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FLORIDA SHOULD PROCEED WITH MEDICAID DRG IMPLEMENTATION

A FLORIDA TAXWATCH RESEARCH REPORT

MARCH 2013

Florida
TaxWatch

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** Due to the interconnected nature of the referenced material in this Report, references are organized by section following the Conclusion.

ABSTRACT The Florida Agency for Health Care Administration (AHCA) plans to implement a prospective payment plan for Medicaid hospital inpatients based on a Diagnosis-Related Group (DRG) model on July 1, 2013. This model will replace the current system of a cost-based, fee-for-service, per diem payment, wherein a flat fee is paid for each day a Medicaid patient is in the hospital. Unlike the per diem model, the DRG model bases payment on pre-grouped categories of conditions being treated.

Payment for Medicaid inpatient services under a DRG system improves the predictability of costs and revenue, moves toward less complexity, and increases transparency.

DRGs create financial incentives for the smart use of resources and the efficient provision of inpatient services by shifting the provider incentive structure to require efficiency for profitability, laying the groundwork for potential long-term cost savings. Most notably, the DRG system creates a logical equity by removing existing variations in payments for similar services across Medicaid hospitals. For example, currently a knee replacement may cost \$500 at one Florida Medicaid hospital, while the same knee replacement for the same individual may cost \$5000 at another Florida Medicaid hospital.¹ With the DRG payment system, this disparity would be eliminated.

This Report provides the basics of the DRG system, discusses criticisms of the planned July 2013 implementation date, and recommends full implementation of the Diagnosis Related Group (DRG) prospective payment system for Medicaid hospital inpatients on July 1, 2013, as currently required by statute.

¹ The costs shown on the cover of this Report and within the body are fictional, and used for illustrative purposes only.

SECTION

1

In compliance with §409.905(5)(f),² Florida Statutes the Florida Agency for Health Care Administration (AHCA) plans to implement a prospective payment plan for Medicaid hospital inpatients based on a Diagnosis-Related Group (DRG) model on July 1, 2013. This model will replace the current system of a cost-based, fee-for-service, per diem payment, wherein a flat fee is paid for each day a Medicaid patient is in the hospital. Unlike the per diem model, the DRG model basis payment on pre-grouped categories of conditions being treated.

AHCA presented an implementation plan to the Legislature in January 2013. After receiving a commissioned report by Navigant Healthcare, a subcontractor of MGT of America, AHCA recommended several actions based on a series of decision points that included selection of factors such as base rates, payment option model for grouping services, adjustors across services and providers, and whether to have a transition period.

The totality of options and factors that impact the ultimate calculation of DRG price and final reimbursement are highly complex in nature and exceed the scope of this report. Information on additional factors may be found at AHCA's website.

Types of Payment Systems

Healthcare payment systems reimburse providers for services rendered. Various

types of existing payment systems seek to determine an appropriate reimbursement amount without overpayment or underpayment. Methods for finding the proper payment for medically necessary services include payments by third-parties, such as insurers. Each method attempts to shift the financial risk of service provision to achieve balance. Payment on a fee-for-service basis, which pays for each service provided, may create incentives for increased utilization or prescription of unnecessary services. Third-party payers use complex cost reports to determine payment. In contrast, when payments are capitated or fixed instead, the provider will not get paid more for additional performance of services, and bears both the potential profit and potential loss of unexpected levels of treatment.

In prospective payment systems, claims are evaluated through decision processes in which line-item services are grouped together for payment purposes. The grouping is done generally by a complex software program referred to as a "grouper," with actual payment amount processed by a "pricer" program. Grouping services into Diagnosis-Related Groups (DRGs) is a commonly used grouping logic employed. DRGs enable payments to be made based on the procedure done and the patient seen, such that for the same condition at the same severity level, payment would be the same across different hospitals rather.

Affected Providers & Services

Under AHCA's DRG conversion plan, providers affected by the DRG Medicaid hospital inpatient methodology include all inpatient acute care providers. The four state-owned psychiatric facilities are excluded. All services performed at the affected providers are included in DRG conversion with limited

² In 2011, the Commission on Review of Taxpayer Funded Hospital Districts, chaired by Florida TaxWatch President & CEO Dominic M. Calabro, recommended that AHCA complete a study on the use of DRGs for reducing inequities in the Medicaid hospital reimbursement system and that the Florida Legislature authorize the development of a DRG-based system for use in hospital payment negotiation within a future managed care environment.

exception. The technical portion of newborn hearing tests will be paid as a supplement in addition to DRG payments. In addition, global fee reimbursements will continue for transplants.

