

Table 1 Claims Exclusions from Datasets

Table 1.A Claims Excluded from Outlier, Rate Setting, and Impact Analysis Processing

Exclusion	Case	% Total Case	Covered Charge Total	% of Total Charge
Beginning Totals: Raw data	1,180,876	100.00%	\$13,607,875,863	100.00%
Interim Segment (leftover after combination)	617	0.05%	\$0	0.00%
Out-of-Date (Service Date<1/1/2003 or >6/30/2005)	400,619	33.93%	\$3,494,681,743	25.68%
Duplicate	18	0.00%	\$231,005	0.00%
Overlap	6,728	0.57%	\$247,725,106	1.82%
Missing DRG Pay Indicator	4	0.00%	\$463,643	0.00%
Missing Member ID	1	0.00%	\$483	0.00%
Missing the 1st Diagnosis Code	56	0.00%	\$0	0.00%
Covered Charge Amount = 0	6,240	0.53%	\$0	0.00%
Low Charge (Bill Amount < 500, with Exceptions)	377	0.03%	\$147,925	0.00%
Net Pay = 0	3	0.00%	\$32,603	0.00%
Ungroupable DRG (469 and 470)	213	0.02%	\$5,369,357	0.04%
Other Out-of-State Provider rather than Border	1,365	0.12%	\$39,953,356	0.29%
Closed Provider	2,205	0.19%	\$32,865,208	0.24%
Claims of out of sample source (not in SFY 2004 and 2005)	135,540	11.48%	\$1,563,932,614	11.49%
Total of claims excluded from further processing	553,986	46.91%	\$5,385,403,042	39.58%
<i>Total of claims for further processing</i>	<i>626,890</i>	<i>53.09%</i>	<i>\$8,222,472,821</i>	<i>60.42%</i>

Table 1.B Claims Excluded from Outlier and Rate Setting Processing

Exclusion	Case	% Total Case	Covered Charge Total	% of Total Charge
Beginning Totals	626,890	100.00%	\$8,222,472,821	100.00%
Border Provider	8,272	1.32%	\$206,804,673	2.52%
Early Discharge	354	0.06%	\$4,702,125	0.06%
One-Day	53,942	8.60%	\$341,139,761	4.15%
Readmission	362	0.06%	\$4,205,203	0.05%
Same-Day	5,613	0.90%	\$26,995,052	0.33%
Temporarily Excluded Provider (The Specialty Hospital and Select Specialty Hospital)	63	0.01%	\$7,016,795	0.09%
Transfer	2,991	0.48%	\$74,381,256	0.90%
Total of Claims Excluded from Outlier and Rate Setting Processing	71,597	11.42%	\$665,244,865	8.09%
<i>Total of claims for calculating outlier thresholds and relative weights</i>	<i>555,293</i>	<i>88.58%</i>	<i>\$7,557,227,956</i>	<i>55.54%</i>

Table 1.C Claims Excluded from Base Rate Processing

Exclusion	Case	% Total Case	Covered Charge Total	% of Total Charge
Beginning Totals	555,293	100.00%	\$7,557,227,956	100.00%
SFY 2004 Claims not selected in DRG sample*	264,629	47.66%	\$3,346,912,606	44.29%
Outlier (DRG and MDC, and one and two years combined)	1,914	0.34%	\$398,770,499	5.28%
Total of Claims Excluded from Rate Setting Processing	266,543	48.00%	\$3,745,683,105	49.56%
<i>Total of claims for rate setting processing</i>	<i>288,750</i>	<i>52.00%</i>	<i>\$3,811,544,850</i>	<i>50.44%</i>

** Claims from 7/1/2003 to 6/30/2005 used to set relative weights as necessary. Only SFY 2005 claims used to set base rates.*

