HMA

HEALTH MANAGEMENT ASSOCIATES

Medicaid Program Changes: Analysis of Potential Savings and Considerations

PREPARED FOR
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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Table of Contents

Provider Focused Efforts: Diagnosis-Related Groups

States utilize a variety of payment structures to reimburse hospital Medicaid inpatient services, including per stay, per diems, and diagnosis related groups (DRGs). Medicare has used DRGs to pay for hospital inpatient care for 33 years. Many commercial insurers across the country also utilize DRG payments.

As of 2014, Alaska is one of 10 states utilizing a per diem methodology as its base Medicaid inpatient reimbursement system. [29] Alaska utilizes a hospital-specific, cost-based per diem, in which the payment is a fixed amount per Medicaid hospital inpatient day regardless of the hospital's charges or costs incurred. The per diem is generally trended forward annually, and in every fourth year rates are rebased utilizing more current cost report information. However, for the last few years, rates have been frozen, and in April the Department of Health and Social Services proposed to adopt Fiscal Year 2018 rate reductions by rule.[30]

Thirty-seven states use DRGs for some or all of their Medicaid hospital inpatient payments. The DRG classification system attempts to align payment for services with the classification of the patient according to the reason for admission, severity of illness, and sometimes risk of mortality. A DRG payment is a single payment for all hospital services provided during an inpatient stay, calculated using an assigned numerical weight (a measure of average case complexity for a particular diagnosis) multiplied by a fixed rate. The fixed rate may be provider-specific or may be standardized across all hospitals. From a payer perspective, the main advantage of DRGs over per diems is the impact on inpatient length of stay, one of the most important drivers of cost. Under DRGs there is a strong incentive to manage length of stay effectively, while no such incentive exists in a per diem model.

DRGs were initially established by Medicare but historically, Medicare DRGs have not effectively mirrored the diversity and resource consumption patterns of the Medicaid population. Because each state has the flexibility to design its own payment programs, the most effective approach has been to modify the nationally recognized Medicare DRG system to better align payments with characteristics of the Medicaid population. States often created their own obstetrical and perinatal DRGs along with modifiers to recognize unique aspects of their delivery system and covered population.

Recently, several Medicaid programs have begun utilizing the All Patients Refined Diagnosis Related Groups (APR DRG). As the name suggests, APR-DRGs were developed to better represent the clinical complexity of non-Medicare patient populations. Each base APR-DRG, considers severity of illness and risk of mortality instead of being based on a single complication or comorbidity. More than one significant diagnosis can add to the APR's clinical severity, as can procedures, age, discharge disposition, and sex. Using four levels of severity of illness or risk of mortality (minor, moderate, major, severe), the

[29] Medicaid and CHIP Payment Access Commission (MACPAC), *States' Medicaid Fee-For-Service Inpatient Hospital Payment Policies.* 2014 http://tinyurl.com/2014macpachospitalratepolicies

[30] The proposed rule also removes the annual provider rate inflation adjustment FY 2018, and eliminates rebasing for providers who would normally be rebased in FY 2018.
Alaska DHSS, *Notice of Proposed Changes- Rate Changes, Medicaid- Facilities, Hospitals, Professional Services, & Waivers.* April 12, 2017. https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=185384

APR-DRG not only facilitates reimbursement but also enables internal and public reporting on these two factors.

Analysis

Advantages and Downsides of a DRG System

As of 2014, over 65 percent of the states utilize a DRG program to pay for Medicaid inpatient services.[31] There several reasons for hospitals to support and oppose a shift from a per diem structure to an acuity based case rate structure. The following highlights some of those considerations.

Adoption of a DRG system better aligns payments with the resources consumed in the provision of care. Overall this is a better strategy for the state, but could have negative consequences for hospitals to the extent the rate does not match the hospital's costs for providing care.

