Florida Agency for Health Care Administration

DRG Payment Implementation

Project Status

August 29, 2012
Presentation by MGT of America, Inc. and Navigant Consulting, Inc.

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Meeting Agenda

Agenda Topic	Time
Introduction	*9:00 – 9:05*
Background and Project Overview	*9:05 – 9:15*
Updates and Activities by the Team Since the Last Public Meeting	*9:15 – 9:45*
Presentation of Data Analyses and Results	*9:45 – 10:30*
Preliminary Recommendations and Decision Points	*10:30 – 11:15*
Stakeholder Comments	*11:15 – 11:50*
Wrap-Up	*11:50 – 12:00*

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Background and Project Overview

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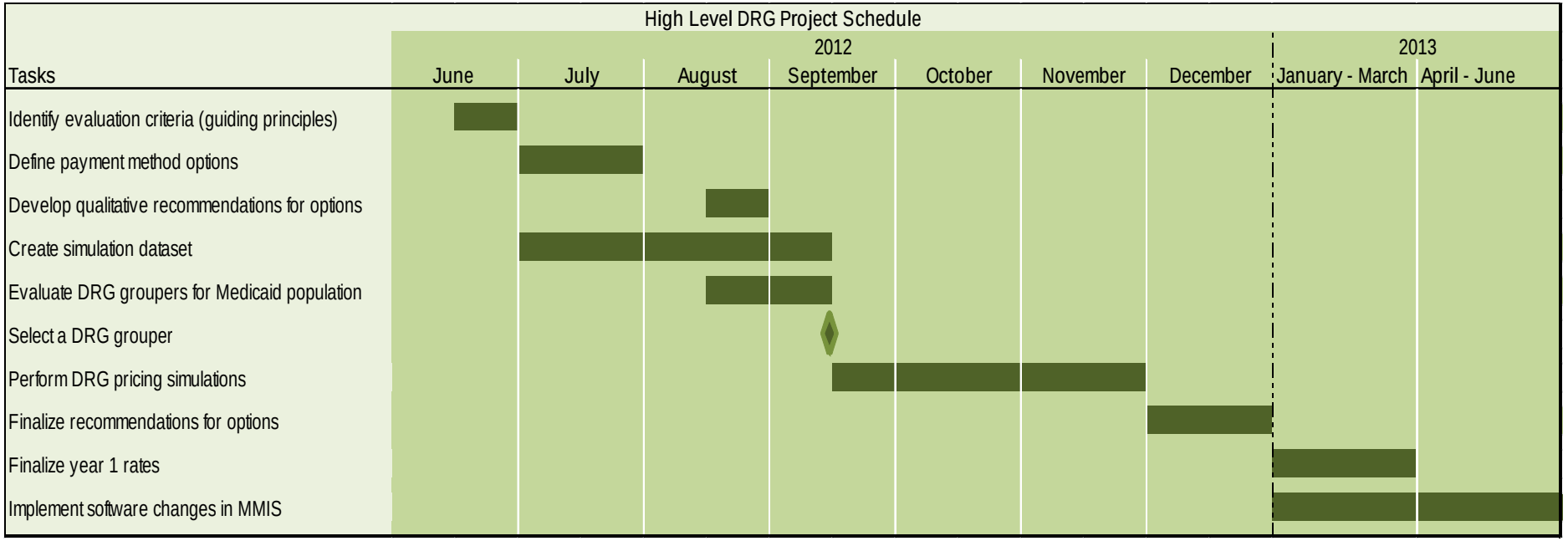
Background

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

Project Overview



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Typical DRG Pricing Formula
Examples

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

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

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

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

= [DRG Base Pymt] + [Outlier Pymt]

