Florida Medicaid
Inpatient Prospective Payment System

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House Health Care Appropriations Subcommittee
January 23, 2013

Topics

Project Overview
What is a Diagnosis Related Group (DRG)?
Selection of APR-DRGs
DRG Pricing Calculation
Payment Design Decisions
Budget and Pay-to-Cost Goals
Detailed Results of Current Payment Simulation
Results of Simulation Excluding IGTs
Summary

Project Overview

Project Basics

- 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
- AHCA engaged MGT of America, and its subcontractor Navigant Healthcare, for project

Project Overview
Public Input

- Five public meetings were held between August 2012 and January 2013.
- Public comments, presentations and questions were received during each meeting
- Individual meetings were held with stakeholders, including: the Florida Hospital Association, the Safety Net Hospital Alliance, HCA Healthcare, H. Lee Moffitt Cancer Center, Orlando Health, representatives of stand-alone children's hospitals, representatives of rehabilitation hospitals, the Florida Association of Health Plans and individual health plans including United Health Plan , Amerigroup and Wellcare, and others stakeholders.
- All supplemental information received from stakeholders was forwarded to Navigant and provided to the Governance committee for consideration
- Historical hospital claims data, used by Navigant in the DRG simulations, was provided to the Florida Hospital Association, and is being provided to other parties at this time now that legal agreements are in place allowing that data sharing.

Project Overview

Payment Method Guiding Principles

Efficiency	Is the option aligned with incentives for providing efficient care?
Access	Does the option promote access to quality care, consistent with federal requirements?
Equity	Does the option promote equity of payment through appropriate recognition of resource intensity and other factors?
Predictability	Does the option provide predictable and transparent payment for providers and the State?
Transparency and Simplicity	Does the option enhance transparency, and contribute to an overall methodology that is easy to understand and replicate?
Quality	Does the option promote and reward high value, quality-driven healthcare services?
Budget Neutrality	Do the payment rates maintain current statewide levels of funding?

Project Overview

Project Steps Completed

- Defined payment method “Guiding Principles”
- Documented DRG payment method options including best practices from other payers
- Constructed payment simulation models to analyze the fiscal impacts of implementing the various methodology options – options were evaluated by comparing simulated payments against:
  - The costs of providing services
  - Payments under the current per diem methodology
- Presented results at 5 public meetings and considered public comment
- Met with ad hoc AHCA DRG Governance Committee on numerous occasions to review results of simulations and make adjustments
- Held audience with and accepted input from various hospital organizations

Project Steps Remaining

- Change Medicaid administrative State Plan (must be approved by the Centers for Medicare and Medicaid Services – CMS)
- Change internal procedures for inpatient program administration
- Change provider documentation
- Create and deliver provider training
- Change medical claims processing software application (FMMIS)
- Recalculate rates and policy adjustors based on refined budget for 2013/2014

What is a Diagnosis Related Group (DRG)?

- Defines the “product of a hospital,” creating a common language for clinical and financial managers
- Each discharge is assigned a DRG code based on information routinely submitted on medical claims (diagnosis codes, procedure codes, age, gender, and birth weight)
- DRGs categorize patients with similar clinical characteristics and requiring similar hospital resource intensity
- Each DRG has a relative weight factor, which recognizes the differences in resource requirements for patients assigned to the DRG
- The DRG relative weight and a hospital base rate are the primary components in calculating payment, which is per discharge
- Payment is aligned with patient acuity – higher payments made for sicker patients
- Payment is generally a fixed amount based on the DRG assignment, thus rewarding hospitals that reduce cost

Selection of APR-DRGs

Comparison of MS and APR-DRGs

Description	MS-DRGs V.30 (CMS - Maintained by 3M)	APR-DRGs V.30 (3M and NACHRI)
Intended population	Medicare (age 65+ or under age 65 with disability)	All patient (based on the Nationwide Inpatient Sample)
Overall approach and treatment of complications and comorbidities (CCs)	Intended for use in Medicare population. Includes 335 base DRGs, initially separated by severity into "no CC", "with CC" or "with major CC". Low volume DRGs were then combined.	Structure unrelated to Medicare. Includes 314 base DRGs, each with four severity levels. The is no CC or major CC list; instead, severity depends on the number and interaction of CCs.
Number of DRGs	746	1,256
Newborn DRGs	7 DRGs, no use of birth weight	28 base DRGs, each with four levels of severity (total 112)
Psychiatric DRGs	9 DRGs; most stays group to "psychoses"	24 DRGs, each with four levels of severity (total 96)

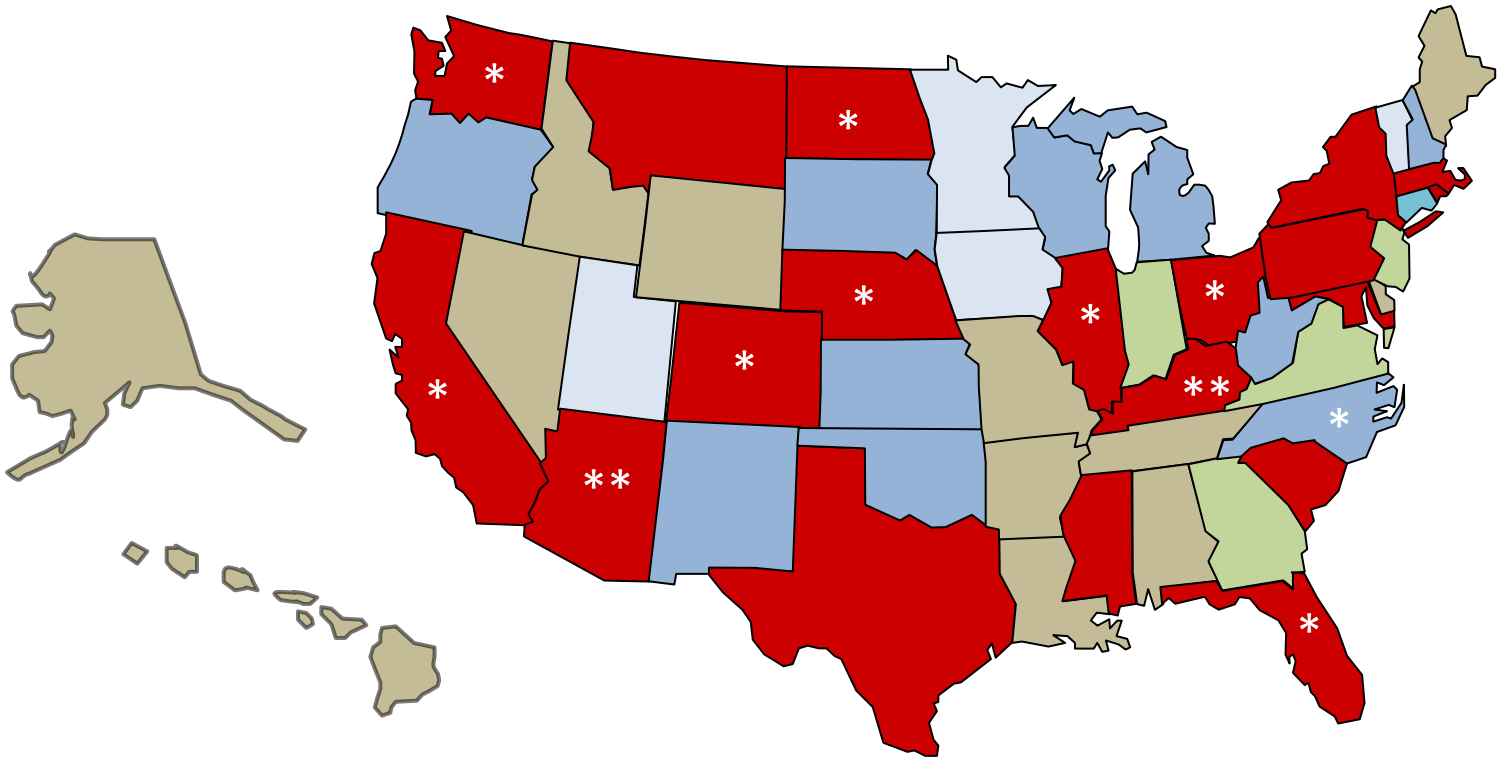
Source: Quinn, K, Courts, C. *Sound Practices in Medicaid Payment for Hospital Care*. CHCS: November 2010, updated with current information by Navigant Healthcare.

