DRG Payment in Mississippi

Plan for Implementation October 1, 2012

Hospital Information Meeting 7/11/12

Revision 7/25/12 affects Page 21

Government Healthcare Solutions

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1. Background
2. How DRG payment will work
3. Hospital impacts
4. Policy reasoning behind payment decisions
5. Next steps

Payment policy decisions remain subject to change before implementation. Two examples are payment for transplants and the documentation and coding adjustment.

Key Points

- DRG implementation for first dates of service starting October 1, 2012
- Rates budget-neutral to 2010-2011
- Cost reports no longer affect payment
  - Hospitals will retain savings from reduced LOS, other efficiencies
  - No need for reprocessing claims
- TAN requirements to be streamlined
- 30-day annual cap in inpatient days eliminated

BACKGROUND

Hospital Payment Methods Nationwide

How Medicaid Pays for Hospital Inpatient Care
As of January 2012

Per Stay -- CMS-DRGs

CO*, IA, IL, KS**, KY, MN, NC**, ND*, OH, UT, VT, WV**

* Moving to APR-DRGs ** Moving to MS-DRGs

Per Stay -- AP or Tricare DRGs

DC, GA, IN, NE, NJ, VA, WA

Per Stay -- MS-DRGs

MI, NH, NM, OK, OR, SD, TX*, WI

* Moving to APR-DRGs

Per Stay -- Other

DE, MA*, NV, WY

* Casemix adjustment based on APR-DRGs

Per Stay -- APR-DRGs

MT, NY, PA, RI

Per Diem

AK, AZ, CA*, FL, HI, LA, MO, MS, TN

* Moving to APR-DRGs

Cost Reimbursement

AL, AR, CT, ID, ME, SC*

* Interim payment using APR-DRGs

Other (Regulated Charges)

MD*

* Casemix adjustment based on APR-DRGs

Guide:

CMS-DRGs:	Centers for Medicare and Medicaid Services Diagnosis Related Groups (used by Medicare until 10/1/07)
MS-DRGs	Medicare Severity DRGs (used by Medicare starting 10/1/07)used by Tricare (formerly Civilian Health and Medical Program of the Uniformed Services)
AP-DRGs	All Patient DRGs (3M)
APR-DRGs	All Patient Refined DRGs (3M)
Tricare-DRGs	DRGs used by Tricare (formerly Civilian Health amd Medical Program for Uniformed Services)

Notes

1. Updates and corrections are welcome. Please contact Kevin Quinn at kevin.quinn@acs-inc.com or 406-457-9550
2. Sources: Individual states, ACS Government Healthcare Solutions, 3M Health Information Systems, Ingenix Inc., Navigant Inc.
3. ACS does not have a financial interest in any DRG grouping algorithm.

BACKGROUND

Current MS Inpatient Payment Method

- FY 11 $643 million, excluding supplementary payments
- Method
  - Each hospital is paid a single per-diem amount for all care
  - Per diem rates are based on Medicare cost reports
  - Per diems subject to ceilings by peer group
  - Essentially all days of care require treatment authorization
- Concerns
  - Hospitals that control costs are penalized
  - Flat per diem payment discourages access to services
  - Admin burden of claim reprocessing and TAN
  - Audit concerns over Medicare cost reports
  - No transparency into what is being purchased
  - Very different payments for similar care

Development of DRG Payment for Mississippi

- 2004-05: Assessment of options
  - Evaluation report delivered 5/24/05
  - Published in *Health Affairs* January/February 2008*
- 2005-06: Detailed design of payment method
  - At least a dozen consultation meetings with hospitals
  - Detailed design report delivered 7/25/06
- 2006: Preparation for implementation (postponed)
  - Coded, tested and ready to go in MMIS
  - 11 training sessions for 750 hospital staff statewide
- 2009: PEER Committee reviews proposed DRG method
- 2012: Legislature orders DRG implementation

*K. Quinn, "New Directions in Medicaid Payment for Hospital Care," *Health Affairs* 27:1, pp. 269-280.

