Florida Agency for Health Care Administration

DRG Payment Implementation

Fourth DRG Public Meeting

November 15, 2012
Presentation by MGT of America, Inc. and Navigant Consulting, Inc.

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Meeting Agenda

Agenda
Results of Simulations 3 – 7
Detailed Results of Simulation 5
Preliminary Policy Decisions
Documentation and Coding Adjustment
DRG Calculator
Next Steps

Results of Simulations 3 – 7

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Characteristics in Common

Simulations 3 – 7 all have the following characteristics:

- Separate provider policy adjustors as follows:
  - Rural hospitals - set to 85% of cost
  - LTACs - set to 60% of cost
  - Rehab hospitals - set to 60% of cost
- IGT payments are casemix adjusted by provider
- A low-side outlier policy is in place and is symmetrical with the high side outlier
- Outlier threshold is $27,425 (only exception is simulation 6)
- Outlier marginal cost percentage is 80% (only exception is simulation 7)

Unique Characteristics and Results

Simul Nbr	Description	Base Rate	Obstetric Pay-to-Cost	Children's Pay-to-Cost	Outlier Percentage
3	• No additional adjustors	$3,263.99	82%	78%	8.6%
4	• Adjustor for OB = 1.15	$3,183.05	87%	77%	8.7%
5	• Adjustor for OB = 1.15 • Adjustor for high Medicaid and high outlier = 1.5	$3,131.73	86%	86%	8.5%
6	• Adjustor for OB = 1.15 • Adjustor for high Medicaid and high outlier = 1.5 • Outlier threshold = $35,000	$3,218.89	87%	85%	7.2%
7	• Adjustor for OB = 1.15 • Adjustor for high Medicaid and high outlier = 1.5 • Outlier threshold = $27,425 • Marginal cost % = 70%	$3,212.02	87%	84%	7.4%

Casemix Adjusting Payments of IGT Funds - Example

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

- Average per discharge IGT add-on payment equals,

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

- For a claim with casemix equal to 0.75,

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

- Separate claim with casemix equal to 0.3,

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

Calculation of Budget Goals by Provider Category

	A	B	C	D	E	F	G	H
	Provider Classification	Stays	Baseline Payment From GR and PMATF	Baseline Payment From Automatic IGTs	Baseline Payment From Self-Funded IGTs	Estimated Cost	Percentage of Cost Goal	Total Budget Goal with IGTs	DRG Reimbursement from GR and PMATF
1	Rural	11,143	$ 45,608,998	$ -	$ -	$ 53,768,677	85%	$ 45,703,375	**$ 45,703,375**
2	LTAC	86	$ 1,510,651	$ 42,706	$ 87,713	$ 2,979,177	60%	$ 1,787,506	**$ 1,657,088**
3	Rehab	525	$ 4,184,588	$ -	$ -	$ 8,381,138	60%	$ 5,028,683	**$ 5,028,683**
4	All Other	406,281	$ 1,528,622,979	$ 1,008,803,087	$ 216,132,801	$ 3,323,561,798			**$1,527,538,070**
5									
6	**Totals:**	418,035	$ 1,579,927,216	$ 1,008,845,793	$ 216,220,514				
7									
8			Overall Total Historical Baseline Payment:		$ 2,804,993,523				

Notes:

1) For rural, LTAC and rehab hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals 95% of estimated cost minus any per-claim payments being made via IGTs. For example, H1 = [G1 - (D1 + E1)].

2) For "All Other" hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals the total historical allowed amount from GR and assessment minus the total planned DRG reimbursement from GR and assessment for rural, LTAC and rehab hospitals.
H4 = [C6 - (H1 + H2 + H3)].

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Detailed Results of Simulation 5

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Simulation 5 Parameters

DRG Payment Simulation 5					
Simulation Parameters	Value - Overall	Value - All Other Hospitals	Value - Rural Hospitals	Value - LTAC Hospitals	Value - Rehab Hospitals
Baseline payment, total	$2,804,993,523	$2,753,558,867	$45,608,998	$1,641,069	$4,184,588
Baseline payment, general revenue and PMATF	$1,579,927,216	$1,528,622,979	$45,608,998	$1,510,651	$4,184,588
Baseline payment, automatic IGTs	$1,008,845,793	$1,008,803,087	$0	$42,706	$0
Baseline payment, self-funded IGTs	$216,220,514	$216,132,801	$0	$87,713	$0
Simulation payment goal	$2,804,993,523	$2,752,473,958	$45,703,375	$1,787,506	$5,028,683
Simulation payment, result	$2,805,003,064	$2,752,473,806	$45,713,283	$1,787,609	$5,028,366
Difference	$9,541	-$153	$9,908	$103	-$317
Simulation payment, general revenue and PMATF	$1,579,936,757	$1,527,537,918	$45,713,283	$1,657,191	$5,028,366
Simulation payment,automatic IGTs	$1,008,845,793	$1,008,803,087	$0	$42,706	$0
Simulation payment, self-funded IGTs	$216,220,514	$216,132,801	$0	$87,713	$0
DRG base price	$3,131.73	$3,131.73	$3,131.73	$3,131.73	$3,131.73
Cost outlier pool (percentage of total payments)	8.5%	9%	2%	27%	8%
Policy adjustor - Provider	n/a	None	2.049	1.651	1.808
	High Medicaid utilization and high outlier payments: 1.5				
Policy adjustor - DRG (service)	Obstetrics - 1.15				
Policy adjustor - Age	None				
Documentation & coding adjustment	None				
Relative weights	APR v.29 national re-centered to 1.0 for FL Medicaid				
Transfer discharge statuses	02, 05, 65, 66				
High side (provider loss) threshold and marginal cost (MC) percentage	$27,425 80%				
Low side (provider gain) threshold and marginal cost (MC) percentage	$27,425 80%				
Charge Cap	None				
Notes: 1) Values are for purposes of illustration only and do not represent Navigant recommendations or AHCA decisions.					