Selection of APR-DRGs

APR-DRGs – Prevalence with 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



Selection of APR-DRGs

MS-DRG Applicability to Medicaid

Designed for classification of Medicare patients …

> "The MS-DRGs were specifically designed for purposes of Medicare hospital inpatient services payment… We simply do not have enough data to establish stable and reliable DRGs and relative weights to address the needs of non-Medicare payers for pediatric, newborn, and maternity patients. For this reason, we encourage those who want to use MS-DRGs for patient populations other than Medicare [to] make the relevant refinements to our system so it better serves the needs of those patients."

Source: CMS, "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule," *Federal Register* 72:162 (Aug. 22, 2007): 47158

Selection of APR-DRGs
Example APR-DRGs*

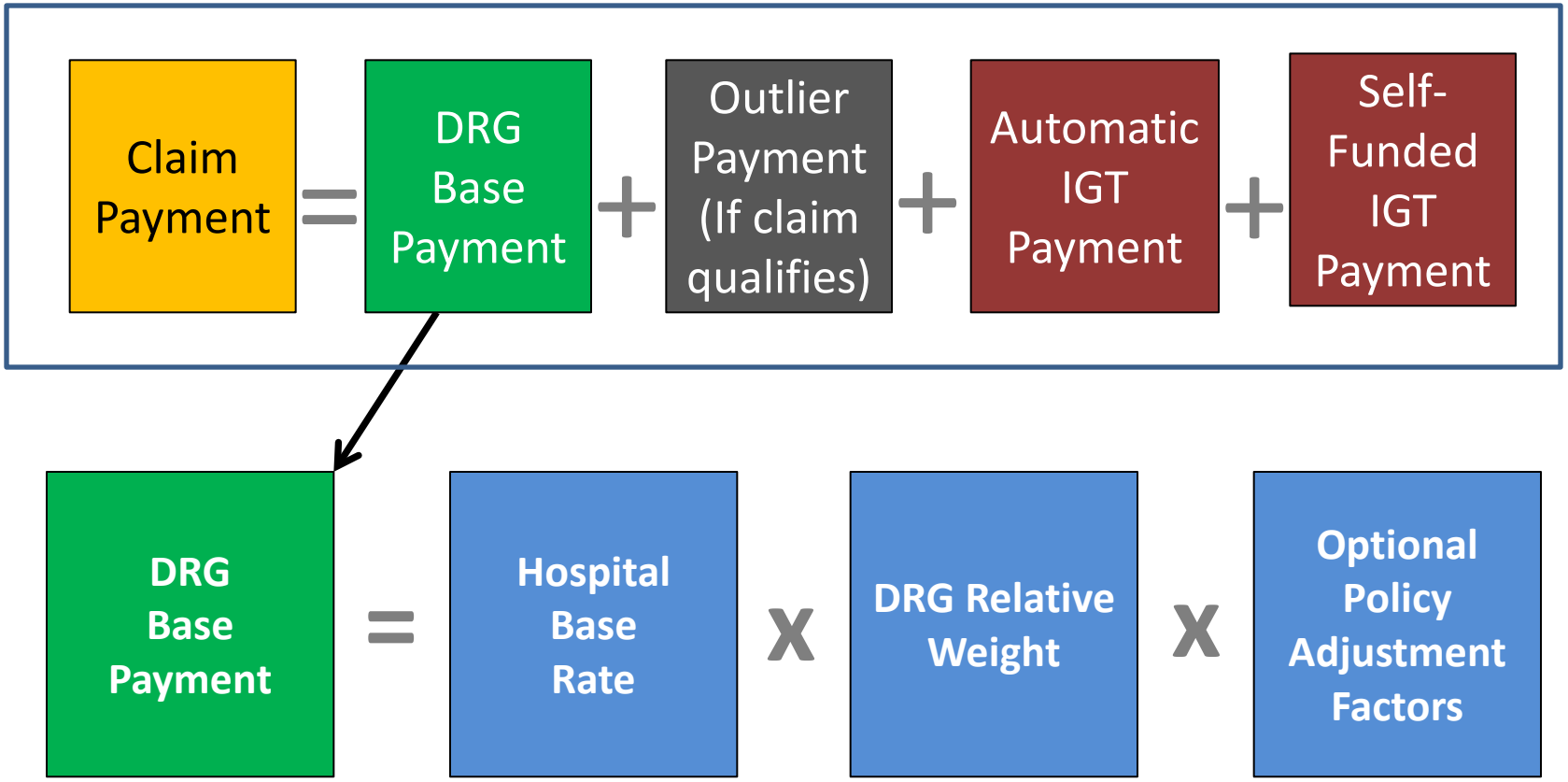
APR DRG	Short Description	Stays	Relative Weight	Average Length of Stay
640-1	Normal Newborn, birth wt > 2,499 grams	70,708	0.13	2.18
540-1	Cesarean Del	24,665	0.71	3.0
640-3	Normal Newborn, birth wt > 2,499 grams	4,307	0.50	3.5
139-2	Other Pneumonia	3,410	0.79	3.7
141-1	Asthma	2,776	0.49	2.1
190-4	Acute Myocardial Infarction	96	3.14	9.5
750-2	Schizophrenia	2,005	0.94	9.8
611-3	Neo birth wt 1,500-1,999g w Maj Anomaly	1,958	6.68	32.8

*All Patient Refined Diagnosis Related Groups

DRG Pricing Calculation
Basics

- Payment is generally determined by multiplying a hospital's "base rate" by the assigned DRG's relative weight factor
- An "outlier" payment provision is typically incorporated to provide additional payments where the base DRG amount is not appropriate – generally cases with extraordinarily high costs
- Payment models are also commonly modified to affect payment for specialty services or providers, including behavioral health, rehabilitation, neonatal, pediatric and others

DRG Pricing Calculation
Formula



Note: DRG base payment is sometimes reduced for transfers and non-covered days.