Use of DRGs can align Medicaid policies and administrative systems with those of other payers, reducing the sets of rules hospitals must manage to get paid. DRGs provide a greater incentive to evaluate efficiencies within hospital product lines, which can streamline processes for hospitals and mean gains for payers as well. However, the size of potential gains is limited by the fact that other payers already pay using DRGs, meaning the majority of efficiency gains (such as reduction in length of stay, for example) were probably captured years ago for most hospitals. On the up-side, because many hospitals have experience with DRGs in Medicare, the incremental cost for a Medicare change would not be very large for most hospitals. If a state adopts DRGs using Medicare DRGs, the cost can be limited to a relatively small amount of IT work and some additional revenue cycle training. More work would be involved for hospitals in a state that chooses to use APR DRG or creates a custom model.

DRG systems require more comprehensive coding than per diem systems. As a result, similar diagnoses across institutions, both locally and nationally, can be compared by resources consumed and outcomes. The additional data also allows payers to reward efficiency and quality. In some cases, new and innovative payment and delivery models can be created such as bundled payments.

DRG systems are significantly more complex than per diem systems. Given the data challenges the state has experienced the past few years there are several concerns, including:

- Reliability of the base data that would be used to build a DRG system
- Availability of two years of data
- System capacity to operate a DRG program, including the ability to pay timely and accurate claims

Payers, including Medicare and other state Medicaid programs, often have multiple payment systems based on location or type of hospital. For instance, critical access hospitals may be paid using a per diem structure while providers in urban areas are paid under a DRG structure. Similar differences often exist between general acute care hospitals and services and psychiatric, rehabilitation and long term care hospitals and services. The vast rural area and the diversity of hospitals in Alaska, including Tribal facilities, would likely mean multiple payment systems if DRGs are implemented. Even if DRGs were

[31] MACPAC, op. cit.

implemented at all non-Tribal hospitals, Tribal facilities would continue to be reimbursed using the federally negotiated rate.

Creating a DRG system will take significant time and financial resources. In the current fiscal environment, it is not clear that the state has the staff or financial capacity to take on that challenge. Additionally, shifting to DRGs also requires a significant investment by providers. It is not clear that all affected Medicaid providers would be ready to transition to DRGs. Another consideration is whether providers have been coding claims with sufficient detail that would allow appropriate grouping of claims.

Assessment of DRGs Based on ASHNHA-Identified Principles

Principle 1: Promotes Access

A major concern with a rate cut is the potential negative impact on access. A DRG model would not likely improve access from the current state but could mitigate the negative consequences of a rate decrease. For one, a conversion to DRGs may result in length of stay and possibly other utilization reductions. If inpatient utilization is reduced, hospitals would experience expense reductions and therefore share in the benefit of lower cost of care. This outcome would be less likely to disrupt the provider network than a rate cut. Second, there are ways to protect the most vulnerable hospitals under a DRG model, which would not be the case under an across the board rate cut. For example, it is common to exclude critical access hospitals from DRG systems.

Principle 2: Share the Burden

As noted above, if there are utilization savings generated from adopting DRGs, a portion of the savings would accrue to hospitals in the form of operating expense reductions. In contrast, under a rate cut, all of the benefit accrues to the state and none to the hospitals. A DRG better aligns payments with resources consumed for a particular diagnosis. For urban hospitals with larger volumes there is greater financial capacity to absorb a patient that requires more resources than the average patient. Conversely and small or critical access hospital with lower volume is a great risk. A per diem system allows providers to be protected against long lengths of stay. The state will need to develop an outlier reimbursement policy for long or costly stays to protect against financial hardships at hospitals. Most DRG systems have outlier programs.

If required to use DRGs, small rural hospitals also may be at greater financial risk than are larger hospitals due to their lower ability to change coding behavior to improve reimbursement. Small hospitals do not have the resources to adjust coding the way larger institutions may. As a result, claims are less likely to change for small hospitals, which could hurt rural relative to urban hospitals.

