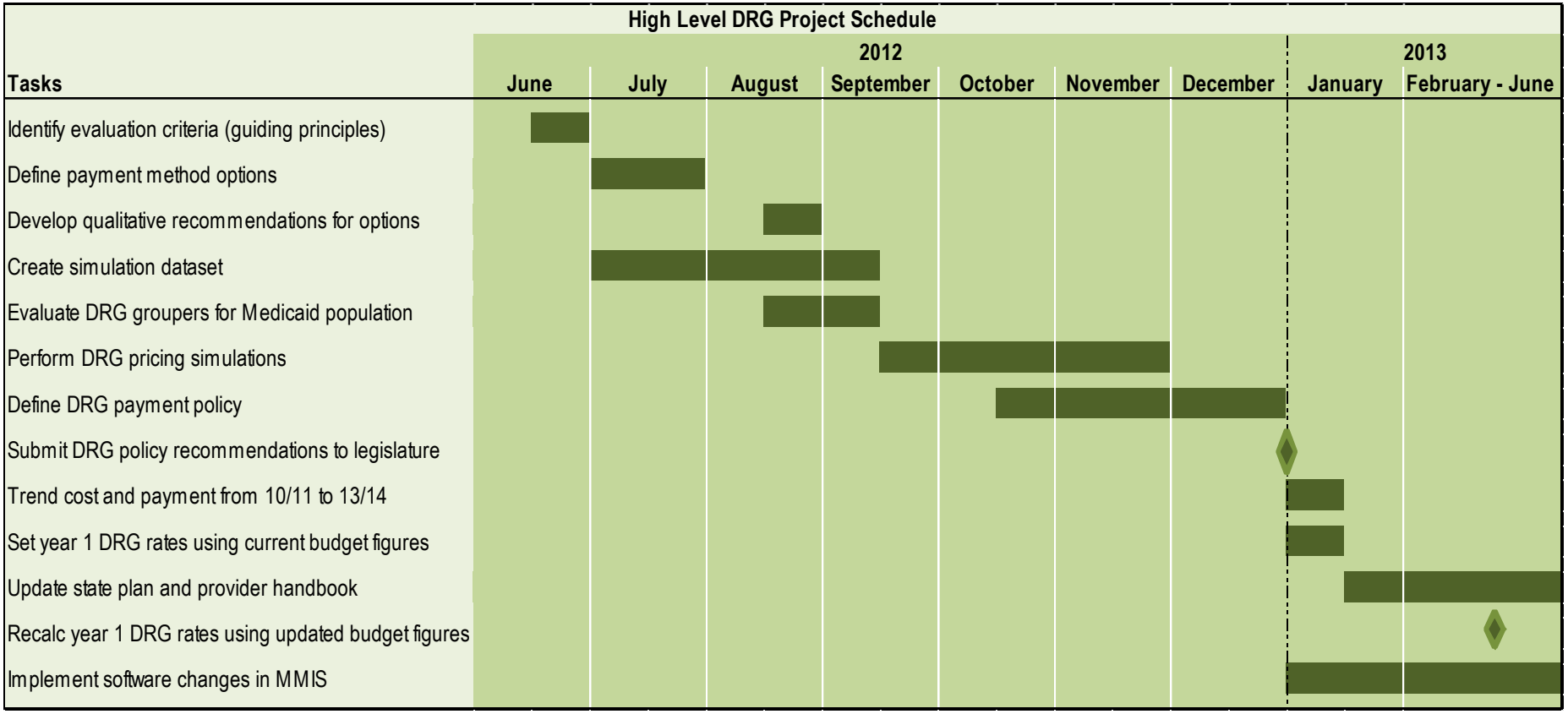
Project Plan



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Key Policy Design / Implementation Decisions

Design Consideration	Decision
Hospital Base Rates	• One standardized amount • No wage area adjustment • 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 • Casemix adjust both supplemental IGT payments on each claim by multiplying the hospital's average per stay IGT payments times (the DRG relative weight / the hospital's casemix)

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Key Policy Design / Implementation Decisions

Design Consideration	Decision
Policy Adjustors	• Rehabilitation services • Rural hospitals • Free-standing long term acute care (LTAC) hospitals • High Medicaid utilization and high outlier hospitals (more than 50% Medicaid utilization – FFS and MC, and more than 30% payments in the form of outliers)
Transition Period	• None

Payment Adjustment for Casemix Difference between Simulation Data and First Year of Implementation	• 7.5% total
	  ○ 1.5% real casemix
	  ○ 6% documentation and coding improvement