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

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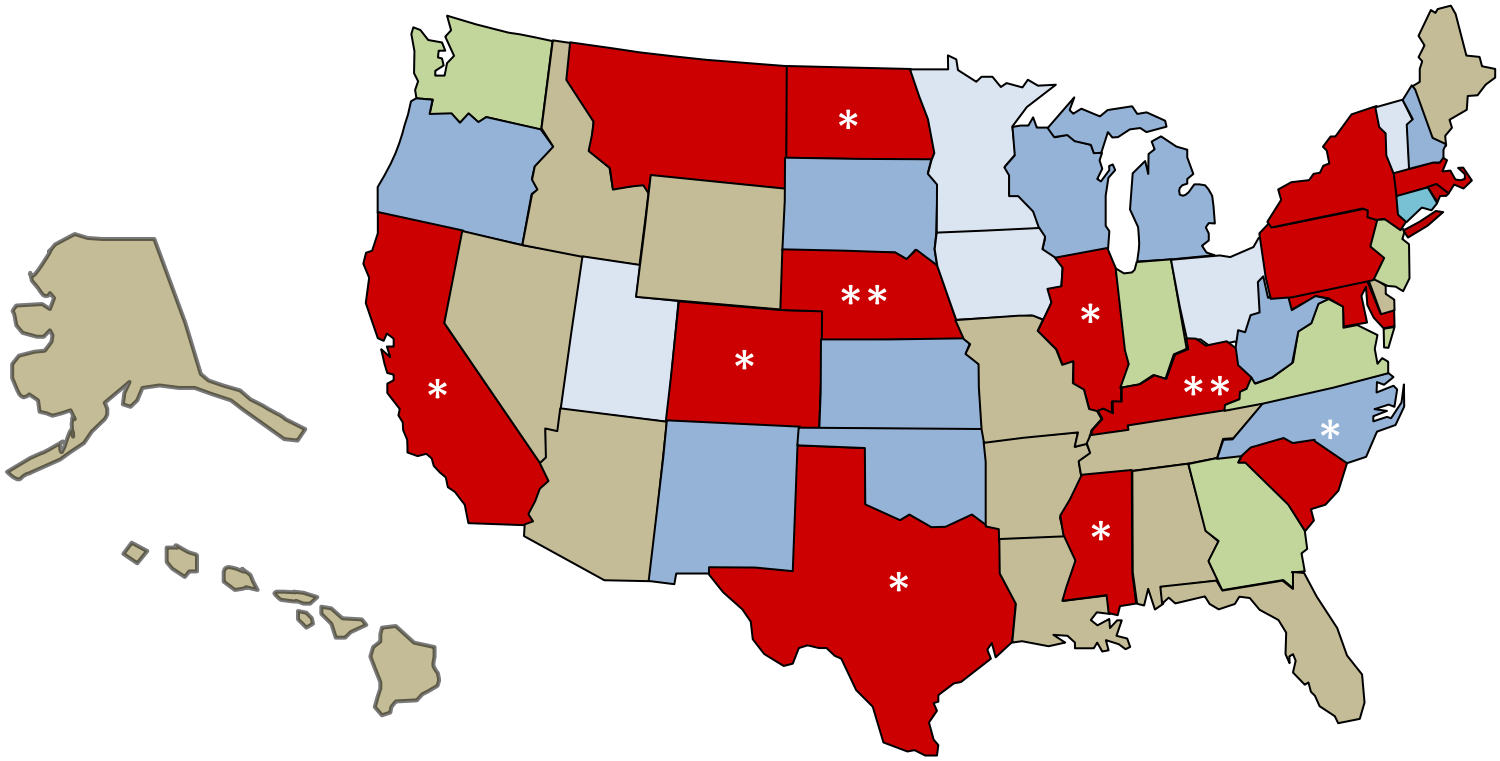
Comparison of State Medicaid Programs

APR-DRGs
MS-DRGs
CMS-DRGs
AP or Tricare DRGs
Per Stay/Per Diem/Cost Reimbursement/Other

* Indicates Moving Toward
** Indicates Under Consideration



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Progress Since Last Public Meeting

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Data

- Combined interim claims into one record per hospital stay
- Created normal newborn claims and shifted from concurrent to non-concurrent newborn claims
- Identified categories for each hospital
- Retrieved Medicare wage index values for each hospital
- Analyzed MS-DRG and APR-DRG groupers using Florida Medicaid data
- Identified percentage of per diem from county billing rates versus IGT funds
- Decided state fiscal year 2010/2011 will be used for pricing simulations

Data - Chaining Interim Claims

- Combined claims with the same recipient ID, provider ID and admission date
- Summed the covered days, charges, allowed amount and reimbursement amount from all claims in a chain
- Kept the diagnosis, surgical procedure codes and DRG from the claim that mapped to the DRG with the highest relative weight
- Kept the patient discharge status from the final claim