DRG Pricing Calculation
Examples

DRG	Hospital Base Rate	DRG Relative Weight	Policy Adjustment Factor	DRG Base Payment	Automatic IGT Payment	Self-Funded IGT Payment	Outlier Payment	Final Claim Payment
640-2	$3,231	0.19	1.733	$1,064	$0	$0	$0	$1,064
321-3	$3,231	5.08	1.000	$16,413	$945	$376	$0	$17,734
194-2	$3,231	0.86	1.000	$2,779	$2,066	$782	$9,200	$14,827

640-2	Normal Newborn, birth weight > 2,499 grams
321-3	Cervical Spinal Fusion
194-2	Heart Failure

Payment Design Decisions

Affected Providers and Services

Design Consideration	Decision
Affected providers	• All inpatient acute care providers except the four state-owned psychiatric facilities
Affected services	• All services at these providers (including psychiatric and rehabilitation), excluding only: o Transplants currently paid via global fee – will continue reimbursement via global fee o Technical component of newborn hearing test will be paid in addition to DRG payment

Payment Design Decisions
DRGs

Design Consideration	Decision
DRG Grouper	• APR-DRGs - version 30, released 10/1/2012
DRG Relative Weights	• National weights re-centered to 1.0 for Florida Medicaid • Re-centering factor is 0.7614 which is the casemix of the 2010/2011 simulation dataset • For each DRG, the Florida Medicaid relative weight equals [national relative weight / 0.7614]

Payment Design Decisions
Standard Payment

Design Consideration	Decision
Hospital Base Rates	• One standardized amount • No wage area adjustment • Base rates used to distribute funds from general revenue and Public Medical Assistance Trust Fund
Per-Claim Add-On Payments	• Used to distribute the IGT funds paid on a per-claim basis today • Two add-ons per claim, one for automatic IGTs and another for self-funded IGTs

Payment Design Decisions
Policy Adjustors

Design Consideration	Decision
Targeted Service Adjustors	• Service adjustor for rehabilitation services
Targeted Provider Adjustors	• Rural hospitals • Free-standing long term acute care (LTAC) hospitals • High Medicaid utilization and high outlier hospitals (more than 50% Medicaid utilization – FFS and MC, and more than 30% payments in the form of outliers)
Application of Adjustors	• Select maximum adjustor from all that apply for the hospital stay

Payment Design Decisions
Payment Adjustments

Design Consideration	Decision
Outlier Payment Policy	• Adopt "Medicare-like" stop-loss model with a single threshold • Apply to cases with unpredictably high hospital cost
Transfer Payment Policy	• Adopt "Medicare-like" model for acute-to-acute transfers • Reduce payment in some cases to the transferring hospital; the receiving hospital receives full DRG payment • Do not include a post-acute transfer policy
Charge Cap	• Pay lesser of Medicaid allowed amount and hospital charges

Payment Design Decisions

Payment Adjustments, cont'd

Design Consideration	Decision
Non-Covered Days o 45-day benefit limit o Undocumented non-citizens o Medicaid fee-for-service eligibility for part of a stay	• Prorate payment based on number of covered days versus total length of stay • For undocumented non-citizens, Medicaid covers only emergency services, which can be only part of a hospital stay • For 45-day benefit limit, reduce payment only if the limit has been exhausted at time of admission. If any days are available within the benefit limit, then pay under normal DRG pricing rules.

Payment Design Decisions
Policy Decisions

Design Consideration	Decision
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 the 45 day benefit limit prior to admission and recipients who are undocumented non-citizens
Interim Claims	• Do not allow

Payment Design Decisions

Initial Implementation Decisions

Design Consideration	Decision
Transition Period	• None
Adjustment for Expected Coding and Documentation Improvements	• 6 percent
Adjustment for Real Casemix Increase between 2010/2011 and 2013/2014	• 0.5 percent per year – 1.5 percent for the three years
Total Payment Adjustment for Casemix Difference between Simulation Data and First Year of Implementation	• 7.5 percent

Budget and Pay-to-Cost Goals

Tentative Inpatient Budget 2013/2014

General Revenue and Public Medical Assistance Trust Fund (PMATF)	Automatic IGTs	Self-Funded IGTs	Total
$1,975,206,378	$622,159,318	$762,775,396	$3,360,141,092

- Values from November 2012 Social Services Estimating Conference
- Values include Federal matching funds
- Values are for inpatient fee-for-service expenditures only
- Totals in DRG pricing simulations are lower because the volume of claims in the simulation dataset is less than the claim volume anticipated in state fiscal year 2013/2014

Pay-to-Cost Goals Used to Set Policy Adjustors

Category	2013/2014 Estimate* Under Current Payment Method	2013/2014 Goal Using DRG Pricing
Florida Medicaid, overall	88%	88%
Rural hospitals	114%	100%
LTAC hospitals	61%	65%
Rehabilitation hospitals	46%	50%
High Medicaid utilization and high outlier percentage hospitals (free-standing children's hospitals)	99%	95%

* Costs inflated; payments calculated using 2012/2013 per diem rates, then increased slightly to align with consensed estimates from the November 2012 Social Services Estimating Conference

