Statewide Inpatient Psychiatric Program Tiered Rate Analysis

Purpose of the Report

During the 2024 Florida Legislative Session, the Agency for Health Care Administration (Agency) was directed to develop a tiered reimbursement model for Statewide Inpatient Psychiatric Program (SIPP) services and submit a report to the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Committee on Appropriations, and the chair of the House of Representatives Appropriations Committee by August 1, 2024. The goal of any new methodology would be to provide variation in payment based on different levels of care needed by patients or the complexity of their disease, which could include the severity of condition, intensity of required therapeutic intervention, diagnoses indicating potentially physically violent or aggressive behaviors; or other appropriate factors. The Agency engaged Milliman, Inc. (Milliman) to conduct the evaluation.

Also of note, during the 2024 Florida Legislative session the Legislature appropriated an additional $7.6 million ($10.1 million once annualized) to provide an increase to current Medicaid reimbursement rate for SIPP services, effective October 1, 2024.

Current Situation in Florida Medicaid

Florida's Medicaid program covers extended residential psychiatric treatment for Medicaid recipients under the age of 21 who require treatment in a psychiatric residential setting due to a primary diagnosis of emotional disturbance or serious emotional disturbance under the SIPP benefit. All providers of SIPP services are subject to the general requirements for providing inpatient psychiatric services to Medicaid recipients under age 21 and must be enrolled in Florida Medicaid.

The Agency currently establishes a single, statewide per diem reimbursement rate for SIPP services. In addition to therapeutic care, SIPP providers are responsible for providing medical, pharmaceutical, dental, and vision services to their patients within the per diem rate. The per diem reimbursement rate is updated annually on January 1, based on the most recent cost report data that has been submitted by SIPP providers. The per diem reimbursement rates for Calendar Year 2024 is $586.43. This does not reflect the rate increase that will go into effect October 1, 2024.

Managed care plans participating in Florida's Statewide Medicaid Managed Care (SMMC) program are required to pay SIPP providers, at a minimum, the payment rates established by the Agency. The capitated plans' contracted rates can reflect market-driven payment variations for different providers and recipients. On average, the SMMC program pays more than the current Florida SIPP fee schedule; however, the capitated plans can pay more or less than the Agency's fee schedule based on market demands. Overall, Florida SIPP providers are reimbursed at 106% of the fee-for-service (FFS) fee schedule, when considering all payments across both FFS and the SMMC program.

Under the FFS and SMMC program, there can be an occasion when the Florida Medicaid program will pay for services that are received by a Florida Medicaid recipient, provided by an out of state provider. This occurs when a service is medically necessary and would be covered in Florida but is currently not available within the state. Data reviewed for this report reflected that out-of-state providers of similar psychiatric residential treatment services were reimbursed, on average, at 90% of the FFS rates for CY 2023 services.

Methodology and Preliminary Findings

Milliman identified a range of preliminary tiered reimbursement model options through:

- Review of stakeholder feedback collected via surveys of both SIPP providers and managed care plans;
- Review of other states' payment methodologies and structures for similar services, particularly Pediatric Residential Treatment facility (or PRTF) services, which included factors that vary across the surveyed states, such as complexity or acuity, provider characteristics (such as setting type and/or size), or provider specific cost-based rates;
- Trends analyzed in Florida's calendar year (CY) 2023 Medicaid claims and encounter data for in-state and out-of-state SIPP services; and
- Review of the existing SIPP provider cost reporting structure and data.

The capitated plan and SIPP provider surveys showed that for patients the presence of behavioral health disorders or intellectual or developmental disabilities resulted in additional challenges for the health plans when seeking placement for recipients eligible for SIPP services as well as higher staffing needs for the facilities. SIPP providers also reported that the costs associated with other medical needs for patients with coexisting conditions were a primary driver of additional resource requirements.

Both SIPP providers and the SMMC plans specifically cited that the placement challenges and higher resource needs were tied to patients with complex behaviors, including physically violent or aggressive behavior, sexually aggressive or acting out behavior, eating disorders, and history of fire setting or arson. SIPP providers further cited self-harm or suicidal behaviors and substance abuse as additional drivers. Neither plan surveys or review of claims and encounter data identified existing payment rate variation based on individual recipient acuity or complexity. However, some variation was observed across providers, which may be associated with SIPP providers offering specialized services for recipients with higher acuity, for which some of the SMMC plans indicated that they had negotiated reimbursement rates higher than the state's FFS rate.

In consideration of the time allotted for completion of this report, three preliminary reimbursement approaches were selected for further modeling, focusing on the use of complexity/acuity of diagnosis to select the payment tier. All three approaches address core issues relating to placement challenges and higher resource needs outlined in the provider and SMMC plan survey responses and leverage diagnosis coding (ICD-10) already captured in Medicaid claims and encounter data. The three preliminary reimbursement approaches are:

1. The creation of a four-tired approach utilizing limited specific diagnosis to select the payment tier;
2. The creation of a multiple tiered approach utilizing the diagnosis related group (DRG) classifications and weights to establish the payment amount; and
3. The creation of a three-tiered approach utilizing the severity of illness (SOI) classifications from the DRG methodology.

In addition, it should be noted that the deadline for the report did not allow sufficient time to conduct further investigation into out-of-state providers of SIPP or PRTF services or analysis of payment experience and methodologies under the Florida Department of Children and Families' Substance Abuse and Mental Health program. In addition, current SIPP cost reports do not require the submission of detailed information relating to diagnosis or level of care, and therefore could not be used to support the development of tiered reimbursement models. Further, while cost reports are required, there is no penalty for failure to submit, and several SIPP providers have never filed a cost report with the Agency.

Calendar year 2021, 2022 and 2023 utilization data for 18 Florida providers, representing $66.1 million in payments, adjusted for projected CY 2024 payment levels, plus the total annualized fee increase of $10.1 million were used to determine the total funds available to include in the budget neutral models discussed in this report.

Development of Modeled Adjusted Payment Rates

Milliman modeled preliminary tiered reimbursement models for the three selected approaches on a budget neutral basis, assuming a baseline expenditure level and then applying an increase of $10.1 million to the overall expenditure level.

Summary of Potential Tiered Reimbursement Model Approaches

Approach	Basis For Developing Payment Rate Adjustments
Approach 1: Diagnosis of I/DD or autism, or diagnosis of potentially physically violent or aggressive behaviors	Four tiers based on limited specific diagnosis: ▪ Tier 1: Recipient is not diagnosed as potentially physically violent; not diagnosed with I/DD or autism ▪ Tier 2: Recipient is diagnosed as potentially physically violent; not diagnosed with I/DD or autism ▪ Tier 3: Recipient is not diagnosed as potentially physically violent; diagnosed with I/DD or autism ▪ Tier 4: Recipient is diagnosed as potentially physically violent; diagnosed with I/DD or autism
Approach 2: 3M APR DRG classifications and weights	Reimbursement tied to individual claim based on DRG classifications and weights ▪ Leverages existing 3M APR DRG diagnostic classifications and reimbursement weights ▪ Reimbursement is tied to individual claim based on classifications and weights ▪ Considers other medical, dental, or vision needs as captured in ICD-10 diagnosis coding for SIPP services
Approach 3: Combined complexity and geographical adjustments	Three tiers based on DRG Severity of Illness classification included in claim or encounter submitted. ▪ SOI 1: Minor ▪ SOI 2: Moderate ▪ SOI 3: Major/Extreme

Next Steps

Because all three of the preliminary tiered reimbursement models will require the collection of additional data and the completion of further analysis to evaluate and validate their appropriateness for adjusting payments for SIPP services or to establish final rate tier classifications and payment rates, the Agency is not recommending a model at this time. The Agency recommends and intends to pursue the following steps:

- Conduct further investigation and analysis of out- of-state provision of SIPP and PRTF services.
- Conduct further investigation and analysis of SIPP and PRTF services funded through the Department of Children and Families' Substance Abuse and Mental Health program.
- Evaluate a potential program design change to carve medical, pharmaceutical, dental, or vision services unrelated to the psychiatric and behavioral health needs of children receiving SIPP services out of the SIPP per diem rate.
- Review and update the SIPP provider cost reporting structure, policies, and procedures, enabling collection of information to support further evaluation, development, and validation of a tiered reimbursement model.
- Engage with the managed care plans and SIPP providers to further evaluate the completeness and accuracy of diagnosis coding in the Medicaid claims and encounter data, and, as necessary, collect improved diagnosis

coding or supplemental diagnosis information to support further evaluation, development, and validation of a tiered reimbursement model.

- Further evaluate and validate potential tiered reimbursement model options leveraging updated SIPP provider cost report data, improved or supplemental diagnosis information, and additional input and feedback from the managed care plans and SIPP providers.
- Develop a final recommended tiered reimbursement model for presentation to the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Committee on Appropriations, and the chair of the House of Representatives Appropriations.

MILLIMAN REPORT

Florida Agency for Health Care Administration

Statewide Inpatient Psychiatric Program Tiered Rate Analysis

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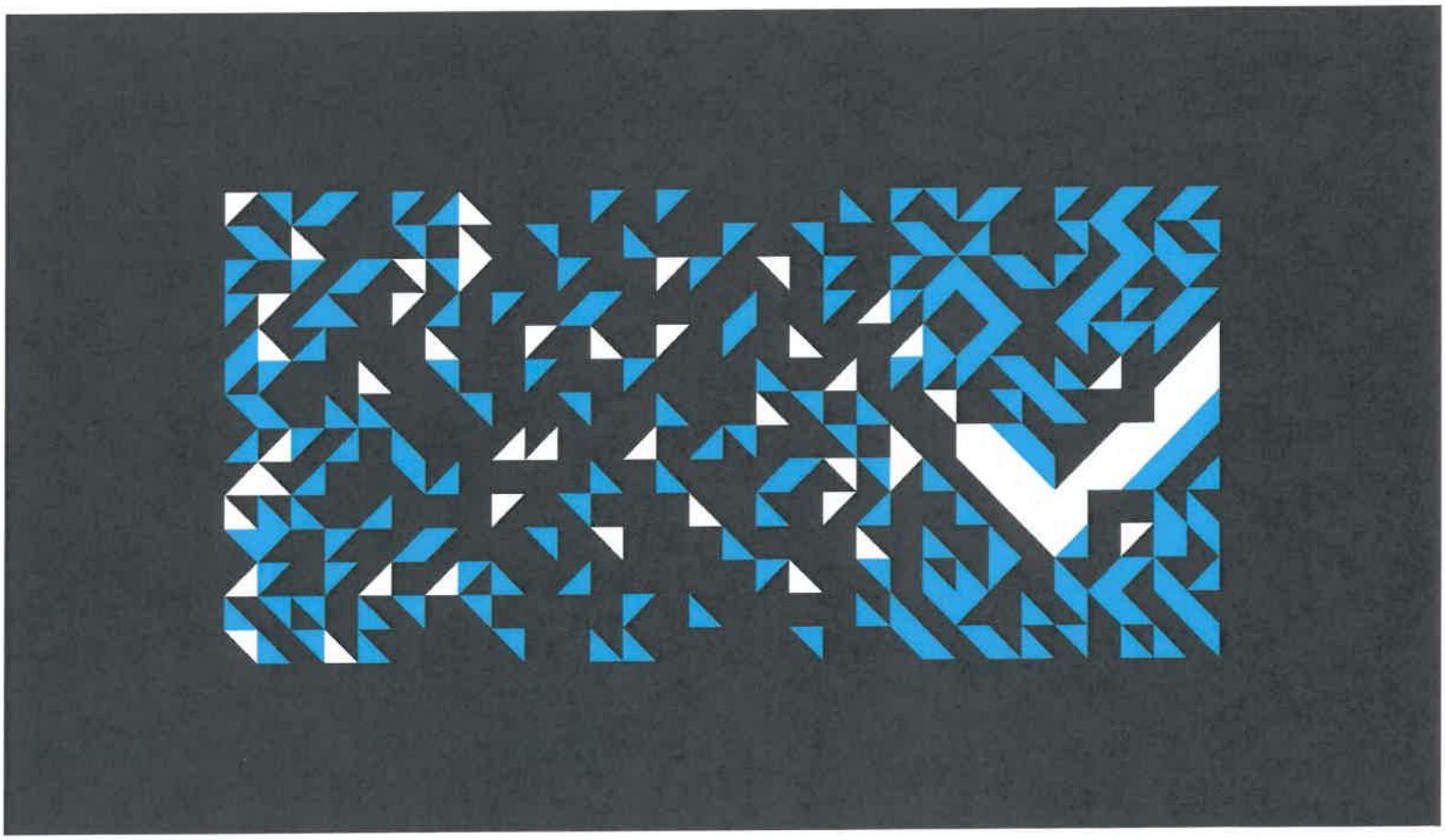