Data - Deliveries and Newborns

- Within each hospital …
  - Determined the average charges and payment for mother versus baby for vaginal deliveries and cesarean sections – used state wide average percentages from Florida Health Finder dataset

	Percentage of Charges	
Delivery Method	Mother	Baby
Vaginal	84%	16%
Cesarean	88%	12%

  - Shifted money from concurrent stay (delivery) to non-concurrent stays (newborn), for each non-concurrent stay in the dataset
  - Created an inferred newborn claim for each concurrent stay not mapped to a non-concurrent stay

Policy

- Completed qualitative analysis of DRG payment method options using guiding principles
- AHCA has held meetings between various stakeholder groups and shared the results with the DRG consulting team. Stakeholder groups may continue to request meetings with the agency.
- Developed an AHCA governance committee for the project
- Tentatively decided to include reimbursement from IGT funds as per-claim add-on payments, outside the DRG base rate

Data Analyses

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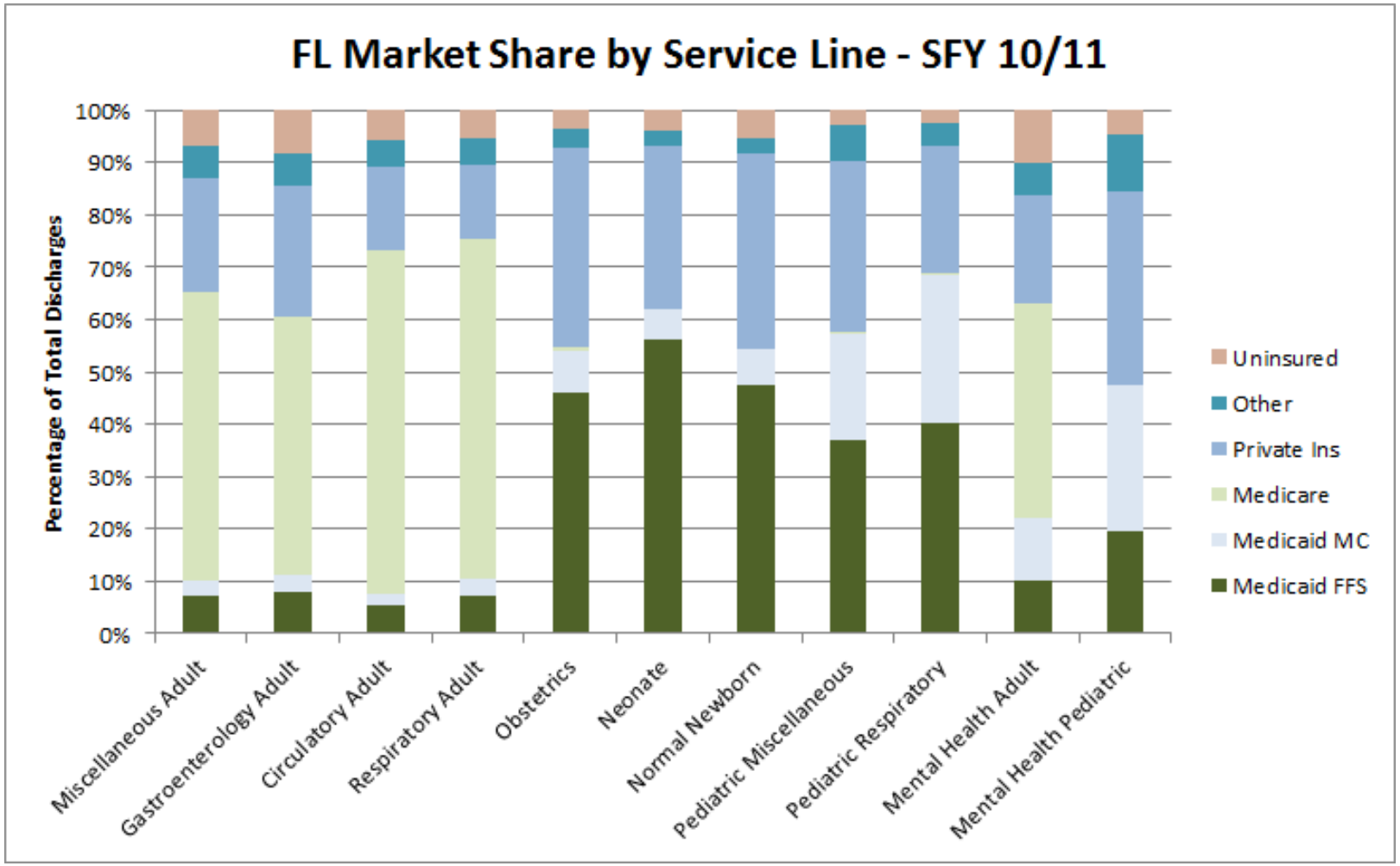
Florida Market Share by Service Line