Summary by Service Line - Total

Simulation 5 Summary of Simulation by Service Line											
Service Line	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
Misc Adult	72,754	1.72	$1,071,944,851	$ 723,992,936	$ 828,777,934	$ 104,784,998	14%	68%	77%	$ 86,285,649	10%
Obstetrics	111,700	0.56	$ 475,669,361	$ 447,707,479	$ 409,155,204	$ (38,552,276)	-9%	94%	86%	$ 3,047,250	1%
Neonate	11,697	4.11	$ 386,225,878	$ 445,320,739	$ 357,826,920	$ (87,493,819)	-20%	115%	93%	$ 46,746,945	13%
Pediatric	46,382	1.09	$ 422,498,126	$ 382,767,281	$ 391,732,645	$ 8,965,364	2%	91%	93%	$ 51,090,175	13%
Gastroent Adult	27,907	1.36	$ 324,529,009	$ 218,095,098	$ 235,222,901	$ 17,127,803	8%	67%	72%	$ 15,594,553	7%
Circulatory Adult	24,526	1.67	$ 330,678,559	$ 170,504,828	$ 254,576,463	$ 84,071,636	49%	52%	77%	$ 17,826,447	7%
Resp Adult	18,090	1.32	$ 204,090,653	$ 156,683,845	$ 147,798,610	$ (8,885,235)	-6%	77%	72%	$ 11,278,459	8%
Normal newborn	90,615	0.16	$ 82,164,916	$ 110,303,520	$ 90,835,112	$ (19,468,408)	-18%	134%	111%	$ 1,304,723	1%
Mental Health	12,443	0.70	$ 44,533,912	$ 100,644,313	$ 51,887,446	$ (48,756,867)	-48%	226%	117%	$ 376,686	1%
Rehab	1,789	1.79	$ 27,626,106	$ 39,040,081	$ 20,668,813	$ (18,371,268)	-47%	141%	75%	$ 1,076,288	5%
Transplant Pediatric	51	16.20	$ 11,811,193	$ 6,245,353	$ 10,439,842	$ 4,194,489	67%	53%	88%	$ 4,069,548	39%
Transplant Adult	81	11.29	$ 6,918,226	$ 3,688,051	$ 6,081,175	$ 2,393,124	65%	53%	88%	$ 803,937	13%
Total	**418,035**	**1.00**	**$ 3,388,690,790**	**$ 2,804,993,523**	**$ 2,805,003,064**	**$ 9,541**	**0%**	**83%**	**83%**	**$ 239,500,661**	**9%**

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

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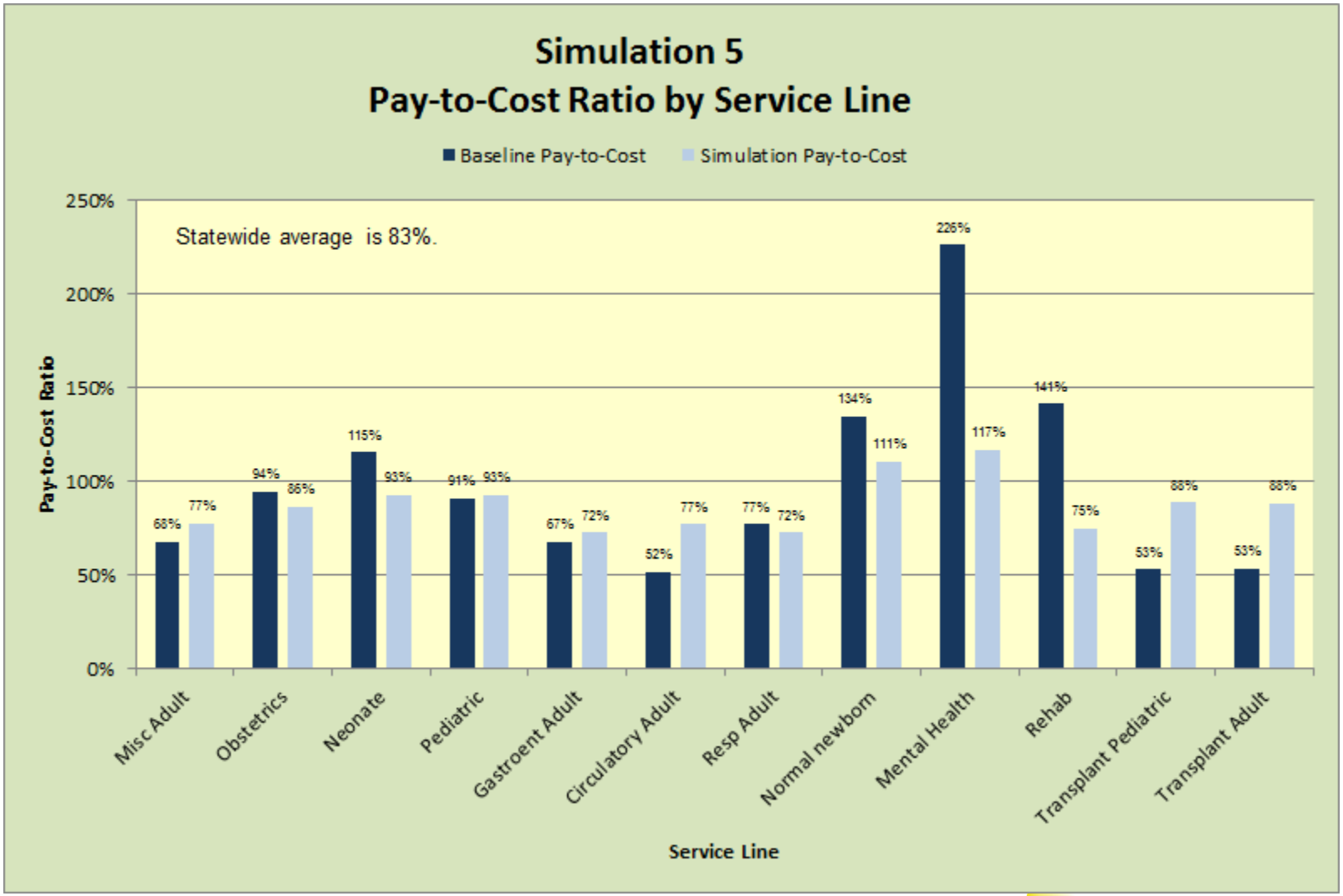
Pay-to-Cost by Service Line - Total



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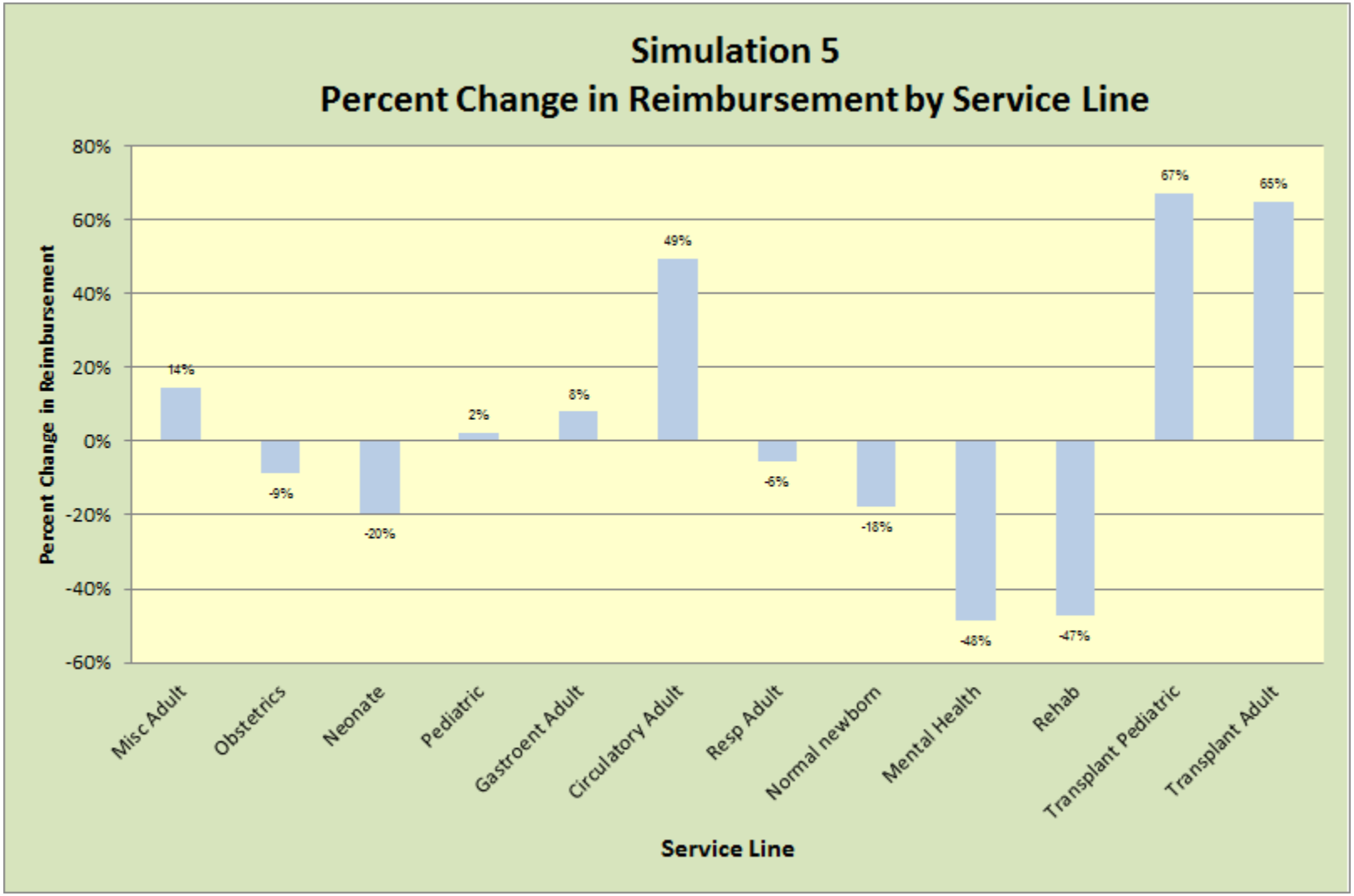
Change in Payment by Service Line