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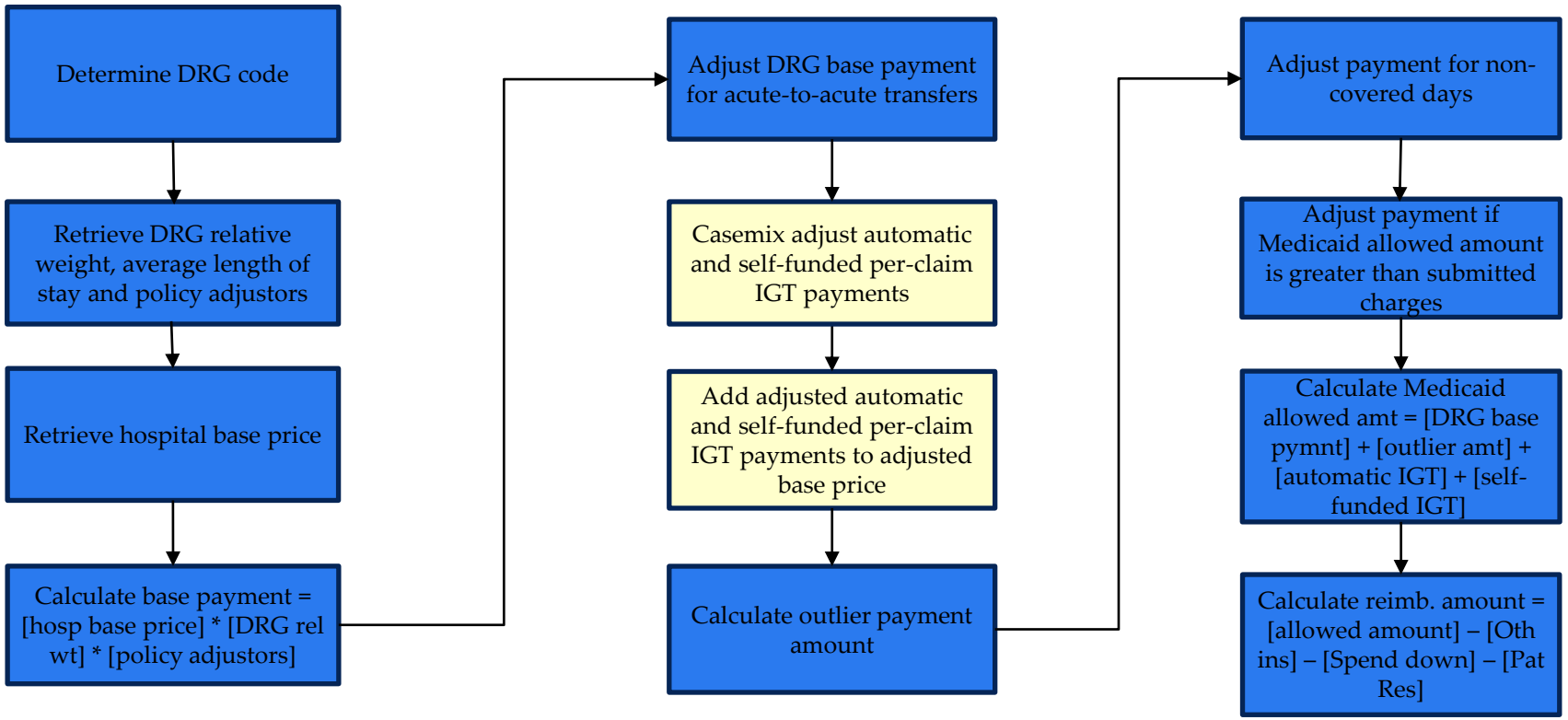
DRG Pricing Calculation



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Cost

Cost

- Applied a single multiplier to all claims to increase the estimated cost values from the midpoint of SFY 10/11 to the midpoint of SFY 12/13
- Used Global Insight healthcare market basket indices to determine inflation factor
- Value used was 1.07769

Payments

Payments

1. Started with 2012/2013 per diem rates
2. Applied 2% inflationary increase to state share
3. Added $50 million to self-funded IGT amounts
4. Multiplied full historical allowed amount by the percentage change in per diem rate applicable to each provider (For example, if a provider's per diem increased by 10% between 10/11 and 13/14, then all the provider's historical allowed amounts were increased by 10%.)
5. Multiplied this new adjusted allowed amount by 2013/2014 percentages for state share, automatic IGTs, and self-funded IGTs
6. Made small additional increase to align with projections made at November 2012 Social Services Estimating Conference

Payments, cont'd

Inpatient Reimbursement Estimates for 2013/2014				
	Baseline Payment From GR and PMATF	Baseline Payment From Automatic IGTs	Baseline Payment From Self-Funded IGTs	Total
Estimating conf nbrs for 2013/2014 *	$ 1,975,206,378	$ 622,159,318	$ 762,775,396	$ 3,360,141,092
Estimate 13/14 minus 10.5% **	$ 1,767,809,708	$ 556,832,590	$ 682,683,980	$ 3,007,326,277
Minus addition 3% to align with simul dataset	$ 1,714,775,417	$ 540,127,612	$ 662,203,460	$ 2,917,106,489
Simul dataset nbrs for 13/14 after steps 1 - 5 ***	$ 1,627,975,470	$ 516,136,317	$ 600,396,850	$ 2,744,508,638
Short fall in simulation dataset	$ 86,799,947	$ 23,991,295	$ 61,806,610	$ 172,597,851
Simul dataset nbrs for 13/14 after step 6 ***	$ 1,714,775,417	$ 540,127,612	$ 662,203,460	$ 2,917,106,489
Notes:				
* From November 2012 Social Services Estimating Conference				
** 10.5% more Medicaid days estimate in 2013/2014 than in 2010/2011; 1,811,047 ==> 2,001,336				
*** Referring to steps on previous slide				

