WYOMING MEDICAID IMPLEMENTATION OF APR DRGS

ALL PROVIDER MEETING

WYOMING DEPARTMENT OF HEALTH

JANUARY 25, 2018

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AGENDA

1. Overview of APR DRGs
2. Policy Decisions
3. APR DRG Model Before Adjustments
4. Transitional Corridor and Documentation and Coding Improvement
5. APR DRG Model with Adjustments
6. Next Steps

PROJECT OVERVIEW

- Navigant was engaged to assist the Wyoming Department of Health (WHD) in the development and implementation of an APR DRG reimbursement methodology
- The Wyoming Department of Health convened a Technical Advisory Group (TAG) which:
  - Consisted of a wide range of providers (general and psychiatric hospitals and Critical Access Hospitals)
  - Provided input and insights on key decisions throughout the project (three meetings)
- Key project milestones:

Date	Milestone
July 2017	All provider meeting introducing APR DRGs and project timeline
July 2017	First TAG meeting
October 2017	Second TAG meeting
November 2017	Third TAG meeting
January 2018	All provider meeting sharing final model and rates
March - June 2018	Provider trainings (APR DRG calculations, APR DRG calculator tool, etc.)
July 1, 2018	Anticipated APR DRG reimbursement go-live date

OVERVIEW OF APR DRGs

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WHAT ARE DRGS?

- Diagnosis-related groups (DRGs) are used by providers and payers to classify patients into clinically-related “groups” for inpatient services.
  - If two patients had the same DRG, they had similar diagnoses and procedures
  - Example: DRG #225 – Appendectomy
- DRGs allow providers and payers to categorize complex patient claims data for analysis and payment.

DRG PER DISCHARGE PAYMENT

DRGs are used by healthcare payers to set prices for inpatient hospital services.

- Allow payers to prospectively determine a unique rate for each provider
- Do not vary based on patient length of stay or provider costs unless extraordinary circumstances result in an “outlier” payment

Since DRG payments are fixed, they are consistent with maintaining the financial incentive for hospitals to manage their cost structure and provide services in an efficient manner.

DRG RELATIVE WEIGHTS

Payers determine a “relative weight” for each DRG that represents the “relative” resource requirements for the service:

- DRG relative weight of 1.0 indicates average resource requirements (relative to all other inpatient services)
- Weight examples:

Example	APR DRG	Example Weight*
Low DRG weight	DRG 640-1 – Normal newborn	0.0969
Average DRG weight	DRG 225-2 – Appendectomy	1.0240
High DRG weight	DRG 002-4 – Heart transplant	21.2277

*APR DRG v33 National Weight

DRG PAYMENT CALCULATION

Note: Outlier payment are calculated separately

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POLICY DECISIONS

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OVERVIEW OF POLICY DECISIONS

Policy	Decision
1. DRG Grouper	APR-DRG 3M™ (version 33)
2. DRG Relative Weights	3M™ National Weights
3. Outlier Payment Policy	Consistent with current practice
4. Transfer Payment Policy	Consistent with current practice
5. Partial Eligibility	Continue current practice
6. Capital Payment	Continue current practice
7. Hospital Acquired Conditions (HAC)	Evaluate using 3M™ HAC
8. Interim Claims	Continue current practice

OVERVIEW OF POLICY DECISIONS, *CONT'D*

Policy	Decision
9. Payment for Specialty Providers	Continue per diem rate for free-standing rehab (no change)
10. Payment for Specialty Services	For transplants, target 100 percent of estimated costs (using billed charges multiplied by hospital-specific CCRs)
11. Budget Goal	Budget neutral, pending executive branch decision
12. Hospital Base Rates	• In-State Level II Trauma Centers – two provider-specific rates • Freestanding Psychiatric Hospitals – one provider-specific rate • All Other Participating Providers – one peer group rate

OVERVIEW OF POLICY DECISIONS, *CONT'D*

Policy	Decision
13. Targeted Policy Adjustors	• Obstetrics: 1.50 • Normal Newborn: 1.90 • Mental Health and Substance Abuse (adult and pediatric): 1.20 • Age Adjustor: 1.30
14. Transitional Period	Corridor payment approach (+5% / -4%)
15. Documentation and Coding Improvement (DCI) Adjustment	Adjust base rates to reflect an anticipated five percent DCI increase; monitor and make additional adjustments if needed