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Detailed Results of Simulation 5

Summary by Provider Category

Simulation 5 Summary of Simulation by Provider Category											
Provider Category	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
LIP	404,649	0.99	$ 3,276,516,038	$ 2,741,173,463	$ 2,733,803,940	$ (7,369,523)	0%	84%	83%	$ 231,902,952	8%
Trauma	167,965	1.18	$ 1,715,320,040	$ 1,579,553,835	$ 1,504,239,152	$ (75,314,683)	-5%	92%	88%	$ 154,756,975	10%
Statutory Teaching	98,543	1.19	$ 1,080,601,335	$ 1,010,602,636	$ 940,904,339	$ (69,698,296)	-7%	94%	87%	$ 92,821,210	10%
High Charity	112,473	0.92	$ 817,142,294	$ 680,515,190	$ 710,219,878	$ 29,704,688	4%	83%	87%	$ 44,956,585	6%
CHEP	75,776	1.01	$ 575,505,264	$ 509,567,290	$ 522,412,919	$ 12,845,628	3%	89%	91%	$ 30,619,922	6%
Public	76,896	0.96	$ 540,926,386	$ 508,160,681	$ 494,884,408	$ (13,276,272)	-3%	94%	91%	$ 32,659,351	7%
General Acute	123,624	0.88	$ 782,909,961	$ 505,436,946	$ 539,975,325	$ 34,538,379	7%	65%	69%	$ 40,890,391	8%
Children	9,263	1.78	$ 199,900,900	$ 171,966,950	$ 172,211,897	$ 244,946	0%	86%	86%	$ 38,712,019	22%
Rural	11,143	0.66	$ 53,768,677	$ 45,608,998	$ 45,713,283	$ 104,285	0%	85%	85%	$ 762,874	2%
Rehabilitation	525	1.71	$ 8,381,138	$ 4,184,588	$ 5,028,366	$ 843,778	20%	50%	60%	$ 378,844	8%
Long Term Acute Care	86	2.87	$ 2,979,177	$ 1,641,069	$ 1,787,609	$ 146,540	9%	55%	60%	$ 476,826	27%
Out of state	412	1.21	$ 3,045,731	$ 1,064,107	$ 1,474,002	$ 409,895	39%	35%	48%	$ 88,888	6%

Notes:

1) Providers may be included in more than one category.

2) "High Charity" is any hospital with 11% or more market share from Medicaid and uninsured recipients.

3) "General Acute" hospitals are those not otherwise categorized as Childrens, CHEP, High Charity, LTAC, Out of state, Rehab, Rural, Teaching or Trauma.

4) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011.

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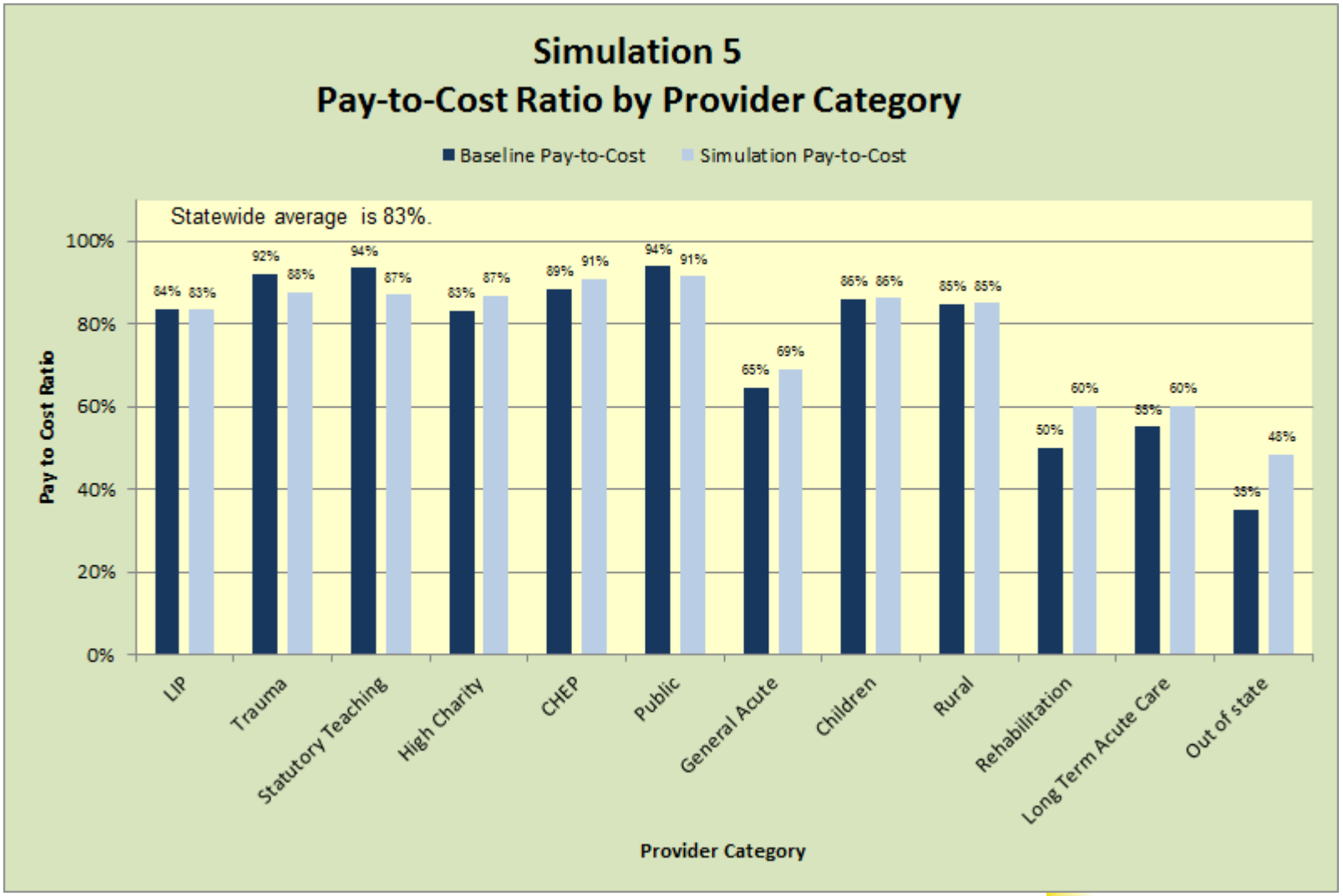
Pay-to-Cost by Provider Category



