

Update on Diagnosis Related Groups (DRG) Implementation

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Background

- The 2012 Legislature directed the Agency to convert Medicaid fee-for-service inpatient hospital reimbursement to a prospective payment system (PPS) which categorizes stays using Diagnosis Related Groups (DRGs) (s. 409.905(5)(f), F.S.).
- The Agency was required to submit a Medicaid DRG plan by January 1, 2013.
 - Plan was submitted on December 21, 2012.
- The Agency was required to implement DRG pricing by July 1, 2013.
 - DRG pricing was implemented July 1, 2013.
- AHCA engaged MGT of America, and its subcontractor Navigant Healthcare.

Background: Previous Hospital Rate Setting Methodology

- Cost-Based “Per Diem” Methodology
 - Payments are based on hospitals’ spending. Rates for hospitals are set on a facility specific basis, based on each facility’s reported costs.
 - Hospital rates are all inclusive, “per diem” rates, based on reported costs for services provided by the hospital to Medicaid recipients on a fee-for-service basis.

What is a Diagnosis Related Group (DRG) Methodology

- Payments are based on patients' needs. Higher payments are made for sicker patients.
- 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 DRG payment, which is per discharge.

What is a Diagnosis Related Group (DRG) Methodology (cont.)

- Payment is generally a fixed amount based on the DRG assignment, thus rewarding hospitals that reduce cost.
- 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 sometimes modified to affect payment for specialty services or providers to ensure fair reimbursement and access to care for Medicaid recipients.
 - Referred to as "policy adjustors".
- The DRG payment also includes additional per claim add-ons, tied to intergovernmental transfers (IGTs)

DRG System Goals

- Efficiency: Aligns with incentives for providing efficient care
- Access: Promotes access to quality care, consistent with federal requirements
- Equity: Promotes equity of payment through appropriate recognition of resource intensity and other factors
- Predictability: Provides predictable and transparent payment for providers and the State
- Transparency and Simplicity: Enhances transparency, and contribute to an overall methodology that is easy to understand and replicate
- Quality: Promotes and rewards high value, quality-driven healthcare services

Impact of Change in Payment Methodology

- The move from a cost-based payment method (previous method) to an acuity-based payment method has a tendency to increase reimbursement for hospitals that have relatively low costs and decrease reimbursement for hospitals with relatively high costs.
- Hospitals with relatively high costs can mitigate the projected changes in reimbursement level by reducing their costs.
 - Example: A reduction in average length stay, which would reduce a hospital's revenue under the current payment method, will increase its pay-to-cost ratio under the new DRG payment method.

Implementation

- On July 1, 2013, the state implemented the new payment method utilizing DRGs.
- The Agency's fiscal agent, Hewlett-Packard (HP), began the implementation phase in February, 2013.
- The effort was categorized into three main areas of focus:
 - Systems: Updating the Florida Medicaid Management Information System (FMMIS) to process inpatient claims according to the Agency's direction.
 - Training: Educating Agency and HP personnel on DRG changes.
 - Provider Outreach: Supporting and educating the hospital provider community on the transition to DRG pricing.

DRG Information on the Web Portal

- A DRG-specific webpage was created on the Florida Medicaid Web Portal at <http://mymedicaid-florida.com> to house all public documents related to the transition.
- A variety of resources were published to the DRG page, including a presentation, FAQs, and a quick reference and awareness guide.

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Agency Initiatives

- DRG Pricing
- ICD-10
- SMMC

DRG Pricing

Florida Medicaid is now processing claims using an inpatient payment method utilizing Diagnosis-Related Groups (DRG) as mandated by the 2012 Florida Legislature. The majority of inpatient claims with dates of services July 1, 2013 or later are now processed under DRG.

The following documents provide essential information regarding billing changes and other information related to DRG:

- [DRG Quick Reference Guide \(QRG\)](#) [361KB] *Updated 5/28/13*
- [DRG Frequently Asked Questions \(FAQ\)](#) [351KB] *Updated 8/7/13*
- [Understanding Diagnosis Related Groups \(DRG\) Training Presentation](#) [1587KB] *Updated 7/31/13*
- [DRG Field Services Representatives Area Map](#) [390KB]

To access these documents, you must have [Adobe Acrobat Reader](#) installed on your machine.

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Providers are encouraged to visit this page regularly for the most current information regarding DRG.

DRG information can also be found on the AHCA Medicaid Institutional Provider Cost Reimbursement page. This page provides information on DRG pricing, DRG simulation results by provider, and a DRG payment calculator.