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Florida Market Share by Service Line

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

Notes:

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

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Comparison of APR-DRGs vs. MS-DRGs

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

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Historical Florida Medicaid Payments by Service Line

State Fiscal Year 2010/2011 All Inpatient Claims by Service Line Fee-for-Service Only						
Service Line	Claims	Days	Charges	Allowed Amount	Reimbursement Amount	APR-DRG Casemix
Misc Adult	67,036	399,522	$ 3,826,860,399	$ 668,870,964	$ 664,064,930	1.28
Neonate	12,122	248,611	$ 1,500,632,488	$ 472,753,960	$ 478,921,087	3.21
Obstetrics	112,516	307,624	$ 1,813,071,492	$ 444,200,242	$ 449,576,775	0.42
Misc Pediatric	32,334	144,073	$ 1,190,378,601	$ 296,089,402	$ 290,425,415	0.90
Gastroent Adult	28,294	137,016	$ 1,308,593,833	$ 224,061,002	$ 222,928,529	1.02
Circulatory Adult	24,907	108,744	$ 1,360,103,078	$ 175,757,918	$ 175,173,934	1.25
Resp Adult	18,392	102,616	$ 833,855,178	$ 162,524,648	$ 161,645,318	1.00
Normal newborn	99,200	31,849	$ 354,323,642	$ 113,453,818	$ 120,398,490	0.12
Mental Health	12,652	64,885	$ 180,254,949	$ 104,552,993	$ 102,866,833	0.53
Resp Pediatric	14,014	53,915	$ 358,931,135	$ 103,261,534	$ 101,994,447	0.62
HIV	3,015	26,622	$ 213,669,402	$ 46,101,760	$ 46,014,122	1.70
Trauma	2,352	23,324	$ 289,742,892	$ 43,035,166	$ 41,587,307	2.70
Rehab	1,833	26,558	$ 87,985,670	$ 40,327,220	$ 39,942,276	1.34
Substance Abuse	2,446	9,585	$ 47,636,013	$ 16,111,253	$ 16,081,745	0.47
Transplant	141	4,353	$ 55,869,069	$ 10,525,518	$ 10,519,453	9.90
Burns	350	3,001	$ 33,720,893	$ 6,505,394	$ 6,484,435	2.38
Total	431,604	1,692,298	$ 13,455,628,733	$ 2,928,132,792	$ 2,928,625,095	0.75
Note: Charges, allowed amount and reimbursement amount include hearing test for newborns.						