Principle 3: Leverage Available Financing Sources

Changing the inpatient reimbursement model from per diem to DRG would decrease the amount of federal funding, to the extent the DRG model results in less reimbursement to hospitals. The DRG model itself does not offer any opportunities for increasing federal participation.

Savings Potential

Usually implementation is modeled to be budget neutral as of the implementation date. Payers expect that over time, DRGs will result in reduced inpatient length of stay and therefore generate savings as compared to per diem reimbursement. However, as DRGs have been in place for several decades for most non-Medicaid admissions, there may not be much additional utilization savings to capture. Accordingly, it is unlikely that the Medicaid program could count on a DRG model to generate enough savings to meet the state budget objectives.

There is also risk to the state. In many DRG conversions hospitals have enhanced their coding efforts, thereby generating spending unanticipated by the state. States typically review coding and payment trends and make adjustments annually, including savings targets. Understanding the resources utilized by diagnosis may lead to agency-initiated care coordination efforts focused on high volume or high cost services. Understanding the variation of resources consumed by diagnosis may also lead to changes in reimbursement to facilitate cost efficiencies at certain hospitals. Similarly, the state could create incentive payments for achieving cost or quality goals.

Lastly, while a rate reduction would provide a more certain outcome for hospitals, a conversion to DRGs would introduce more volatility from hospital to hospital. For urban hospitals with larger volumes there is greater financial capacity to absorb a patient that requires more resources than the average patient. Conversely and small or critical access hospital with lower volume is a great risk. A per diem system allows providers to be protected against long lengths of stay. The state will need to develop an outlier reimbursement policy for long or costly stays to protect against financial hardships at hospitals. Most DRG systems have outlier programs.

Implementation Considerations

For the state, running two inpatient payment systems (DRG, cost based per diems) is burdensome, especially given the state's limited resources. In the short term, evaluating DRGs creates significant demand on staff and IT. The effort includes capturing and verifying data to build the simulation models. Significant data verification is necessary and modeling is essential. Once a system is designed there are policies and procedures to be written around the new program. The state would need to publish new regulations to govern the program, file an updated State Plan with CMS, and potentially make legislative changes. Ultimately, the systems will need to be programed to operate consistent with the system design. The state will then need to test the payment systems to insure payment accuracy.

From the provider perspective there will be large implementation costs including purchasing the DRG grouper, learning the new policies and procedures, training staff and clinicians on the new requirements related prior authorization, coding, and documentation. To the extent the new system aligns with other payers, there should be some administrative efficiencies realized.

It takes significant time and resources by both the provider community and the state to vet a conversion from one payment system to another, in this case per diems to DRGs. The investment, often a couple of years, is essential because neither side wants the projections to vary drastically from what actually occurs. On the surface incorrect estimates are merely a budget error, however, a substantial decline in

revenue for a provider could have a devastating and harmful impact on their ability to serve the community.

Given the inadequacies of the Medicaid data and the fiscal pressures faced by the state, transitioning to Medicaid DRGs does not seem prudent or feasible in the short term. Furthermore, in many states providers such as critical access hospitals have been exempted from DRGs because the resources to operationalize the new system is excessive given their limited inpatient volume.

Recommendation

States that have implemented new DRG systems often take multiple years for the rate reform process. Building reliable datasets that can be utilized to develop case weights and rates is essential. Alaska Medicaid has failed to demonstrate the ability to produce accurate data on a consistent basis and therefore it is believed that the financial risk exceeds the benefits of moving to a DRG system at this time. That said, there is great value in planning for a transition to DRGs. The hospital industry should work to collect data over the next two years in anticipation of converting to DRGs. Providers should review their coding practices to ensure sufficient data is captured on each claim.

There are a number of potential benefits of moving to DRGs, but it is probably not reasonable to expect that the state would assume savings potential as an alternative to a rate cut, and it would be a costly endeavor. Therefore HMA does not recommend pursuing additional analysis of DRG conversion for Alaska hospitals.