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Executive Summary

The Florida Agency for Health Care Administration (Agency) engaged Milliman, Inc. (Milliman) to identify and evaluate options for a tiered reimbursement model to account for differing levels of care necessitated by patient acuity or complexity for Florida Medicaid's Statewide Inpatient Psychiatric Program (SIPP) services, per the requirements of the SFY 2024-2025 General Appropriations Act (GAA) to:

> *"…develop and implement a tiered reimbursement model for the Florida Medicaid Statewide Inpatient Psychiatric Program. The tiered reimbursement model shall be budget neutral and based on at least three but no more than six tiers to account for differing levels of care necessitated by patient disease complexity and behavior acuity. The agency shall submit the proposed reimbursement model to the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Committee on Appropriations, and the chair of the House of Representatives Appropriations Committee by August 1, 2024."*

Florida's Medicaid program covers extended residential psychiatric treatment to Medicaid recipients under the age of 21 who require treatment in a psychiatric residential setting due to a primary diagnosis of emotional disturbance or serious emotional disturbance under the SIPP benefit..[1] These SIPP services are provided by residential treatment centers for children and adolescents that qualify as a psychiatric residential treatment facility (PRTF) under the requirements of 42 CFR 483, Subpart G, or by hospitals with specialized psychiatric programs. All providers of SIPP services are subject to the general requirements for providing inpatient psychiatric services to Medicaid recipients under age 21 as defined in 42 CFR 441, Subpart D, and must be enrolled with Florida Medicaid..[2] Generally, providers of SIPP services enroll with the Florida Medicaid program under a provider specialty code that specifically identifies them as a provider of SIPP services.

The Agency currently establishes a single, statewide per diem reimbursement rate — which does not account for variation in the acuity or complexity of need for individual recipients — for SIPP services covered under Florida Medicaid's fee-for-service program. The per diem reimbursement rate is updated annually on January 1, and is calculated as the weighted average per diem cost of SIPP services based on the most recent cost report data that has been submitted by SIPP providers, according to the methodologies and data sources specified in Attachment 4.19-A of Florida's State Plan. Additionally, managed care plans participating in Florida's Statewide Medicaid Managed Care (SMMC) program are required to pay SIPP providers, at a minimum, the payment rates established by the Agency.

In contrast, the Agency currently establishes reimbursement rates for acute inpatient hospital services covered under Florida Medicaid's fee-for-service program using the 3M™ All Patient Refined Diagnosis Related Groups (APR DRG) classifications and associated relative weights. The APR DRG based rates account for variation in the acuity of individual recipients based on the diagnosis information reported in the claims records submitted by the hospitals providing the services. The APR DRG-based reimbursement rates for acute inpatient hospital services are updated annually to achieve simulated budget targets established by the Agency, according to the methodologies and data sources specified in Attachment 4.19-A of Florida's State Plan. While managed care plans participating in Florida's SMMC program are not required to pay for acute inpatient hospital services according to the APR DRG-based methodology or rates established by the Agency, managed care plans generally pay for acute inpatient hospital services using a similar APR DRG based methodology.

To complete this work, we identified a range of preliminary tiered reimbursement model options through a review of other states' payment methodologies and structures for services provided by those states' PRTF providers (which are similar to Florida's SIPP services), analysis of Florida's calendar year (CY) 2023 Medicaid claims and encounter data for SIPP services and similar psychiatric residential treatment services provided by out-of-state providers, review of the existing SIPP provider cost reporting structure and data, and stakeholder feedback collected via surveys of SIPP providers and managed care plans. Highlights included:

- **Other state approaches.** A review of publicly available materials for 10 states, including all seven other states in the same southeastern CMS region as Florida (CMS Region IV, which includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) and Kansas, Nebraska, and Ohio, revealed a wide range of payment methodologies and structures for PRTF services, including rate tiers based on provider characteristics, rate tiers based on recipient acuity or complexity, provider-specific rates, one state

[1] Florida Agency for Health Care Administration. Statewide Inpatient Psychiatric Program Coverage Policy. Available at: https://www.flrules.org/gateway/readRefFile.asp?refId=6157&filename=SIPP_Coverage_Policy_Adoption1.pdf Accessed June 23, 2024.

[2] Ibid.

with reimbursement based on usual and customary charges, and one state with a single statewide rate. Among the reviewed states with rate tiers based on recipient acuity or complexity, rate tiers were defined based on the presence of aggressive or sexually acting out behaviors, the intensity of required therapeutic intervention, or the presence of intellectual or developmental disabilities.

- **Analysis of Medicaid claims and encounter data.** In our analysis of the managed care program encounter data, we did observe rate variation across managed care plans and SIPP providers, but we did not observe rate variation across individual recipients. These findings are supported by responses that we received in the SIPP provider and managed care plan surveys that indicated that managed care plans are providing reimbursement rates higher than the per diem rate established by the Agency for certain SIPP providers, but are not currently reimbursing SIPP providers using tiered reimbursement models based on individual recipient acuity or complexity. Additionally, while we rely on the recipient diagnosis information reported in existing Medicaid claims and encounter data in the preliminary tiered reimbursement model approaches presented in this report, current reimbursement methodologies do not rely directly on this diagnosis information. As a consequence, the diagnosis information reported in the existing Medicaid claims and encounter data submitted by SIPP providers may not fully reflect the acuity or complexity of the recipients receiving care.

  In addition to analyzing claims and encounter data for SIPP providers, we also analyzed claims and encounter data for similar psychiatric residential treatment services provided by out-of-state providers. These similar psychiatric residential treatment services provided by out-of-state providers were reimbursed, on average, at 90% of the Agency's SIPP per diem rate, compared to reimbursement of 106% (across fee-for-service and managed care) of the Agency's SIPP per diem rate for Florida SIPP providers.

- **Review of existing SIPP provider cost reporting structure and data.** The existing SIPP cost report collects information required to support the current methodology for establishing a single, statewide SIPP per diem rate. However, data is not collected at the level of granularity that would be required to support evaluation and development of a tiered reimbursement model that accounts for differing levels of care necessitated by patient disease complexity and behavior acuity. Certain Florida SIPP providers have either never submitted cost reports or the most recently submitted cost report is several years old.

- **SIPP provider input.** None of the SIPP providers indicated that they had negotiated plan payment of tiered rates based on individual recipient acuity or complexity. SIPP providers indicated that the primary factors requiring higher staffing or other resource requirements for recipients receiving SIPP services include the presence of behavioral health disorders, intellectual or developmental disabilities, as well as other medical needs. Specific behaviors cited by the SIPP providers as requiring higher staffing or other resource requirements included physically violent or aggressive behavior, sexually aggressive or acting out behavior, eating disorders, history of fire setting or arson, self-harm or suicidal behavior, substance abuse, or any other behaviors that would require greater supervision (e.g., a higher staffing ratio) or placement of the child in a single room. Additionally, SIPP providers asserted that they are financially responsible for medical, pharmaceutical, dental, or vision services unrelated to the psychiatric or behavioral health needs of recipients receiving SIPP services in their facilities under the current program design, and that these costs can be a source of substantial resource requirement variation for some recipients.

- **Managed care plan input.** None of the managed care plans indicated that they had negotiated to pay tiered rates based on individual recipient acuity or complexity, but some of the managed care plans indicated that they provided reimbursement rates higher than the per diem rate established by the Agency for certain SIPP providers. Specific reasons cited by these plans for providing higher reimbursement rates to certain SIPP providers included specialized services offered by the providers, maintaining access to care, contract history with the providers, provider cost variation, Single Case Agreements for out-of-network facilities, and other market forces. The managed care plans indicated that the presence of behavioral health disorders and intellectual or developmental disabilities can present challenges when seeking placement for recipients eligible for SIPP services. Specific behaviors cited by the plans as presenting challenges when seeking placement included physically violent or aggressive behavior, sexually aggressive or acting out behavior, eating disorders, and history of fire setting or arson.

Using the administrative claims and encounter data available for preliminary modeling of rate tier options, we identified three preliminary tiered reimbursement models:

1. Tiers based on a diagnosis of one or more conditions indicating potentially physically violent or aggressive behaviors; intellectual or developmental disability (I/DD) or autism.

2. Tiers based on 3M™ All Patient Refined Diagnosis Related Groups (APR DRG) classifications and associated relative weights.

3. Tiers based on 3M™ APR DRG Severity of Illness (SOI) classifications.

All three preliminary tiered reimbursement models were selected based on their ability to (1) address SIPP provider feedback related to primary factors requiring higher staffing or other resource requirements for recipients receiving SIPP services, (2) address managed care plan input related to challenges when seeking placement for recipients eligible for SIPP services, and (3) leverage recipient-level diagnosis information, provided on claim records submitted by SIPP providers using the International Classification of Diseases 10th Revision (ICD-10) diagnosis coding currently available in Medicaid claims and encounter data.

Milliman is not advocating for, recommending, or endorsing any specific tiered reimbursement model for SIPP services. All final decisions regarding the design, modeling methodologies, parameters, and assumptions, and other aspects of the tiered reimbursement model are the responsibility of the Agency.

Milliman completed analyses for the three potential preliminary tiered reimbursement models selected. However, all three of the preliminary tiered reimbursement models require the collection of additional data and the completion of further analysis to evaluate, refine, and validate their appropriateness for adjusting payments for SIPP services or to establish final rate tier classifications and payment rates.

The Agency recommends completing a more comprehensive SIPP rate study to:

- Conduct further investigation and analysis of out- of-state provision of SIPP and PRTF services.

- Conduct further investigation and analysis of SIPP and PRTF services funded through the Department of Children and Families' Substance Abuse and Mental Health program.

- Evaluate a potential program design change to carve medical, pharmaceutical, dental, or vision services unrelated to the psychiatric and behavioral health needs of children receiving SIPP services out of the SIPP per diem rate.

- Review and update the SIPP provider cost reporting structure, policies, and procedures, enabling collection of the information to support further evaluation, development, and validation of a tiered reimbursement model.

- Engage with the managed care plans and SIPP providers to further evaluate the completeness and accuracy of diagnosis coding in the Medicaid claims and encounter data, and, as necessary, collect improved diagnosis coding or supplemental diagnosis information to support further evaluation, development, and validation of a tiered reimbursement model.

- Further evaluate and validate potential tiered reimbursement model options leveraging updated SIPP provider cost report data, improved or supplemental diagnosis information, and additional input and feedback from the managed care plans and SIPP providers.