Detailed Results of Current Simulation

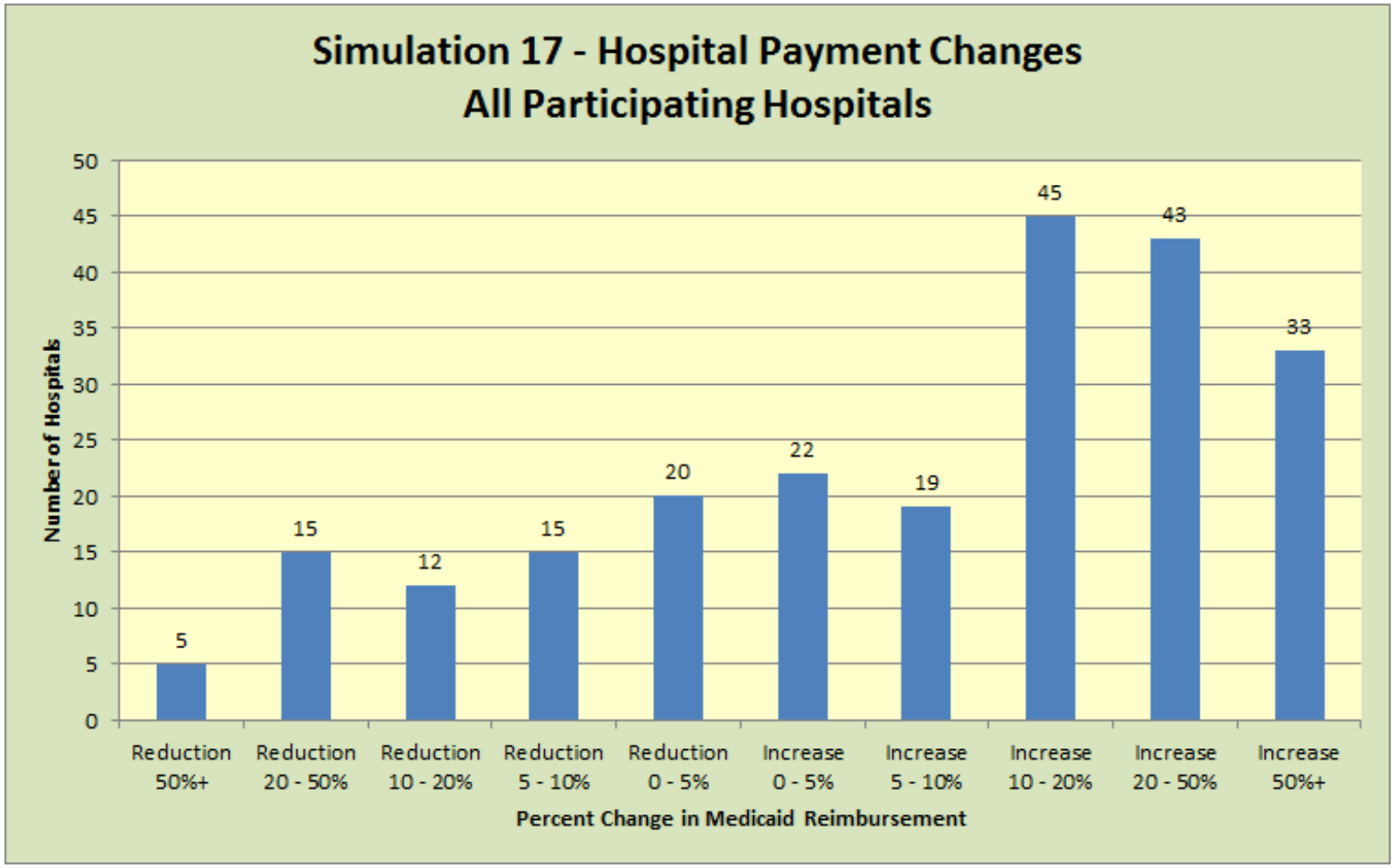
Final Rates*

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

* All rates subject to change based on updates from the Social Service Estimating Conference and direction from FL Legislature.