Table 1.D Claims Excluded and Included in Impact Analysis

Exclusion/Inclusion	Cases	%of Total Cases	Covered Charge Total	% of Total Charge
Total of claims for rate setting processing (Table 1.C)	288,750		\$3,811,544,850	
<i>Add back in - Items excluded from rate setting but included in impact analysis:</i>				
Outliers	1,344		\$290,446,096	
Border, transfer and other non-Medicare cases	28,319		\$252,941,813	
Subtotal	318,413		4,354,932,759	
<i>Remove - Items included in rate setting but excluded from impact analysis:</i>				
SFY 2004 Claims	8,846	2.78%	\$193,544,222	4.44%
SFY 2005 Medicare claims	52,499	16.49%	\$1,045,129,416	24.00%
Total of Claims Excluded from Impact Analysis	61,345	19.27%	\$1,238,673,637	28.44%
Total of Claims for Impact Analysis	257,068	80.73%	\$3,116,259,122	71.56%

Note: Line-item totals in Table 1.D may not match to same items in previous tables 1.A – 1.C because of a different exclusion hierarchy. Ex. Some Outliers are also 2004 claims and 2005 Medicare crossover claims.

Table 2.1
Summary of claims data in impact based on DRG grouper v16 and v23
All Peer Groups*

Type	DRG	Payment System	Cases	Percent of Total Cases	Total Charges	Percent of Total Charges	Total Payments	Percent of Total Payments
Inliers	V16	CMO	189,939	93.0%	\$1,513,116,435	87.7%	\$651,855,295	86.9%
		FFS	46,852	88.5%	\$1,163,698,751	83.6%	\$394,556,686	80.9%
		Total	236,791	92.1%	\$2,676,815,187	85.9%	\$1,046,411,981	84.6%
	V23	CMO	183,826	90.0%	\$1,495,698,558	86.7%	\$667,381,742	87.4%
		FFS	46,692	88.2%	\$1,143,649,223	82.2%	\$415,794,985	82.1%
		Total	230,518	89.7%	\$2,639,347,780	84.7%	\$1,083,176,727	85.3%
Outliers	V16	CMO	719	0.4%	\$119,935,630	7.0%	\$57,009,860	7.6%
		FFS	1013	1.9%	\$144,680,443	10.4%	\$68,787,763	14.1%
		Total	1,732	0.7%	\$264,616,073	8.5%	\$125,797,623	10.2%
	V23	CMO	504	0.3%	\$118,404,485	6.9%	\$43,806,639	5.7%
		FFS	851	1.6%	\$184,394,264	13.3%	\$66,205,285	13.1%
		Total	1,355	0.5%	\$302,798,749	9.7%	\$110,011,924	8.7%
All Others	V16	CMO	13,495	6.6%	\$91,930,472	5.3%	\$40,892,671	5.5%
		FFS	5,050	9.5%	\$82,897,390	6.0%	\$24,417,021	5.0%
		Total	18,545	7.2%	\$174,827,862	5.6%	\$65,309,692	5.3%
	V23	CMO	19,823	9.7%	\$110,879,495	6.4%	\$52,088,440	6.8%
		FFS	5,372	10.2%	\$63,233,099	4.5%	\$24,192,272	4.8%
		Total	25,195	9.8%	\$174,112,593	5.6%	\$76,280,712	6.0%
Totals	V16	CMO	204,153	100.0%	\$1,724,982,537	100.0%	\$749,757,825	100.0%
		FFS	52,915	100.0%	\$1,391,276,585	100.0%	\$487,761,470	100.0%
		Total	257,068	100.0%	\$3,116,259,122	100.0%	\$1,237,519,296	100.0%
	V23	CMO	204,153	100.0%	\$1,724,982,537	100.0%	\$763,276,822	100.0%
		FFS	52,915	100.0%	\$1,391,276,585	100.0%	\$506,192,543	100.0%
		Total	257,068	100.0%	\$3,116,259,122	100.0%	\$1,269,469,364	100.0%

*12 months of SFY 2005 non-Medicare claims. Includes border providers that are not included in Tables 2.2, 2.3, and 2.4.