- Evaluate a potential program design change to carve medical, pharmaceutical, dental, or vision services unrelated to the psychiatric or behavioral health needs of recipients receiving SIPP services out of the SIPP per diem rate.

- Develop a final recommended tiered reimbursement model for presentation to the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Committee on Appropriations, and the chair of the House of Representatives Appropriations Committee.

Introduction

The Florida Agency for Health Care Administration (Agency) engaged Milliman, Inc. (Milliman) to identify and evaluate options for a tiered reimbursement model to account for differing levels of care necessitated by patient acuity or complexity for Statewide Inpatient Psychiatric Program (SIPP) services, per the requirements of the SFY 2024-2025 General Appropriations Act (GAA) to:

> *"...develop and implement a tiered reimbursement model for the Florida Medicaid Statewide Inpatient Psychiatric Program. The tiered reimbursement model shall be budget neutral and based on at least three but no more than six tiers to account for differing levels of care necessitated by patient disease complexity and behavior acuity. The agency shall submit the proposed reimbursement model to the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Committee on Appropriations, and the chair of the House of Representatives Appropriations Committee by August 1, 2024."*

Based on information shared by the Agency, we understand that the new tiered reimbursement model is intended to address concerns that the current approach of establishing a single statewide rate may not adequately reimburse providers for higher complexity cases that could require higher staffing or other resource requirements. In particular, the Agency raised concerns about higher staffing or other resource requirements when seeking placements for recipients who may be physically violent, sexually aggressive, or who may otherwise present with higher complexity needs. The Agency further expressed concerns that the current rate structure may be contributing to a lack of capacity to place recipients with higher complexity behavioral needs with in-state providers, and that this may be contributing to placements of these recipients with out-of-state providers.

While the new tiered reimbursement model must be designed to be budget neutral, the SFY 2024-2025 GAA also appropriated funding to increase rates for SIPP services effective October 1, 2024, with a requirement that the managed care plans participating in the Statewide Medicaid Managed Care (SMMC) Program pass through the fee increase to SIPP providers. Based on information shared by the Agency, we understand that an annualized amount of $10,125,164 has been appropriated to increase SIPP rates relative to baseline funding levels.

BACKGROUND ON FLORIDA'S STATEWIDE INPATIENT PSYCHIATRIC PROGRAM

In 2001, the Centers for Medicare and Medicaid Services established psychiatric residential treatment facilities (PRTFs) as a new category of facility that could provide Medicaid covered inpatient psychiatric services for individuals under the age of 21, subject to the requirements of 42 CFR 441, Subpart D, and 42 CFR 42 CFR 483, Subpart G. In 2002, the Agency implemented Florida's Statewide Inpatient Psychiatric Program under 1915(b) waiver authority to provide specialized diagnostic, treatment, and aftercare services to high-risk Medicaid recipients under the age of 18..[3] Today, under the Florida Medicaid State Plan, the Statewide Inpatient Psychiatric Program currently covers extended residential psychiatric treatment to Medicaid recipients under the age of 21 who require treatment in a psychiatric residential setting due to a primary diagnosis of emotional disturbance or serious emotional disturbance..[4]

SIPP services are provided by residential treatment centers for children and adolescents that qualify as a PRTF under the requirements of 42 CFR 483, Subpart G, or by hospitals with specialized psychiatric programs. All providers of SIPP services are subject to the general requirements for providing inpatient psychiatric services to Medicaid recipients under age 21 as defined in 42 CFR 441, Subpart D, and must be enrolled with Florida Medicaid..[5] Generally, providers of SIPP services enroll with the Florida Medicaid program under a provider specialty code that specifically identifies them as a provider of SIPP services.

The Agency currently establishes a single, statewide per diem reimbursement rate — which does not account for variation in the acuity or complexity of need for individual recipients — for SIPP services covered under Florida Medicaid's fee-for-service program. The per diem reimbursement rate is updated annually on January 1, and is calculated as the weighted average per diem cost of SIPP services based on the most recent cost report data that has been submitted by SIPP providers, according to the methodologies and data sources specified in Attachment 4.19-A of Florida's State Plan. Additionally, managed care plans participating in Florida's Statewide Medicaid Managed Care

[3] The Louis De La Parte Florida Mental Health Institute. Statewide Inpatient Psychiatric Program: Report 5. Available at: http://mhlp.fmhi.usf.edu/_assets/docs/ahca/2004-ArmstrongSIPP%20final%203-29-05.pdf. Accessed June 23, 2024.
[4] Florida Agency for Health Care Administration. Statewide Inpatient Psychiatric Program Coverage Policy. Available at: https://www.flrules.org/gateway/readRefFile.asp?refId=6157&filename=SIPP_Coverage_Policy_Adoption1.pdf. Accessed June 23, 2024.
[5] Ibid.

(SMMC) program are required to pay SIPP providers, at a minimum, the payment rates established by the Agency. The fee-for-service per diem reimbursement rates for the most recent four years are summarized in Figure 1, below.[6]

FIGURE 1: SUMMARY OF CURRENT AND HISTORICAL SIPP PER DIEM RATES

Year	State Plan Per Diem Rate	YoY % Change in Per Diem Rate
CY 2021	$478.04	
CY 2022	$483.78	1.2%
CY 2023	$513.31	6.1%
CY 2024[1]	$586.43	14.2%

1. *The State Plan per diem rate will be updated October 1, 2024, to account for the appropriation provided in the SFY 2024-2025 GAA to increase SIPP rates. The updated rate was not available at the time of this report.*

In contrast, the Agency currently establishes reimbursement rates for acute inpatient hospital services covered under Florida Medicaid's fee-for-service program using the 3M™ All Patient Refined Diagnosis Related Groups (APR DRG) classifications and associated relative weights. The APR DRG-based rates account for variation in the acuity of individual recipients based on the diagnosis information reported in the claims records submitted by the hospitals providing the services. The APR DRG-based reimbursement rates for acute inpatient hospital services are updated annually to achieve simulated budget targets established by the Agency, according to the methodologies and data sources specified in Attachment 4.19-A of Florida's State Plan. While managed care plans participating in Florida's SMMC program are not required to pay for acute inpatient hospital services according to the APR DRG-based methodology or rates established by the Agency, managed care plans generally pay for acute inpatient hospital services using a similar APR DRG based methodology.

The remainder of this report describes the identification of preliminary tiered reimbursement model options, selection of three preliminary tiered reimbursement model options for further analysis, and illustrative tiered reimbursement rate modeling of the preliminary model options selected.

[6] Florida Agency for Health Care Administration. Statewide Inpatient Psychiatric Program (SIPP) Rates. Available at: https://ahca.myflorida.com/medicaid/cost-reimbursement/hospital-rates-ambulatory-surgical-centers. The 2021 SIPP rate was downloaded on August 27, 2021, the 2022 SIPP rate was downloaded on August 3, 2022, the 2023 SIPP rate was downloaded on June 15, 2023, and the 2024 SIPP rate was downloaded on June 15, 2024.

Identification of Preliminary Tiered Reimbursement Models

We identified tiered reimbursement model options through a review of other states' payment methodologies and structures for PRTF providers (which are similar to Florida's SIPP services), analysis of Florida's calendar year (CY) 2023 Medicaid claims and encounter data for SIPP services and similar psychiatric residential treatment services provided by out-of-state providers, review of the existing SIPP provider cost reporting structure and data, and stakeholder input collected via surveys of SIPP providers and managed care plans.

STAKEHOLDER INPUT

We collected stakeholder input on tiered reimbursement model options through voluntary surveys distributed to SIPP providers and managed care plans. Figures 2 and 3 below summarize the survey approaches and related observations, respectively.

FIGURE 2: SIPP PROVIDER AND MANAGED CARE PLAN SURVEY APPROACH

STAKEHOLDER SURVEYS	DESCRIPTION AND APPROACH
SIPP Provider Survey	▪ Developed in consultation with the Agency and collected: – Contact information – Existing reimbursement model structures and rates for SIPP services – Primary factors impacting variation in staffing needs and costs of providing SIPP services based on recipient acuity or complexity – Factors impacting ability to accept recipients eligible for SIPP services in their facility – Tools used to evaluate client needs and develop care plans – Number of covered days and payments for SIPP services ▪ Distributed via a provider alert for Residential and Psychiatric Facilities (Provider Type 16) on June 13, 2024, with a due date of June 21, 2024; of the 18 providers we identified as providing SIPP services in CY 2023, eight surveys were received by the survey due date
Managed Care Plan Survey	▪ Developed in consultation with the Agency and collected: – Existing reimbursement model structures and rates for SIPP services – Primary factors impacting variation in existing reimbursement rates for SIPP services across providers or for individual recipients – Challenges experienced with placing recipients who require SIPP services with in-state providers – Tools used to evaluate client needs and develop care plans – Total SIPP and non-SIPP PRTF days and payments ▪ Sent via email to the 11 capitated plans on June 13, 2024, with a due date of June 21, 2024; surveys from all capitated plans were received by the survey due date

FIGURE 3: SIPP PROVIDER AND MANAGED CARE PLAN SURVEY RESPONSES

STAKEHOLDER SURVEYS	SUMMARIZATION OF RESPONSES
SIPP Provider Survey	▪ Existing reimbursement model structures and rates for SIPP services: – No use of tiered rates based on individual recipient acuity or complexity (though some providers indicated that they had negotiated higher rates for specific placements on a case-by-case basis) ▪ Primary factors impacting staffing needs and cost variation or impacting ability to place recipients in their facilities: – Complex behaviors requiring greater supervision (e.g., a higher staffing ratio) or placement of the child in a single room, such as: • Physically violent or aggressive behavior • Sexually aggressive or acting out behavior • Eating disorders • History of fire setting or arson • Self-harm or suicidal behavior • Substance abuse – Staffing shortages, due to limited ability to increase wages and regulatory processes that require staff be put on administrative leave during investigations – Costs for medical, pharmaceutical, dental, or vision services unrelated to the psychiatric or behavioral health needs of recipients receiving SIPP services: • Recipient medical bills (e.g., hospital visits, eye doctor visits, pharmacy costs, and other medical-related costs)
Managed Care Plan Survey	▪ Existing reimbursement model structures and rates for SIPP services: – No use of tiered rates based on individual recipient acuity or complexity, but some of the managed care plans indicated that they had negotiated higher reimbursement rates for certain SIPP providers ▪ Primary factors impacting variation in existing reimbursement rates for SIPP services across providers: – Specialized services offered by certain providers – Maintaining access to care – Contract history with certain providers – Provider cost variation – Single Case Agreements for out-of-network facilities (including some out-of-state facilities) – Other market forces ▪ Challenges experienced with placing recipients who require SIPP services with in-state providers: – Lack of available beds, resulting in long wait lists – Medically complex recipients – Recipients with intellectual disabilities – Complex behaviors including physically violent or aggressive behavior, sexually aggressive or acting out behavior, eating disorders, and history of fire setting or arson – Facility age limits and gender restrictions ▪ Out-of-state PRTF service providers: – Most managed care plans did not report placing recipients of SIPP services with out-of-state providers

OTHER STATE APPROACHES FOR TIERED REIMBURSEMENT MODELS FOR PRTF SERVICES

Milliman conducted a review of reimbursement methodologies used by 10 other state Medicaid programs, including all seven other states in the same southeastern Centers for Medicare and Medicaid Services (CMS) region as Florida (CMS Region IV), for PRTF services..[7] We reviewed publicly available information, including State Plan Amendments (SPAs), administrative code and coverage policies, and fee schedules. Appendix A provides a listing of sources relied on.