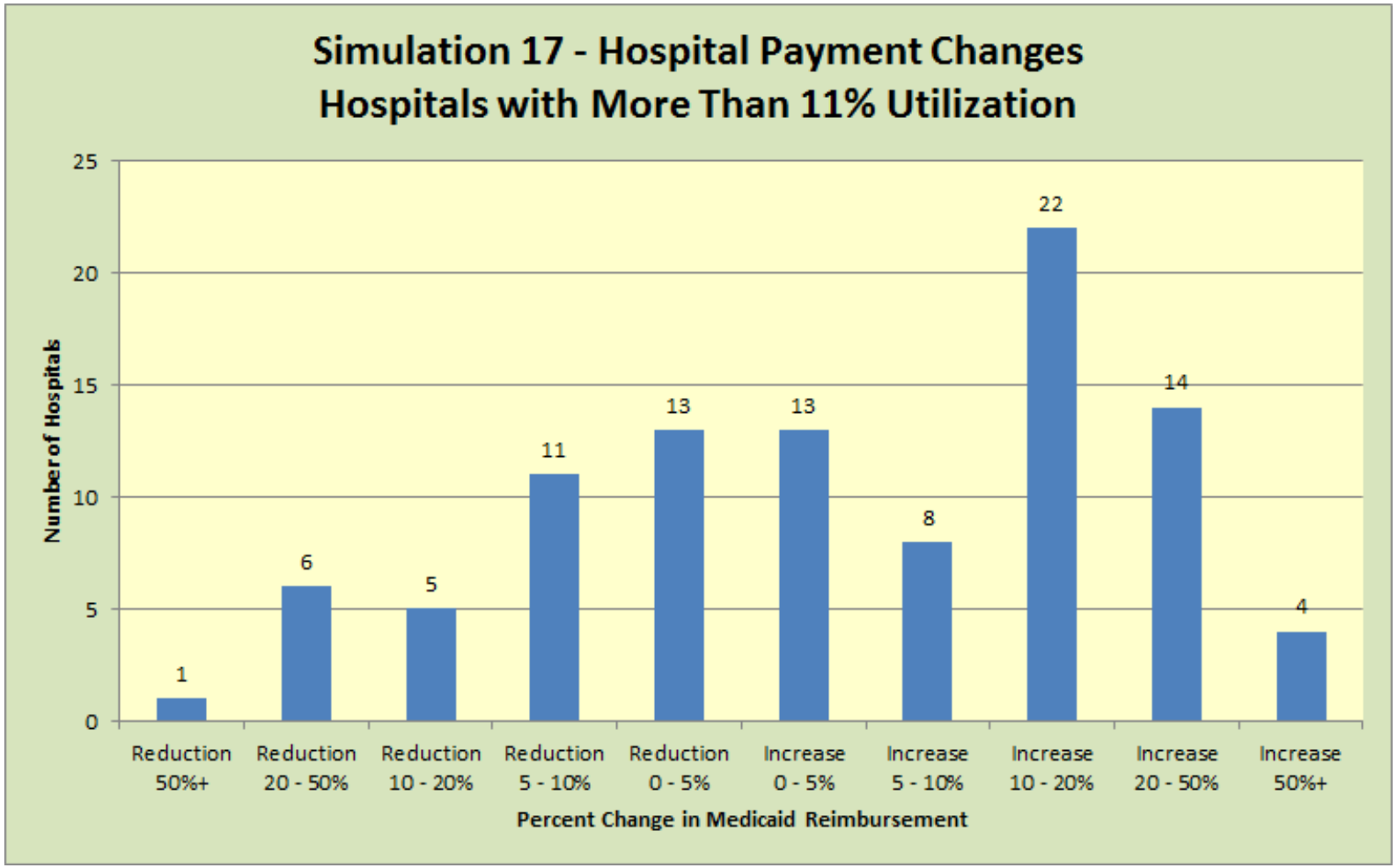
Detailed Results of Current Simulation

Provider Impact – All Hospitals



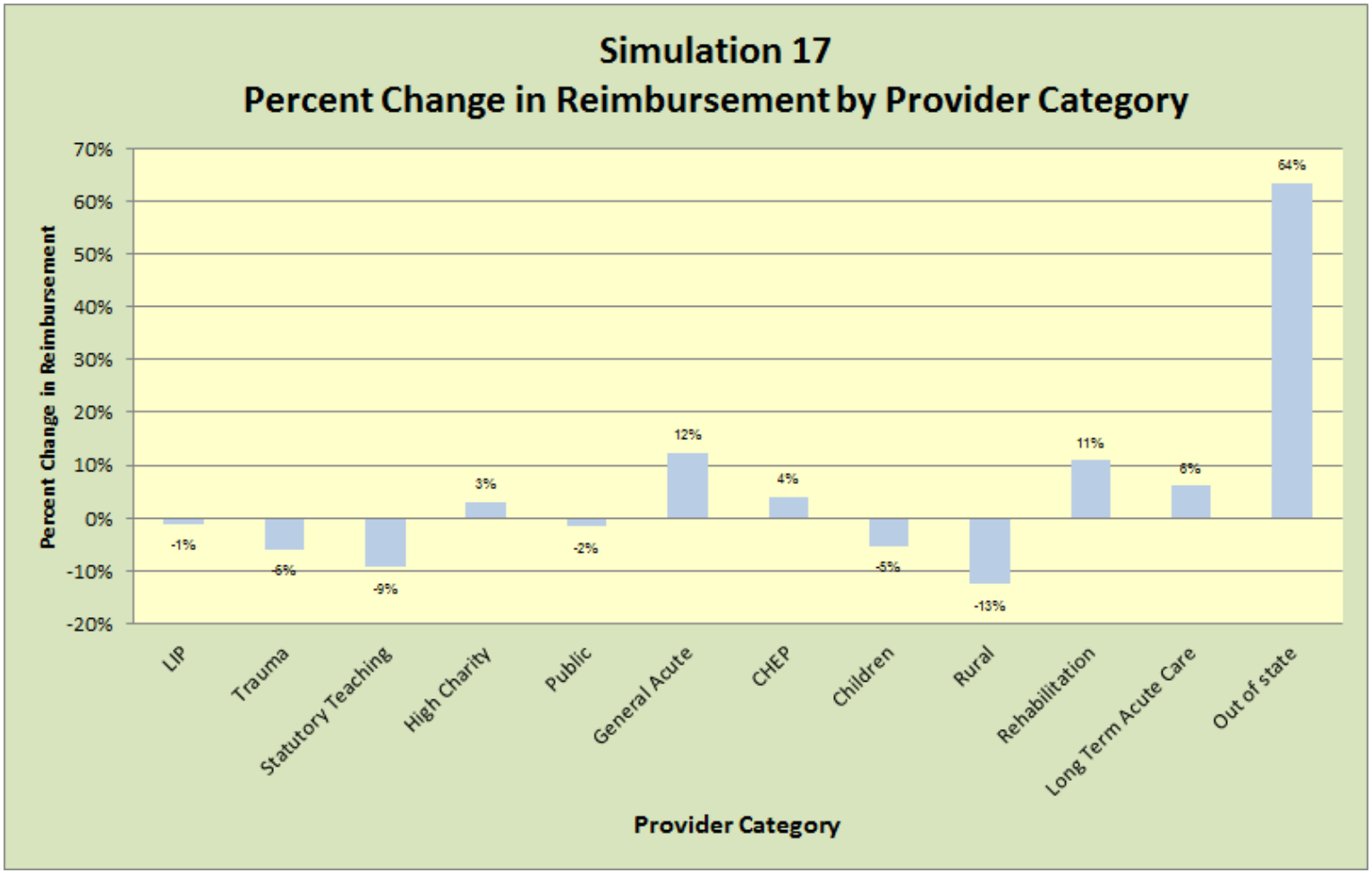
Detailed Results of Current Simulation

Provider Impact – Hospitals with > 11% Medicaid



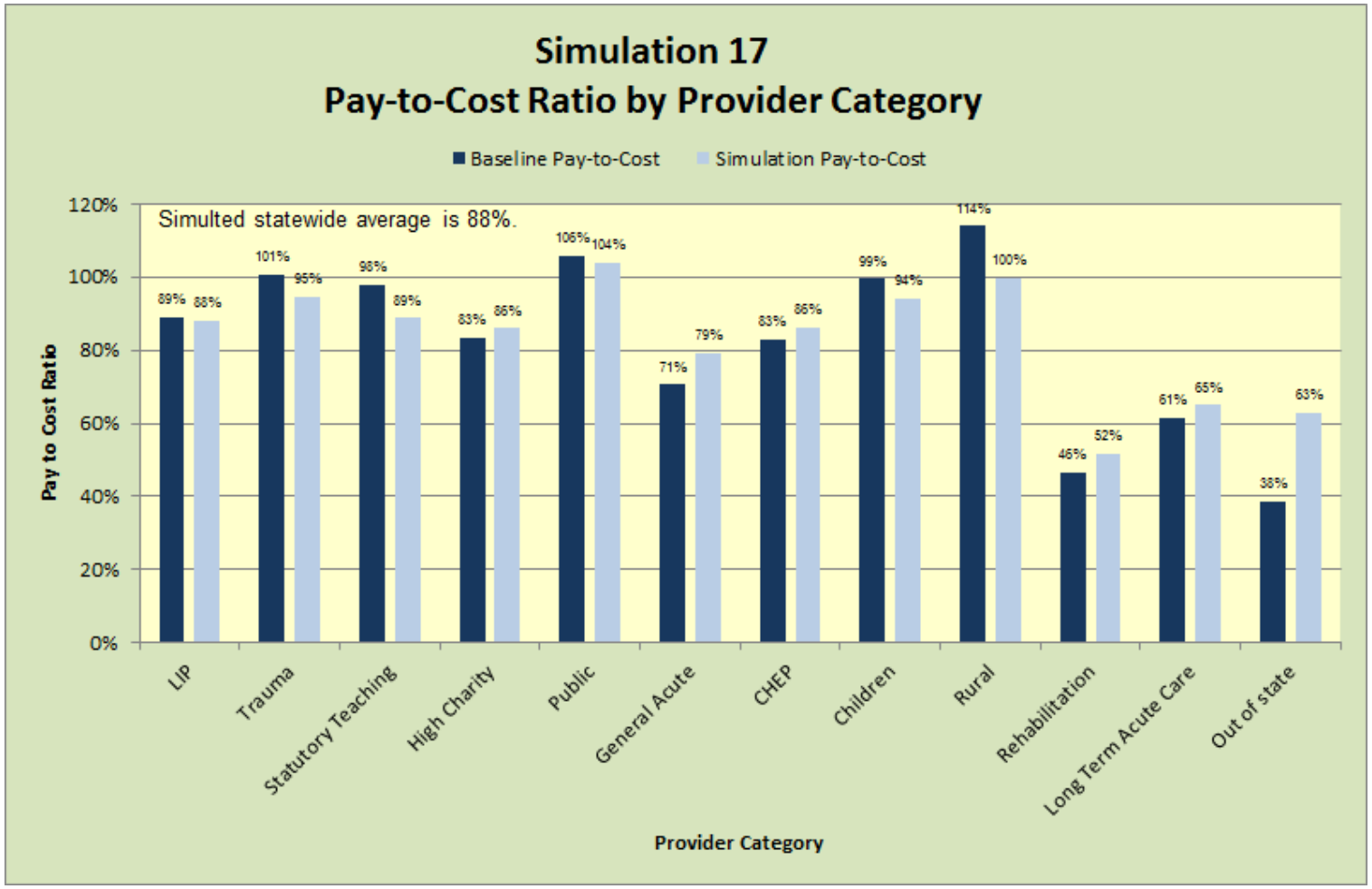
Detailed Results of Current Simulation

Change in Payment by Provider Category



Detailed Results of Current Simulation

Pay-to-Cost by Provider Category



Detailed Results of Current Simulation

Summary by Provider Category

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

Notes:

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

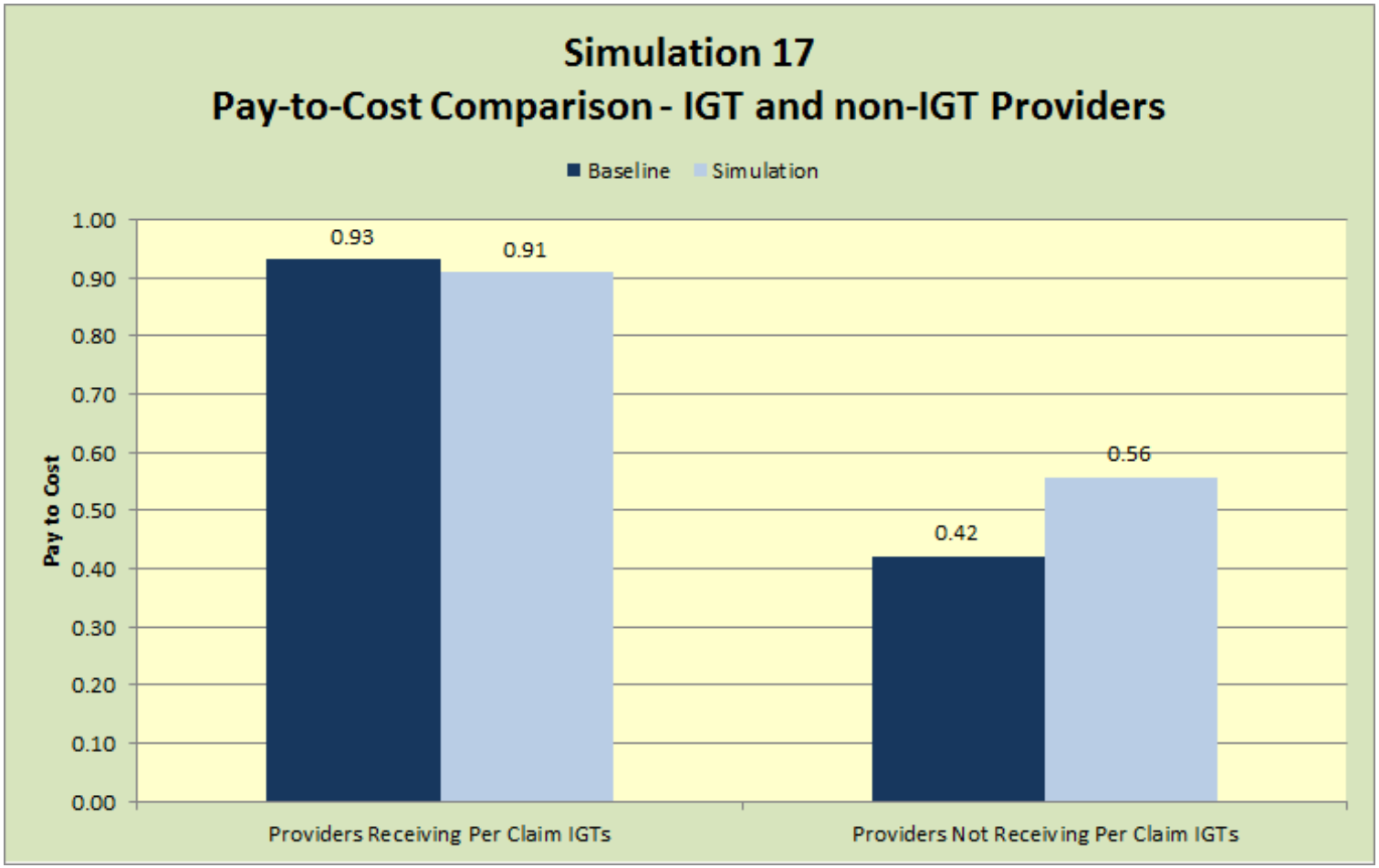
2) "High Charity" is any hospital with 11% or more market share from Medicaid and uninsured recipients.

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

4) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011 then inflated to midpoint of 2013/2014.