APR-DRG Selection

AHCA selected APR-DRGs, or “All Patient Refined-Diagnosis Related Groups,” as Florida’s DRG grouping method algorithm of choice. For reasons detailed below, this was the most logical and beneficial selection available.

There have been many types of DRG grouping methods over the years. For example, MS-DRGs or “Medicare Severity-DRGs,” were established by the Centers for Medicare and Medicaid Services (CMS) in 2007, and SR-DRGs or “Severity Refined-DRGs” were proposed in 1994 by the federal precursor to CMS, the Health Care Financing Administration (HCFA).

Navigant presented DRG selection options on the six DRG grouping algorithms currently being used in the United States. With the exception of one algorithm, developed by OptumInsight, all other DRG algorithms have been developed in conjunction with 3M. According to Navigant, three of the grouping algorithms are either being phased out or do not reflect current practice. Therefore, Florida Medicaid had a true selection of three: MS-DRGs, APR-DRGs (All Patient Refined-DRGs), or APS-DRGs (All Payer Severity-adjusted DRGs).

As detailed in Navigant’s report to AHCA, APR-DRGs currently consist of 1258 total DRGs, including 314 base DRGs. This provides the fewest number of base DRGs for easier initial coding reference. It also provides the most total DRGs to capture more services, including frequently overlooked services in

pediatric and obstetrical care. AHCA has recommended using the most recent APR-DRG grouper, version 30, which was released by 3M in October 2012.

A comparison of DRGs is shown in Table 1 on the following page.

Table 1: Detailed Comparison of Select DRG Algorithms

Description	MS-DRGs V.28 (CMS - Maintained by 3M)	APR-DRGs V.28 (3M and NACHRI)	APS-DRGs V.28 (OptumInsight - formerly Ingenix)
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. There is no CC or major CC list; instead, severity depends on the number and interaction of CCs.	Structure based on MS-DRGs but adapted to be suitable for an all-patient population. Includes 407 base DRGs, each with three severity levels. Same CC and major CC list as MS-DRGs.
Number of DRGs	746	1,258	1,223
Newborn DRGs	7 DRGs, no use of birth weight	28 base DRGs, each with four levels of severity (total 112)	9 base DRGs, each with three levels of severity, based in part on birth weight (total 27)
Psychiatric DRGs	9 DRGs; most stays group to “psychoses”	24 DRGs, each with four levels of severity (total 96)	10 base DRGs, each with three levels of severity (total 30)
Payment Use by Medicaid	MI, NH, NM, OK, OR, SD, WI	<i>Operational:</i> MA, MD, MT, NY, PA, RI, SC <i>Announced:</i> CA, CO, IL, ND, TX	None
Payment use by other payers	Commercial plan use	BCBSMA, BCBSTN	Commercial plan use
Other users	Medicare, hospitals	Hospitals, AHRQ, MedPAC, JCAHO, various state “report cards”	Hospitals, AHRQ, various state “report cards”
Uses in measuring hospital quality	Used as a risk adjustor in measuring readmissions. Used to reduce payment for hospital-acquired conditions.	Used as risk adjustor in measuring mortality, readmissions, complications	Used as risk adjustor in measuring mortality and readmissions and to reduce payment for hospital-acquired conditions

Navigant Healthcare (2012, July 24). DRG Payment Method Options, Select DRG Algorithms (Table 3, in part). Retrieved from http://ahca.myflorida.com/Medicaid/cost_reim/pdf/DRG_Payment_Method_Options_FL_AHCA_2012-07.pdf. Sourced from: Quinn, K., Courts, C. Sound Practices in Medicaid Payment for Hospital Care; Center for Healthcare Strategies, November 2010. Updated by Navigant with additional and more current information.

Calculating the Formula

To calculate prospective payment based on DRGs, a formula is applied that encompasses various factors including a hospital base rate, a DRG relative weight, and a policy adjustor. Navigant presented AHCA with several options and decision points that impact whether, and to what extent, each factor impacts the payment calculation.

The main components of a basic DRG payment formula include a hospital base rate, a DRG relative weight, and policy adjustors. Each of these components can be adjusted to achieve a state's Medicaid and fiscal goals. A brief overview of the basic components is shown in the table at the bottom of the page. The DRG conversion plan involved many complex aspects that are not fully covered in this report. For example, decision points included how to handle late charges and interim claims.