BACKGROUND

Joint Legislative PEER Committee Review

"PEER believes that the ACS-recommended APR-DRG payment method better accomplishes the management objectives and goals for a new payment method than the present method or the Medicare DRG method. The APR-DRG payment method would be a sustainable, rational method that better addresses the client service cost care payment requirements for the state Medicaid population while improving client access to hospitals, rewarding hospital efficiency for reducing state costs through more efficient client treatment, increasing fairness to hospitals for payments for client care, improving the purchasing clarity of client hospital services, and reducing the administrative burden for final payments on the hospitals and the DOM."

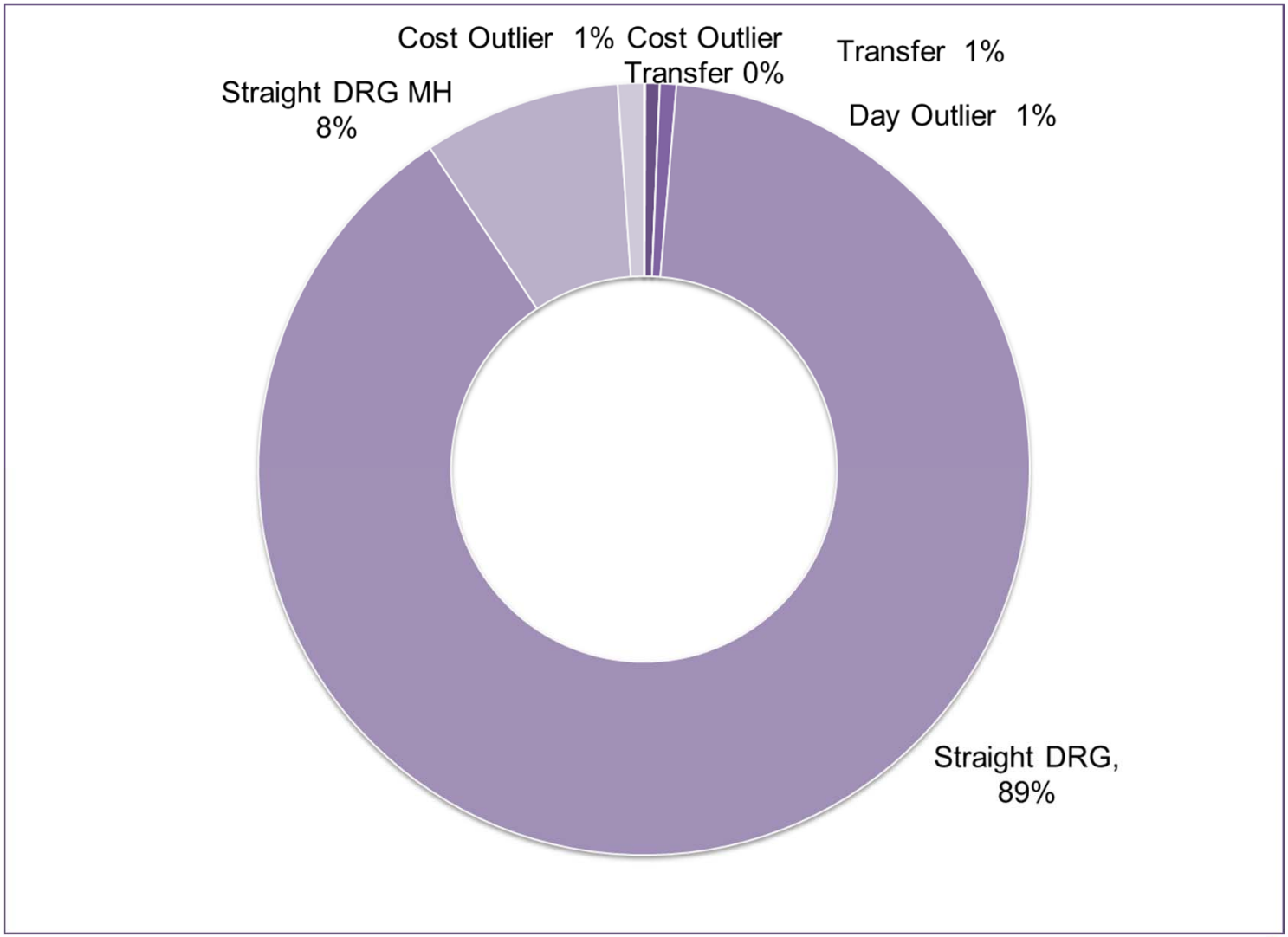
-- Mississippi Joint Legislative Committee on Performance Evaluation and Expenditure Review, *Benefits and Limitations of an All Patient Refined Diagnosis Related Groups Inpatient Hospital Services Payment Method for Mississippi Medicaid Patients,* Report No. 530 to the Mississippi Legislature (Jackson, MS: PEER, 2009). Report available at www.peer.state.ms.us/530.html.