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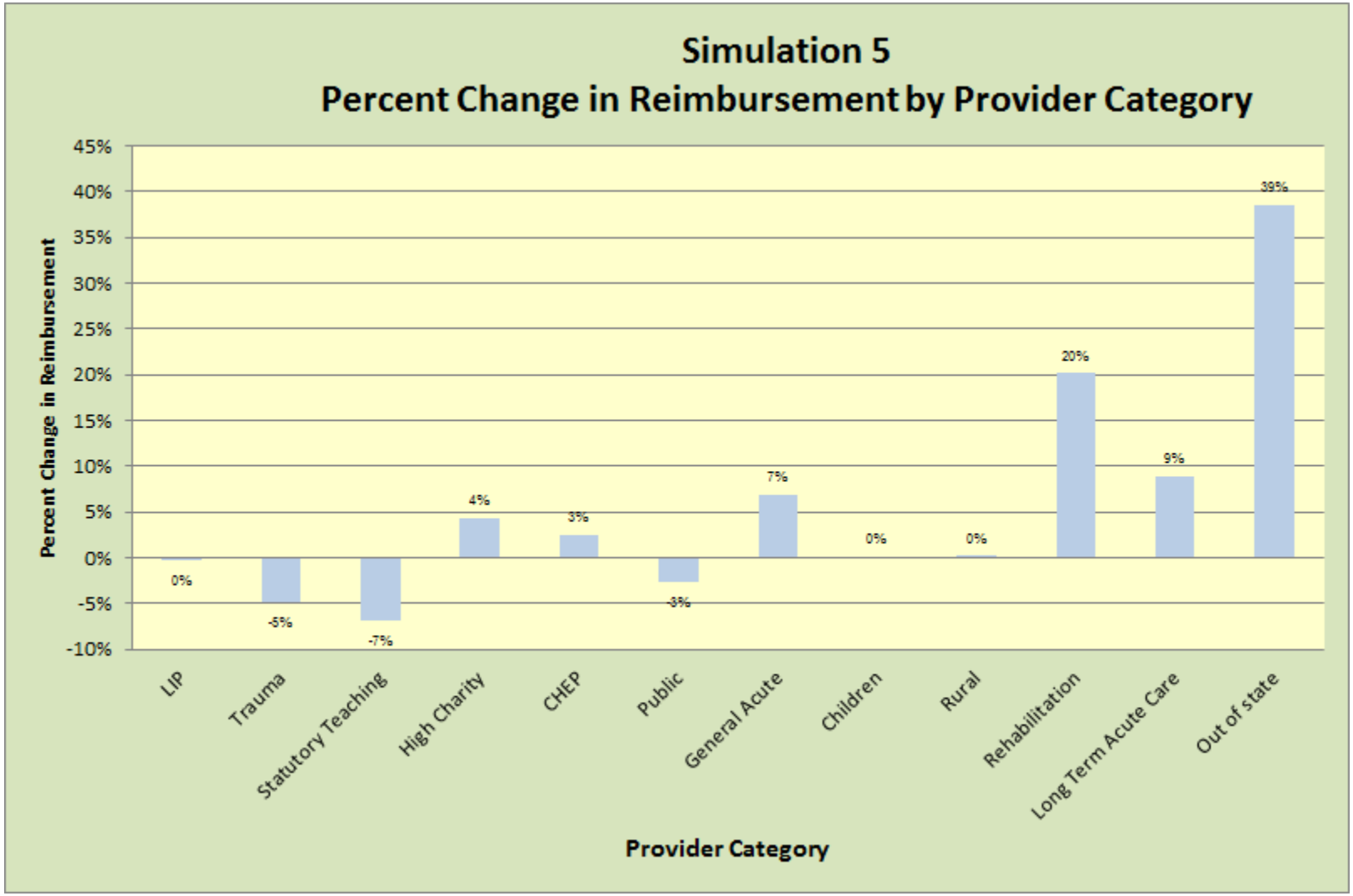
Change in Payment by Provider Category