Provider/Hospital Base Rate

AHCA has recommended one standardized, statewide provider base rate. This allows for a simple, understandable basis that creates an equitable baseline across hospitals.

The provider base rate is a major component of the DRG formula. As a policy, state Medicaid agencies could elect to apply a single statewide base rate across all hospitals, which theoretically would incentivize hospitals to increase or maintain efficiency to maximize return. With a statewide base rate, adjustments could be added for individual hospitals evidencing measurable and reasonable cost differences. Another option would be to assign each hospital its own base rate, which would not address efficiency goals, but still could achieve budget neutrality. Navigant reported that most states select an option somewhere in between these two extremes.

AHCA was presented with various considerations within Provider Base Rate calculations that included wage area adjustments, which were discussed in legislative committee meetings. AHCA elected not to implement the use of wage-index areas. A geographic wage area index comparatively adjusts for the differences

Table 2: Brief Summary of DRG Conversion Plan Claim Formulas

Basic/Regular Claims	$[\text{DRG Base Payment}] = [\text{Hospital Base rate}] * [\text{DRG relative weight}] * [\text{Policy adjustor(s)}]$
Transfer Claims	Adjusts the base payment using a per diem method in comparison to the DRG base payment; follows a model used by Medicare
Partial Eligibility	For hospital stays which are only partially eligible for Medicaid coverage, the base payment is adjusted using calculations that compare the per diem method to the DRG base payment. From this, the lower payment is selected.
Outliers	For extreme situations with high hospital costs that are unpredictable, a stop-loss Medicare model that generates outlier payments above a single loss threshold would be applied.

in wages across the state and is used by Medicare and the states to provide higher payments in regions that traditional pay higher wages for hospital employees. For example, a provider in Miami may be paid significantly different wages than a provider in Gadsden county.

The wage area index acts as a multiplier to a common base rate in the DRG formula, and can be applied selectively to the entire base or only a portion of it. Florida could develop a state-specific wage index for this purpose, although the administrative burden may be considerable. In the alternative, Florida could adopt Medicare's wage indices or wait for CMS to complete its current redesign of wage areas. Using the currently available 2012 Medicare wage area indices, Navigant analyzed geographic regions in the state of Florida and found that the average value was 0.9303, fairly close to 1.0. As the multiplier was close to 1.0, AHCA concluded that wage areas it "did not seem to make much of a difference" to the provider payment. As a result, AHCA elected not to recommend a wage area adjustment. As reported by AHCA to the House Health Care Appropriations Subcommittee, a majority of hospitals in Miami-Dade, Broward, and Pinellas counties already "came out ahead" with the DRG system.

Another option was to adjust provider base rates in consideration of hospital categories or peer groups. For example, a peer group may consist of rural hospitals, children's hospitals, teaching hospitals, or hospitals handling particularly complex cases resulting in outlier payments. The classification of peer groups would require clear criteria, and incentives would be created for hospitals to be classified within certain peer groups to obtain higher payments. AHCA elected not

to recommend base rate adjustments on the basis of hospital categories or peer groups, instead addressing certain groups through policy adjustors, discussed later in this section.

DRG Relative Weight

To account for the Medicaid casemix, a multiplier referred to as relative weight is utilized. The DRG relative weights for Florida Medicaid were based on national weights. The Medicaid casemix in Florida was compared to the national Medicaid casemix using a 2010/2011 simulated data set.

"If you look at our old system it's like changing from advanced calculus to trigonometry. There is really no way of making hospital reimbursement incredibly simple. We believe that this system is simpler than the one we are leaving behind."

– Justin Senior, Deputy Secretary for Medicaid,
Florida Agency for Health Care Administration

By "re-centering" the national weights to 1.0 (a multiplier of one that does not impact the formula) for Florida based weights for each DRG, the Florida Medicaid relative weight for each DRG was determined to be the national relative weight divided by the re-centering factor of 0.7614.

Policy-Based Adjustors

Policy adjustors are optional as another way for a state Medicaid agency to tailor the DRG payment formula to the needs and priorities of its particular state. Payments for certain types of inpatient hospital care are increased or decreased as a state policy decision. To protect or improve access to care, and to incentivize specific types of care, the Medicaid agency can elect to use a policy adjustor, which acts as a multiplication factor in the DRG equation. If no adjustment is made, the policy adjustor is 1.0: the rest of the formula is multiplied by 1.0 and does not change.