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Pay-to-Cost Figures for Policy Adjustors

Category	2010/2011	Goal, 2010/2011 Simulations	2013/2014 Estimate*	Goal, 2013/2014 Simulations
Florida Medicaid, overall	91%	91%	88%	88%
Rural hospitals	98%	98%	114%	100%
LTAC hospitals	66%	66%	61%	65%
Rehabilitation hospitals	54%	60%	46%	50%
High Medicaid utilization and high outlier percentage hospitals (free-standing children's hospitals)	97%	95%	99%	95%
Obstetric services	104%	>= 91%	99%	>= 88%

* Costs inflated; payments calculated using 2012/2013 per diem rates, then increased slightly to align with projections presented at November 2012 SSEC

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Final Rates (Simulation 17)*

Parameter	Value*	Goal
Hospital base rate	$ 3,230.64	Budget neutrality for the Medicaid program
Rural provider adjustor	1.733	Pay-to-cost ratio of 100%
LTAC provider adjustor	1.633	Pay-to-cost ratio of 65%
High Medicaid utilization and high outlier provider adjustor	1.762	Pay-to-cost ratio of 95%
Rehabilitation service adjustor	1.30	Free-standing rehab pay-to-cost of 50%
Outlier threshold	$ 31,000	Overall outlier payment percentage between 5 and 10%
Outlier marginal cost factor	80%	Overall outlier payment percentage between 5% and 10%

* All rates subject to change based on updates from the Social Services Estimating Conference and direction from legislature.

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Calculation of Budget Goals by Provider Category

	A	B	C	D	E	F	G	H	I
	Provider Classification	Stays	Baseline Payment From GR and PMATF	Baseline Payment From Automatic IGTs	Baseline Payment From Self-Funded IGTs	Estimated Cost	Percentage of Cost Goal	Total Budget Goal with IGTs	DRG Reimbursement from GR and PMATF
1	Rural	11,140	$ 50,266,032	$ 6,556,021	$ 303,015	$ 50,108,442	100%	$ 50,108,442	**$ 43,249,407**
2	LTAC	86	$ 1,365,292	$ -	$ 283,076	$ 2,688,734	65%	$ 1,747,677	**$ 1,464,601**
3	High Medicaid & High Outlier	9,229	$ 142,780,176	$ 45,760,831	$ 1,864,429	$ 190,763,390	95%	$ 181,225,220	**$ 133,599,960**
4	All Other	397,552	$1,520,363,917	$487,810,761	$ 659,752,940	$3,079,379,988			**$1,536,461,450**
5									
6	**Totals:**	418,007	$1,714,775,417	$540,127,612	$ 662,203,460				
7									
8				Total Budgeted Payment:	$ 2,917,106,490				

Notes:

1) For rural, LTAC, and high-Medicaid-high-outlier hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals a percentage of estimated cost minus any per-claim payments being made via IGTs. For example, I1 = [H1 - (D1 + E1)].

2) For "All Other" hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals the total historical allowed amount from GR and assessment minus the total planned DRG reimbursement from GR and assessment for rural, LTAC, and high-Medicaid-high-outlier hospitals. I4 = [C6 - (I1 + I2 + I3)].

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Summary by Service Line - Total

Simulation 17 Summary of Simulation by Service Line												
Service Line	Stays	Casemix Recentered	Casemix DCI	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
Misc Adult	72,745	1.70	1.83	$ 1,049,338,607	$ 758,939,658	$ 860,110,424	$ 101,170,765	13%	72%	82%	$ 73,775,242	9%
Neonate	11,641	4.10	4.41	$ 382,962,880	$ 460,717,205	$ 372,611,823	$ (88,105,382)	-19%	120%	97%	$ 58,184,376	16%
Obstetrics	111,700	0.57	0.62	$ 463,395,877	$ 457,674,917	$ 408,328,621	$ (49,346,296)	-11%	99%	88%	$ 2,624,619	1%
Pediatric	46,320	1.11	1.19	$ 419,469,726	$ 402,818,179	$ 407,201,120	$ 4,382,941	1%	96%	97%	$ 46,299,537	11%
Gastroent Adult	27,910	1.34	1.44	$ 315,005,545	$ 226,189,382	$ 242,541,742	$ 16,352,359	7%	72%	77%	$ 12,795,008	5%
Circulatory Adult	24,525	1.69	1.81	$ 323,051,525	$ 176,606,751	$ 267,428,406	$ 90,821,655	51%	55%	83%	$ 13,902,964	5%
Resp Adult	18,092	1.31	1.40	$ 198,943,694	$ 162,254,933	$ 153,613,165	$ (8,641,768)	-5%	82%	77%	$ 9,628,006	6%
Normal newborn	90,713	0.16	0.18	$ 80,677,975	$ 113,891,255	$ 94,444,109	$ (19,447,146)	-17%	141%	117%	$ 1,180,581	1%
Mental Health	12,442	0.68	0.73	$ 43,551,130	$ 104,004,283	$ 49,897,929	$ (54,106,355)	-52%	239%	115%	$ 255,998	1%
Rehab	1,787	1.92	2.07	$ 27,785,993	$ 42,432,034	$ 24,782,163	$ (17,649,871)	-42%	153%	89%	$ 697,808	3%
Transplant Pediatric	51	14.60	15.69	$ 11,402,025	$ 7,036,233	$ 10,383,257	$ 3,347,024	48%	62%	91%	$ 4,109,176	40%
Transplant Adult	81	10.49	11.27	$ 7,355,577	$ 4,541,658	$ 6,795,925	$ 2,254,268	50%	62%	92%	$ 707,303	10%
Total	**418,007**	**1.00**	**1.075**	**$ 3,322,940,554**	**$ 2,917,106,490**	**$ 2,898,138,683**	**$ (18,967,807)**	**-1%**	**88%**	**87%**	**$ 224,160,618**	**8%**