Characteristics of DRG Payment

- Payment per stay, with higher rates for sicker patients as determined by grouping diagnoses and major procedures
- Defines the “product of a hospital,” creating a common language for clinical and financial managers
- Enables access for sicker patients because hospital margins are evened out for patients of different severity
- Rewards hospitals that reduce cost
- Rewards complete coding of diagnoses and procedures
- Improves transparency and fairness
    - Similar pay for similar care
- Enables State control over payments and policy priorities

CLAIMS PAYMENT

How Claims Will Be Paid



CLAIMS PAYMENT

Key Payment Values

Payment Parameter	Value	Use
APR-DRG version	**V.29**	Groups every claim to a DRG
DRG Base Price	**$6,284**	Rel wt x DRG base price = DRG base rate
MH pediatric policy adjustor	**2.08**	Increases relative wt and payment rate
MH adult policy adjustor	**1.75**	Increases relative wt and payment rate
Rehabilitation policy adjustor	**2.11**	Increases relative wt and payment rate
DRG cost outlier threshold	**$30,000**	If loss > $30,000, stay is a cost outlier
DRG marginal cost percentage	**60%**	Calculate DRG cost outlier payment
DRG long stay threshold	**19**	If MH stay > 19 days, stay is a day outlier Continued stay review required > 19 days
DRG day outlier statewide amt	**$450**	Calculate DRG day outlier payment
Transfer statuses	**02,05,07,65,66**	Define stays for transfer pricing
DRG interim claim threshold	**30**	Stay > 30 days is eligible for interim payment
DRG interim claim per diem amt	**$450**	Calculate payment on interim claims
Note: Key payment values are subject to change before the October 1 implementation		

1. Straight DRG—Physical Health

Example: 47-year-old male with heart attack				
APR-DRG	Severity	DRG Base Price	Payment Rel Wt	DRG Base Rate
190-1	Minor	$6,284	0.6850	$4,305
190-2	Moderate	$6,284	0.8035	$5,049
190-3	Major	$6,284	1.0665	$6,702
190-4	Severe	$6,284	1.9974	$12,552

- Other DRGs applicable for heart attack include cardiac catheterization with AMI, chest pain without diagnosis of heart attack, etc.

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2. Straight DRG—Mental Health

- Same rates for general and freestanding hospitals.
- "Policy adjustor" boosts relative weight and therefore base payment for 72 mental health DRGs
- Different policy adjustors for pediatric (< 21) and adult

Example: Schizophrenia, moderate severity

APR-DRG	Age	DRG Base Price	Payment Rel Wt	DRG Base Rate
750-2	Pediatric	$6,284	1.4302	$8,987
750-2	Adult	$6,284	1.2033	$7,562

CLAIMS PAYMENT

Top DRGs by Total Stays

APR-DRG	Stays	ALOS	Total Pmt	DRG Base Rate	
				Pediatric	Adult
640-1 Normal Newborn, Bwt >2499G	11,250	2.1	$10,062,271	$850	$850
560-1 Vaginal Del	4,685	2.0	$13,096,363	$2,701	$2,701
540-1 Cesarean Del	3,266	3.0	$15,574,050	$4,607	$4,607
560-2 Vaginal Del	2,602	2.4	$8,257,192	$3,059	$3,059
540-2 Cesarean Del	1,094	4.1	$6,259,756	$5,535	$5,535
753-2 Bipolar Dis	904	7.7	$6,593,417	$6,833	$5,749
138-1 Bronchiolitis & RSV Pneumonia	900	2.3	$1,715,692	$1,842	$1,842
751-2 Maj Depression	730	6.7	$4,451,606	$6,182	$5,202
139-2 Oth Pneumonia	720	3.8	$2,673,222	$3,628	$3,628
139-1 Oth Pneumonia	719	2.7	$1,813,878	$2,442	$2,442
141-1 Asthma	649	2.2	$1,478,831	$2,203	$2,203
566-2 Oth Antepartum Diags	562	3.0	$1,713,833	$2,977	$2,977
138-2 Bronchiolitis & RSV Pneumonia	535	3.1	$1,395,788	$2,439	$2,439
753-1 Bipolar Dis	500	6.3	$2,909,926	$5,427	$4,566
750-2 Schizophrenia	457	11.1	$3,552,660	$8,987	$7,562
249-1 Non-Bact Gastroenteritis, N & V	449	2.1	$988,803	$2,128	$2,128