Navigant presented three types of commonly-used adjustors for AHCA to consider: service adjustors, age/service adjustors, and provider/service adjustors. Service adjustors are applied to certain types of care without regard to beneficiary or provider considerations. Age/service adjustors are typically used to raise payment levels for Medicaid recipients within a pre-determined age range, and is frequently used by states to augment payment for pediatric patients. Similarly, provider/service adjustors are utilized for specific provider categories.

As a policy decision, AHCA could elect to implement all three policy adjustor type options, any mix of any number of policy adjustor type options, or no options. AHCA's DRG implementation plan targeted two types of policy adjustors: service, and provider/service. Specifically, AHCA's plan elected a service adjustor for rehabilitation services. It also elected a provider adjustor for "rural hospitals, free-standing long term acute care (LTAC) hospitals, and High Medicaid utilization and high outlier hospitals." High outlier hospitals were defined as those with

more than 50% Medicaid utilization, both fee-for-service and managed care, and with more than 30% payments in the form of outliers. (cite) A practical impact of this provider adjustor is to help incentive critical access points in rural communities. In addition, the high Medicaid utilization and high outlier considerations of this policy adjustor result in children's hospitals having an increase.

Per Claim Add-Ons

Per Claim Add-On payments are currently used to distribute intergovernmental transfer (IGT) funds paid on a per-claim basis. The DRG conversion would distribute IGT funds in two separate add-ons per claim: one for automatic IGTs and the other for self-funded IGTs. This will allow for greater transparency and accountability in tracking IGT funding, distribution, and need.

The automatic and self-funded IGTs, now included as part of the inpatient per diem under the cost-based methodology, will function as supplemental payments on top of DRG base and outlier payments in the DRG payment methodology, which will raise the overall claim payment and limit the impact of changing the payment system and the corresponding redistribution of inpatient dollars.

Transition

AHCA has recommended against a transition period in its DRG conversion plan. The concept of a DRG conversion transition period, as used by other states, does not signify that all providers are insulated from financial changes for, say, a one-year transitional period. Instead, it would be more likely that only certain providers, such

as those that would lose more than X percent in the original data projections (some pre-determined percent) would be insulated from losses beyond that amount for a short period of time. Given the budget-neutral nature of the DRG conversion, such a transition period would insulate a small margin of providers, and the rest of the providers would get paid less to subsidize the buffer.

Payment Adjustment

The simulation data run by Navigant and reviewed by AHCA are projections and do not guarantee actual payment numbers for the first year of implementation. Changes to casemix and coding improvements may occur. To adjust payment for any casemix differences between the simulation data and the actual first year of DRG implementation, AHCA decided to use 7.50%. This number reduces DRG base price for anticipated casemix increases, and is based on historical data and expected health care changes. This follows other state Medicaid DRG implementation practices.

Other States

Navigant presented AHCA with a report that included a summary table of what other states have elected in their DRG system designs. In looking at other states while assessing Florida's needs, AHCA has stated that Pennsylvania's choices were most applicable to Florida, as Pennsylvania converted directly from a per diem methodology to the APS-DRG system. Navigant's table of other state decisions is reproduced (in part) on the following page.

AHCA's stated objectives in the DRG conversion included the determination of a payment methodology that was budget neutral and incentivized cost-efficiency.

SECTION 2

Budget Neutrality & Provider Revenue

Budget neutrality results in a zero-sum game: for every hospital that sees an increase in payment based on any DRG formula adjustment, another hospital will see their funding decreased to make up for the first hospital's increase.

Medicaid payments typically comprise approximately 11% of most hospitals' revenue streams. Therefore, a hospital that receives a 10% cut in Medicaid payments under a DRG prospective payment system has an overall revenue impact of 10% off of 11%, or a 1.1% decrease in overall revenue. Another consideration of impact is the total number of Medicaid patients for a particular provider. If a hospital will see a 50% decrease in Medicaid payments under a DRG system, this would impact the revenue of a provider that serves a total of five Medicaid patients much differently than that of a provider serving 500 Medicaid patients.

Shifting Incentives

Providers that lose revenue under the new DRG system initially may eventually benefit from the DRG system by shifting internal policies to maximize efficiency. AHCA does not provide assistance in reviewing internal policies toward that end, and providers may end up paying outside consulting firms to find cost-saving and efficiency opportunities within internal policies and practices. AHCA plans to provide technical assistance with regard to DRG formula and coding issues.