Notes:
1) "Transplant" includes only those cases paid per diem, not through the global period.
2) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011 then inflated to midpoint of 2013/2014.

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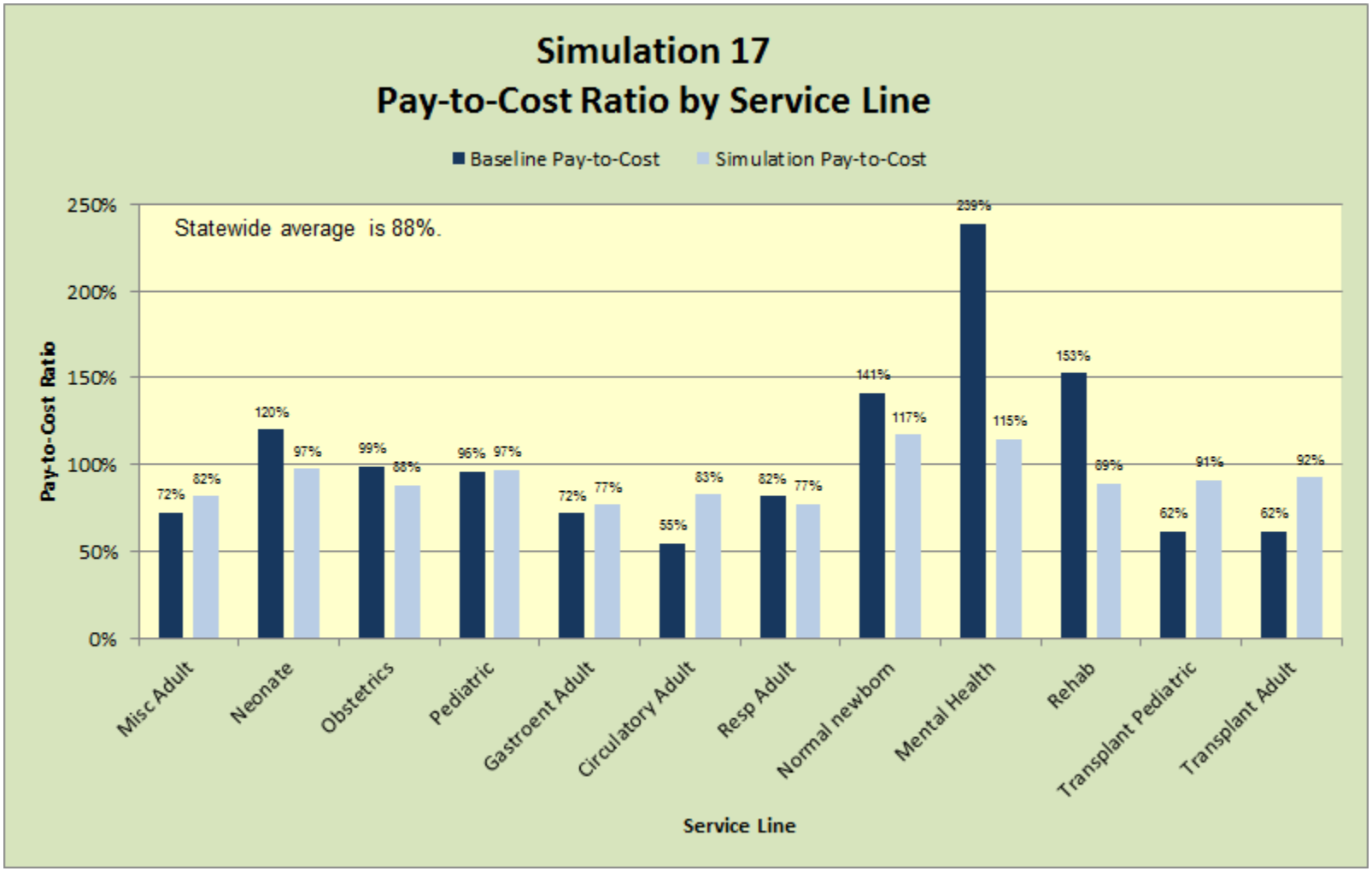
Pay-to-Cost by Service Line - Total