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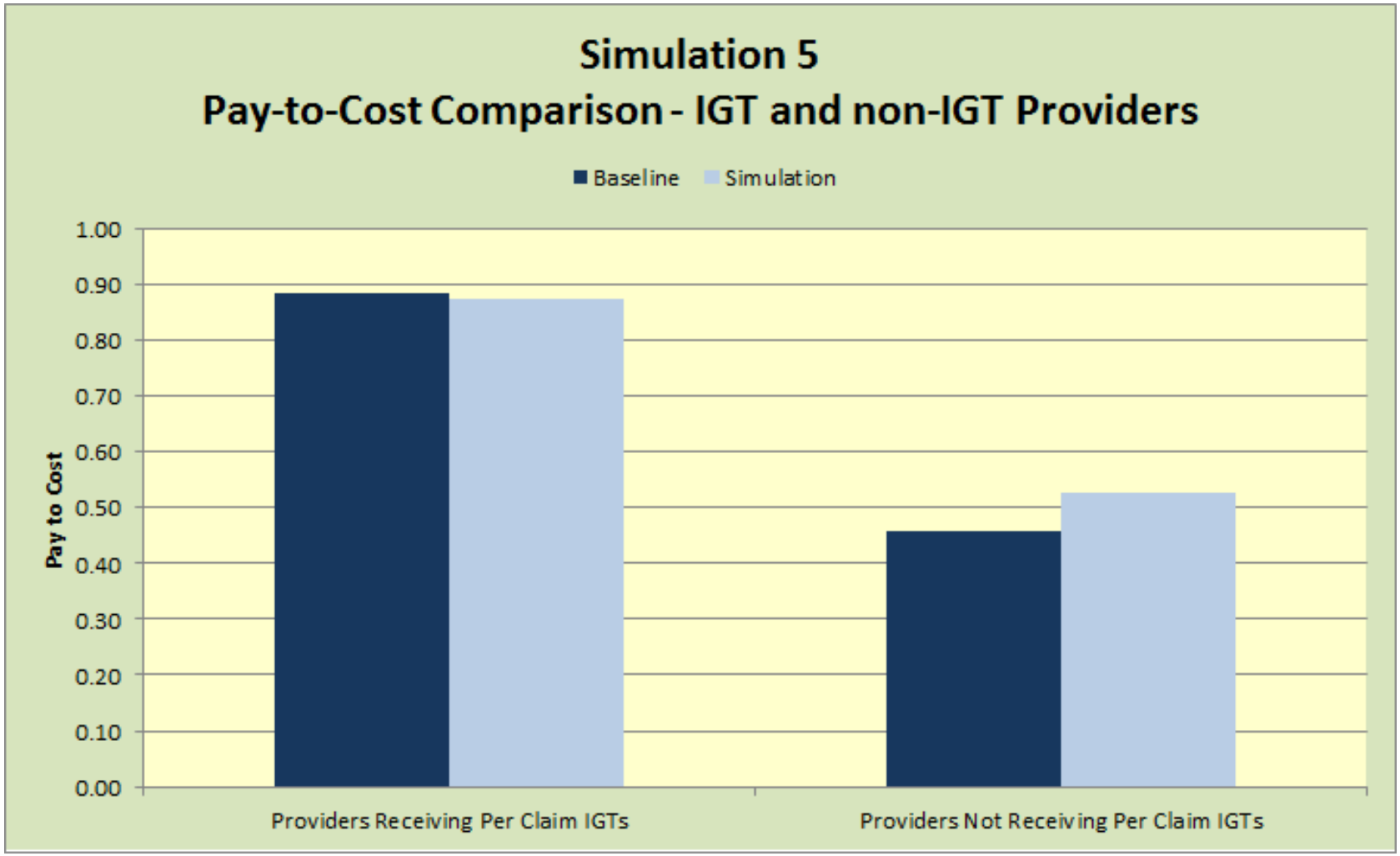
Pay-to-Cost Comparison – IGT vs. non-IGT Providers



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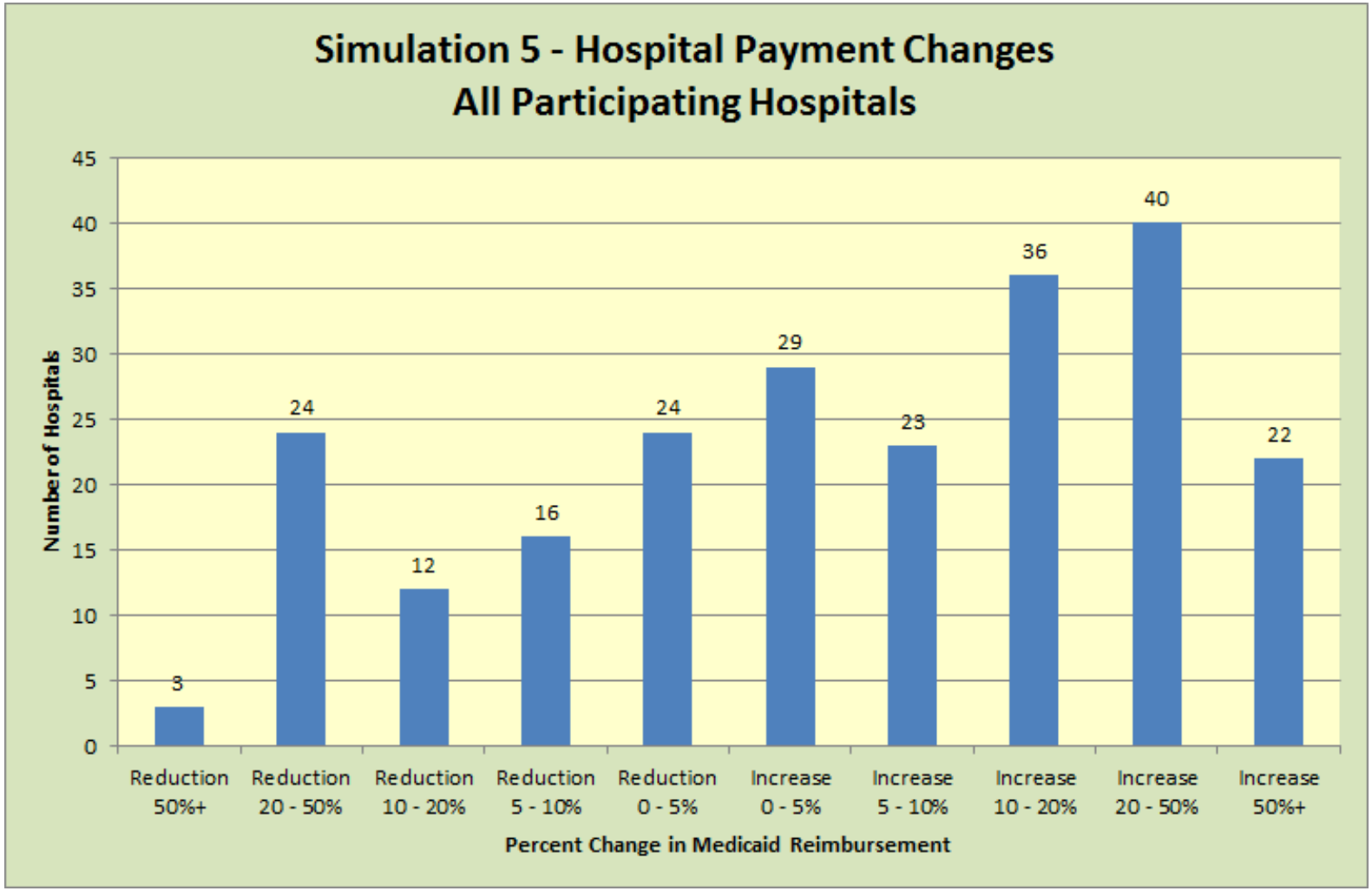
Provider Impact – All Hospitals