Table 3: Decisions Made in Other States

DRG Grouping

Category	CA	NY	TX	VA	PA	IL
Grouper	APR (planned for implementation 7/1/2013)	APR	APR (effective 9/1/2012)	AP	APR	APR
Relative weights	National weights adjusted (re-centered) for CA casemix	New York specific	Texas specific	National	Adopted New York weights, adjusted (re-centered) for PA casemix	National weights adjusted (re-centered) for Illinois case mix

Provider Base Rates

Category	CA	NY	TX	VA	PA	IL
Provider groupings with separate standard base rates	Remote rural All other	Single common base rate	Single common base rate	Single common base rate, but separate rate for State Teaching Hospitals	Single statewide operating rate (excludes capital and medical education)	Long-term acute care hospitals All other hospitals
Base rate adjustments	Medicare wage indices	Hospital's labor costs wage equalization factor (WEF) and each hospital's GME costs using updated cost basis and formula	Geographic wage adjustment Medical education Trauma designation	Medicare wage indices Rural hospitals Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher Adjustment for medical education	Adopted Medicare wage index adjustment if hospital's Medicare index exceeded 1.0. If below 1.0, no adjustment.	Geographic wage adjustments using Medicare values and method Adjustments for critical access and specialty providers are maintained through legacy supplemental payments outside of DRG model – but will be phased out over time.

Pricing Rules

Category	CA	NY	TX	VA	PA	IL
Policy adjustors	1.25 for pediatrics 1.25 for most neonates 1.75 for neonates at a facility operating a certified NICU surgery unit	None	None	None	Provider-specific teaching hospital adjustments of either 5% (Teaching) or 10% (Advanced Teaching). Designations based on Medicare resident to bed ratio – Advanced Teaching above average ratio, Teaching below average ratio. Provider-specific adjustments based on Medicaid utilization ranging from 0% to 20%.	Yes – for critical access hospitals only – value TBD. No other policy adjustors, but enhanced funding for specialty services (children's, neonatal, pediatric, etc.) are accommodated through legacy supplemental payments made outside of the DRG model. Supplemental funding will be gradually incorporated into DRG model over time, and may be replaced with additional policy adjustors.

SECTION

3

AHCA did not include a policy adjustor for Graduate Medical Education (GME). Stakeholders grew concerned for teaching hospitals; options were weighed; and Governor Rick Scott proposed a potentially beneficial solution currently under consideration by the Florida Legislature that increases transparency and provides a recurring funding source. The Governor's proposal carries several advantages that make it preferable to including GME in DRG payment calculations.

Graduate Medical Education

Several studies have shown that medical students are most likely to remain in the state in which they do their residency program, rather than where they attend medical school. Therefore, investment in graduate medical education will have the likely effect of retaining quality physicians in the state of Florida when there is evidenced need for more primary care practitioners currently and as the Medicaid population increases in number.

Teaching hospitals are believed to evidence higher cost-based per diem payments than non-teaching hospitals as a result of the graduate medical education that is provided, although per diem calculations did not specifically account for GME. The conversion to DRGs would place teaching hospitals level with non-teaching hospitals without a GME adjustor or some other administrative action. Governor Scott has proposed an option that addresses the GME issue.

AHCA has testified that it is difficult to determine what portions of hospital payments are attributable to graduate medical education. The Governor's Office of

Policy and Budget (OPB) utilized a January 2010 report by the statutorily created Graduate Medical Education Committee in setting an amount to attribute to GME. The report states: "Over \$28 million in GME-related payments are embedded in the teaching hospitals' fee-for-service per diem payments; these costs are also embedded in the HMO capitated payments. Often times Medicaid HMOs are not willing to pay teaching hospitals their per diem rates."

The Governor's Proposed Budget for FY2013-14 recommendation transferred \$28 million from AHCA's inpatient hospital dollars line item and \$24 million from a community health center education line item, also within AHCA's inpatient hospital funding, for a total of \$52 million to the Florida Department of Health's budget for graduate medical education under the titling of the "Statewide Medicaid Residency Program." In addition, Governor Scott recommended adding \$28 million of new revenue dollars to the Program. The budget recommendation includes rolling the total amount into the Department of Health's recurring base budget. This total additional funding of \$80 million, which includes Medicaid federal matching funds, is expected to create more than 700 new residency positions at the current Medicaid residency funding level of approximately \$29,000 per resident.