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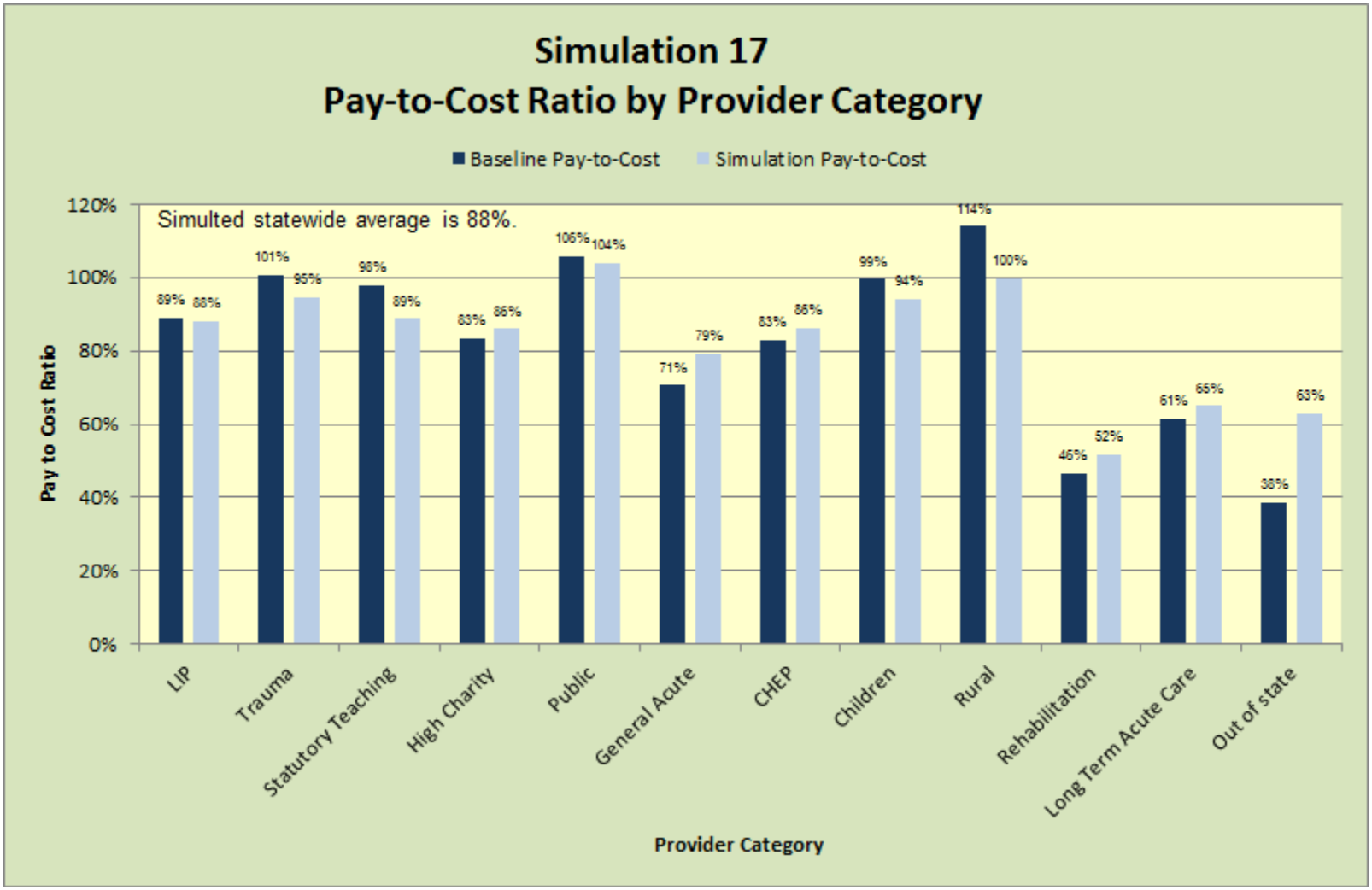
Summary by Provider Category