1. DRG GROUPER

Decision: Use APR DRG Grouper

Leading DRG Groupers Today

- Medicare-Severity DRGs (**MS-DRGs**): publicly available product designed for elderly population with 754 groups
- All-Patient Refined DRGs (**APR DRGs**): 3M propriety product designed for all patient populations

APR DRGs Are The Most Comprehensive

- Contain a severity of illness level range of 1-4 within each DRG

3M™ APR DRG version 33 has been available since October 2015, is ICD-10 compliant and has 1,256 different DRGs.

2. DRG RELATIVE WEIGHTS

Background

- 3M's national weights are based on two years of Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample discharges (over 15 million Medicare, Medicaid and private insurer discharges, including Wyoming data).
- Development of state-specific weights requires a minimum of 30 claims for every APR DRG after removal of outlier claims to ensure statistical stability.

Decision

- **Use 3M's "standard" APR DRG national weights (version 33).**

Rationale

- 3M's national weights reflect a robust set of data representing the services that Wyoming Medicaid provides.
- Wyoming Medicaid has insufficient claims volume to calculate robust state-specific weights.

3. OUTLIER PAYMENT POLICY: CURRENT APPROACH

Background

Current LOC outlier payment calculation involves:

- Identifying estimated claim costs using provider-specific cost-to-charge ratios.
- Identifying estimated costs above a predetermined fix-loss threshold (twice LOC rate).
- Calculating outlier payment by applying a marginal cost percentage (75 percent) to the estimated costs over the fix-loss threshold.

LOC's use of a fix-loss threshold and marginal cost percentage is consistent with Medicare.

Decision

- **Continue use of a fix-loss threshold and marginal percentage.**
- **Use provider-specific cost-to-charge ratios to estimate claim costs for purposes of outlier payment determination.**
- **Fix-loss threshold will be similar to that under LOC: two times a peer group-specific cost-based standard deviation (acute care hospitals, critical access hospitals, freestanding psychiatric hospitals and children's hospitals).**

Rationale

- Maintain consistency with Medicare and prior LOC approach.

4. TRANSFER PAYMENT POLICY: ACUTE TO ACUTE

Background

Under the level of care:

- Both the transferring and discharging hospitals receive a per diem payment not to exceed the LOC payment.
- Less than one-day stays are reimbursed separately.
- Outlier payments can apply.

Decision

- **Transferring hospital gets per diem payment not to exceed full DRG payment.**
- **Discharging (final) hospital gets full DRG payment.**
- **Outlier payments can apply.**

Rationale

- Consistent with Medicare methodology and similar to LOC.

5. PARTIAL ELIGIBILITY

Background

- This scenario occurs when a recipient is only eligible for Medicaid during a portion of the stay; occurs rarely.

Decision

- **Continue LOC payment policy.**

Rationale

- Occurs rarely and consistent with current policy.

6. CAPITAL PAYMENT

Background

- LOC uses a per-claim capital add-on of $277.87.

Decision

- **Continue use of capital add-on at current per discharge payment amount.**

Rationale

- Payments help cover cost of facility improvements, building projects, equipment modernization, etc.

7. HOSPITAL ACQUIRED CONDITIONS (HACs)

Background

- CMS requires that hospitals do not receive any additional payments to treat patients with HACs. Wyoming Medicaid identifies HACs by determining if any of the diagnosis codes submitted on a claim are on CMS' HAC list and were not present on admission (POA). If the presence of a HAC would increase payments, no additional payments are allowed.
- Currently Wyoming Medicaid identifies and reviews these cases manually.

Decision

- **Identify HACs using 3M™ HAC logic, and adjust payment if needed.**

Rationale

- No desk review, automated in software.
- Supports compliance with federal requirement.

8. INTERIM CLAIMS

Background

- States implementing DRGs typically prohibit the submission of interim claims.
- Wyoming Medicaid only allows interim billing under LOC for rehabilitation claims (paid on a per diem).