Table 2.2
Summary of claims data in impact based on DRG grouper v16 and v23
Statewide Peer Group*

Type	DRG	Payment System	Cases	Percent of Total Cases	Total Charges	Percent of Total Charges	Total Payments	Percent of Total Payments
Inliers	V16	CMO	180,954	94.1%	\$1,325,668,506	91.0%	\$572,461,588	90.9%
		FFS	43,459	89.6%	\$1,047,070,544	85.2%	\$347,695,994	82.8%
		Total	224,413	93.2%	\$2,372,739,050	88.4%	\$920,157,582	87.7%
	V23	CMO	174,860	90.9%	\$1,301,926,718	89.4%	\$575,807,210	90.2%
		FFS	43,283	89.2%	\$1,037,989,554	84.5%	\$370,334,280	84.6%
		Total	218,143	90.6%	\$2,339,916,271	87.1%	\$946,141,489	87.9%
Outliers	V16	CMO	426	0.2%	\$59,990,514	4.1%	\$26,847,741	4.3%
		FFS	819	1.7%	\$113,105,875	9.2%	\$52,715,066	12.6%
		Total	1,245	0.5%	\$173,096,389	6.5%	\$79,562,807	7.6%
	V23	CMO	308	0.2%	\$62,274,321	4.3%	\$20,812,248	3.3%
		FFS	681	1.4%	\$139,595,960	11.4%	\$47,835,518	10.9%
		Total	989	0.4%	\$201,870,281	7.5%	\$68,647,766	6.4%
All Others	V16	CMO	10,939	5.7%	\$70,903,549	4.9%	\$30,364,730	4.8%
		FFS	4,246	8.8%	\$68,624,023	5.6%	\$19,771,048	4.7%
		Total	15,185	6.3%	\$139,527,572	5.2%	\$50,135,778	4.8%
	V23	CMO	17,151	8.9%	\$92,361,530	6.3%	\$41,688,635	6.5%
		FFS	4,560	9.4%	\$51,214,929	4.2%	\$19,695,649	4.5%
		Total	21,711	9.0%	\$143,576,459	5.4%	\$61,384,284	5.7%
Totals	V16	CMO	192,319	100.0%	\$1,456,562,568	100.0%	\$629,674,059	100.0%
		FFS	48,524	100.0%	\$1,228,800,442	100.0%	\$420,182,107	100.0%
		Total	240,843	100.0%	\$2,685,363,011	100.0%	\$1,049,856,166	100.0%
	V23	CMO	192,319	100.0%	\$1,456,562,568	100.0%	\$638,308,092	100.0%
		FFS	48,524	100.0%	\$1,228,800,442	100.0%	\$437,865,446	100.0%
		Total	240,843	100.0%	\$2,685,363,011	100.0%	\$1,076,173,538	100.0%

*12 months of SFY 2005 non-Medicare claims. Border providers are excluded.

Table 2.3
Summary of claims data in impact based on DRG grouper v16 and v23
Pediatric Peer Group*

Type	DRG	Payment System	Cases	Percent of Total Cases	Total Charges	Percent of Total Charges	Total Payments	Percent of Total Payments
Inliers	V16	CMO	6,562	72.0%	\$146,562,100	70.0%	\$65,424,607	66.7%
		FFS	2,350	75.2%	\$72,274,482	67.2%	\$24,529,079	59.5%
		Total	8,912	72.8%	\$218,836,582	69.0%	\$89,953,685	64.6%
	V23	CMO	6,592	72.3%	\$152,180,750	72.6%	\$77,450,848	74.6%
		FFS	2,362	75.6%	\$62,781,865	58.4%	\$28,267,706	61.0%
		Total	8,954	73.1%	\$214,962,614	67.8%	\$105,718,554	70.4%
Outliers	V16	CMO	246	2.7%	\$46,387,910	22.1%	\$23,185,100	23.6%
		FFS	146	4.7%	\$27,444,207	25.5%	\$13,613,257	33.0%
		Total	392	3.2%	\$73,832,117	23.3%	\$36,798,357	26.4%
	V23	CMO	163	1.8%	\$41,480,345	19.8%	\$16,937,807	16.3%
		FFS	122	3.9%	\$36,982,141	34.4%	\$15,063,482	32.5%
		Total	285	2.3%	\$78,462,487	24.7%	\$32,001,289	21.3%
All Others	V16	CMO	2,311	25.3%	\$16,573,876	7.9%	\$9,475,293	9.7%
		FFS	629	20.1%	\$7,874,076	7.3%	\$3,093,251	7.5%
		Total	2,940	24.0%	\$24,447,952	7.7%	\$12,568,544	9.0%
	V23	CMO	2,364	25.9%	\$15,862,792	7.6%	\$9,389,503	9.1%
		FFS	641	20.5%	\$7,828,758	7.3%	\$3,027,912	6.5%
		Total	3,005	24.5%	\$23,691,550	7.5%	\$12,417,415	8.3%
Totals	V16	CMO	9,119	100.0%	\$209,523,887	100.0%	\$98,085,000	100.0%
		FFS	3,125	100.0%	\$107,592,765	100.0%	\$41,235,587	100.0%
		Total	12,244	100.0%	\$317,116,651	100.0%	\$139,320,586	100.0%
	V23	CMO	9,119	100.0%	\$209,523,887	100.0%	\$103,778,158	100.0%
		FFS	3,125	100.0%	\$107,592,765	100.0%	\$46,359,100	100.0%
		Total	12,244	100.0%	\$317,116,651	100.0%	\$150,137,258	100.0%