Notes:

1) Data reflect the six months from October 2010 to March 2011

2) Total payment includes the DRG base payment, outlier payments, adjustments, etc.

CLAIMS PAYMENT

Top DRGs by Total Payments

APR-DRG	Stays	ALOS	Total Pmt	DRG Base Rate	
				Pediatric	Adult
540-1 Cesarean Del	3266	3.04	$15,574,050	$4,607	$4,607
560-1 Vaginal Del	4685	2.02	$13,096,363	$2,701	$2,701
640-1 Normal Newborn, Bwt >2499G	11250	2.12	$10,062,271	$850	$850
560-2 Vaginal Del	2602	2.35	$8,257,192	$3,059	$3,059
753-2 Bipolar Dis	904	7.68	$6,593,417	$6,833	$5,749
540-2 Cesarean Del	1094	4.05	$6,259,756	$5,535	$5,535
751-2 Maj Depression	730	6.74	$4,451,606	$6,182	$5,202
593-4 Neo Bwt 750-999G w/o Maj Proc	23	66.97	$3,824,949	$142,723	$142,723
589-4 Neo Bwt <500G or <24 Wks	32	2.23	$3,776,058	$2,908	$2,908
750-2 Schizophrenia	457	11.08	$3,552,660	$8,987	$7,562
753-1 Bipolar Dis	500	6.27	$2,909,926	$5,427	$4,566
540-3 Cesarean Del	329	6.84	$2,792,130	$8,202	$8,202
588-4 Neo Bwt <1500G w Maj Proc	11	95.23	$2,754,126	$235,995	$235,995
139-2 Oth Pneumonia	720	3.81	$2,673,222	$3,628	$3,628
720-4 Septicemia & Disseminated Inf	132	9.6	$2,571,118	$17,179	$17,179

Notes:

1) Data reflect the six months from October 2010 to March 2011

2) Total payment includes the DRG base payment, outlier payments, adjustments, etc.

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3. Cost Outlier Case

- Cost outlier payments supplement base payments in exceptional cases (physical health DRGs only)
- Same calculation model as Medicare, intended to make about 5% of payments as outliers
- TAN on days required if stay exceeds 19 days

Example: DRG 003-4 Bone marrow transplant

Step	Explanation	Amount
DRG base payment	$6,284 * 24.7717	$155,665
Estimated cost	$640,000 * 39%	$249,600
Estimated loss	$249,600 - $155,665	$93,935
Cost outlier case	$93,935 > $30,000	Yes
Est. loss - outlier threshold	$93,935 - $30,000	$63,935
Cost outlier payment	$63,935 * 60%	$38,361
DRG payment	$155,665 + $38,361	**$194,026**

4. Day Outlier Case

- Day outlier payments supplement base payments in exceptional cases (mental health DRGs only)
- TAN on days required if stay exceeds 19 days

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Step	Explanation	Amount
DRG base payment	$6,284 * 2.8509	$17,915
Length of stay	25 days	
Day outlier case?	25>19	Yes
Day outlier payment	(25 - 19) * $450	$2,700
DRG payment	Base + outlier	**$20,615**

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5. Transfer Cases

- Transfer = discharge status 02, 05, 07, 65, 66
- Transfer adjustment made only if LOS less than national ALOS minus 1 day
- Payment adjustment follows Medicare model

Example: DRG 190-3, heart attack *LOS = 3 days; transferred to another general hospital*		
Step	Explanation	Amount
DRG base payment	$6,284 * 1.0665	$6,702
Transfer case	Discharge status = 02	
National ALOS	4.87	
Tsf adjustment	($6,702 / 4.87) * (3+1)	$5,505
DRG payment		**$5,505**