Simulation 17 Summary of Simulation by Provider Category												
Provider Category	Stays	Casemix Recentered	Casemix DCI	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
LIP	404,620	0.99	1.07	$ 3,211,965,823	$ 2,860,291,083	$ 2,826,600,355	$ (33,690,727)	-1%	89%	88%	$ 217,492,088	8%
Trauma	167,942	1.19	1.28	$ 1,719,730,833	$ 1,730,385,472	$ 1,626,314,308	$ (104,071,163)	-6%	101%	95%	$ 149,525,983	9%
Statutory Teaching	98,530	1.19	1.28	$ 1,089,986,603	$ 1,067,045,755	$ 967,357,200	$ (99,688,555)	-9%	98%	89%	$ 93,386,255	10%
High Charity	112,464	0.91	0.98	$ 788,454,451	$ 657,824,339	$ 678,185,504	$ 20,361,166	3%	83%	86%	$ 44,582,831	7%
Public	76,884	0.96	1.03	$ 555,580,178	$ 587,410,570	$ 577,475,907	$ (9,934,664)	-2%	106%	104%	$ 32,244,987	6%
General Acute	123,619	0.88	0.94	$ 741,748,703	$ 523,577,680	$ 588,367,061	$ 64,789,382	12%	71%	79%	$ 30,268,415	5%
CHEP	75,786	1.01	1.09	$ 573,978,730	$ 475,370,010	$ 494,713,908	$ 19,343,899	4%	83%	86%	$ 33,861,041	7%
Children	9,263	1.79	1.93	$ 191,573,836	$ 190,581,597	$ 180,245,623	$ (10,335,975)	-5%	99%	94%	$ 35,439,967	20%
Rural	11,140	0.66	0.71	$ 50,108,442	$ 57,125,068	$ 49,945,678	$ (7,179,390)	-13%	114%	100%	$ 391,489	1%
Rehabilitation	525	1.85	1.99	$ 8,428,885	$ 3,915,175	$ 4,343,021	$ 427,846	11%	46%	52%	$ 201,899	5%
Long Term Acute Care	86	2.87	3.09	$ 2,688,734	$ 1,648,369	$ 1,747,615	$ 99,246	6%	61%	65%	$ 116,898	7%
Out of state	412	1.22	1.31	$ 2,792,935	$ 1,074,871	$ 1,757,629	$ 682,758	64%	38%	63%	$ 25,840	1%

Notes:
1) Providers may be included in more than one category.
2) "High Charity" is any hospital with 11% or more market share from Medicaid and uninsured recipients.
3) "General Acute" hospitals are those not otherwise categorized as Childrens, CHEP, High Charity, LTAC, Out of state, Rehab, Rural, Teaching or Trauma.
4) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011 then inflated to midpoint of 2013/2014.

Pay-to-Cost by Provider Category



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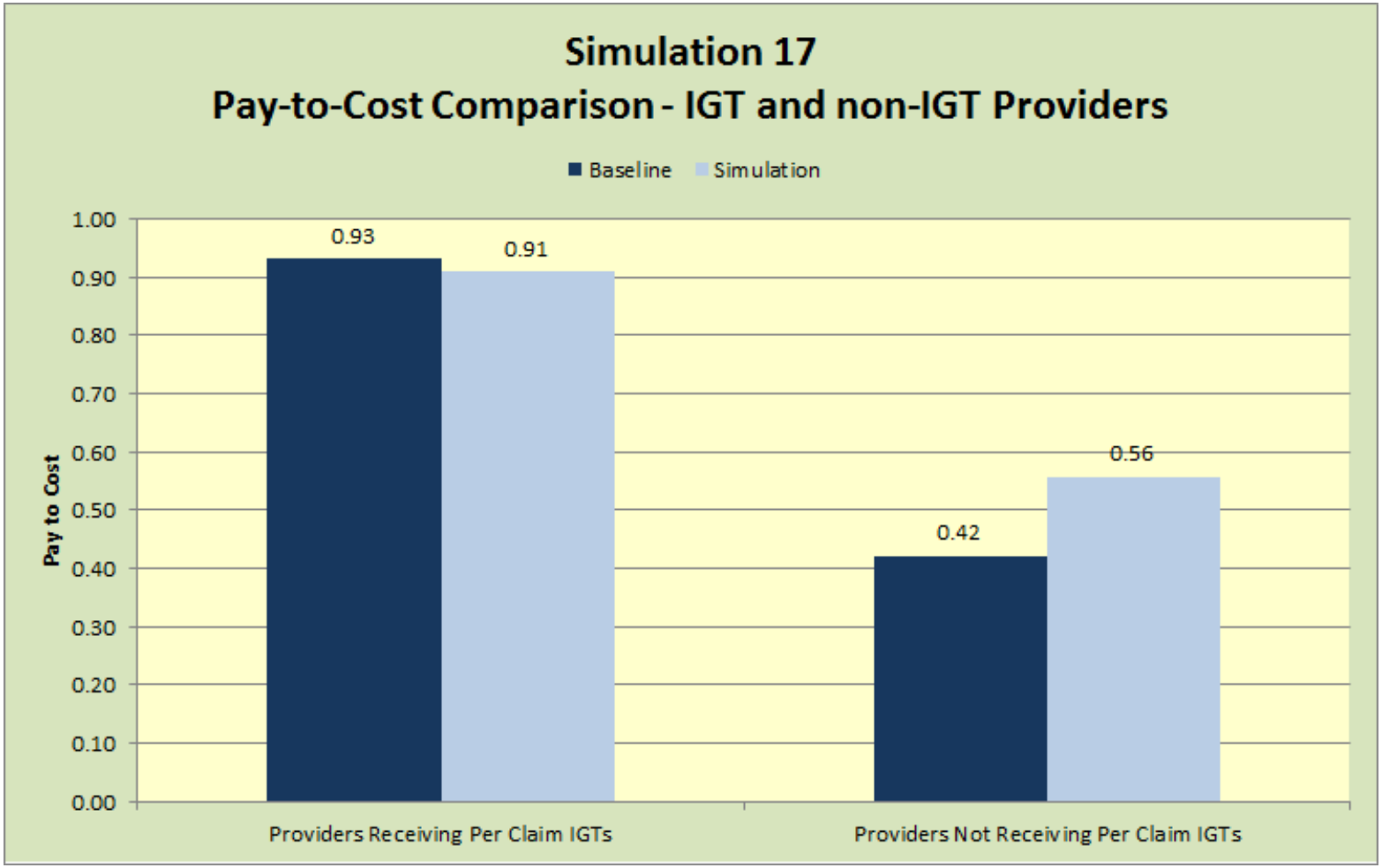
Pay-to-Cost Comparison – IGT vs. non-IGT Providers