*12 months of SFY 2005 non-Medicare claims

Table 2.4
Summary of claims data in impact based on DRG grouper v16 and v23
Specialty Peer Group*

Type	DRG	Payment System	Cases	Percent of Total Cases	Total Charges	Percent of Total Charges	Total Payments	Percent of Total Payments
Inliers	V16	CMO	36	85.7%	\$2,160,271	88.6%	\$1,660,647	94.0%
		FFS	304	81.7%	\$22,271,532	82.4%	\$15,567,073	87.3%
		Total	340	82.1%	\$24,431,803	82.9%	\$17,227,720	87.9%
	V23	CMO	35	83.3%	\$2,066,445	84.8%	\$923,961	80.9%
		FFS	311	83.6%	\$21,397,595	79.2%	\$9,515,088	79.6%
		Total	346	83.6%	\$23,464,040	79.6%	\$10,439,049	79.7%
Outliers	V16	CMO	2	4.8%	\$129,367	5.3%	\$70,979	4.0%
		FFS	32	8.6%	\$2,421,730	9.0%	\$1,573,163	8.8%
		Total	34	8.2%	\$2,551,096	8.7%	\$1,644,142	8.4%
	V23	CMO	2	4.8%	\$276,886	11.4%	\$157,428	13.8%
		FFS	31	8.3%	\$4,437,580	16.4%	\$1,914,645	16.0%
		Total	33	8.0%	\$4,714,466	16.0%	\$2,072,073	15.8%
All Others	V16	CMO	4	9.5%	\$148,295	6.1%	\$34,892	2.0%
		FFS	36	9.7%	\$2,337,303	8.7%	\$693,096	3.9%
		Total	40	9.7%	\$2,485,598	8.4%	\$727,988	3.7%
	V23	CMO	5	11.9%	\$94,602	3.9%	\$61,099	5.4%
		FFS	30	8.1%	\$1,195,390	4.4%	\$524,908	4.4%
		Total	35	8.5%	\$1,289,991	4.4%	\$586,007	4.5%
Totals	V16	CMO	42	100.0%	\$2,437,933	100.0%	\$1,766,518	100.0%
		FFS	372	100.0%	\$27,030,564	100.0%	\$17,833,332	100.0%
		Total	414	100.0%	\$29,468,497	100.0%	\$19,599,850	100.0%
	V23	CMO	42	100.0%	\$2,437,933	100.0%	\$1,142,488	100.0%
		FFS	372	100.0%	\$27,030,564	100.0%	\$11,954,641	100.0%
		Total	414	100.0%	\$29,468,497	100.0%	\$13,097,128	100.0%

*12 months of SFY 2005 non-Medicare claims

Table 3
Overview of capital data (overall and by a sample of hospitals)

Per discharge and per day capital amounts used in 12 months of SFY 2005 payment calculations (v23)

Hospital	Non-Medicare Cases	Capital Add-on/Case	Capital add-on/Case/Day
Egleston Childrens (000000943A)	5,401	\$1,396.99	\$211.38
Grady Memorial (000000855A)	12,658	\$768.92	\$137.85
Shepherd Spinal Center (000248069A)	116	\$4,081.66	\$102.57
...
Total/Average	257,068	\$528.43	\$127.93