6. Prorated Payment

- Occurs when patient has some days ineligible for Medicaid
- Hospitals may submit claim for entire stay

Example: DRG 190-3, heart attack
LOS = 10 days but covered days = 3 days

Step	Explanation	Amount
DRG base payment	$6,284 * 1.0665	$6,702
Prorated case	LOS > covered days	
National ALOS	4.87	
Prorated adjustment	($6,702 /4.87) * (3+1)	$5,505
DRG payment		**$5,505**

7. Interim Claims

- No longer required under any circumstances
- Hospitals can choose to submit interim claims if a stay exceeds 30 days.
- Interim payment of $450/day intended to provide cash flow

Example: Neonate 1200g with respiratory distress syndome

Claim	Type of Bill	Days	Interim Per Diem	Payment
1st interim claim	112	31	$ 450	$ 13,950
2nd interim claim	113	35	$ 450	$ 15,750
Void 1st interim claim	118	-31	$ 450	$ (13,950)
Replace 2nd interim claim	117	80		$ 98,943
DRG payment = net of four claims				**$ 114,693**

Other Credits and Debits

- Credits
  - Medical education will be paid as a per-claim add-on
  - DSH will continue to be paid outside the claims processing system
  - For individual hospitals, changes in DSH payment may offset changes in claim payment
- Debits
  - “DRG payment” = Allowed amount
  - Allowed amount minus TPL minus copayment = Medicaid reimbursement
  - No change to TPL or copayment policy

HOSPITAL IMPACTS

Treatment Authorization Streamlining

- TAN for admission: No change
- TAN for continued stay review:
  - Only required for stays that exceed 19 days
  - Readmission within 19 days requires new TAN for admission
  - Continued stay review will be required only for 2.2% of all stays

	TAN--Admission		TAN--Continued Stay Review	
	Previous Policy	**Effective Oct. 1**	**Previous Policy**	**Effective Oct. 1**
Deliveries	Yes, but automatic	Yes, but automatic	Only after 3 days (vaginal) or 5 days (cesarean)	Only after 19 days
"Well baby" = newborn LOS less than or equal to 5 days	No	No	Not applicable	Not applicable
"Sick baby" = Newborn LOS more than 5 days	Yes	Yes—Should be obtained before Day 6	All days	Only after 19 days
All other stays	Yes	Yes	All days	Only after 19 days

Notes:

1) LOS = length of stay. A newborn is identified by the presence of admit type = 4 on the claim

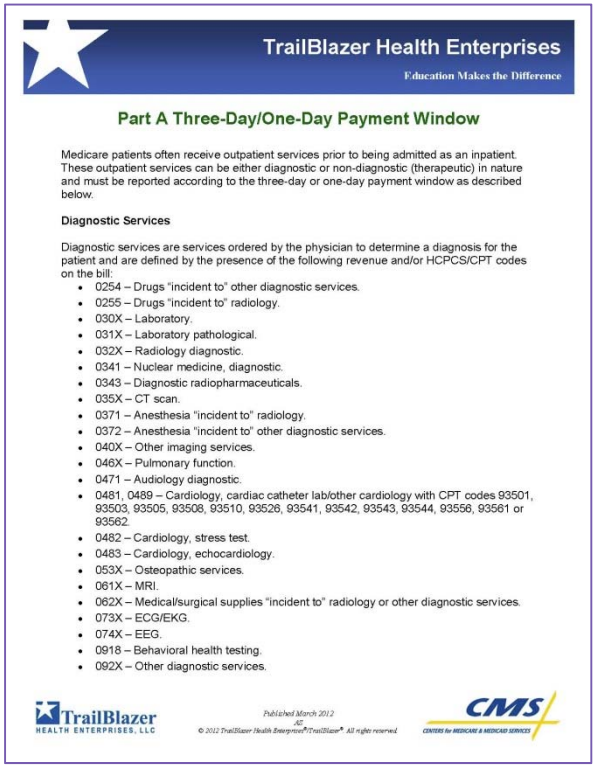
2) Newborns who are well babies or newborn sick babies who become ill and are discharged on or before Day 5 will not require a TAN. Only newborns who remain sick and continue to require inpatient care on or after Day 6 will require a TAN.