Decision

- **Continue current policy.**

Rationale

- Consistent with LOC policy.

9. PAYMENT FOR SPECIALTY PROVIDERS

Background

- Due to large variation in lengths of stay and cost among certain specialty providers, APR DRG weights may not appropriately reflect the relative resources needed to treat a patient in all areas of the United States.

Decision

- **Continue to pay rehabilitation hospitals on a per diem basis using existing rates.**

Rationale

- Exclusion of rehabilitation hospitals from a per discharge payment methodology is consistent with current LOC policy and uses patient-specific lengths of stay.

10. PAYMENT FOR SPECIALTY SERVICES

Background

- Due to large variation in lengths of stay and cost for certain specialty services, (e.g., transplant) APR DRG weights may not appropriately reflect the relative resources needed to treat a patient in all areas of the United States.

Decision

- **Exclude transplants from APR DRG payment methodology and target 100 percent of estimated costs (using billed charges multiplied by hospital-specific CCRs)**

Rationale

- There are few occurrences of transplants and their costs vary widely. Cost-based approach addresses risk for both providers and the State and promotes access.

11. BUDGET GOAL

Background

- This can be set by State or by historic experience. Budget neutrality can be determined individually by hospital or in the aggregate for all inpatient services.

Decision

- **Maintain budget neutrality, pending executive branch decision.**

Rationale

- Implementation of APR DRGs is not intended to alter the Medicaid inpatient budget pool or the structure of the supplemental payment programs.

12. HOSPITAL BASE RATES

Background

- APR DRG weights are developed to capture the average relative resources for a stay, DRG weights alone are not designed to align with State-specific policies, a State's Medicaid mission, and/or to support Medicaid patient access.

Decision

- **A combined peer group and provider-specific approach with policy adjustment factors reduces volatility and supports comparable payment levels for key service offerings.**

Rationale

- An unadjusted, single base rate shows large gains/losses among in-state providers, reduction in CAH payments, and large reductions in highest volume service lines.

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13. TARGETED POLICY ADJUSTORS

Background

- In the absence of a policy adjustors, Wyoming Medicaid payments for obstetrics and normal newborn claims (~58% of claims) and mental health/substance abuse have an overall payment reduction under APR DRG relative to LOC.

Decision

- **Implement policy adjustment factors for the following service lines: obstetrics, normal newborn, mental health & substance abuse.**
- **Implement an age adjustor for recipients less than 19 years old.**

Rationale

- Targeted policy adjustors address the reduction in payments for the above service lines that are critical to the Medicaid program.

14. TRANSITIONAL PERIOD

Background

- Transitional periods can ease the impact of payment methodology changes.
- When implementing APR DRG payment methodology, some states have employed a transitional period and others have not.

Decision

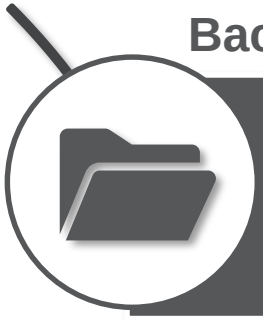
- **Implement a corridor payment approach (+5% / -4%). Providers outside of the corridor but at or above 100 percent of estimated costs are not eligible for a corridor adjustment.**

Rationale

- Eases the payment model transition and allow time for provider budget planning and other adjustments.

15. DOCUMENTATION AND CODING IMPROVEMENT ADJUSTMENT

Background



- Documented case mix is expected to increase upon APR DRG implementation due to better claims documentation; this can result in higher than projected expenditures.
- Payors typically implement DCI policies when implementing APR DRGs to account for increases in documented case mix.

Decision

- **Implement a prospective DCI adjustment factor to all hospital base rates.**

Rationale

- Supports budget neutrality and avoids retrospective provider “clawbacks” including the administrative burden of claims reprocessing or recoupment.