Table 4

Overview of GME data (overall and by hospital)

Per discharge GME amounts used in 12 months of SFY 2005 payment calculations

Hospital	Non-Medicare Cases w/ GME	GME Add-on per Case
Atlanta Medical Center (000000789A)	7,246	\$431.37
Crawford Long (000000503A)	6,112	\$111.84
Dunwoody Medical Center (000001669A)	1,923	\$511.96
Egleston Childrens (000000943A)	5,401	\$523.56
Emory University (000000712A)	1,591	\$924.02
Floyd Medical Center (000000756A)	4,528	\$184.09
Grady Memorial (000000855A)	12,658	\$1,147.82
Hughes Spalding Childrens (000679808A)	1,467	\$851.59
Medical Center Central Georgia (000001207A)	7,627	\$458.89
Medical College of Georgia (000000723A)	5,687	\$896.70
Memorial Medical Center (000001273A)	6,872	\$370.63
Northlake Regional (000000547A)	261	\$164.55
Phoebe Putney (000001482A)	6,745	\$106.69
Piedmont (000001504A)	936	\$33.97
Satilla Regional (000001229A)	2,149	\$39.32
Scottish Rite (000001636A)	5,376	\$84.31
South Fulton (000001713A)	3,883	\$27.11
The Medical Center (000001196A)	5,221	\$251.96
Wesley Woods Geriatric (000339831A)	69	\$417.35
Total/Average	85,752	\$462.17

Table 5
Sample of Cost-to-Charge Ratio data

Hospital ID	Hospital	Peer Group	Type	Start Date	End Date	XIX IP Overall CCR (Capped)	XIX IP Operating CCR (Capped)
00000943A	Egleston Childrens	Pediatric	AF	1/1/2004	12/31/2004	0.510	0.452
00679808A	Hughes Spalding Childrens	Pediatric	AF	1/1/2004	12/31/2004	0.546	0.418
00001636A	Scottish Rite	Pediatric	AF	1/1/2004	12/31/2004	0.531	0.471
00472513A	Kindred	Specialty	AF	9/1/2003	8/31/2004	0.326	0.282
00000778A	Roosevelt Warm Springs	Specialty	AU	7/1/2003	6/30/2004	0.959	0.849
00248069A	Shepherd Spinal Center	Specialty	AF	4/1/2003	3/31/2004	0.553	0.508
00368387A	Walton Rehabilitation	Specialty	AF	7/1/2003	6/30/2004	0.628	0.583
00339831A	Wesley Woods Geriatric	Specialty	AU	9/1/2003	8/31/2004	0.687	0.616
00000052A	Appling General Hospital	Statewide	AF	9/1/2003	8/31/2004	0.431	0.385

Procedure for Calculating Operating CCRs

Necessary Data Elements for CCR Calculations

Cost Report Data

- ❑ Hospital Fiscal Year End Date
- ❑ Major Movable Equipment Costs
- ❑ Building & Fixtures Costs
- ❑ Total Hospital Charges
- ❑ Total Hospital Costs
- ❑ Medicaid Inpatient Charges
- ❑ Medicaid Inpatient Costs

Other Data Provided by DCH or from MMIS Claims Files

- ❑ Number of Total Beds – provided by DCH
- ❑ Peer Group – provided by DCH
- ❑ Ownership type – public or private, provided by DCH
- ❑ Graduate Medical Education (GME) Costs – provided by DCH from cost reports
- ❑ Non-Allowable Cost Ratio – provided by DCH
- ❑ Trend Factor – provided by DCH based on peer group, bed size and ownership type

Procedure for Calculating Operating CCRs (cont'd)

Calculating CCRs from Hospital Cost Report Data

Step 1: Calculate Overall Hospital CCR

Overall Hospital CCR = Total Hospital Costs / Total Hospital Charges

Step 2: Calculate Overall Medicaid Hospital CCR

Overall Medicaid Hospital CCR = Medicaid Inpatient Hospital Costs / Medicaid Inpatient Hospital Charges
Result is capped at 1.000.