Among the states reviewed, there was substantial variation in payment methodologies and structures for PRTF services, including rate tiers based on provider characteristics (e.g., provider size as measured by number of beds, or whether the provider is a hospital or PRTF), rate tiers based on recipient acuity or complexity, provider-specific rates, one state with reimbursement based on usual and customary charges, and one state with a single statewide rate. The three reviewed states with rate tiers based on recipient acuity or complexity were Kentucky, Ohio, and Tennessee. Among these three states, rate tiers were defined based on the presence of aggressive or sexually acting out behaviors, the intensity of required therapeutic intervention, or the presence of intellectual or developmental disabilities. The results of the state scan were used to inform potential approaches for acuity-based tiering structures and were reviewed and discussed with the Agency's policy and program staff.

Figure 4 below provides a summary of the tiered reimbursement approaches for Kentucky, Ohio, and Tennessee, the three reviewed states with rate tiers based on recipient acuity or complexity.

FIGURE 4: SUMMARY OF OTHER STATES' PRTF REIMBURSEMENT APPROACHES

DESCRIPTION	KENTUCKY	OHIO	TENNESSEE
Number of Tiers	2	4	4
Payment Rate (Per Diem)	\$500 – Level I \$600 – Level II *See below for tier definitions*	\$799.93 – Base \$1,092.60 – Cottage \$1,036.55 – MI/IDD \$1,243.85 – Cottage MI/IDD *See below for tier definitions*	\$550 – SED Mid \$558 – AS-ND Mid \$638 – SED High \$652 – AS-ND High *See below for tier definitions*
Facility Specifications	Level I Community-based, and home-like facility with a maximum of nine (9) beds Level II Home-like facility with a maximum of twelve (12) beds	Base Residential setting with a maximum of twelve (12) beds Cottage Detached residential setting with a maximum of six (6) beds	Does not specify the use of bed-size or facility type in tiering definitions At least 50% of children / youth in a PRTF are placed in a family-based setting
Recipient Diagnosis	Level I Emotional disability or severe emotional disability Level II Have a severe emotional disability and persistent aggressive behaviors, intellectual disability, sexually acting out behaviors, or developmental disability	Base Primary mental health DSM 5 diagnosis, with or without a co-occurring substance use disorder MI/IDD Presents with symptoms consistent with a DSM 5 behavioral health disorder, as well as a co-occurring intellectual or developmental disability, and requires intensive out-of-home therapeutic intervention	Severely Emotionally Disturbed (SED) - Significant psychiatric needs and cannot maintain treatment or safety in the community - Psychiatric status may be unstable and over the course of treatment may experience episodes of heightened acuity that require increased supervision Autism Spectrum – Neurodevelopmental (AS-ND) Both a mental health diagnosis and an Autism Spectrum or Neurodevelopmental Disorder diagnosis (includes youth with intellectual disabilities who also have a mental health diagnosis)

[7] Alabama, Georgia, Kentucky, Kansas, Mississippi, Nebraska, North Carolina, Ohio, South Carolina, and Tennessee were included in this reimbursement methodology review.

DESCRIPTION	KENTUCKY	OHIO	TENNESSEE
Recipient Ages (in Years)	Level I Six (6) to twenty-one (21) Level II Four (4) to twenty-one (21)	Six (6) to twenty-one (21) Cannot be placed in the same unit / cottage that exceed age ranges more than three years apart	Five (5) to seventeen (17)
Staffing Ratios	Minimum of ten (10) to one (1)	Base - Daytime 1:3 - Overnight 1:6 Cottage - Daytime 1:3 - Overnight 1:3 Base MI/IDD - Daytime 1:2 - Overnight 1:3 Cottage MI/IDD - Daytime 1:2 - Overnight 1:3	Severely Emotionally Disturbed (SED) - SED Mid must have the staffing capacity for 1:1 supervision when a child/youth presents with extraordinary psychiatric needs - SED High requires 1:1 supervision Autism Spectrum – Neurodevelopmental (AS-ND) - AS-ND Mid requires daytime staffing from 1:6 to 1:1 and overnight staffing from 1:8 to 1:1 (depending on the clinical needs of any child in the program) - AS-ND High requires 1:1 supervision
Rate Development	Did not specify rate development methodology. The per diem rates will be increased annually by the Medicare Economic Index (MEI).	Independent Rate Model (IRM) *See Appendix B for additional information*	Did not specify rate development methodology. The majority of PRTF services are provided through managed care program.

SUMMARY OF EXISTING VARIATION IN SIPP PAYMENT

Milliman analyzed CY 2023 Medicaid claims and encounter data to assess current SIPP payment rate variation. We did observe rate variation across managed care plans and SIPP providers, but we did not observe rate variation across individual recipients. These findings support responses that we received in the SIPP provider and managed care plan surveys that indicated that managed care plans are providing reimbursement rates higher than the per diem rate established by the Agency for certain SIPP providers, but are not currently reimbursing SIPP providers using tiered reimbursement models based on individual recipient acuity or complexity.

Selection of Preliminary Tiered Reimbursement Models

We discussed the findings of our review of other states' payment methodologies and structures for PRTF services, analysis of Florida's CY 2023 Medicaid claims and encounter data for SIPP services, review of current SIPP provider cost reporting structure and data, and stakeholder input collected via surveys of SIPP providers and managed care plans with Agency program and policy experts. In coordination with the Agency, we then selected three preliminary tiered reimbursement model options for further analysis and illustrative tiered reimbursement rate modeling using the available administrative claims and encounter data:

1. Tiers based on a diagnosis of one or more conditions indicating potentially physically violent or aggressive behaviors; intellectual or developmental disability (I/DD) or autism.

2. Tiers based on 3M™ All Patient Refined Diagnosis Related Groups (APR DRG) classifications and associated relative weights.

3. Tiers based on 3M™ APR DRG Severity of Illness (SOI) classifications.

All three preliminary tiered reimbursement models were selected based on their ability to (1) address SIPP provider feedback related to primary factors requiring higher staffing or other resource requirements for recipients receiving SIPP services, (2) address managed care plan input related to challenges when seeking placement for recipients eligible for SIPP services, and (3) leverage International Classification of Diseases 10th Revision (ICD-10) diagnosis coding currently available in Medicaid claims and encounter data.

Milliman is not advocating for, recommending, or endorsing any specific tiered reimbursement model for SIPP services. All final decisions regarding the design, modeling methodologies, parameters, and assumptions, and other aspects of the tiered reimbursement model are the responsibility of the Agency.

Milliman completed analysis and illustrative tiered reimbursement rate modeling for the three preliminary tiered reimbursement models selected. However, all three of the preliminary tiered reimbursement models require the collection of additional data and the completion of further analysis to evaluate, refine, and validate their appropriateness for adjusting payments for SIPP services or to establish final rate tier classifications and payment rates. Figure 5, below, summarizes potential benefits and limitations associated with each of the preliminary tiered reimbursement model approaches.

FIGURE 5: SUMMARY OF POTENTIAL BENEFITS AND LIMITATIONS OF TIERED REIMBURSEMENT MODEL APPROACHES

Approach	Potential Benefits	Potential Limitations
Approach 1: Diagnosis indicating potentially physically violent or aggressive behaviors, or diagnosis of I/DD or autism	▪ Most flexibility to align with the specific primary factors requiring higher staffing or other resource requirements for recipients receiving SIPP services, based on stakeholder input and further analysis ▪ Best aligned with tiered reimbursement models based on recipient acuity or complexity identified in Milliman's review of other state PRTF reimbursement approaches ▪ Less complex to understand and implement, as compared to Approaches 2 or 3	▪ Does not directly identify physically violent or aggressive behavior due to limitations in the ICD-10 diagnosis code set ▪ Does not consider other behaviors that may be associated with higher staffing or resource requirements (e.g., sexually aggressive or acting out behavior, eating disorders, history of fire setting or arson, self-harm or suicidal behavior, substance abuse) ▪ Does not consider other medical, dental, or vision needs[1] ▪ Further analysis required to establish final recommended rate tier classifications and payment rates
Approach 2: 3M™ APR DRG classifications and weights	▪ Leverages existing 3M™ APR DRG classifications and associated relative weights ▪ 3M™ APR DRG diagnostic classifications and relative weights are updated regularly to account for updates in ICD-10 code sets, and changes in clinical practice patterns and resource requirements ▪ Managed care plans are familiar with the 3M™ APR DRGs due to Florida Medicaid's DRG-based payment system for acute inpatient hospital services ▪ Considers other medical, pharmaceutical, dental, or vision needs as captured in ICD-10 diagnosis coding for SIPP services[1]	▪ APR DRG classifications and weights were developed by 3M™ for the specific purpose of adjusting payments for acute hospital services. Further analysis would be required to evaluate and validate appropriateness for adjusting payments for SIPP services. ▪ Non-hospital SIPP providers may have little to no familiarity with the 3M™ APR DRGs ▪ More complex to understand and implement, as compared to Approach 1 ▪ Further analysis required to establish final recommended rate tier classifications and payment rates
Approach 3: 3M™ APR DRG SOI classifications	Approach 3 shares the same potential benefits and additional limitations as Approach 2, but would collapse the number of rate tiers from 33 APR DRG / SOI classifications observed in the CY 2023 claims and encounter data to 3 APR DRG SOI classifications.	

1. *SIPP providers have asserted that they are financially responsible for services unrelated to the psychiatric or behavioral health needs of recipients receiving SIPP services in their facilities under the current program design. Consideration for other medical, pharmaceutical, dental, or vision needs has been identified as a potential benefit or limitation of each approach assuming no change in current program design. If the program design were revised to carve medical, pharmaceutical, dental, and vision services unrelated to the psychiatric and behavioral health needs of recipients of SIPP services out of SIPP per diem rates, Approach 1 may be best aligned with the revised program design.*

The Agency recommends completing a more comprehensive SIPP rate study to:

- Engage with the SIPP providers and managed care plans to further evaluate the completeness and accuracy of diagnosis information reported in the Medicaid claims and encounter data submitted by SIPP providers, and, as necessary, collect revised or supplemental diagnosis information to support further evaluation, development, and validation of a tiered reimbursement model.
- Review and update the SIPP provider cost reporting structure, policies, and procedures, enabling collection of the information required to support further evaluation, development, and validation of a tiered reimbursement model.
- Evaluate a potential program design change to carve medical, pharmaceutical, dental, or vision services unrelated to the psychiatric or behavioral health needs of recipients receiving SIPP services out of the SIPP per diem rate.

- Further evaluate and validate potential tiered reimbursement model options leveraging revised or supplemental diagnosis information, updated SIPP provider cost report data, and additional input and feedback from the SIPP providers and managed care plans.

- Develop a final recommended tiered reimbursement model for presentation to the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Committee on Appropriations, and the chair of the House of Representatives Appropriations Committee.

Appendix B provides more information on the proposed approach to further evaluate and validate potential tiered reimbursement model options and develop a final recommended model.

Analysis of Preliminary Tiered Reimbursement Models

Milliman conducted a review of CY 2023 experience for the Florida Medicaid Statewide Inpatient Psychiatric Program. Based on guidance from the Agency, we identified SIPP providers as those enrolled as provider type '16' (Residential and Freestanding Psychiatric Facility) and with an active SIPP contract. Additionally, we limited the dataset to claims and encounters with revenue code '0100' (Room and board – all-inclusive plus ancillary) or '0101' (Room and board – all inclusive) and for which the recipient was under the age of 21 on the first date of service. Only claims and encounters with last dates of service on January 1, 2023 through December 31, 2023 were considered. Our analysis includes both claims reimbursed on a fee-for-service basis and encounters reimbursed by managed care plans. Managed care plan encounters accounted for almost all SIPP services.