3) LOS is used to differentiate well babies and sick babies only for purposes of TAN authorization. Payment for the baby's stay will depend on the assigned APR-DRG. There are 116 newborn APR-DRGs that reflect the baby's birthweight, diagnoses and procedures.

HOSPITAL IMPACTS

Three-Day Outpatient Window

- Medicaid to emulate Medicare's three-day outpatient window
  - Though in cases of difference, Medicaid policy will apply
- More inclusive definition—essentially all services in the three days before admission will be bundled
- Exception: Use condition code 51 on the outpatient claim to indicate clinically distinct services that are separately payable
- Estimated financial impact of $2.4 million per year has been built into the DRG base price



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Education Makes the Difference

Part A Three-Day/One-Day Payment Window

Medicare patients often receive outpatient services prior to being admitted as an inpatient. These outpatient services can be either diagnostic or non-diagnostic (therapeutic) in nature and must be reported according to the three-day or one-day payment window as described below.

Diagnostic Services

Diagnostic services are services ordered by the physician to determine a diagnosis for the patient and are defined by the presence of the following revenue and/or HCPCS/CPT codes on the bill:

- 0254 – Drugs "incident to" other diagnostic services.
- 0255 – Drugs "incident to" radiology.
- 030X – Laboratory.
- 031X – Laboratory pathological.
- 032X – Radiology diagnostic.
- 0341 – Nuclear medicine, diagnostic.
- 0343 – Diagnostic radiopharmaceuticals.
- 035X – CT scan.
- 0371 – Anesthesia "incident to" radiology.
- 0372 – Anesthesia "incident to" other diagnostic services.
- 040X – Other imaging services.
- 046X – Pulmonary function.
- 0471 – Audiology diagnostic.
- 0481, 0489 – Cardiology, cardiac catheter lab/other cardiology with CPT codes 93501, 93503, 93505, 93508, 93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561 or 93562.
- 0482 – Cardiology, stress test.
- 0483 – Cardiology, echocardiology.
- 053X – Osteopathic services.
- 061X – MRI.
- 062X – Medical/surgical supplies "incident to" radiology or other diagnostic services.
- 073X – ECG/EKG.
- 074X – EEG.
- 0918 – Behavioral health testing.
- 092X – Other diagnostic services.

TrailBlazer HEALTH ENTERPRISES, LLC

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

http://www.trailblazerhealth.com/Publications/Job%20Aid/three-dayrule.pdf

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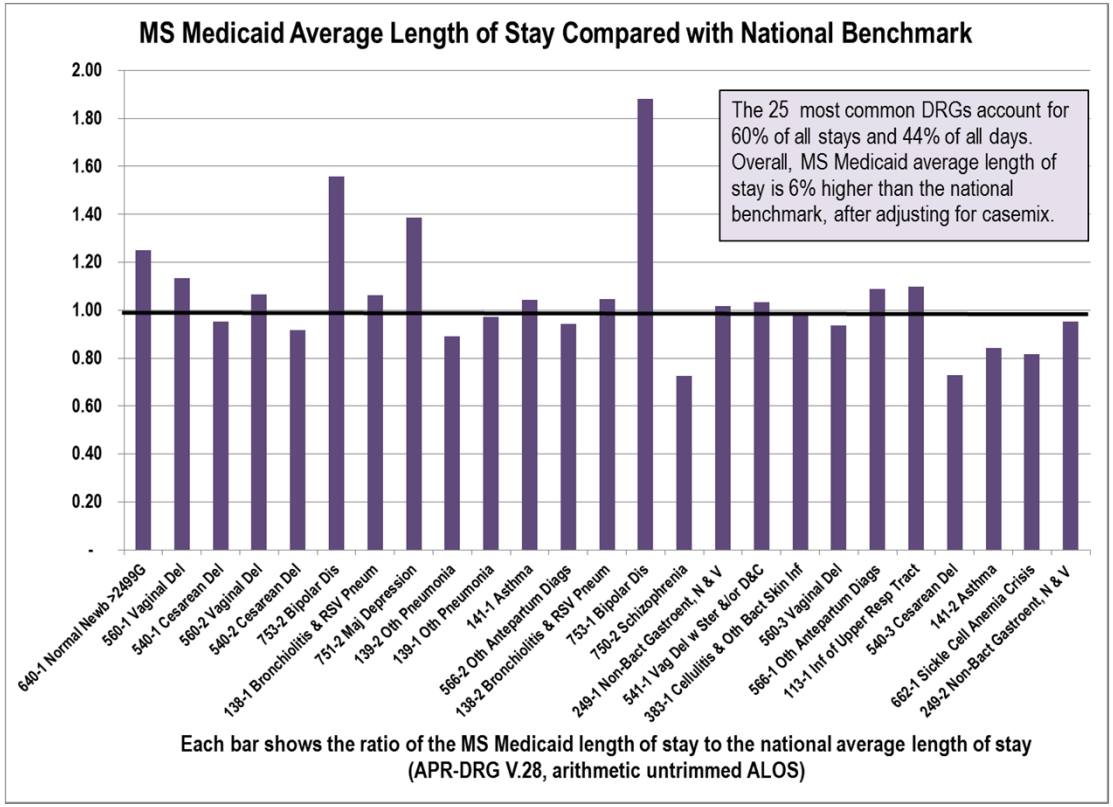
CLAIMS PAYMENT