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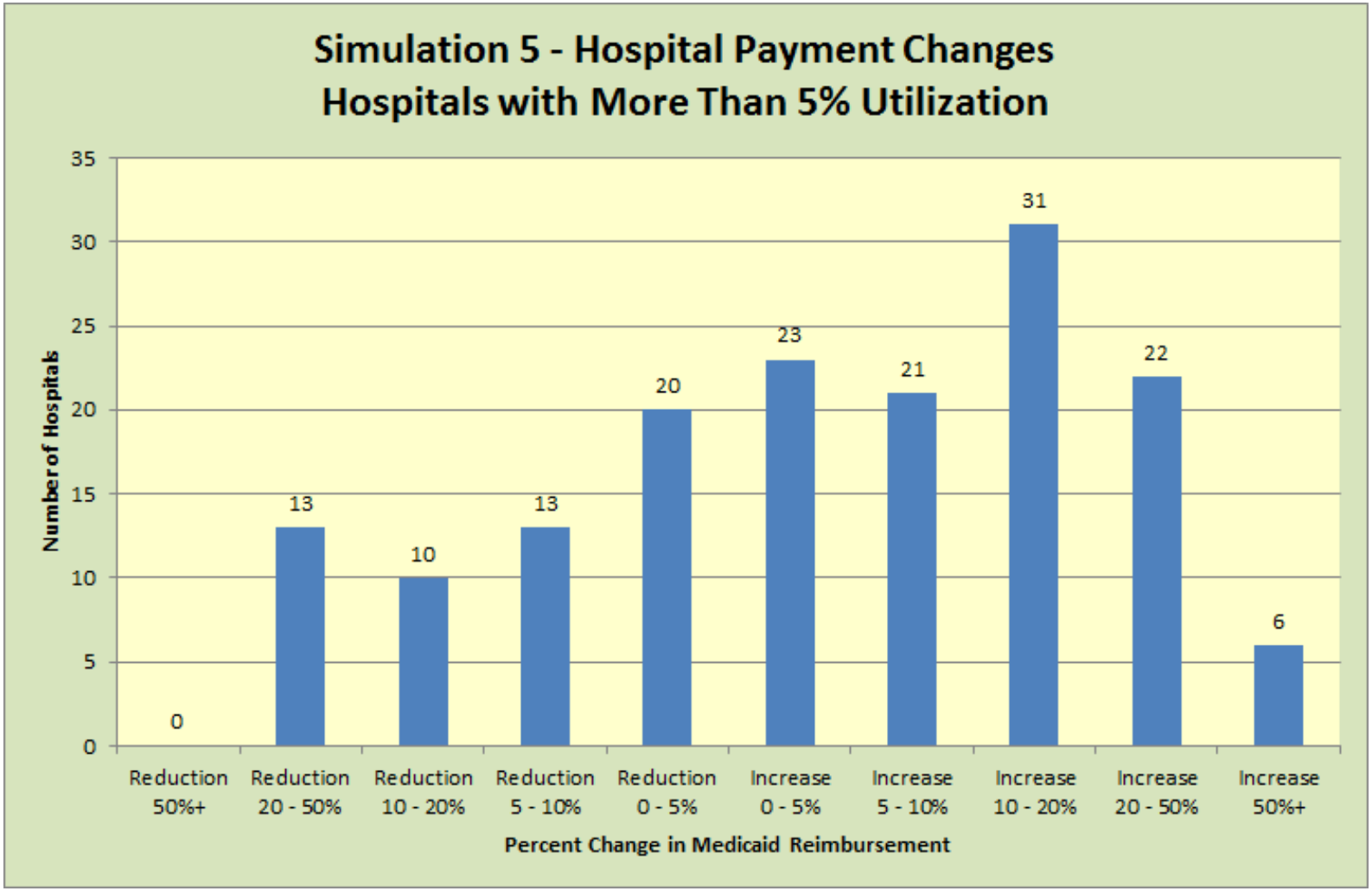
Provider Impact – Hospitals with > 5% Medicaid



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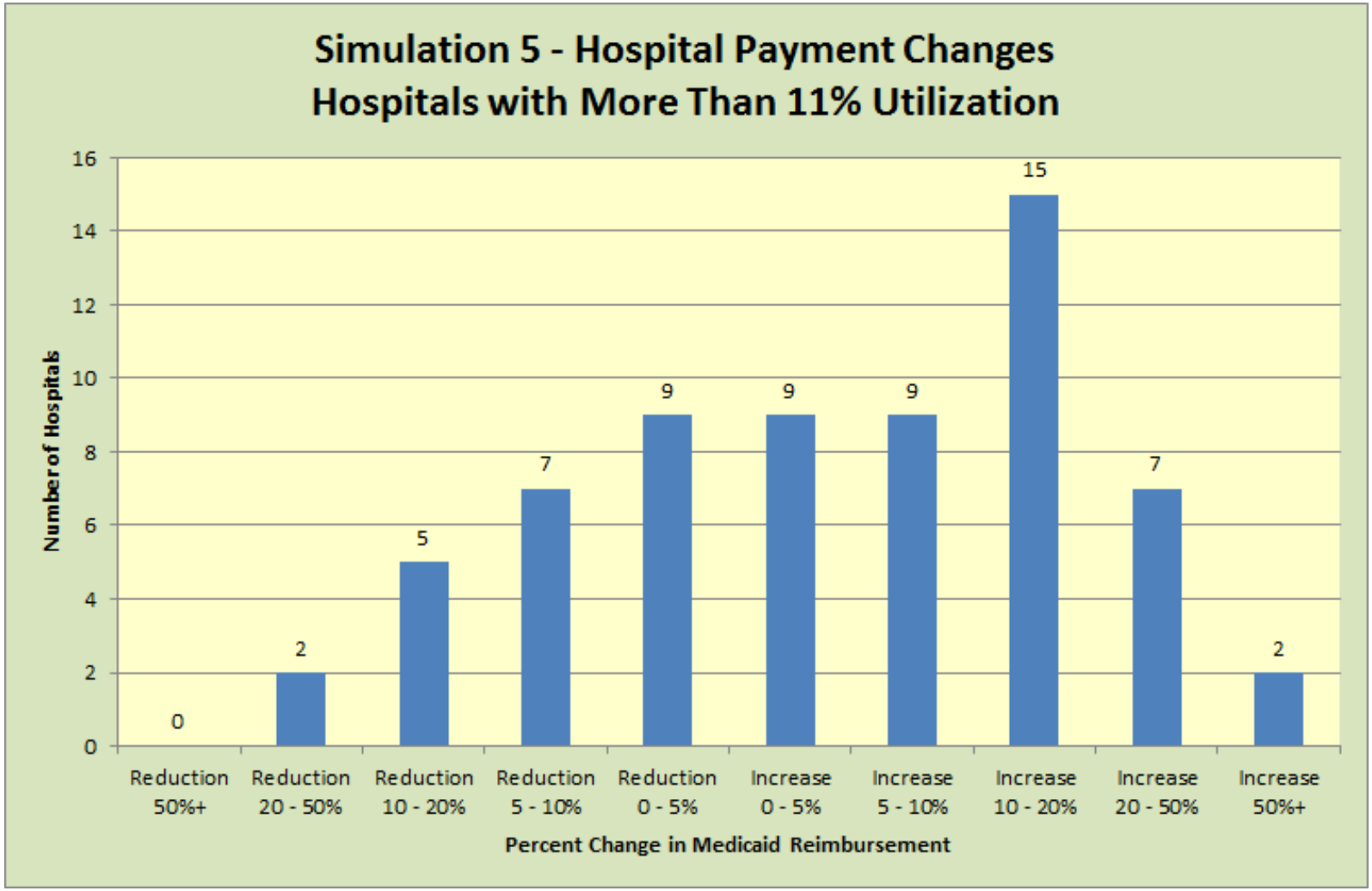
Provider Impact – Hospitals with > 11% Medicaid



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Preliminary Design Decisions

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Preliminary Design Decisions

Design Consideration	Preliminary Decision
DRG Grouper	• APR-DRGs (version 30, released 10/1/2012)
DRG Relative Weights	• National weights re-centered to 1.0 for Florida Medicaid
Hospital Base Rates	• One standardized amounts • Adjust standardized base rate using Medicare wage indices • Base rates used to distribute funds from general revenue and Public Medical Assistance Trust Fund
Per-Claim Add-On Payments	• Used to distribute the IGT funds paid on a per-claim basis today • Two add-ons per claim, one for automatic IGTs another for self-funded IGTs