Accounting for GME needs separately from DRG methodology may yield benefits. Funding GME separately allows for greater transparency and easier management. There will be simpler accountability as the number of residencies will be reported under the Statewide Medicaid Residency Program. The clear delineation of GME dollars and the transparency that it creates may allow for additional metrics to be gauged

over time to better determine return on investment and more easily discern what additional assistance is needed without the confounding factors that go into DRG payment assessment. Moreover, this may make GME funding more predictable and less subject to fluctuation. Keeping GME embedded in DRG calculations as either part of the provider base rate adjustment or through a policy adjustor does not supply these benefits and may not safeguard GME over the long term as well.

Delaying Implementation

Delay may be a question, but Florida TaxWatch does not believe it is the answer.

During various committee meetings before the Florida Legislature, stakeholders have requested that the implementation of DRG conversion be delayed beyond July 1, 2013 on a number of bases: inability to provide input during conversion plan development, that more time is needed to consider policy options and test pilot the payment system, and that funding will be redistributed from nonprofit hospitals to for-profit hospitals. While remaining open to ongoing discussion with stakeholders throughout the process and beyond, AHCA plans to implement DRG conversion on July 1, 2013 as currently ordered by the Florida Legislature.

SECTION 4

A Brief Note on the DRG Plan Process – Public & Governance Meetings

Five public meetings were held between August 2012 and January 2013: August 2, August 29, October 11, November 15, and January 8. At the public meetings, public comments, questions, and recommendations were discussed. Reports are available at AHCA's website. AHCA met with individual stakeholders in the hospital and health plan sectors to seek their input for system design. Concerns and recommendations from the individual meetings were forwarded to Navigant for incorporation into the subcontractor's report. In addition, AHCA has shared report data with various stakeholders, including Florida Hospital Association (FHA) and others. This has afforded stakeholders the opportunity to review and run their own payment models

if so desired. AHCA had to overcome some unanticipated delays when sharing the report data as a result of privacy concerns and trade secrets issues with 3M's proprietary APR-DRG grouper system. AHCA still awaits and welcomes input from the stakeholders. AHCA has repeatedly stated during legislative committee meetings that it has an open door policy, and is always willing to work with stakeholders before, during, and after DRG implementation.

AHCA used a Governance Committee model to make decisions on the inpatient hospital DRG conversion process. A small internal agency governance committee met on several occasions (August 29, September 18, October 9, November 6, and December 12) to consider options and recommendations. Brief summary reports are available at AHCA's website. As explained by AHCA in legislative committee meetings, these limited-attendee meetings included high-level AHCA management staff and representatives of the subcontractor Navigant. While the Governance Committee meetings were not open to the public, AHCA has publicly conveyed the rationale behind its DRG decisions during presentations before Florida House and Senate committee meetings, which are televised and open to the public.

AHCA Notably Places Its High-Stakes Bet with Confidence

In many respects, AHCA will be held accountable for its DRG recommendations. If AHCA's reimbursement payments were to get ahead of the set appropriation, which is unexpected, it would suggest that significant adjustments are needed. Both the Florida Legislature and stakeholders would view AHCA as responsible for a miscalculation in

some form, and the agency would be taken to task in correcting the matter. Knowing this, AHCA exhibits confidence in the decisions made, the implementation plan presented, and in moving forward with full DRG conversion on July 1, 2013.

Policy Options During the Regular 2013 Legislative Session

Full implementation, with or without adjustments to AHCA's implementation plan, appears likely to occur on July 1, 2013. The current law does not require AHCA to report back to the Florida Legislature prior to schedule DRG implementation on July 1, 2013. The Legislature may act to postpone implementation, add policy adjustors, or change other aspects of recommendations.

Policy Adjustors

Unless an across-the-board delay is specifically mandated during this session, it is unlikely that the July 1 date will change. It is unclear what changes could be accomplished if full implementation were delayed for a year. For example, given the complexities of DRG formulation, most optional changes would require a multi-year development of alternative, non-tested systems.

The Legislature has opportunities to create policy adjustors. AHCA has publicly stated that it does not believe that the creation or addition of any policy adjustors during session will impact the July 2013 implementation date. Due to budget neutrality in the DRG payment system, any policy adjustors will result in a decrease to providers that do not fall within the adjustor, likely through a change in the base rate. The Legislature may choose to pass Governor

Scott's budget recommendation for GME. In the alternative, the Legislature may choose to account for GME by adding an adjustor and factoring it into the DRG payment calculation. As previously discussed, this approach appears to be less transparent.