Based on the criteria outlined above, we identified 18 Florida providers that provided SIPP services with last dates of service in CY 2023, representing $66.1 million in fee-for-service and managed care plan payments. There are also similar psychiatric residential treatment services provided by out-of-state providers to Florida Medicaid recipients under the age of 21. Based on discussions with the Agency and information provided by Florida's managed care plans, we understand that in certain situations, recipients receive services out-of-state because they were unable to be placed with a Florida SIPP provider. Based on guidance provided by the agency, we identified a total of 11 out-of-state providers that provided similar psychiatric residential treatment services with last dates of service in CY 2023, representing $3.6 million in managed care plan payments. Exhibits included in this report have a separate summary for the similar psychiatric residential treatment services provided by out-of-state providers.

SIPP PROVIDER OVERVIEW

Exhibit 1 provides an overview of the 18 Florida SIPP providers based on information included in provider-submitted cost reports and additional information provided by the Agency. Cost report data is incomplete as certain Florida SIPP providers have either never submitted cost reports or the most recently submitted cost report is several years old. We note that the SIPP providers are well distributed throughout the state, with a provider in most major cities. Among the providers that submitted cost reports, most providers indicated that they offer specialized services for treatment of recipients with severe emotional disorder disturbance and emotional / behavioral problems. However, the majority of providers indicated that they do not offer specialized services for treatment of recipients who are sexual offenders, have developmental disabilities, or have eating disorders.

The Florida SIPP provider cost reports include information about their capacities, as measured by the available beds reported in each provider's cost report. Based on information provided in response to our survey of SIPP providers, some providers attribute unused beds to challenges maintaining adequate staffing levels.

Milliman reviewed experience for Florida SIPP providers and out-of-state providers. By provider, we reviewed total covered days, actual provider reimbursement (reflecting amounts paid by managed care plans and the State on a fee-for-service basis), and average actual per diem rates, which represent average rates across all stays. Based on information provided by SIPP providers, we understand that providers are generally paid on a per diem basis; however, the per diem amounts vary based on rates negotiated between each managed care plan and SIPP provider, claims spanning multiple rate periods, as well as the use of Single Case Agreements in limited circumstances. We also reviewed estimated provider reimbursement rates that would have been paid had the claim been reimbursed at the prevailing per diem reimbursement rates established by the Agency (i.e., the State fee-for-services rates) during the dates of service. Based on this review, on average, Florida SIPP providers were reimbursed at 106% (across fee-for-service and managed care) of State fee-for-service rates for CY 2023 services. Out-of-state providers of similar psychiatric residential treatment services were reimbursed, on average, at 90% of the State fee-for-service rates for CY 2023 services.

RECIPIENT ACUITY OR COMPLEXITY VARIATION ACROSS SIPP PROVIDERS

Milliman analyzed the variability in acuity or complexity levels of recipients of SIPP services using the three preliminary tiered reimbursement model options selected. The first approach is to classify recipients into tiers based on a diagnosis indicating potentially physically violent or aggressive behaviors, or a diagnosis of intellectual or developmental disability (I/DD) or autism. The second and third approaches identify the complexity of a member using the 3M™ APR DRG software. All three approaches rely on diagnosis information reported in the claims and encounters for SIPP services to determine differences in acuity or complexity between recipients. Additionally, for all three approaches, only diagnosis information submitted by the SIPP provider in the claim or encounter record for a specific stay is considered when determining the tier assignment for that stay, without consideration for diagnosis information that may have been submitted on any other claims or encounter records for the same member. Each approach is described in more detail below.

Approach 1: Diagnosis of Potentially Physically Violent or Aggressive Behaviors; or Diagnosis of I/DD or Autism

The first approach classifies individual stays into one of four tiers based on the following diagnosis categories:

- Tier 1: Recipient is not diagnosed as potentially physically violent; not diagnosed with I/DD or autism
- Tier 2: Recipient is diagnosed as potentially physically violent; not diagnosed with I/DD or autism
- Tier 3: Recipient is not diagnosed as potentially physically violent; diagnosed with I/DD or autism
- Tier 4: Recipient is diagnosed as potentially physically violent; diagnosed with I/DD or autism

Each tier is established based on the presence of specific ICD-10 diagnosis codes on the provider claim or encounter record:

- To identify recipients with a diagnosis indicating potentially physically violent or aggressive behaviors, we relied on the presence of ICD-10 diagnosis code 'F3481' (Disruptive Mood Dysregulation Disorder). We note that diagnosis code 'R456' (Violent Behavior) was added to the ICD-10 diagnosis code set in October of 2023. While this code could potentially be used to better identify recipients diagnosed as physically violent, it was not present on any of the CY 2023 claims or encounter records in the Analytical Dataset.

- To identify recipients diagnosed with I/DD, we relied on the list of diagnosis codes from the Healthcare Cost and Utilization Project (HCUP) Clinical Classifications Software (CCS) diagnosis category of '654' (Developmental Disorders).

- To identify recipients diagnosed with autism, we relied on the presence of ICD-10 diagnosis code 'F840' (Autistic Disorder).

Exhibit 2 includes a summary of CY 2023 services across all SIPP provider separately for each of the four tiers described above. For each individual provider, we do not observe material differentiation between the average per diem paid for recipients across tiers, supporting our understanding that providers are generally reimbursed on a per diem basis with little to no differentiation based on individual recipient acuity or complexity. We do, however, observe differences in the average per diem across tiers at a statewide level, which appears to be primarily driven by higher reimbursement rates among the providers that treat recipients diagnosed with I/DD or autism.

Exhibit 2 also includes a summary of CY 2023 services across all out-of-state providers of similar psychiatric residential treatment services. We observe a similar distribution of stays across diagnosis categories for these out-of-state providers as we observe for the Florida SIPP providers.

Approach 2: 3M™ APR DRG Classifications and Weights

The second approach relies on the version 41 3M™ APR DRG classifications and associated weights. The APR DRG grouper primarily relies on ICD-10 diagnosis codes, but also considers ICD-10 procedure codes and other patient-related claims data, to classify individual facility stays into specific APR DRG and Severity of Illness (SOI) categories. Each APR DRG has four SOI classifications (i.e., minor, moderate, major, and extreme).

SIPP providers have asserted that they are financially responsible for medical, pharmaceutical, dental, or vision services unrelated to the psychiatric or behavioral health needs of recipients receiving SIPP services in their facilities under the current program design. Consideration for medical, pharmaceutical, dental, or vision needs has been identified as a potential benefit of an APR DRG based tiered reimbursement model assuming no change in current program design. If the program design were revised to carve medical, pharmaceutical, dental, and vision services unrelated to the psychiatric and behavioral health needs of recipients of SIPP services out of SIPP per diem rates, Approach 1 may be best aligned with the revised program design.

Exhibit 3 summarizes CY 2023 services by APR DRG assignment. Of the 123,989 days associated with SIPP stays with CY 2023 last dates of service, 120,766 days (97%) are assigned to one of 33 mental health APR DRG and SOI combinations. The most prevalent APR DRG assignment is for Bipolar Disorders, accounting for just over half of all days associated with SIPP stays. While 3,223 days are assigned to non-mental health APR DRGs, the assignment of a non-mental health APR DRG does not necessarily indicate that a mental health related diagnosis code was not present.

Exhibit 3 similarly summarizes experience for out-of-state providers of similar psychiatric residential treatment services. While the volume of services provided by out-of-state providers is minimal, we do not observe a material difference in the distribution of APR DRG assignments between services provided by out-of-state and in-state providers, and Bipolar Disorders are also the most common APR DRG assignment for services provided by out-of-state providers.

Approach 3: 3M™ APR DRG SOI Classifications

The third approach uses only the SOI classifications from the APR DRG assignments described above. Exhibit 4 includes a summary of CY 2023 services across all SIPP and out-of-state providers for each of the SOI classifications. None of the CY 2023 stays are assigned to SOI 4 (Extreme), and 3% of days are associated with stays assigned to SOI 3 (Major). For each individual provider, we do not observe material differentiation between the average per diem paid for recipients across SOIs, again implying that providers are generally reimbursed on a per diem basis with little to no differentiation based on individual recipient acuity or complexity. We do, however, observe differences in the average per diem across SOIs at a statewide level, which appears to be primarily driven by higher reimbursement rates among the providers that treat recipients assigned to higher SOIs.

LIMITATIONS ON USE OF DIAGNOSIS DATA

Each of the approaches outlined above relies on diagnosis information submitted by providers in administrative claims and encounter data. This reliance places a substantial emphasis on the quality and consistency of diagnosis reporting by the providers and diagnosis collection by the managed care plans. Current reimbursement methodologies do not explicitly rely on diagnostic coding, and the diagnosis reporting may therefore not be fully reflective of a recipient's complexity or acuity. Further, diagnostic coding could substantially improve upon implementation of a model that relies on any of the three approaches outlined above.

Additionally, there are several drivers of patient level of need reported by SIPP providers in survey responses that are not fully measured using diagnosis coding. For example, while there is an ICD-10 code for violent behavior, this code was added to the ICD-10 code set on October 1, 2023, and is not observed in the CY 2023 SIPP experience analyzed. Client assessment data may provide a more complete picture of client acuity or complexity. However, based on survey responses from SIPP providers, we understand that there are a variety of different assessment tools currently used by SIPP providers to evaluate recipient needs.

Illustrative Tiered Reimbursement Rate Modeling

Milliman has modeled illustrative rates under the three preliminary tiered reimbursement model options selected. However, as previously described, all three of the preliminary tiered reimbursement models require the collection of additional data and the completion of further analysis to evaluate, refine, and validate their appropriateness for adjusting payments for SIPP services or to establish final rate tier classifications and payment rates. The Agency therefore recommends further evaluation and refinement of the tiered reimbursement models to establish final recommended tiered payment rates leveraging revised or supplemental diagnosis information, updated SIPP provider cost report data, and additional input and feedback from the SIPP providers and managed care plans.

At the direction of the Agency, tiered rates have been calculated targeting simulated payments equal to a projection of CY 2024 reimbursement levels for SIPP services with last dates of service on January 1, 2023, through December 31, 2023, plus $10,125,164 in annualized, recurring appropriation that was provided in the SFY 2024-2025 GAA to increase SIPP rates relative to baseline funding levels. Both claims reimbursed on a fee-for-service basis and encounters reimbursed by managed care plans have been included in our modeling of illustrative rates, and some of these claims and encounters span service dates going back as far as CY 2021.

To project CY 2024 reimbursement levels, we applied an adjustment to the actual payment amount reported on each claim or encounter to trend CY 2021, CY 2022, and CY 2023 reimbursement levels to a CY 2024 basis. We calculated this adjustment as the CY 2024 State fee-for-service per diem rate divided by the average effective State fee-for-service per diem rate for the service dates spanned by the claim or encounter (i.e., the average reimbursement rate that would have been paid had the claim or encounter been reimbursed at the prevailing State fee-for-service per diem rate). The impact of this adjustment varies across individual claims and encounters depending on each claim or encounter's service dates. However, across all SIPP services included in this modeling, total projected payments under CY 2024 reimbursement levels are 16.4% higher than actual reported paid amounts.

APPROACH 1: DIAGNOSIS OF POTENTIALLY PHYSICALLY VIOLENT OR AGGRESSIVE BEHAVIORS; OR DIAGNOSIS OF I/DD OR AUTISM

Under this preliminary tiered reimbursement model, each stay is classified into one of four reimbursement tiers. For each tier, we establish an illustrative relativity factor, which is intended to represent the relative cost to the provider of providing care for a recipient classified into a given tier.