Preliminary Recommendations

Design Consideration	Preliminary Decision

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

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

Preliminary Recommendations

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

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Preliminary Recommendations

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

Documentation and Coding Adjustment

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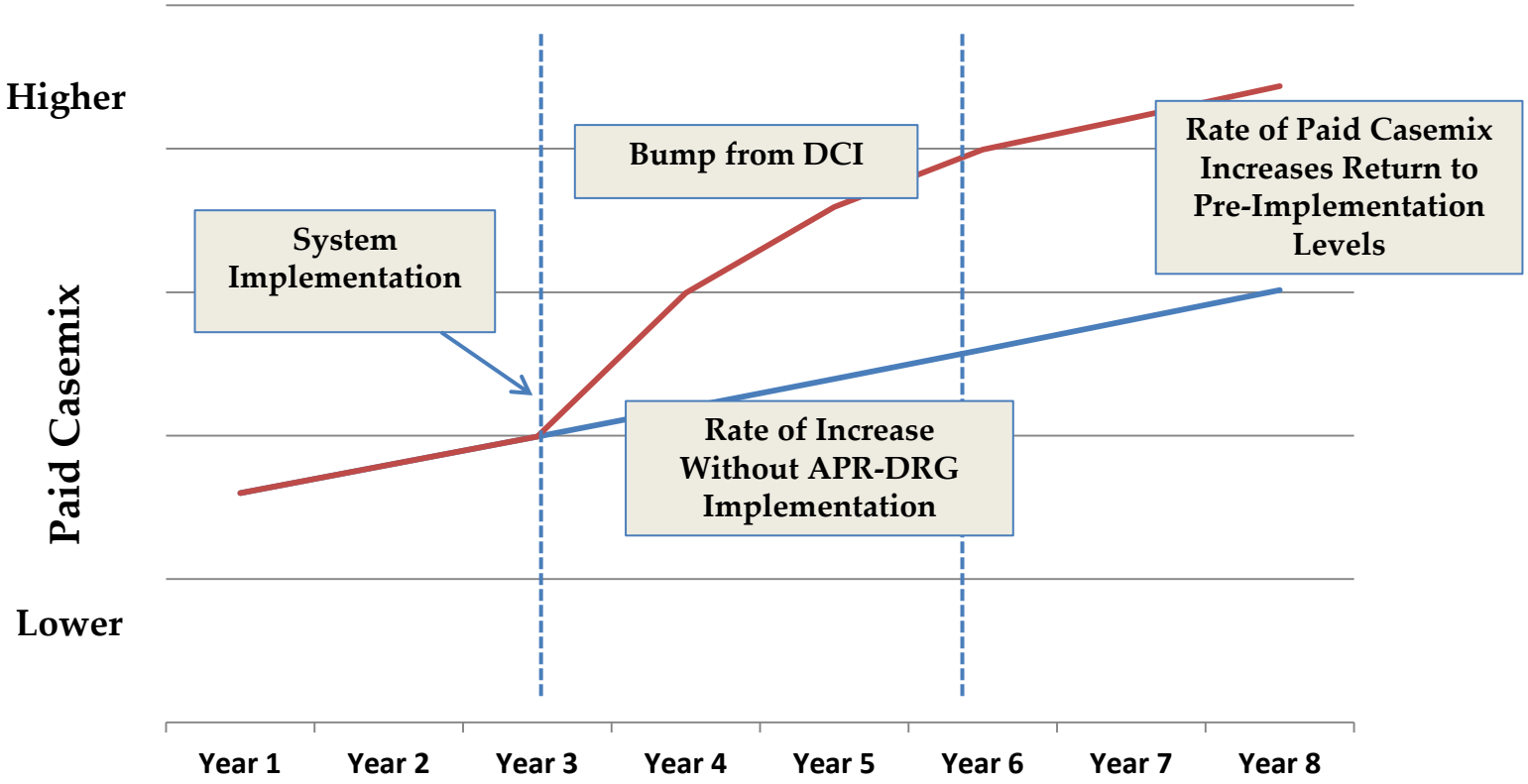
Justification

Illustration of Potential Impacts to Paid Casemix from Coding and Documentation Improvement



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Justification

Why does the DCI bump occur?

- Coding and documentation improvements are a necessary and appropriate response by providers to the requirements under the APR-DRG model.
- Because the same level of coding rigor was not required for payment purposes under the legacy per diem model, we assume that case mix in our simulation models is understated.
- We expect that case mix will increase in future periods, beyond actual increases in patient acuity.

Example of Importance of Coding with APR-DRGs

Coding requirements are significantly different for APR-DRGs, even when compared to the requirements under the current Medicare MS-DRG model.

Patient Record	Version 1 Coding	Version 2 Coding
DX 1 – V3000 – Live newborn	Include	Include
DX 2 – 745.4 – Ventricle septal defect	Include	Include
DX 3 – V290 – Observation	**Exclude**	Include
DX 4 – 745.5 – Ostium secoundum type arial septal defect	**Exclude**	Include
DX 5 – 774.6 – Unspecified fetal and neonatal jaundice	**Exclude**	Include
Same legacy Medicaid per diem and MS-DRG assignment - 389, Full Term Neonate w/Major Problems		
Different APR-DRG Assignments – 640 - Neonate Birthwt > 2499G, Normal Newborn or Neonate w Other Problem	**SOI = 2** **RW = .1871**	**SOI = 3** **RW = .4847**

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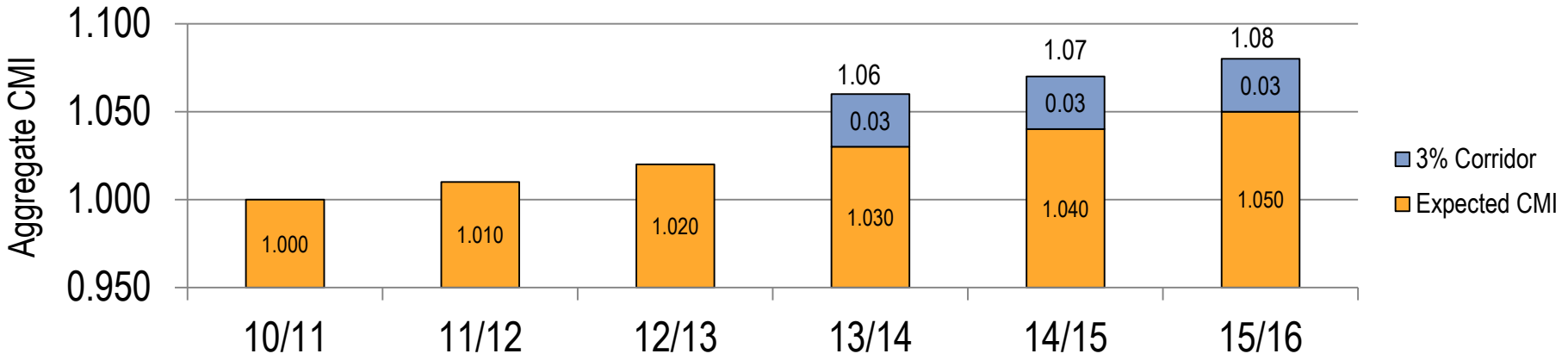
Corridor Approach with Prospective Rate Adjustment