Transition Period & Delay

Certain stakeholders have publicly testified that, while they support the move to a DRG prospective payment system, they would like the implementation postponed for further analysis and transition preparation. As previously discussed, a transition period would only apply to a limited number of providers, and the remaining providers would be placed in a position of subsidizing the transition.

Costs and benefits of fully delaying implementation must be weighed. Given the complexity of the DRG algorithms and calculations, and the zero-sum guarantee with a budget-neutral system, it is most unlikely that any viable alternative methodology would arise within a year's delay that would satisfy all stakeholders. During that year, stakeholders could run data projections under various DRG design scenario and advocate for a different design decision to increase a provider's revenue which, in turn, would decrease another hospital's revenue. The projections would remain hypothetical and untested, and the actual impact across all Florida hospitals would take even longer to surmise. In the interim, Florida would continue to run a payment system that inappropriately rewards the overutilization and over-prescription of health services.

Ability to adjust after July 1, 2013

The decisions made at the start of the implementation process are not permanently fixed. Over time, changes will be made to the DRG payment methodology, whether it is from new APR-DRG codes being added or refined, or from policy changes directed by the Florida Legislature. Given billing cycles, payments will likely still be received under the old cost-based reimbursement system for some time, and it may take providers time to determine how the DRG payments affect their individual hospitals.

In the event that interim change is determined necessary, AHCA may seek approval for a budget amendment during the active fiscal year through the Joint Legislative Budget Commission (LBC), or the Legislature may take other forms of interim action.

Summary Table of AHCA's Decisions

Key Design Considerations	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: Transplants currently paid via global fee – will continue reimbursement via global fee AND Technical component of newborn hearing test will be paid in addition to DRG payment
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]
Hospital Base Rates	One standardized amount; No wage are 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
Targeted Service Adjustors	Service adjustor for rehabilitation services
Targeted Provider Adjustors	Rural hospitals. Free-standing long term acute care (LTAC) hospitals, and 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)
Outlier Payment Policy	Adopt “Medicare-like” stop-loss model with a single threshold; Apply to cases with unpredictably high hospital cost
Transition Period	None
Total Payment Adjustment for Casemix Difference between Simulation Data and First Year of Implementation	7.50%

Agency for Health Care Administration (2013, February 13). Presentation on Diagnosis Related Group (DRG) Conversion Implementation Plan to the Florida Senate Appropriations Subcommittee on Health and Human Services. Meeting packet, “Key DRG Design Considerations” table. Retrieved from http://www.flsenate.gov/PublishedContent/Committees/2012-2014/AHS/MeetingRecords/MeetingPacket_2033.pdf.

SECTION Conclusion

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The DRG design decisions proposed by AHCA in its report to the Florida Legislature are well-reasoned, maximize equity across hospitals, and consider Florida's particular Medicaid casemix. The design decisions generally assist rural, High Medicaid utilization and children's hospitals through the addition of policy adjustors. Separating graduate medical education (GME) from DRG funding considerations allows for greater transparency and accountability. One way this can be accomplished is through adoption of the Governor's budget recommendation for the Statewide Medicaid Residency Program.

Any additional policy adjustors desired by the Legislature may be added without known impact to the implementation date of July 1, 2013. Any transition period addition would not impact all providers, only select outliers, with all unaffected providers subsidizing the transitional financial buffer provided to the select outliers.

A true delay of implementation does not appear to yield any substantial benefit, as agreement of a satisfactory design across stakeholders is unlikely, opportunities for better-resourced providers to advocate for improved revenue would increase, the impact of data projections across all providers would remain untested, and Florida would spend more time utilizing a payment system that inappropriately awards inefficiency.

Continuous opportunities exist past the current implementation date to adjust and refine Florida's DRG system. In order to clearly determine whether any adjustments and refinements are needed in the best interests of Florida as a state and, therefore, in the best interest of the Florida taxpayer, implementation must continue on July 1, 2013 as planned.

REFERENCES

Section 1

§ 409.905(5)(f), Florida Statutes (2012).

Abbey, D.C. (2012). Prospective payment systems (Healthcare payment systems). Boca Raton, FL: Taylor & Francis.

Agency for Health Care Administration (2013, January 23). Presentation on Diagnosis Related Groups (DRGs) Report to the Florida House of Representatives Health Care Appropriations Subcommittee. Meeting packet retrieved from <http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2703&Session=2013&DocumentType=Meeting%20Packets&FileName=HlthCareApprop1-23-13%20ONLINE.pdf>.