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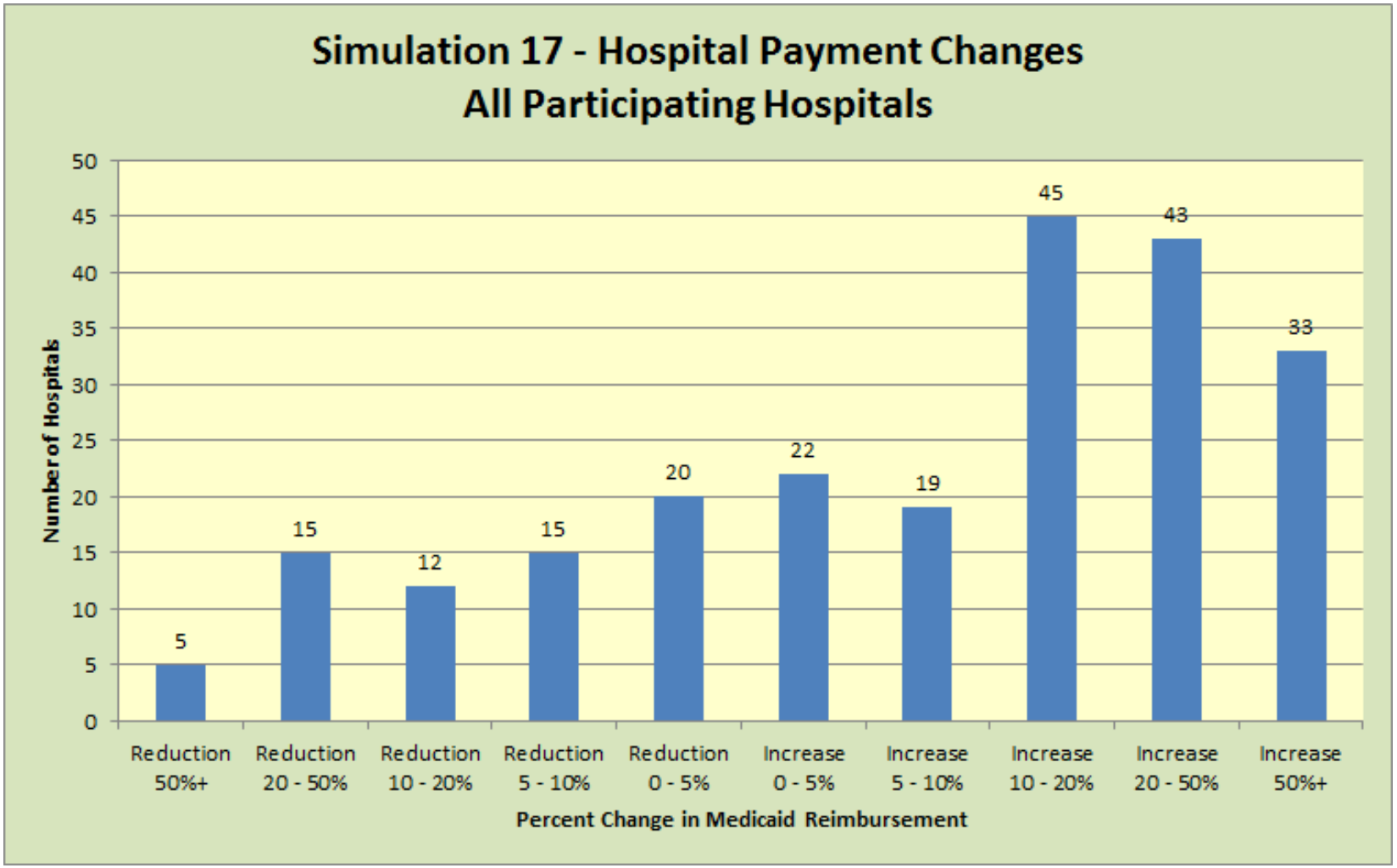
Provider Impact – All Hospitals