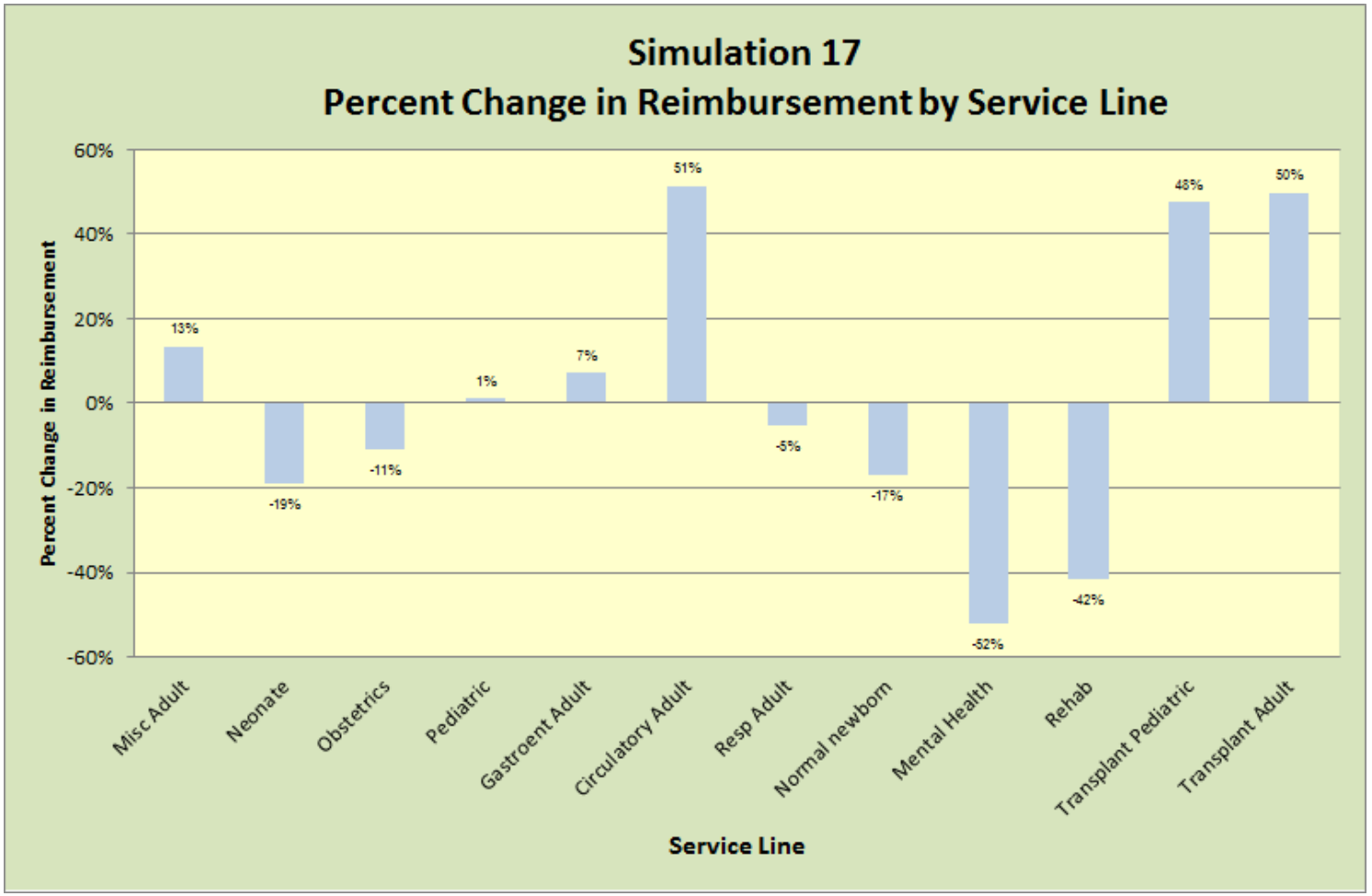
Detailed Results of Current Simulation

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



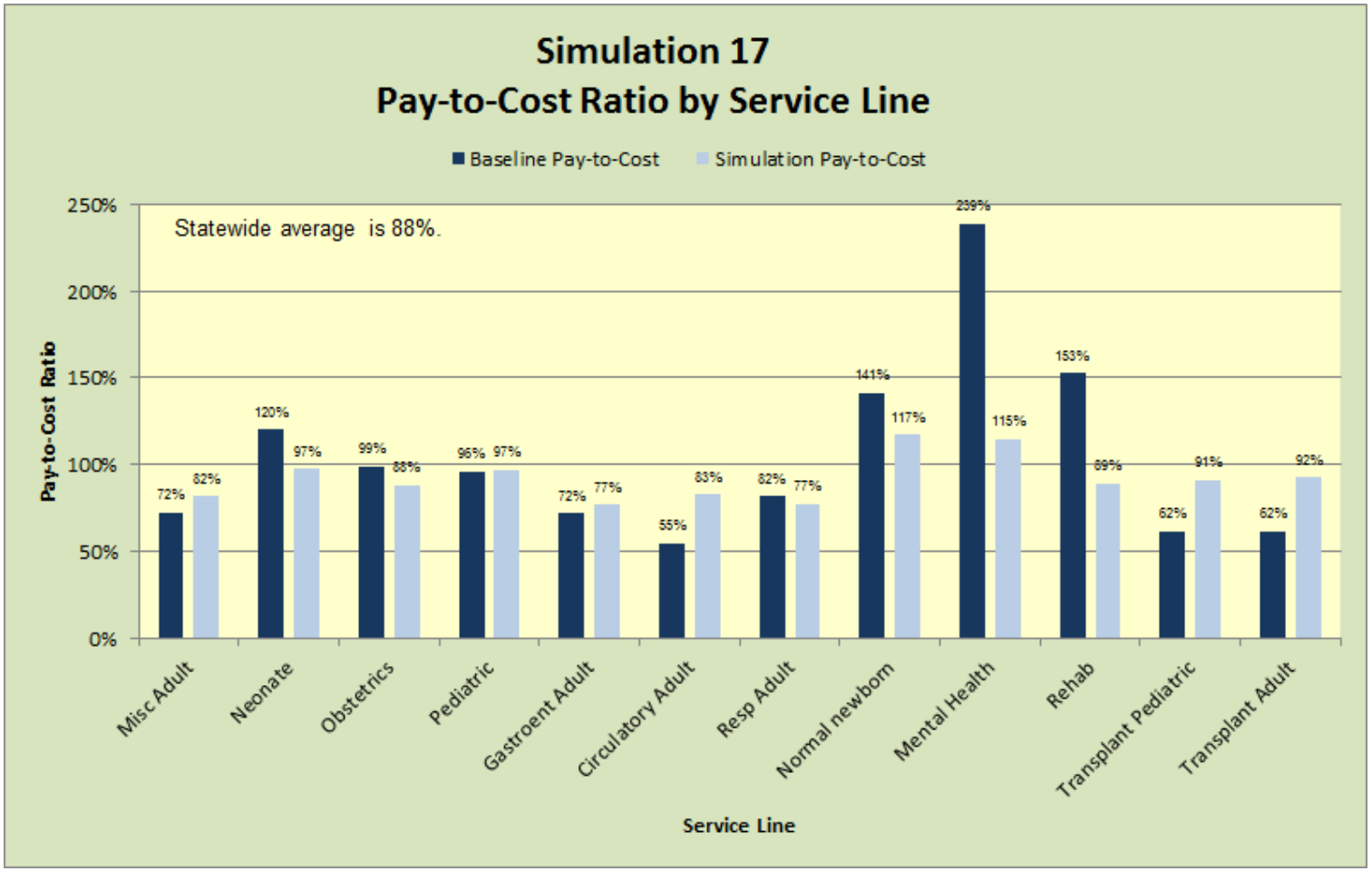
Detailed Results of Current Simulation

Change in Payment by Service Line



Detailed Results of Current Simulation

Pay-to-Cost by Service Line



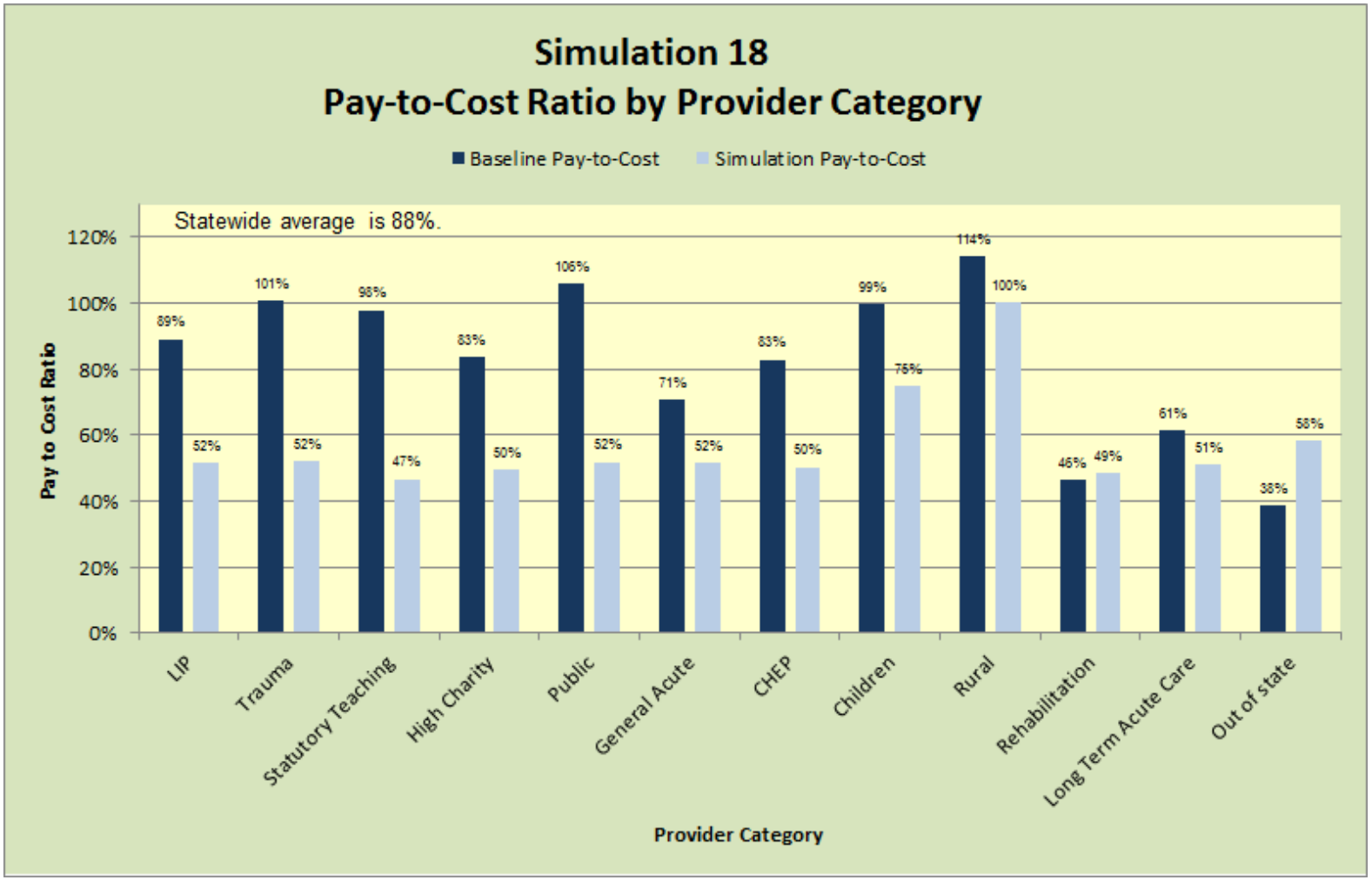
Detailed Results of Current Simulation
Summary by Service Line

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

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