Impacts: Financial Management

- Managing LOS and cost per day are rewarded
- Increase revenue by increasing casemix and volume
- Increase margins by increasing efficiency
- No cost settlement process



HOSPITAL IMPACTS

The Importance of Coding

- APR-DRG severity assignment:
  - No single complications/comorbidities list
  - Depends on interaction of PDx with multiple SDx and Px
  - APR-DRG granularity => opportunities to increase severity of illness
- Logic and experience (e.g., Medicare, MD, PA) => measured casemix will increase
- Newborn casemix expected to increase in particular (due to birthweight coding, inferred newborn claims)
- Overall, 3.5% documentation and coding adjustment built into DRG base price
- For stays at psych hospitals, additional 2.87% to reflect expected improvement in coding completeness
- Hospitals must ensure that coding is complete, accurate and defensible

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Impacts: Coding & Billing

- Newborns require their own claims
- Medicaid to follow Medicare re three-day outpatient window
- Increased importance of diagnosis/procedure coding
- No length-of-stay TAN unless over 19 days
- TAN first service day will be checked against admit date
- 30-day hospital limit removed
- Non-covered days can be billed; payment will be prorated
- Interim claims (TOB 112 and 113) may be billed but TOB 114 and 115 will be denied
- Hospitals not required to buy APR-DRG software

Analytical Dataset Used for DRG Simulation

- Discharge date in range October 2010 to March 2011
- Additional claims from before October 2010 or after March 2011 if part of same stay (i.e., interim claims)
- Categories of service 01 and 27
  - Acute general, rehab, LTAC, freestanding psych
- Excludes Medicare crossovers and swing beds
- Data subjected to multiple validation checks
- Interim claims chained into complete stays
- 10,846 inferred stays created for normal newborns originally billed on mother's claim
- Cost of each stay estimated using hospital-specific cost data
- Total payment = $307 million for 55,568 stays

POLICY REASONING

Fiscal Impact of Eliminating 30-Day Limit

- No more 30-day limit on inpatient care
- Hospitals with over 1,000 exhausted days:
  - North MS, UMC, MS Baptist, Mem Gulfport, St. Dominic-Jackson, Singing River, Delta Regional, Forrest County, Anderson Regional
- DRG base price adjusted to offset increased coverage
- 6% offset reflects Medicaid-primary patients plus patients who exhaust both Medicare and Medicaid benefit

Inpatient Exhausted Benefit--Medicaid Primary Payer		
	Days	Hospital Cost
Total inpatient	494,175	$ 634,690,585
Exhausted benefit days	23,657	$ 37,664,835
Percent	4.8%	5.9%
Notes 1) Source is Mississippi Hospital DSH Survey, 2012 2) The figures exclude Medicare/Medicaid dual eligibles.		

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Next Steps

- FAQ and DRG Pricing Calculator to be posted and updated on DOM and Xerox provider relations websites
- DOM to finalize DRG base price and other payment policies
- Table showing expected impacts by hospital for all hospitals will be released on DOM/Xerox websites
- Hospitals may request more detailed simulation results
  - Will not include claim-level protected health information
  - Email wayne.akins@xerox.com from your hospital email address with your title and confirm that you are authorized by your hospital to receive this information
  - Provide hospital name and NPI

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