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APR DRG MODEL: BEFORE DCI AND TRANSITIONAL CORRIDOR ADJUSTMENTS

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APR DRG MODEL USES SFY 2016 AND 2017 DATA

SFY	Stays	Case Mix	Charges	LOC Payment	Capital	Total Payment
16	9,310	0.6539	$277,560,925	$70,747,117	$2,586,970	$73,334,087
17	7,746	0.6353	$206,116,257	$54,829,409	$2,152,381	$56,981,790
Total	**17,056**	**0.6455**	**$483,677,182**	**$125,576,526**	**$4,739,351**	**$130,315,877**

Note: Claims grouped using APR DRG Grouper Version 32 to process ICD-9 and ICD-10 claims. The claim count in SFY 2017 is lower than SFY 2016 because the SFY 2017 dataset does not include the claims runout after June 30, 2017, as it is taken from the QRA-related analyses which are based on dates of payment. Model summary dollars do not reflect supplemental payments or any third party liability. LOC payment totals include outlier payments.

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APR DRG BASE RATE DETERMINATION

SFY19 APR DRG base rates use a combination of provider-specific rates and a peer group

In-State Level II Trauma Centers – two provider-specific rates

Free-standing Psychiatric Hospitals – one provider-specific rate

All Other Participating Providers – one peer-group rate

Category	Level II Trauma Provider A	Level II Trauma Provider B	Free-Standing Psych	All Other Providers
Base Rate	$9,223.30	$7,239.50	$7,034.52	$8,747.93
Stays	2,831	2,684	688	10,853
APR-DRG Case Mix	0.5662	0.6867	0.5577	0.6615
Model Outlier Percent w/o capital	4.2%	7.8%	2.7%	8.1%

Note: Based on SFY 2016-2017 claims.

APR DRG POLICY ADJUSTORS INCREASE THE PROVIDER BASE PAYMENT

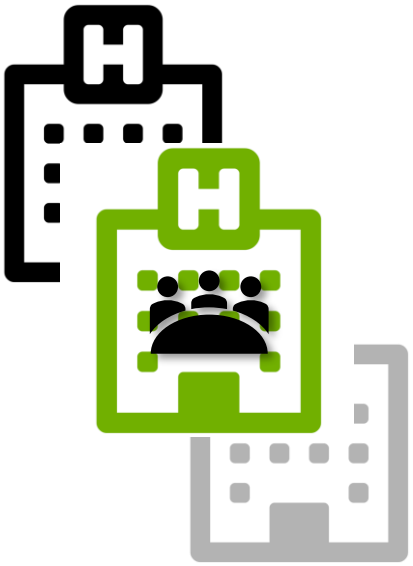
- No more than one policy adjustment factor per claim is used.
- MMIS will use max logic to select the largest multiplier.

Adjustor Type	Adjustor Defined	Factor*
Service Line	Obstetrics	1.50
Service Line	Normal Newborn	1.90
Service Line	Mental Health	1.20
Service Line	Substance Abuse	1.20
Age	Less than 19 years	1.30

*Factor default value equals 1.0

APR DRG OUTLIER POLICY

- Outlier payments are cost-based calculation with a marginal percentage and outlier threshold (similar to LOC policy)
- Marginal percentage = 75 percent
- Outlier threshold = two times the standard deviation (SD) by hospital type



Hospital Type	SD	Outlier Threshold
Acute Care Hospital	$19,665.52	$39,331.04
Critical Access Hospital	$6,441.76	$12,883.52
Children's Hospital	$92,985.26	$185,970.52
Psychiatric Hospital	$3,094.36	$6,188.72

Note: Based on SFY 2016-2017 claims.

APR DRG MODEL SUMMARY – BY SEVERITY OF ILLNESS

SFY 2016-17 CLAIMS

A	B	C	D	E	F	G	H = F - E	I = H ÷ E
SOI	SOI Defined	Stays	Case Mix	LOC Payment with Capital	Estimated DRG Payment with Capital	Estimated Outlier Payment w/ Capital (%)	Estimated Payment Change ($)	Estimated Payment Change (%)
1	Minor	9,163	0.3133	$ 41,231,612	$ 37,598,642	1.6%	$(3,632,971)	-8.8%
2	Moderate	5,147	0.5912	$ 36,542,146	$ 34,850,431	3.4%	$(1,691,715)	-4.6%
3	Major	2,235	1.2674	$ 28,583,853	$ 30,386,450	5.8%	$ 1,802,597	6.3%
4	Extreme	511	4.4286	$ 23,958,266	$ 27,464,282	20.7%	$ 3,506,016	14.6%
Total		**17,056**	**0.6455**	**$ 130,315,877**	**$ 130,299,805**	**7.1%**	**$ (16,072)**	**0.0%**