Centers for Medicare & Medicaid Services (2013). Acute Inpatient Prospective Payment System (PPS). Available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>. Discussing DRGs as used in Medicare.

Commission on Review of Taxpayer Funded Hospital Districts (2011, December 30). Final Report. Available at <http://ahca.myflorida.com/mchq/FCTFH/pdf/122911Meeting/FinalReportRF2.pdf>.

Navigant Healthcare (2012, July 24). DRG Payment Method Options. Retrieved from http://ahca.myflorida.com/Medicaid/cost_reim/pdf/DRG_Payment_Method_Options_FL_AHCA_2012-07.pdf.

Navigant Healthcare (2012, August 24). DRG Payment Method Options (with Navigant's Preliminary Recommendations). Retrieved from http://ahca.myflorida.com/Medicaid/cost_reim/pdf/DRG_Payment_Method_Options_FL_AHCA_2012-08-24.pdf.

Navigant Healthcare (2012, December 21). DRG Conversion Implementation Plan Final. Retrieved from http://ahca.myflorida.com/Medicaid/cost_reim/pdf/DRG_Payment-Conversion_Implementation_Plan-FL_AHCA-Final.pdf.

Navigant Healthcare (Undated). Simulation 19 Results by Provider. Retrieved from http://ahca.myflorida.com/Medicaid/cost_reim/pdf/Summary_of_DRG_Simulation_19_Results_by_Provider.pdf.

Quinn, K. (2008). New Directions In Medicaid Payment For Hospital Care. *Health Affairs*, 27(1), 269-280. doi: 10.1377/hlthaff.27.1.269.

Section 2

Agency for Health Care Administration (2013, February 13). Presentation on Diagnosis Related Group (DRG) Conversion Implementation Plan to the Florida Senate Appropriations Subcommittee on Health and Human Services. Video podcast retrieved from http://www.flsenate.gov/media/videoplayer.cfm?EventID=2443575804_2013021162.

Navigant Healthcare (2012, July 24). DRG Payment Method Options. Retrieved from http://ahca.myflorida.com/Medicaid/cost_reim/pdf/DRG_Payment_Method_Options_FL_AHCA_2012-07.pdf.

Navigant Healthcare (Undated). Simulation 19 Results by Provider. Retrieved from http://ahca.myflorida.com/Medicaid/cost_reim/pdf/Summary_of_DRG_Simulation_19_Results_by_Provider.pdf.

Section 3

Executive Office of Governor Rick Scott (2013). Florida Families First: Fiscal Year 2013-2014 Budget Recommendations. Available at <http://www.floridafamiliesfirst.com/web%20forms/BudgetMain.aspx>.

Executive Office of Governor Rick Scott (2013). Florida Families First: Fiscal Year 2013-2014 Recommended Budget-Frequently Asked Questions. Retrieved from <http://www.flgov.com/wp-content/uploads/2013/01/2013-Budget-FAQ.pdf>.

Section 4

Agency for Health Care Administration (2012). Diagnosis Related Group (DRG) Inpatient Payment Review Governance Meeting Summaries. Available at http://ahca.myflorida.com/Medicaid/cost_reim/.

Agency for Health Care Administration (2012-2013). Diagnosis Related Group (DRG) Inpatient Payment Review Meeting Agendas. Available at http://ahca.myflorida.com/Medicaid/cost_reim/.

Agency for Health Care Administration (2013, January 23). Presentation on Diagnosis Related Groups (DRGs) Report to the Florida House of Representatives Health Care Appropriations Subcommittee. Meeting packet retrieved from <http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2703&Session=2013&DocumentType=Meeting%20Packets&FileName=HlthCareApprop1-23-13%20ONLINE.pdf>.

Agency for Health Care Administration (2013, January 23). Presentation on Diagnosis Related Groups (DRGs) Report to the Florida House of Representatives Health Care Appropriations Subcommittee. Video podcast retrieved from <http://www.myfloridahouse.gov/Sections/Committees/committeesdetail.aspx?SessionId=73&CommitteeId=2703>.

Agency for Health Care Administration (2013, February 13). Presentation on Diagnosis Related Group (DRG) Conversion Implementation Plan to the Florida Senate Appropriations Subcommittee on Health and Human Services. Video podcast retrieved from http://www.flsenate.gov/media/videoplayer.cfm?EventID=2443575804_2013021162.

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