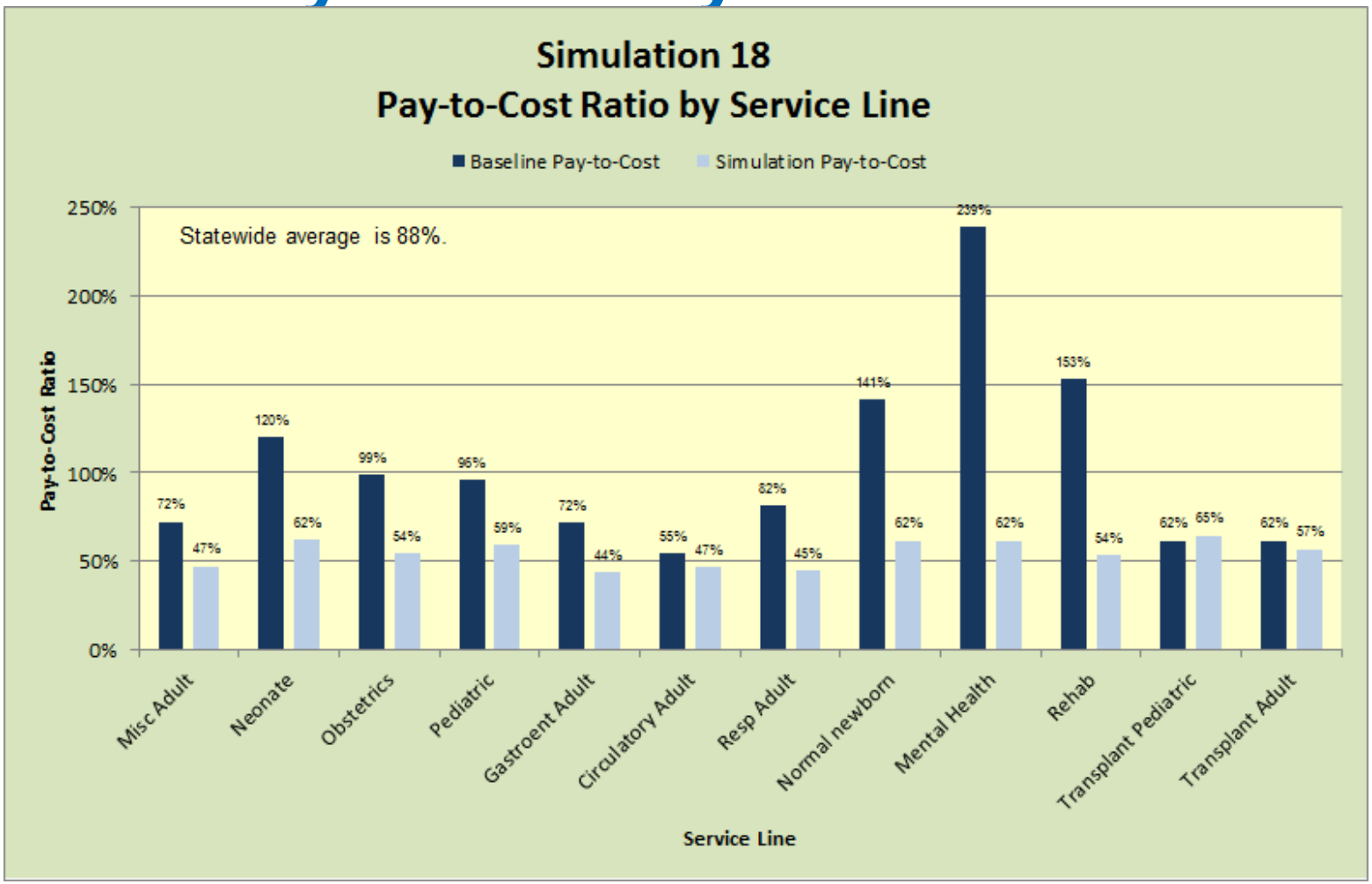
Simulation Excluding IGT Funds

Pay-to-Cost by Provider Category



Simulation Excluding IGT Funds

Pay-to-Cost by Service Line



Project Summary

- Anticipating implementation on July 1, 2013
- New payment method gets away from cost-based reimbursement
- With this change, some hospitals will see increases in Medicaid reimbursement; others will see decreases
- Inter-Governmental Transfer (IGT) funds will be distributed as supplemental payments in addition to DRG payment

Questions?