These illustrative relativity factors are based on a high-level review of reimbursement structures in other states and expectations around cost drivers of providing care. These factors are not a direct result of our review of current Florida SIPP providers' operations or experience and may not accurately reflect expected variation in staffing or other resource requirements necessitated by patient disease complexity and behavior acuity. Their use is only intended to allow the reader to review a potential outcome of this type of tiered reimbursement model.

Figure 6 below displays the illustrative relativity factors and resulting illustrative CY 2024 reimbursement rates for each tier, inclusive of the $10.1 million in annual recurring appropriation provided in the SFY 2024-2025 GAA to increase SIPP rates relative to baseline funding levels.

FIGURE 6: APPROACH 1 ILLUSTRATIVE RELATIVITY FACTORS AND RATES BY TIER

TIER LEVEL	DIAGNOSTIC CATEGORY TIER DESCRIPTION	ILLUSTRATIVE RELATIVITY FACTOR	ILLUSTRATIVE SIPP REIMBURSEMENT RATE
Tier 1	Recipient is not diagnosed as potentially physically violent; not diagnosed with I/DD or autism	1.00	$675.57
Tier 2	Recipient is diagnosed as potentially physically violent; not diagnosed with I/DD or autism	1.05	$709.35
Tier 3	Recipient is not diagnosed as potentially physically violent; diagnosed with I/DD or autism	1.10	$743.12
Tier 4	Recipient is diagnosed as potentially physically violent; diagnosed with I/DD or autism	1.15	$776.90

APPROACH 2: 3M™ APR DRG CLASSIFICATIONS AND WEIGHTS

The second approach relies on the 3M™ APR DRG classifications and relative weights to establish illustrative relativity factors and resulting illustrative CY 2024 reimbursement rates. The APR DRG relative weights represent the relative average billed charges for acute inpatient hospital stays assigned to a particular APR DRG relative to the average charges of all acute inpatient hospital stays. Because we are developing per diem rates, we adjusted the 3M™ version 41 APR DRG relative weights to exclude the portion of the weights that reflect expected variation in length of stay.[8] We then re-centered the adjusted relative weights to the SIPP claims experience, such that the average re-centered relative weight for all SIPP days in the Analytical Dataset is 1.0.

APR DRG classifications and weights were developed by 3M™ for the specific purpose of adjusting payments for acute inpatient hospital services and may not fully reflect expected variation in staffing or other resource requirements necessitated by patient disease complexity and behavior acuity for SIPP services. Their use is only intended to allow the reader to review a potential outcome of this type of tiered reimbursement model.

Figure 7 below displays the average adjusted and re-centered 3M™ relative weights and resulting illustrative CY 2024 average reimbursement rates for each base APR DRG classification, inclusive of the $10.1 million in annual recurring appropriation provided in the SFY 2024-2025 GAA to increase SIPP rates relative to baseline funding levels. We limit this summary to include only the mental health base APR DRGs that were assigned to SIPP claims in our model.

[8] APR DRG v41.0 Weights and Trims - Traditional calculation. Published by 3M™ on September 13, 2023. Retrieved from 3M™ HIS website on September 13, 2023.

FIGURE 7: APPROACH 2 AVERAGE DRG WEIGHTS AND ILLUSTRATIVE RATES BY BASE APR DRG

DRG	APR DRG DESCRIPTION	AVERAGE ADJUSTED AND RE-CENTERED RELATIVE WEIGHT	AVERAGE ILLUSTRATIVE SIPP REIMBURSEMENT RATE
750	Schizophrenia	0.9503	$666.98
751	Major Depressive Disorders and Other or Unspecified Psychoses	0.9477	$665.11
752	Disorders Of Personality and Impulse Control	1.0543	$739.97
753	Bipolar Disorders	0.9393	$659.24
754	Depression Except Major Depressive Disorder	0.9677	$679.14
755	Adjustment Disorders and Neuroses Except Depressive Diagnoses	1.0690	$750.27
756	Acute Anxiety and Delirium States	2.0859	$1,463.94
757	Organic Mental Health Disturbances	1.2445	$873.46
758	Behavioral Disorders	0.9411	$660.50
759	Eating Disorders	1.2635	$886.77
760	Other Mental Health Disorders	1.1075	$777.24

APPROACH 3: 3M™ APR DRG SOI CLASSIFICATIONS

Under the third tiered reimbursement model, each stay is classified into one of three reimbursement tiers based on 3M™ APR DRG SOI assignment. While there are four SOI levels in the 3M™ APR DRG classification system, no stays in the Analytical Dataset were assigned to SOI level 4 (Extreme), and we therefore collapsed SOI levels 3 and 4 into a single rate tier. For each tier, we establish an illustrative relativity factor, which is intended to represent the relative cost to the provider of providing care for a recipient classified into a given tier.

These illustrative relativity factors are approximately based on the average re-centered relative weights for stays assigned to the given SOI levels. These factors are not a direct result of our review of current Florida SIPP providers' operations or experience and may not fully reflect expected variation in staffing or other resource requirements necessitated by patient disease complexity and behavior acuity. They are only intended to allow the reader to review a potential outcome of this type of tiered reimbursement model.

Figure 8 below displays illustrative relativity factors and resulting illustrative CY 2024 reimbursement rates for each tier, inclusive of the $10.1 million in annual recurring appropriation provided in the SFY 2024-2025 GAA to increase SIPP rates relative to baseline funding levels.

FIGURE 8: APPROACH 3 ILLUSTRATIVE RELATIVITY FACTORS AND RATES BY TIER

TIER LEVEL	SOI TIER DESCRIPTION	ILLUSTRATIVE RELATIVITY FACTOR	ILLUSTRATIVE SIPP REIMBURSEMENT RATE
Tier 1	SOI 1: Minor	1.00	$684.25
Tier 2	SOI 2: Moderate	1.05	$718.47
Tier 3	SOI 3/4: Major / Extreme	1.10	$752.68

Data Reliance and Important Caveats

This report is intended for the internal use of the Agency to assist in evaluating options and approaches to implement a tiered reimbursement model for Statewide Inpatient Psychiatric Program (SIPP) services. This report may not be appropriate, and should not be used, for other purposes. Milliman recognizes that materials it delivers to the Agency may be public records subject to disclosure to third parties; however, Milliman does not intend to benefit, and assumes no duty or liability to other parties who receive this work. We understand this report will be shared publicly with the Executive Office of the Governor's Office of Policy and Budget, the chair of the Senate Committee on Appropriations, and the chair of the House of Representatives Appropriations Committee. This report should be distributed in its entirety. Any user of this report must possess a certain level of expertise to not misinterpret the information presented.

Milliman completed analysis and illustrative rate modeling for three preliminary tiered reimbursement models selected by the Agency. However, there are a number of limitations associated with these analyses. Because current reimbursement methodologies do not rely on ICD-10 diagnosis coding, the coding in the CY 2023 claims and encounter records that we have relied on may not fully reflect patient disease complexity and behavior acuity. Additionally, the current SIPP cost report has limited instructions and granularity into the reported costs, and the data collected does not provide sufficient granularity to support evaluation and development of a tiered reimbursement model that accounts for differing levels of care necessitated by patient disease complexity and behavior acuity. Due to these and other limitations, all three of the preliminary tiered reimbursement models would require the collection of additional data and the completion of further analysis to evaluate, refine, and validate their appropriateness for adjusting payments for SIPP services or to establish final rate tier classifications and payment rates.

Milliman is not advocating for, recommending, or endorsing any specific tiered reimbursement model for SIPP services. All final decisions regarding the design, modeling methodologies, parameters, and assumptions, and other aspects of the tiered reimbursement model are the responsibility of the Agency.

We relied on several sources of data from the participating managed care capitated plans, the Agency, and other sources in performing the analyses described in this report. Those data sources include Agency eligibility data, capitated plan encounter data, state fee-for-service experience, SIPP provider cost reports, results from surveys of the SIPP providers and managed care plans, and other supporting information, data, and guidance received from the Agency. We relied on the Agency for the accuracy of the eligibility data, fee-for-service data, and other supporting information. We also relied on the Agency for the collection and processing of the capitated plan encounter data and other supporting information. We also relied on the Agency for information on the identification of SIPP services and similar psychiatric residential treatment services provided by out-of-state providers, CY 2021-2024 fee-for-service SIPP rates, and other data. We relied on the capitated plans to provide accurate encounter data as certified by the plan and accurate follow-up information related to this data, as well as the accuracy of information provided in survey responses. We relied on information retrieved from the Florida Medicaid Provider Master List (PML) to identify out-of-state Medicaid Provider IDs. We relied on the ICD-10 diagnosis code list produced by CMS and the Healthcare Cost and Utilization Project (HCUP) Clinical Classifications Software (CCS) diagnosis categories to classify SIPP stays to certain diagnosis categories. We relied on APR DRG assignments produced by the 3M™ Grouper Plus Content Services (GPCS), as well as DRG classifications and weights published on the 3M™ Health Information Systems (HIS) website. We relied on SIPP providers for the accuracy of information provided in cost reports and survey responses. **We did not audit any of the data sources or other information**, but we did assess the information for reasonableness. If the data or other information used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

Milliman developed certain models to calculate the values included in this report. The intent of the models was to analyze and model illustrative rates for preliminary tiered reimbursement models for SIPP services. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant ASOPs. The models, including all input, calculations, and output, may not be appropriate for any other purpose. The models rely on interim assumptions and methodologies and will necessarily differ from actual results in the event the State implements a tiered reimbursement strategy. It is certain that actual experience will not conform exactly to the assumptions used.

Actual reimbursement for SIPP services will differ from the simulated estimates due to differences in health care trend, managed care efficiency, enrollment changes, the impact of the COVID-19 pandemic and the PHE unwinding, changes in diagnosis coding completeness and accuracy, potential shifting of utilization and case-mix between SIPP and non-SIPP providers of similar services, changes in negotiated reimbursement rates and Single Case Agreements between managed care plans and SIPP providers, and many other factors. It is certain that actual experience will not

conform exactly to the assumptions used. Actual amounts will differ from simulated amounts to the extent that actual experience is better or worse than expected.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. James Johnson is an actuary at Milliman, is a member of the American Academy of Actuaries, and meets the Qualification Standards of the Academy to render the actuarial communication contained herein. To the best of his knowledge and belief, this communication is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Tools Archive for Clinical Classifications Software Refined. Healthcare Cost and Utilization Project (HCUP). March 2021. Agency for Healthcare Research and Quality, Rockville, MD.
www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccsr_archive.jsp

EXHIBITS

This material assumes that the reader is familiar with the State of Florida's Medicaid program, Florida's Statewide Inpatient Psychiatric Program, Florida Medicaid benefits, and provider rate setting principles. The material was prepared solely to assist the Agency in evaluating tiered reimbursement rate model options for the Statewide Inpatient Psychiatric Program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit 1
State of Florida Medicaid - Agency for Health Care Administration (Agency)
Statewide Inpatient Psychiatric Program Trend Rate Analysis
Overview of Current SIPP Providers Based on Provider-Submitted Cost Reports