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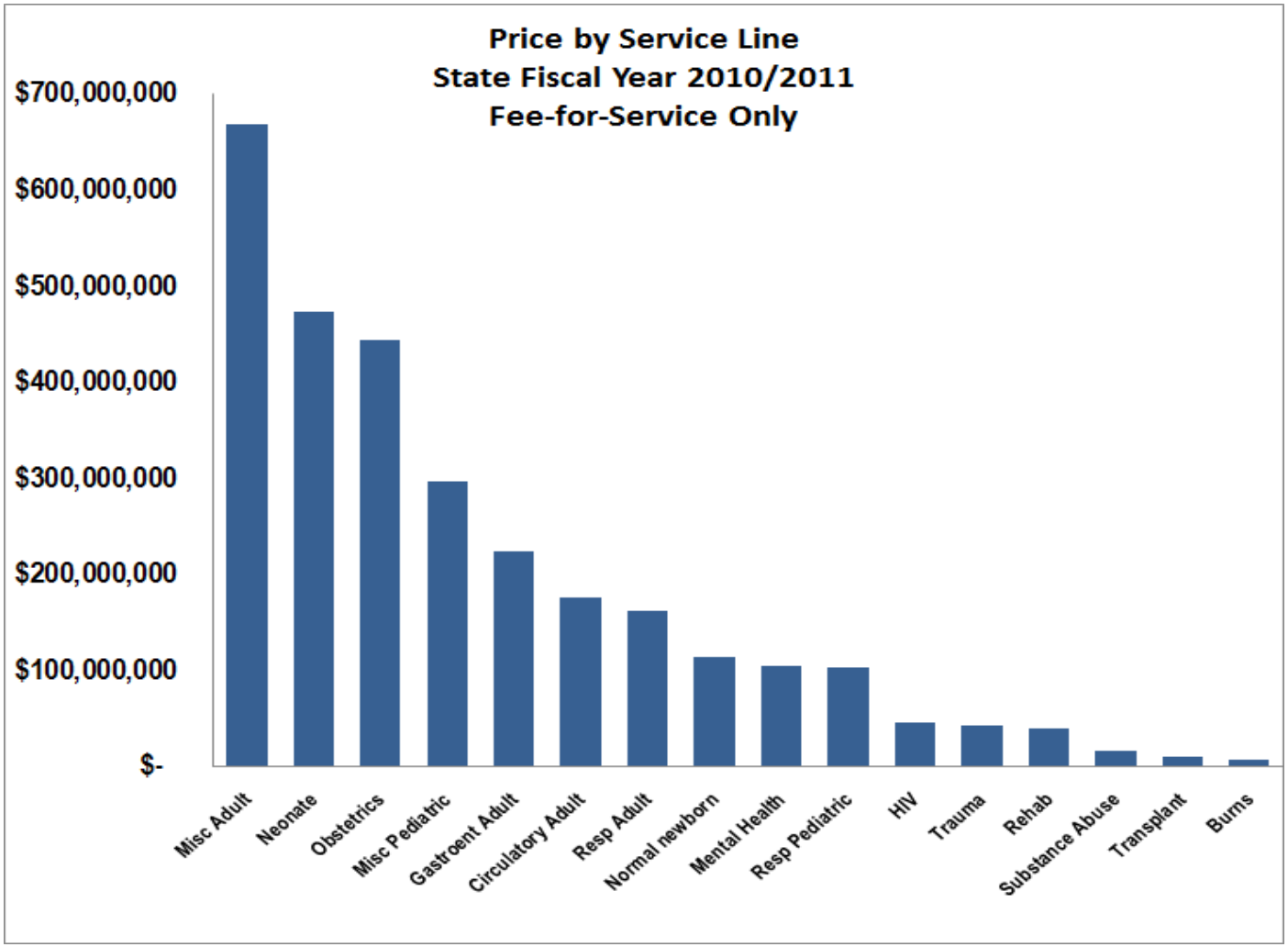
Historical Florida Medicaid Payments by Service Line



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Historical FL Medicaid Payments by Provider Categ

State Fiscal Year 2010/2011 All Inpatient Claims by Provider Grouping Fee-for-Service Only						
Provider Grouping	Claims	Days	Charges	Allowed Amount	Reimbursement Amount	APR-DRG Casemix
LIP	338,878	1,383,465	$ 10,795,799,962	$ 2,588,606,894	$ 2,588,360,720	0.77
Trauma	173,031	826,737	$ 6,171,802,980	$ 1,664,784,645	$ 1,661,247,638	0.90
Statutory Teaching	101,581	489,881	$ 3,718,079,547	$ 1,057,174,824	$ 1,059,735,886	0.90
High Charity	115,680	431,410	$ 3,665,764,666	$ 699,514,005	$ 701,751,377	0.69
Public	79,078	304,667	$ 2,173,300,712	$ 523,589,231	$ 524,806,169	0.72
CHEP	78,665	313,786	$ 2,429,402,300	$ 521,395,843	$ 522,615,867	0.75
General Acute	126,867	402,205	$ 3,256,961,883	$ 512,651,234	$ 514,038,677	0.65
Children	9,701	76,969	$ 778,239,756	$ 198,394,821	$ 191,925,599	1.39
Rural	11,335	25,882	$ 143,565,498	$ 45,544,173	$ 45,814,924	0.49
Out of state	1,407	8,548	$ 61,881,051	$ 16,646,222	$ 16,589,830	1.15
Rehabilitation	534	7,680	$ 17,210,394	$ 4,250,082	$ 4,235,103	1.27
Long Term Acute Care	126	2,449	$ 11,756,955	$ 2,390,722	$ 2,351,258	2.02
Notes: 1) Charges, allowed amount and reimbursement amount include hearing test for newborns. 2) Hospitals may be included in more than one category.						