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Provider Outreach Highlights

- A series of DRG webinars, consisting of general overview, payment methodology, and prior authorization impact, was created to provide an opportunity for hospitals to participate in electronic and virtual training.
 - Thirteen (13) webinars were conducted with over 900 attendees.
- HP's seven (7) dedicated DRG Field Services Representatives (FSRs) contacted all active participating hospital providers in the state of Florida and “border” hospitals.
 - This contact resulted in 100 on-site provider visits.

Triage Support

- For the period of 07/01/13 – 09/30/13, a triage unit was implemented to monitor post-implementation issues, inpatient claims, and provide support to the submitting hospital providers.
- As of 09/12/13, as part of the triage provider outreach, 223 hospitals have been contacted to discuss initial DRG claims and outcomes.
- Since implementation, ten (10) system change orders related to DRG were created and implemented. All change orders were expedited in order to lessen the impact to the provider community.

DRG Claim Metrics, as of 09/09/13

- Hospitals with paid DRG claims: 230
- Total DRG claims paid: 41,993
 - Average per claim reimbursement: \$4,749.83
- Total DRG reimbursement: \$199,464,263.12
- The top 100 most costly DRG claims reimbursed in August had an average relative weight of 9.70, an average length of stay of 17.71 days, and an average total reimbursement of \$79,885.05.

DSS Data

- Seventeen (17) Decision Support System reports were created to gauge the impact of DRG, compare historical payments to new payments, and identify any areas of concern.
 - As of 09/12/13, sixteen (16) reports have been completed. Results were distributed by HP to the Agency on a weekly basis during the Triage period.

DSS Data

- One report compares total inpatient expenditures against the prior year. The chart below represents a monthly comparison of total inpatient expenditures for the month of July 2012 to the month of July 2013.

DOS Month / Year	07/2012	07/2013
Sum Of Covered Days	226,507	94,203
Sum Of Reimbursed Amount	\$246,852,933.43	\$100,445,027.38
Sum Of Billed Amount	\$1,692,201,263.86	\$638,788,953.88
Paid Claims Count	33,689	23,419
Denied Claims Count	9,003	4,183
Total Claims Count:	42,692	27,602

- The 2013 reimbursed amount is lower for several reasons
 - Hospitals are paid at discharge, not the daily per diem
 - The simplest claims are billed first
 - Daily bills from June still being paid in July
 - Impact of the discontinuation of interim claims
 - For 2013 this report only includes DRG admissions and excludes any inpatient claim with a date of admission of June 30 and prior

DRG Payment Monitoring

- Additional monitoring reports will include:
 - Overall Medicaid inpatient expenditures
 - Payments by hospital compared to previous year and compared to prediction from DRG payment simulations
 - Actual casemix
 - Readmission rates
 - Prevalence of outlier payments
 - Average length of stay

Next Steps – Self Funded IGTs

- DRG add-ons related to IGTs include an add-on for automatic IGT distributions tied to special designations, and for self funded IGTs provided by local governmental entities for rate enhancements.
- By October 31, 2013, the Agency will recalculate and update the DRG base rate and policy adjustors after the actual self-funded IGT letters of agreement are finalized.
- When the new DRG payment parameters become effective, they will be retroactive back to July 1, 2013, and posted on the Medicaid cost reimbursement website.
- All inpatient claims with admissions beginning July 1, 2013 will be re-priced.

Next Steps – Casemix Reconciliation

- The Agency will review and potentially update the DRG payment parameters again effective March 1, 2014 based on actual measure casemix (average DRG relative weight)
 - Base rate was set under assumption that casemix will be 1.05 (5% above casemix from rate setting dataset)
 - 5% increase in casemix expected primarily because of improved documentation and coding on hospital claims
 - This DRG payment parameter adjustments will be prospective – covering admissions from March 1, 2014 through June 30, 2014
 - Adjustments will maintain budget neutrality for SFY 2013-14

Next Steps – Transitional Payment Reconciliation

- \$65 million made available in FY 2013-14 for quarterly payments to hospitals expected to see Medicaid revenue decrease with move from per diem to DRG methodology.
 - All rural hospitals set budget neutral.
 - Hospitals that were predicted to lose \$300,000 or more were provided additional funds to cover some of the revenue reduction.
- Reconciliation of transitional funds will compare actual DRG reimbursement in FY 2013-14 to estimated reimbursement under per diem payment method.
- Adjustments in transitional funds must stay within \$65 million in total.

Questions?