Note: Model summary dollars do not reflect supplemental payments

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APR DRG MODEL SUMMARY – IN-STATE VERSUS OUT-OF-STATE PARTICIPATING PROVIDERS

SFY 2016-17 CLAIMS

A	B	C	D	E	F	G = E - D	H = G ÷ D
Status	Stays	Case Mix	LOC Payment with Capital	Estimated DRG Payment with Capital	Estimated Outlier Payment w/ Capital (%)	Estimated Payment Change ($)	Estimated Payment Change (%)
In-State	14,782	0.4949	$ 81,282,774	$ 83,481,272	3.5%	$ 2,198,498	2.7%
Out-of-State Participating	2,274	1.6243	$ 49,033,103	$ 46,818,533	13.4%	$(2,214,570)	-4.5%
Total	**17,056**	**0.6455**	**$ 130,315,877**	**$ 130,299,805**	**7.1%**	**$ (16,072)**	**0.0%**

Note: Model summary dollars do not reflect supplemental payments

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APR DRG MODEL SUMMARY – BY SERVICE LINE

SFY 2016-17 CLAIMS

A	B	C	D	E	F	G = E - D	H = G ÷ D
Service Line	Stays	Case Mix	LOC Payment with Capital	Estimated DRG Payment with Capital	Estimated Outlier Payment w/ Capital (%)	Estimated Payment Change ($)	Estimated Payment Change (%)
Rehab	16	1.5371	$ 155,135	$ 247,825	9.8%	$ 92,690	59.7%
Neonate	807	1.9398	$ 19,134,157	$ 20,971,871	15.5%	$ 1,837,714	9.6%
Misc Pediatric	1,242	1.2061	$ 16,266,495	$ 17,812,480	4.8%	$ 1,545,984	9.5%
Gastroent Adult	547	1.1759	$ 5,390,975	$ 5,693,452	2.8%	$ 302,477	5.6%
Obstetrics	5,231	0.3998	$ 27,603,908	$ 28,384,492	0.2%	$ 780,585	2.8%
Resp Pediatric	755	0.5630	$ 4,842,869	$ 4,900,067	0.2%	$ 57,198	1.2%
Normal newborn	4,675	0.1267	$ 11,026,548	$ 10,996,384	0.4%	$ (30,163)	-0.3%
Misc Adult	1,945	1.3684	$ 27,386,642	$ 25,614,246	11.8%	$(1,772,396)	-6.5%
Resp Adult	490	0.9576	$ 4,732,122	$ 4,284,124	5.4%	$ (447,999)	-9.5%
Mental Health Adult	134	0.5134	$ 865,897	$ 770,487	2.8%	$ (95,410)	-11.0%
Burns	11	4.2999	$ 1,678,670	$ 1,471,479	65.2%	$ (207,191)	-12.3%
Circulatory Adult	294	1.4503	$ 4,815,519	$ 4,056,967	11.8%	$ (758,553)	-15.8%
Substance Abuse	57	0.6304	$ 479,314	$ 395,956	1.5%	$ (83,358)	-17.4%
Mental Health Pediatric	852	0.5394	$ 5,937,627	$ 4,699,974	2.4%	$(1,237,652)	-20.8%
Total	**17,056**	**0.6455**	**$ 130,315,877**	**$ 130,299,805**	**7.1%**	**$ (16,072)**	**0.0%**

Note: Model summary dollars do not reflect supplemental payments

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APR DRG MODEL SUMMARY – BY PROVIDER TYPE