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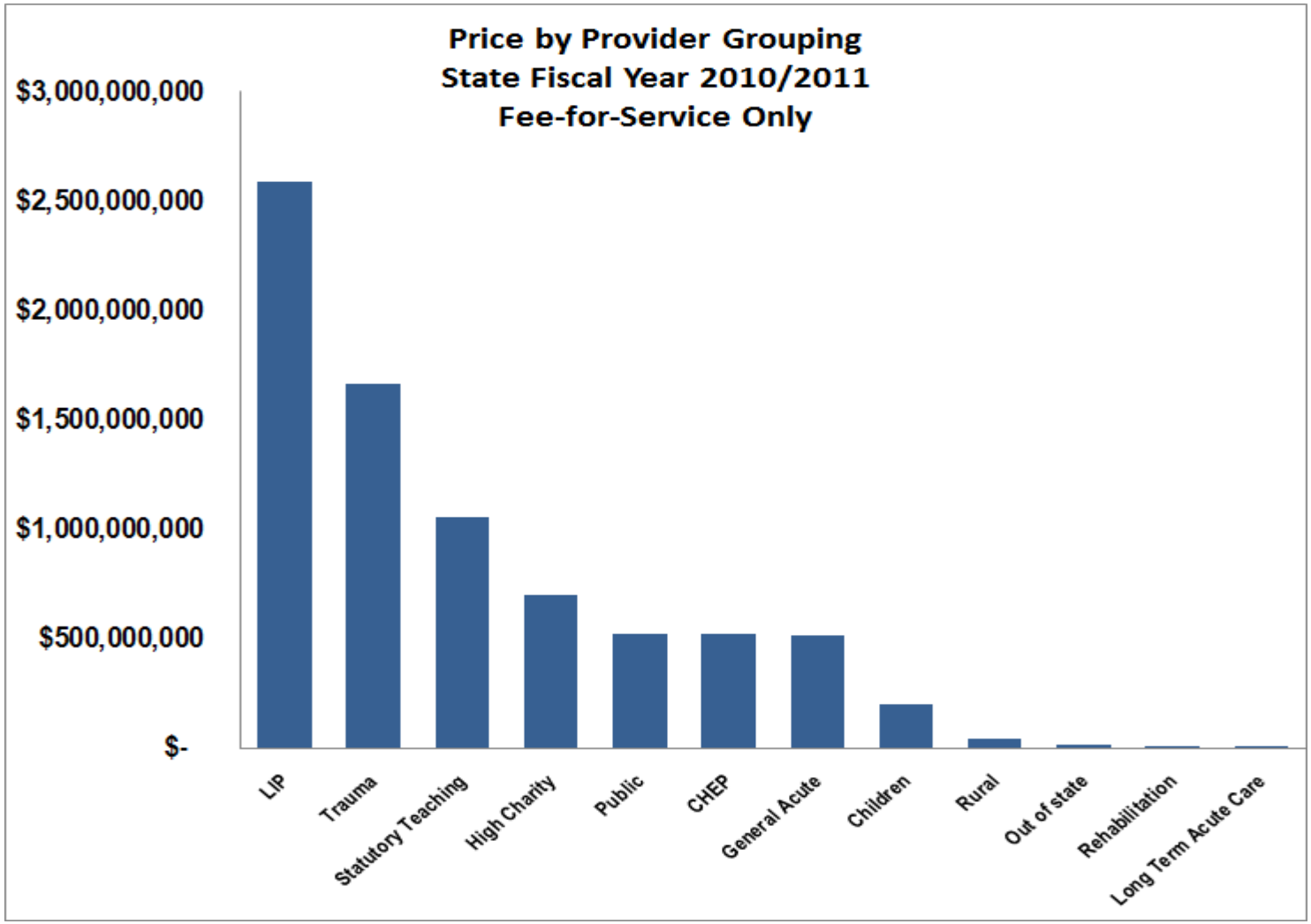
Historical FL Medicaid Payments by Provider Categ



Preliminary Recommendations

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Preliminary Recommendations

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

Preliminary Recommendations

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

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Preliminary Recommendations

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

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Preliminary Recommendations

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

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Questions and Discussion

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