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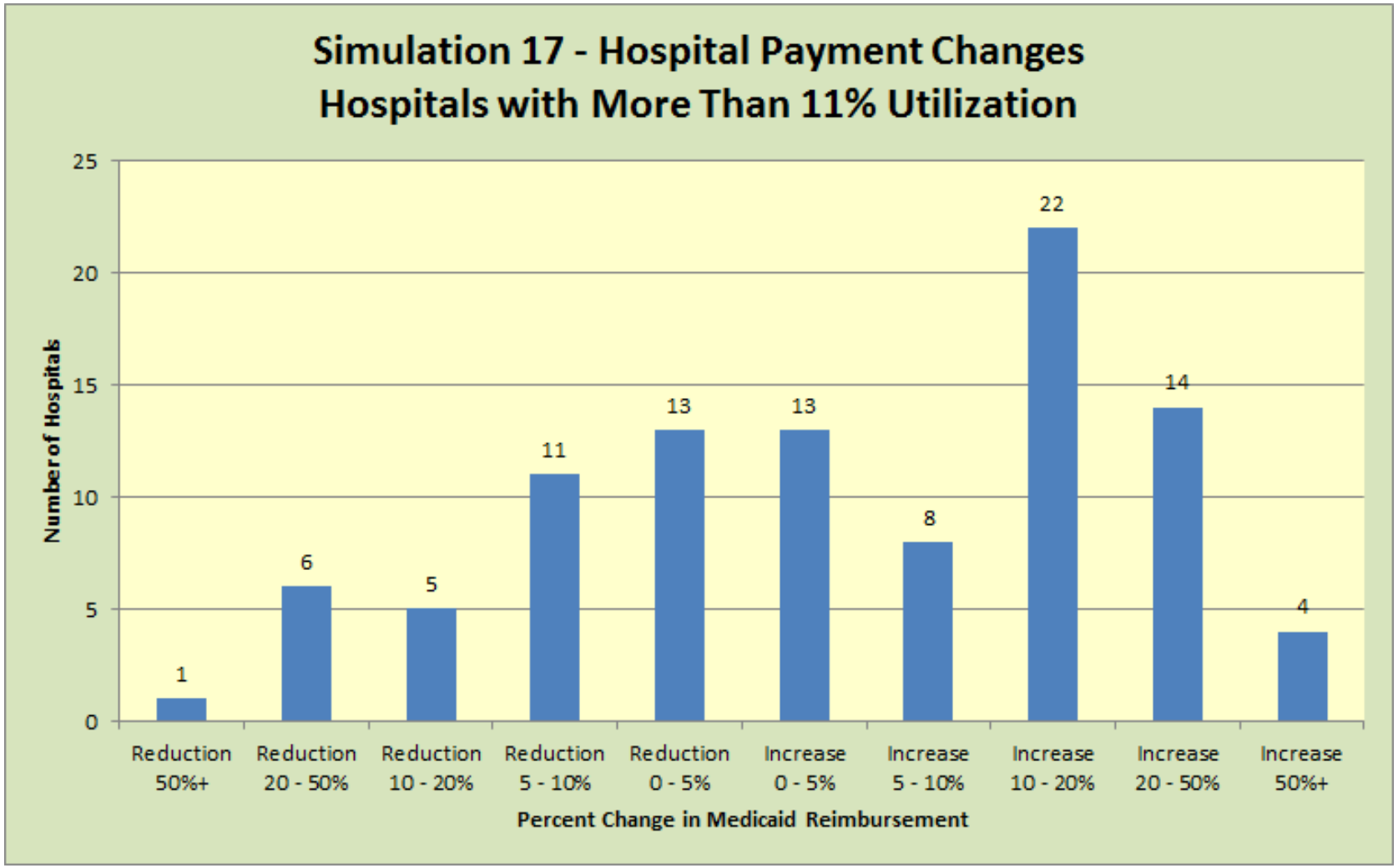
Provider Impact – Hospitals with > 11% Medicaid



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Interpretation of Individual Hospital Simulation Results

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What Simulation does NOT Indicate

- Purpose of DRG simulation is to determine base rate and other DRG pricing parameters
- Simulation results are NOT intended as a prediction of total Medicaid reimbursement in 2013/2014
- Simulation dataset does NOT reflect Medicaid volume for 2013/2014 (eligibility changes)
- Even for 2010/2011, the simulation dataset is missing some claims that were intentionally dropped because they did not represent complete hospital stays

How DRG Simulation Can be Used

- Hospitals can apply DRG simulation percent payment change to their own estimates of total Medicaid reimbursement under the per diem method to estimate total reimbursement under DRG payment method
- Hospitals may also estimate total Medicaid reimbursement under the DRG method using the following formula:

Total Reimb = (1 + hospital prcnt pymt from outliers)
* hospital Medicaid volume
* hospital DCI casemix
* base rate

Questions / Comments

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