SFY 2016-17 CLAIMS

A	B	C	D	E	F	G = E - D	H = G ÷ D
Provider Type	**Stays**	**Case Mix**	**LOC Payment with Capital**	**Estimated DRG Payment with Capital**	**Estimated Outlier Payment w/ Capital (%)**	**Estimated Payment Change ($)**	**Estimated Payment Change (%)**
CAH	2,034	0.3830	$ 9,545,559	$ 10,005,963	5.1%	$ 460,404	4.8%
AH	13,629	0.6273	$ 97,663,797	$ 98,370,865	5.4%	$ 707,068	0.7%
CHILD	705	1.8393	$ 18,096,059	$ 18,129,361	18.1%	$ 33,302	0.2%
PSYCH	688	0.5577	$ 5,010,462	$ 3,793,615	2.6%	$ (1,216,847)	-24.3%
Total	**17,056**	**0.6455**	**$ 130,315,877**	**$ 130,299,805**	**7.1%**	**$ (16,072)**	**0.0%**

Note: Model summary dollars do not reflect supplemental payments

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APR DRG MODEL SUMMARY – PROVIDER SUMMARY, PRIOR TO DCI AND TRANSITIONAL CORRIDOR ADJUSTMENTS

- Handout #1
- Estimated payment changes are based on SFY 2016-2017 claims data.
- Modeled claims are not adjusted for utilization.
- WDH may make further adjustments if needed to achieve budget neutrality or meet other budget requirements.

The model parameters, assumptions and analyses on the following slides are tentative and preliminary and have been prepared for discussion purposes only. All values should be considered draft and subject to change. All values use modeled assumptions and do not reflect actual payment. Actual provider payment levels under the new APR DRG system may vary significantly from estimates based on historical data, due to changes in case mix, service line mix, patient utilization, and other changes.

TRANSITIONAL CORRIDOR AND DCI

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TRANSITIONAL PERIOD

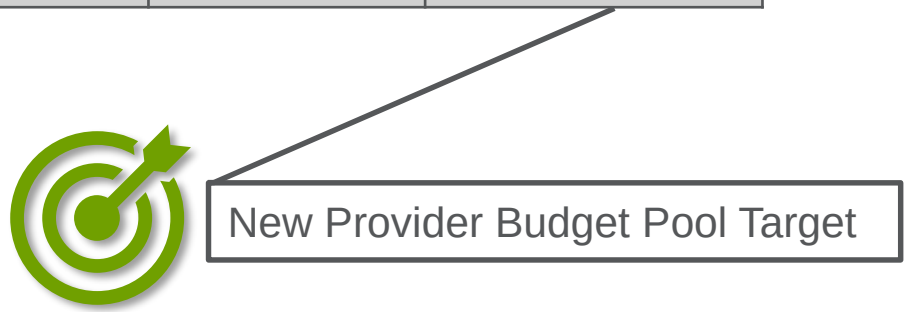
- To ease the payment model transition and allow time for provider planning, WDH will use a corridor payment approach in year one of implementation.
- WDH has modeled the adjustments to base rates based on two years of data as follows:

1. Compute payment difference between current and new payment methodology as a percent.
2. Using established threshold, calculate the maximum amount a provider can gain or lose under the new methodology. Providers outside of the corridor but at or above 100 percent of estimated costs are not eligible for a corridor adjustment.
3. For providers outside the corridor, use the maximum gain/loss amount to develop a provider-specific rate.
4. For providers inside the corridor, use base rate.

CALCULATION OF CORRIDOR ADJUSTMENTS

- WDH has developed a corridor limiting gains to 5 percent and losses to 4 percent.
- Providers at or above 100 percent estimated cost do not receive a corridor adjustment.
- Corridor example:

LOC Pmt	APR DRG Pmt	Diff ($)	Diff (%)	Outside Corridor?	Max (+5%/-4%)
$10,000	$11,000	$1,000	10%	Yes - Over	$10,500



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ADJUSTMENT FOR DOCUMENTATION AND CODING IMPROVEMENT

For SFY19 rate setting, WDH will implement a prospective DCI adjustment factor to all hospital base rates.

5%

WDH has identified a five percent adjustment factor based on a review of other states' experiences and TAG feedback.