Medicaid Provider ID	Provider Name	State	City	Severe Emotional Disorder Disturbance Treatment	Conduct Disorder Treatment	Substance Abuse Treatment	Sexual Offender Treatment	Specialized Eating Disorder Treatment	Developmentally Disabled	Mental Illness Treatment	Parent-Youth Conflict	Issues of Abuse and Neglect Treatment	Emotional and Behavioral Problems Treatment	Other Specialized Services	Client Considerations (Children and Youth Not Accepted for Placement)
003300300	Baycare Behavioral Health	FL	New Port Richey	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes		Sexual offender
114277100	Brooksville Youth Academy	FL	Brooksville	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes		
060304016	Citrus Health Network	FL	Pembroke Pines	Yes	No	Yes	No	No	No	Yes	Yes	Yes	Yes	Victim Of Human Trafficking , Chronic Behavioral Problems	
060849116	Daniel Memorial, Inc.	FL	Jacksonville	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes		Pregnant, not medically stable, not cognitively appropriate. Not able to treat sexually aggressive youth.
029573622	Devereux Foundation, Inc.	FL	Orlando	Yes	Yes	No	No	No	No	Yes	Yes	Yes	Yes		Youth without primary Mental Health diagnosis
113376200	Fairwinds Treatment Center	FL	Clearwater	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
101789200	Family Center For Recovery	FL	Lantana	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
029582516	Florida Palms Academy	FL	Hollywood	Yes	No	Yes	No	No	No	Yes	Yes	Yes	Yes		Children who do not meet medical criteria for SIPP
012293100	Gulf Coast Treatment Center	FL	Ft Walton Bch	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes		
060271019	Lakeview Center, Inc.	FL	Pensacola	Yes	No	No	No	No	No	No	No	No	No		
070565916	Palm Shores Behavioral Health Center	FL	Bradenton	No	No	No	No	No	No	Yes	No	No	No		Sexual offenders, IQ below 80.
023780200	Personal Enrichment Through Mental Health Services	FL	Pinellas Park	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
105211200	Rockland Treatment Center	FL	New Port Richey	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
070894917	Sandy Pines Behavioral	FL	Tequesta	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Trauma, Grief & Loss	Mental illness is not the primary diagnosis
112795300	Sms Behavioral Health Services	FL	Daytona Beach	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
111751400	Sms Healthcare Inc	FL	Ocala	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
104784700	Suncoast Behavioral Health Center	FL	Bradenton	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
022844200	The Devereux Foundation	FL	Viera	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Exhibit 2
State of Florida Medicaid - Agency for Health Care Administration (Agency)
Statewide Inpatient Psychiatric Program Tiered Rate Analysis
SIPP Provider Experience by by Diagnosis Category - CY 2023 Discharges

FL SIPP Providers

Diagnosis Category	Description	Days	Actual Paid	Estimated Effective FFS Paid Amount	Actual Per Diem	Estimated Effective FFS Per Diem	Ratio of Actual to Estimated Effective FFS Per Diem
Tier 1	Recipient is Not Diagnosed as Potentially Physically Violent; Not Diagnosed with I/DD or Autism	61,539	$32,612,664	$31,106,370	$529.95	$505.47	1.05
Tier 2	Recipient is Diagnosed as Physically Violent; Not Diagnosed with I/DD or Autism	41,666	21,473,247	20,974,704	515.37	503.40	1.02
Tier 3	Recipient is Not Diagnosed as Potentially Physically Violent; Diagnosed with I/DD or Autism	7,617	4,357,291	3,814,232	572.05	500.75	1.14
Tier 4	Recipient is Diagnosed as Potentially Physically Violent; Diagnosed with I/DD or Autism	13,167	7,617,899	6,592,682	578.56	500.70	1.16
FL SIPP Providers Subtotal		**123,989**	**$66,061,101**	**$62,487,989**	**$532.80**	**$503.98**	**1.06**

Out-of-State Providers with Similar Services

Diagnosis Category	Description	Days	Actual Paid	Estimated Effective FFS Paid Amount	Actual Per Diem	Estimated Effective FFS Per Diem	Ratio of Actual to Estimated Effective FFS Per Diem
Tier 1	Recipient is Not Diagnosed as Potentially Physically Violent; Not Diagnosed with I/DD or Autism	4,232	$1,962,095	$2,103,849	$463.63	$497.13	0.93
Tier 2	Recipient is Diagnosed as Physically Violent; Not Diagnosed with I/DD or Autism	2,567	1,090,680	1,282,152	424.89	499.47	0.85
Tier 3	Recipient is Not Diagnosed as Potentially Physically Violent; Diagnosed with I/DD or Autism	892	379,194	447,005	425.11	501.13	0.85
Tier 4	Recipient is Diagnosed as Potentially Physically Violent; Diagnosed with I/DD or Autism	404	207,545	201,324	513.73	498.33	1.03
Out-of-State Providers with Similar Services Subtotal		**8,095**	**$3,639,515**	**$4,034,330**	**$449.60**	**$498.37**	**0.90**

Exhibit 3
State of Florida Medicaid - Agency for Health Care Administration (Agency)
Statewide Inpatient Psychiatric Program Tiered Rate Analysis
SIPP Provider Experience by APR DRG - CY 2023 Discharges

FL SIPP Providers
Mental Health APR DRGs

Version 41 APR DRG	Version 41 APR DRG Description	Days	Actual Paid	Estimated Effective FFS Paid Amount	Actual Per Diem	Estimated Effective FFS Per Diem	Ratio of Actual to Estimated Effective FFS Per Diem
753	BIPOLAR DISORDERS	61,568	$32,308,225	$30,979,589	$524.76	$503.18	1.04
755	ADJUSTMENT DISORDERS AND NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	19,404	10,280,971	9,804,611	529.84	505.29	1.05
758	BEHAVIORAL DISORDERS	12,758	6,794,801	6,422,901	532.59	503.44	1.06
751	MAJOR DEPRESSIVE DISORDERS AND OTHER OR UNSPECIFIED PSYCHOSES	13,835	7,410,798	7,021,204	535.66	507.50	1.06
750	SCHIZOPHRENIA	5,560	2,924,071	2,779,247	525.91	499.86	1.05
757	ORGANIC MENTAL HEALTH DISTURBANCES	2,685	1,479,563	1,345,670	551.05	501.18	1.10
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	2,247	1,140,223	1,126,919	507.44	501.52	1.01
759	EATING DISORDERS	885	597,426	452,744	675.06	511.57	1.32
756	ACUTE ANXIETY AND DELIRIUM STATES	793	420,307	399,613	530.02	503.93	1.05
760	OTHER MENTAL HEALTH DISORDERS	778	396,475	397,347	509.61	510.73	1.00
752	DISORDERS OF PERSONALITY AND IMPULSE CONTROL	253	202,841	128,568	801.74	508.17	1.58
FL SIPP Providers Mental Health APR DRGs Subtotal		**120,766**	**$63,955,701**	**$60,858,415**	**$529.58**	**$503.94**	**1.05**

Other APR DRGs

Version 41 APR DRG	Version 41 APR DRG Description	Days	Actual Paid	Estimated Effective FFS Paid Amount	Actual Per Diem	Estimated Effective FFS Per Diem	Ratio of Actual to Estimated Effective FFS Per Diem
660	MAJOR HEMATOLOGIC OR IMMUNOLOGIC DIAGNOSES EXCEPT SICKLE CELL CRISIS AND COAGULATIOI	773	$463,200	$383,718	$599.22	$496.40	1.21
776	OTHER DRUG ABUSE AND DEPENDENCE	1,939	1,344,525	983,555	693.41	507.25	1.37
861	SIGNS, SYMPTOMS AND OTHER FACTORS INFLUENCING HEALTH STATUS	102	60,600	52,358	594.12	513.31	1.16
775	ALCOHOL ABUSE AND DEPENDENCE	299	192,175	153,480	642.73	513.31	1.25
774	COCAINE ABUSE AND DEPENDENCE	56	22,400	28,745	400.00	513.31	0.78
770	DRUG AND ALCOHOL ABUSE OR DEPENDENCE, LEFT AGAINST MEDICAL ADVICE	54	22,500	27,719	416.67	513.31	0.81
FL SIPP Providers Other APR DRGs Subtotal		**3,223**	**$2,105,400**	**$1,629,574**	**$653.24**	**$505.61**	**1.29**

Out-of-State Providers with Similar Services
Mental Health APR DRGs

Version 41 APR DRG	Version 41 APR DRG Description	Days	Actual Paid	Estimated Effective FFS Paid Amount	Actual Per Diem	Estimated Effective FFS Per Diem	Ratio of Actual to Estimated Effective FFS Per Diem
753	BIPOLAR DISORDERS	3,391	$1,484,851	$1,695,611	$437.88	$500.03	0.88
758	BEHAVIORAL DISORDERS	2,637	1,183,337	1,308,697	448.74	496.28	0.90
757	ORGANIC MENTAL HEALTH DISTURBANCES	473	211,675	235,059	447.52	496.95	0.90
751	MAJOR DEPRESSIVE DISORDERS AND OTHER OR UNSPECIFIED PSYCHOSES	429	211,860	209,609	493.85	488.60	1.01
755	ADJUSTMENT DISORDERS AND NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	730	316,299	362,213	433.29	496.18	0.87
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	330	158,745	169,245	481.05	512.86	0.94
750	SCHIZOPHRENIA	105	72,748	53,898	692.84	513.31	1.35
Out-of-State Providers with Similar Services Mental Health APR DRGs Subtotal		**8,095**	**$3,639,515**	**$4,034,330**	**$449.60**	**$498.37**	**0.90**

Exhibit 4
State of Florida Medicaid - Agency for Health Care Administration (Agency)
Statewide Inpatient Psychiatric Program SOI Tiered Rate Analysis
SIPP Provider Experience by APR DRG Severity of Illness (SOI) Level - CY 2023 Discharges

FL SIPP Providers

Severity of Illness Category	Description	Days	Actual Paid	Estimated Effective FFS Paid Amount	Actual Per Diem	Estimated Effective FFS Per Diem	Ratio of Actual to Estimated Effective FFS Per Diem
Tier 1	Minor	64,363	$33,582,812	$32,504,801	$521.77	$505.02	1.03
Tier 2	Moderate	55,552	30,035,584	27,953,733	540.68	503.20	1.07
Tier 3	Major or Extreme	4,074	2,442,705	2,029,455	599.58	498.15	1.20
FL SIPP Providers Subtotal		**123,989**	**$66,061,101**	**$62,487,989**	**$532.80**	**$503.98**	**1.06**

Out-of-State Providers with Similar Services

Severity of Illness Category	Description	Days	Actual Paid	Estimated Effective FFS Paid Amount	Actual Per Diem	Estimated Effective FFS Per Diem	Ratio of Actual to Estimated Effective FFS Per Diem
Tier 1	Minor	6,604	$2,928,038	$3,287,542	$443.37	$497.81	0.89
Tier 2	Moderate	1,355	626,729	677,893	462.53	500.29	0.92
Tier 3	Major or Extreme	136	84,748	68,895	623.15	506.58	1.23
Out-of-State Providers with Similar Services Subtotal		**8,095**	**$3,639,515**	**$4,034,330**	**$449.60**	**$498.37**	**0.90**

APPENDIX A

References: Other State Research

APPENDIX A

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APPENDIX B

IRM Tiered Rate Model Work Plan

Florida Agency for Health Care Administration
Statewide Inpatient Psychiatric Program Tiered Rate Analysis

August 1, 2024

This material assumes that the reader is familiar with the State of Florida's Medicaid program, Florida's Statewide Inpatient Psychiatric Program, Florida Medicaid benefits, and provider rate setting principles. The material was prepared solely to assist the Agency in evaluating tiered reimbursement rate model options for the Statewide Inpatient Psychiatric Program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

APPENDIX B

PROPOSED APPROACH AND WORK PLAN TO ESTABLISH FINAL RECOMMENDED TIERED PAYMENT MODEL

An independent rate model (IRM) approach can be distinguished from other provider payment methodologies in that it estimates the average costs for each service given the resources (salaries and other expenses) reasonably expected to be necessary to deliver the services. This approach relies on multiple independent data sources, as well as input from subject matter experts (SMEs) to develop rate model assumptions to construct the fee schedule rates. By contrast, many cost-based methods rely primarily on the actual reported historical costs incurred while delivering services, which can be affected by operating or service delivery decisions made by providers. These operating or service delivery decisions may be inconsistent with program service delivery standards or affected by potential program funding limitations that do not necessarily consider the average resource requirements associated with providing the treatment model. Figure 9 provides an overview of the key components and elements of the IRM approach.