Proposed Adjustment Parameters	
1.	State adjusts rates downward for SFY13/14 to reflect 3% reduction in Relative Weights/Casemix.
2.	Analyze CMI after first year under APR-DRGs. If actual CMI in SFY 13/14 is less than "expected", State adjusts rates upward in following year to compensate for 3% reduction.
3.	If actual CMI in SFY 13/14 is greater than "expected", but falls within the "corridor", State adjusts rates upward in the following year to compensate for amount of 3% reduction not used up by casemix increases.
4.	If actual CMI in SFY 13/14 is greater than combined "expected" and "corridor", State adjusts rates in the following year downward to compensate for additional cost to the state resulting from casemix increases.
5.	State will make similar adjustments for SFY 14/15, 15/16 and subsequent years, if necessary.

DRG Calculator

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DRG Calculator

Will be available shortly on AHCA website.

Florida Medicaid DRG Pricing Calculator

Note: **This calculator has not been approved and is subject to change before implementation of payment by DRG. Specific policy values are for purposes of illustration only.**

Indicates data to be input by the user — *Indicates payment policy parameters set by Medicaid*

Information	Data	Comments or Formula
INFORMATION FROM THE HOSPITAL		
Submitted charges	$50,000.00	UB-04 Field Locator 47 minus FL 48
Length of stay	31	Used for transfer pricing and covered days adjustments
Medicaid covered days	31	Used for covered days adjustment
Patient discharge status = 02, 05, 65 or 66? (transfer)	No	Used for transfer pricing adjustment
Patient age (in years)	25	Used for age adjustor
Other health coverage	$0.00	UB-04 Field Locator 54 for payments by third parties
Patient share of cost	$0.00	Includes spend-down or copayment
Hospital-specific cost-to-charge ratio	35.00%	Used to estimate the hospital's cost of this stay
Hospital average per discharge automatic IGT add on pymt	$0.00	
Hospital average per discharge self-funded IGT add on pymt	$0.00	
Hospital casemix	0.75	Hospital's annual average FL Medicaid APR-DRG relative weight
Hospital category	All Other	From drop down list - used to determine provider policy adjustor
Wage index	0.9062	
APR-DRG	089-4	From separate APR-DRG grouping software
APR-DRG INFORMATION		
APR-DRG description	MAJOR CRANIAL/FACIAL BONE PROCEDURES	Look up from DRG table
Casemix relative weight--re-centered for FL Medicaid	10.0754	Look up from DRG table
Service adjustor	1.00	Look up from DRG table
Age adjustor	1.00	Look up from DRG table
Average length of stay for this APR-DRG	20.75	Look up from DRG table
HOSPITAL INFORMATION		
Provider adjustor	1.000	Look up from provider adjustor table
Labor portion	0.620	IF E19 < 1 then 0.62 else 0.688
Provider base rate	$2,825.53	=(E32*E29*E19)+(E32*(1-E29))
PAYMENT POLICY PARAMETERS SET BY MEDICAID		
DRG base price	$3,000	Used for DRG base payment
Cost outlier threshold	$27,425	Used for cost outlier adjustments
Marginal cost percentage	80%	Used for cost outlier adjustments
Casemix adjustment factor	1.00	Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
Age cut-off for age policy adjustor	18	
DRG BASE PAYMENT		
Pre Transfer DRG base payment	$58,629.79	=IF E11 < E36 Then E30*E26*E24*E25*E28*E35 Else E30*E26*E24*E28*E35
TRANSFER PAYMENT ADJUSTMENT		
Is a transfer adjustment potentially applicable?	No	Look up E10
Per diem payment amount	N/A	IF E40="Yes", then (E38 / E26) * (E9 + 1) rounded to 2 places, else "N/A"
Is per diem payment amount < full stay base payment?	N/A	IF E40 ="Yes" then [if (E41 < E38), then "Yes" else "No"] Else "N/A"
Full stay DRG base payment	$58,629.79	IF E42 = "Yes" Then E41 Else E38
FULL STAY ADD-ON IGT PAYMENTS		
IGT casemix adjustor	27.67	E26 / E17
Full stay automatic IGT add-on payment	$0.00	E15 * E45
Full stay self-funded IGT add-on payment	$0.00	E16 * E45
Pre outlier payment amount	$58,629.79	E43 + E46 + E47
COST OUTLIER		
Estimated cost of the stay	$17,500.00	E7 * E14
Does this claim require an outlier payment?	No	IF (E50-E48) > E33 Then "Yes" Else "No"
Estimated loss on this case	N/A	IF E51 = "Yes" Then E50 - E48 Else "N/A"
DRG cost outlier payment increase	$0.00	IF E51 = "Yes" (E52 - E33) * E34 rounded to 2 places, Else 0
NON-COVERED DAYS PAYMENT ADJUSTMENT		
Are covered days less than length of stay	No	IF E9 < E8 Then "Yes" Else "No"
Non-covered day reduction factor	1.0000	IF E55 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
Adjusted DRG base payment	$58,629.79	E43 * E56
Adjusted outlier payment	$0.00	E53 * E56
Adjusted automatic IGT add-on payment	$0.00	E46 * E56
Adjusted self-funded IGT add-on payment	$0.00	E47 * E56
Pre-charge cap allowed amount	$58,629.79	E57 + E58 + E59 + E60
CHARGE CAP		
Does the charge cap apply?	Yes	IF E61 > E7 Then "Yes" Else "No"
Charge cap reduction factor	0.8528	IF E63 = "Yes" Then E7 / E61 Else 1.0
Final DRG base payment	$50,000.00	E57 * E64
Final outlier payment	$0.00	E58 * E64
Final DRG payment	$50,000.00	E65 + E66
Final automatic IGT add-on payment	$0.00	E59 * E64
Final self funded IGT add-on payment	$0.00	E60 * E64
CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT		
Allowed amount	$50,000.00	E67 + E68 + E69
Other health coverage	$0.00	E12
Patient share of cost	$0.00	E13
Payment amount	$50,000.00	IF (E71-E72-E73) > 0, then E71-E72-E73, else 0
11/12/2012		

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

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Next Steps

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Finalize Simulation with SFY 2010/2011 Data

- Convert to version 30 APR-DRGs
- Change from provider gain outlier to charge cap
- Add proration for non-covered days
- Finalize policy decisions

Adjust Simulation Dataset to Model 2013/2014

- Apply rate changes and IGT funding level changes (either those from SFY 12/13 or those predicted for 13/14)
- Make adjustments based on real casemix increase and predicted casemix increase from documentation and coding improvements
- Apply inflation factor to charges from SFY 10/11 to 13/14 (used in calculation of estimated cost)
- Apply most current AHCA cost-to-charge ratios
- Apply FFY 2013 Medicare wage indices

Questions and Discussion

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