WDH will monitor DCI during the first year of implementation and implement additional adjustments needed to achieve budget neutrality.

WDH use of prospective adjustments eliminates administrative burden of claims reprocessing or recoupment.

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APR DRG MODEL:
AFTER DCI AND TRANSITIONAL CORRIDOR ADJUSTMENTS

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APR DRG MODEL SUMMARY – PROVIDER SUMMARY, AFTER DCI AND TRANSITIONAL CORRIDOR ADJUSTMENTS

- Handout #2
- Estimated payment changes are based on SFY 2016-2017 claims data.
- Modeled claims are not adjusted for utilization.
- WDH may make further adjustments if needed to achieve budget neutrality or meet other budget requirements.

The model parameters, assumptions and analyses on the following slides are tentative and preliminary and have been prepared for discussion purposes only. All values should be considered draft and subject to change. All values use modeled assumptions and do not reflect actual payment. Actual provider payment levels under the new APR DRG system may vary significantly from estimates based on historical data, due to changes in case mix, service line mix, patient utilization, and other changes.

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NEXT STEPS

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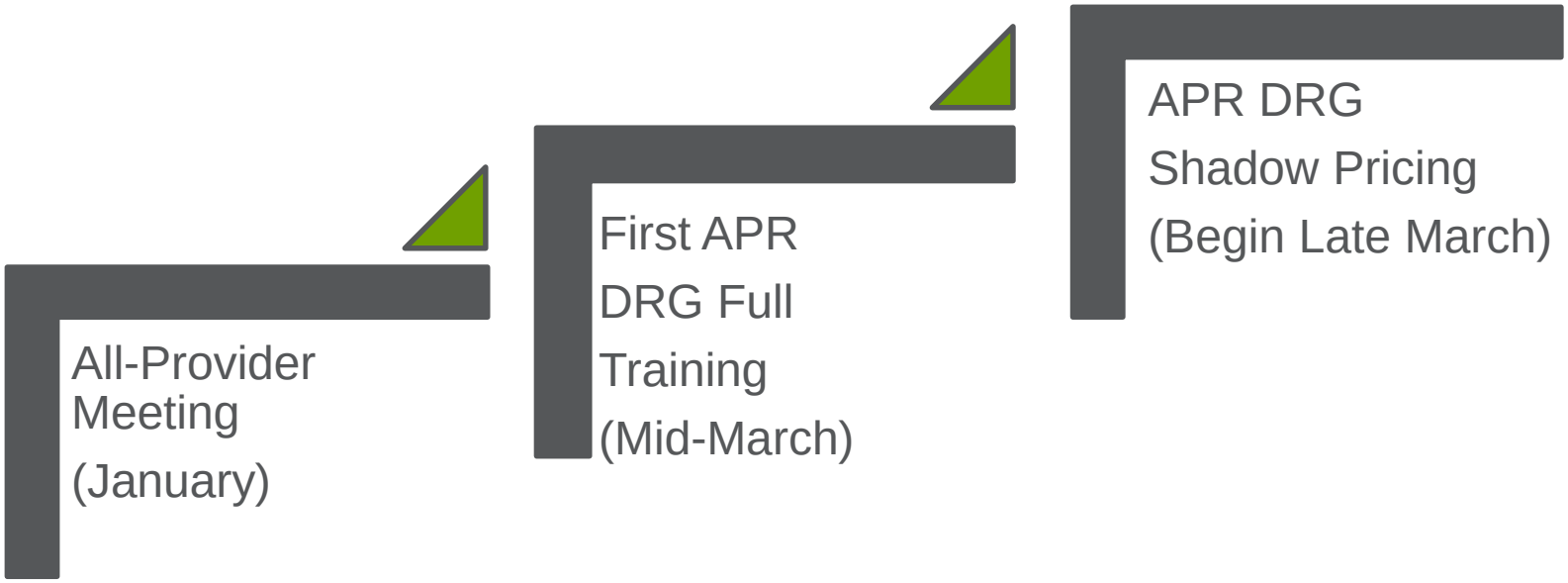
NEXT STEPS



Questions or comments in the meantime?
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