FIGURE 9: INDEPENDENT RATE MODEL COMPONENTS

Component	Elements	Sub-elements	Clarifying Notes
Direct Care Staff and Supervisor Salaries and Wages	Service-related Time	Direct Time	Corresponding time unit, or staffing requirement assumptions where not defined Adjusted for staffing ratios for some services (i.e., more than one person served concurrently, e.g., in group counseling)
		Indirect Time	Service-necessary planning, note taking and preparation time
		Transportation Time	Travel time related to providing service
		PTO / Training / Conference Time	Paid vacation, holiday, sick, training and conference time.
		Supervisor Time	Supervisory time of direct care staff
	Wage Rates	Can Vary for Overtime and Weekend Shift Differentials	Wage rates vary depending on types of direct service employees, which have been assigned to provider groups
Employee Related Expenses	Payroll-related Taxes and Fees	Federal Insurance Contributions Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Insurance (SUI), Workers Compensation	Applicable to all employees, and varies by wage level assumption

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Component	Elements	Sub-elements	Clarifying Notes
	Employee Benefits	Health, Dental, Vision, Life and Disability Insurance, and Retirement Benefits	Amounts may vary by provider type
Transportation	Vehicle Operating Expenses	Includes all Ownership and Maintenance-Related Expenses	
Administration, Program Support, Overhead	All other business-related costs	Includes program operating expenses, including management, accounting, legal, information technology, etc.	Applied as a percentage of total costs
Room and Board	Costs for housing	Includes all living expenses as these are residential facilities	Amounts may vary based upon tier to account for facility enhancements

Below is an overview of the work plan we have developed to provide final recommended rates under a tiered reimbursement model.

Task 1 – Stakeholder Engagement

We recommend a provider survey and four stakeholder meetings to capture the current SIPP provider experience and requirements to meet the needs of the recipients' receiving services at each tier level.

The cost reports for some SIPP providers are many years old and do not capture resources at the tier level. The provider survey will capture current wages, staffing levels (by tier), education and training requirements (by tier), costs (by tier), and other relevant service-related information. The provider survey will be reviewed by stakeholders to ensure it aligns with the providers' reporting structure and capabilities.

In addition to the provider survey, we propose four stakeholder meetings. The stakeholder meetings will capture feedback on the current provider experience that may not be easily reportable (e.g., recent changes in wages or turnover, challenges with staffing specific tiers, facility costs for tiers, etc.), review the provider survey, and collect feedback on the draft rates and cost report changes.

Task 2 – Rate Setting

We will compile the provider survey results and will aggregate the information by tier to develop tier specific SIPP per diem rates. For SIPP services, we would utilize a 24/7 Shift-Based Rate Model IRM. A 24/7 shift-based model is used for services where more than one individual is served in a residential setting, where direct care staff are expected to be on-site for scheduled periods or shifts and set up to provide care on a 24/7 basis. This model would be adjusted to align with the requirements to deliver services to each of the tiers.

We recommend reviewing the draft calculated rates with the Agency and the stakeholders to capture their feedback. Once we have captured all feedback, we will finalize the rates and include them in the draft and final report.

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Task 3 – Cost Report Adjustments

As previously mentioned, the cost report has limitations as it is currently constructed and should be updated to better define allowable and non-allowable costs, while also referencing federal cost report rules. Since the cost report is used directly for rate setting, it is important that it exclude non-allowable costs and only reflect costs for services included in the calculated per diem rate – i.e., many SIPP providers deliver non-SIPP services and the cost report needs to be prescriptive in how costs for SIPP services are allocated. We recommend reviewing other states' SIPP cost reports for an inventory of best practices and updating the Florida cost report to reflect those best practices. We will review the cost report with the Agency and SIPP providers for feedback.

Task 4 – Final Report and Rate Recommendations

The final report and recommendations will be delivered to the Agency. The report will include:

- Stakeholder feedback
- Data captured from the provider survey
- SIPP rates that are adjusted by tier
- Cost report and instructions updates, inclusive of recommended policy changes

We will present the draft report for the Agency's review and will finalize the report based upon the Agency's feedback. We will review every component of the report throughout the project with both the Agency and stakeholders.

APPENDIX C

SIPP Illustrative Tiered Rate Model Methodology and Data Sources

Florida Agency for Health Care Administration
Statewide Inpatient Psychiatric Program Tiered Rate Analysis

August 1, 2024

This material assumes that the reader is familiar with the State of Florida's Medicaid program, Florida's Statewide Inpatient Psychiatric Program, Florida Medicaid benefits, and provider rate setting principles. The material was prepared solely to assist the Agency in evaluating tiered reimbursement rate model options for the Statewide Inpatient Psychiatric Program. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

APPENDIX C

BASE DATA

To perform the illustrative tiered rate analyses described in this report, we relied on claims data files provided to us by the Agency's Bureau of Medicaid Data Analytics (MDA). These claims data files include inpatient fee-for-service (FFS) claim and managed care encounter records from the Florida Medicaid Management Information System (FMMIS). Medicare crossover claims are excluded from the data sets provided by MDA because Medicare is the primary payer on these claims. The FFS claim and managed care encounter records consist of clinical and administrative information about each inpatient hospital stay, including information required to assign a 3M™ APR DRG to each claim using 3M™ Grouper Plus Content Services (GPCS) software and information required to calculate payment according to Florida Medicaid's per diem-based payment methodology for SIPP services.

The claims data spans multiple years of incurred dates and includes claims submitted through December 31, 2023. Prior to grouping and pricing the data for use in the illustrative rate models, we applied a number of adjustments and exclusions to the inpatient FFS claim and managed care encounter records that we received from the Agency. These adjustments and exclusions are based on documented processes for simulations of the hospital DRG-based payment systems used in past years, our own analysis of the data, and additional information from the Agency. We provide additional detail regarding these adjustments and exclusions below. Based on applying these adjustments and exclusions, we established a data set that will be used for the SIPP rate analysis (the Analytical Dataset) containing 132,084 days from FFS claims and managed care encounter records, from inpatient stays with last dates of service on January 1, 2023, through December 31, 2023, submitted through December 31, 2023.

In developing the Analytical Dataset, we performed reasonableness and internal consistency testing and analysis. The intent of this testing and analysis was to understand and appropriately use the source data and validate that our process is working as intended. We also solicited feedback from MMA managed care plans to better understand and use their encounter data records. The Analytical Dataset represents the culmination of our data processing steps and other testing and validation performed.

As described further below, we also relied on other sources to develop the Analytical Dataset and simulate payments under both the baseline and simulated payment scenarios in the illustrative rate models. In relying on these data sources, we reviewed them for reasonableness, but we did not audit them.

ADJUSTMENTS AND EXCLUSIONS APPLIED TO CLAIMS AND ENCOUNTER DATA

We applied similar adjustments and exclusions to the inpatient FFS claim and managed care encounter data as the methodologies documented in the Simulation of SFY 2024-2025 APR DRG Payments Methodology Report dated January 31, 2024. These adjustments and exclusions fall into these broad categories:

1. Limiting the data to a unique set of inpatient admissions that were reimbursed by the Medicaid program. Additionally, based on our review of the SIPP claims and encounters, we identified records with CY 2021 or 2022 last dates of service that appeared to be interim claims for longer stays with last dates of service in CY 2023 for inclusion in the Analytical Dataset.

2. Adding and adjusting information on the claims data to facilitate appropriate use of key data fields in the illustrative tiered rate models.

3. Removing claims not identified as SIPP services or similar psychiatric residential treatment services provided by out-of-state providers or not eligible for inclusion in the Analytical Dataset for simulating illustrative tiered SIPP rates, based on direction from the Agency, and analysis of potential data issues.

Removing Claims Not Eligible for SIPP Reimbursement or Inclusion in Analytical Dataset

To limit the data to SIPP services and similar psychiatric residential treatment services provided by out-of-state providers, as well as to limit to claims eligible for inclusion in the Analytical Dataset for simulating illustrative tiered SIPP rates, we applied the following key additional limitations and exclusions:

- Limited the data set to claims with a last date of service between January 1, 2023 and December 31, 2023 inclusive.

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- Removed claims that did not have Provider Type '16' reported on the claim.
- For Florida providers, we removed claims that did not have an active SIPP contract with the Agency.
- For out-of-state providers with similar services, we removed claims that did not have Provider Specialty Codes '300,' '301,' '303,' or '306' reported on the claim.
- Removed claims for recipients with a calculated age of 21 or older. For each claim, we calculated the recipient's age using the birth and admit dates. The primary birth date sources for encounters and FFS claims were, respectively, eligibility data and birth dates entered on the claim. Recipients with no available birth date were removed from the Analytical Dataset.
- Removed claims without the presence of either revenue code '0100' (Room and board – all-inclusive plus ancillary) or '0101' (Room and board – all inclusive) on any claim line.
- Removed claims with actual per diems that were either below $300 or above $1,100, as either the days or actual paid may not be correctly reported or calculated. For this exclusion, we calculated the actual per diems based on dividing the actual paid amount by the final days assigned to each claim (either covered days or length of stay) plus one.

We relied on guidance from the Agency for information to identify SIPP services and similar psychiatric residential treatment services provided by out-of-state providers, including enrolled provider classification fields from the claims data, revenue codes, and client age limitations.

To identify out-of-state providers, we relied on Medicaid Provider ID level Service Location State information downloaded from the Florida Medicaid Provider Master List (PML) and accessed on July 19, 2023.

APR DRG ASSIGNMENTS

We assigned APR DRGs to the FFS claim and managed care encounter records using 3M™ GPCS software. In assigning APR DRGs, we applied several edits and adjustments to mitigate grouping errors. The APR DRG grouper preferences and settings used, as well as the edits and adjustments applied to mitigate grouping errors, are described below. *If the Agency and its MMIS vendor use grouper preferences or settings in the implementation of an APR DRG based payment system for SIPP services that are different from the preferences and settings documented below, the APR DRG classifications that we have assigned may not be appropriate for simulating payments.*

We performed a high level review of the version 41 APR DRGs that were assigned to the claims and encounters in our Analytical Dataset, and confirmed that they were reasonable for recipients receiving SIPP services (primary diagnosis of emotional disturbance or serious emotional disturbance). We also compared our version 41 APR DRG assignments with the APR DRGs that were assigned by FMMIS to validate our source data, processing, and grouper settings.

APR DRG GROUPER PREFERENCES AND SETTINGS

We used the following preferences and settings in the 3M™ GPCS software when assigning the version 41 APR DRGs, consistent with the Agency's APR DRG grouper preferences and settings for acute inpatient hospital services:

- Interpretation of Undetermined POA Indicators: W treated as N, U treated as N.
- Birth Weight Option: Entered or coded weight with default.
- Discharge DRG Option: Compute excluding only non-POA Complication of Care codes.
- Entered Code Mapping: Automatically determine code mapping.
- Mapping Type: Historical.

The APR DRG assignments used in the simulation model are not adjusted using Hospital Acquired Condition (HAC) logic.

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