Step 3: Calculate Medicaid Capital Hospital CCR

Total Capital Costs = Major Movable Equipment + Building & Fixtures Costs
Medicaid Inpatient Allocation Ratio = Medicaid Inpatient Hospital Costs / Total Hospital Costs
Medicaid Capital Allocation Costs = Total Capital Costs * Medicaid Inpatient Allocation Ratio
Medicaid Capital Hospital CCR = Medicaid Capital Allocation Costs / Medicaid Inpatient Hospital Charges

Step 4: Calculate Medicaid GME Hospital CCR

Medicaid GME Allocation Costs = Graduate Medical Education (GME) Costs * Medicaid Inpatient Allocation Ratio
Medicaid GME Hospital CCR = Medicaid GME Allocation Costs / Medicaid Inpatient Hospital Charges

Step 5: Calculate Medicaid Operating Hospital CCR

Medicaid Inpatient Operating Costs = Medicaid Inpatient Hospital Costs – (Medicaid Capital Allocation Costs + Medicaid GME Allocation Costs)
Medicaid Operating Hospital CCR = Medicaid Inpatient Operating Costs / Medicaid Inpatient Hospital Charges
This CCR cannot be greater than 1.000 and if it is greater than 1.000, the CCR is obtained by subtracting the sum of the Medicaid GME and Capital Hospital CCRs from 1.000.

Procedure for Calculating Operating CCRs (cont'd)

Additional Modifications to the Calculated CCRs:

Step 6: Non-Allowable Cost Ratio Modification All of the CCRs just calculated were multiplied by the Non-Allowable Cost Ratio, which was provided by DCH. For the Overall and Operating CCRs, we multiply the ratio by the non-capped CCR. If the Overall CCR continues to be over 1.000, it is capped at 1.000. For the Operating CCR, if it is over 1.000, the capped Operating CCR is obtained by subtracting the sum of the newly modified Medicaid GME and Capital Hospital CCRs from 1.000.

Step 7: Trend Factor Modification for 2005 CCRs In order to trend forward to 2005 using 2004 data we apply a trend factor. We were given five separate trend factors based on the hospital's peer group, ownership type and bed size. There are trend factors for: pediatric hospitals, hospitals with under 51 beds, hospitals with between 51 and 100 beds, private hospitals with more than 100 beds and public hospitals with more than 100 beds. The bed size, peer group and ownership type for each hospital was taken from information provided by DCH.

Once we have the appropriate trend factor for each hospital, this factor is multiplied by each of the CCRs that were modified by the Non-Allowable Cost Ratio in Step 6. Again, for both the Overall and Operating CCRs, we multiply the trend factor by the non-capped CCR. If the Overall CCR continues to be over 1.000, it is capped at 1.000. For the Operating CCR, if it is over 1.000, the capped Operating CCR is obtained by subtracting the sum of the newly modified Medicaid GME and Capital Hospital CCRs from 1.000.

These modified CCRs become our 2005 CCRs for all hospitals in which the 2004 Hospital Fiscal Year (HFY) ended on June 30, 2004 or later. For any hospital with a 2004 HFY ending prior to June 30, 2004, the trend factor is applied twice. This is not very widespread, as the trend factor had to be applied twice for only 17 out of 154 hospitals.

Inflation Methodology

The base rates are based on claims data from SFY 2005. There are two components that relate to the point in time reflected by the costs used to calculate the base rates.

- The charges on each claim during SFY 2005 are converted to costs using a CCR that corresponds to the month of the claim's dates of service. Hospital-specific CCRs have been trended forward based on trend factors supplied by DMAS.
- The costs on each claim are then inflated or deflated to end of December 2004 depending on the date of the claim. Claims with dates of service between July 1, 2004 and December 30, 2004 are inflated to December 31, 2004. Claims with dates of service between January 1, 2005 and June 30, 2005 are deflated to December 31, 2004.

Table 6
Claims and charges that changed DRG classification (is no longer in same DRG grouping)
Top 10 Pairs by Claims Volume

DRG V16	DRG V23	Cases	Covered Charge Total
Total (335 Pairs)		12,047	\$449,577,592.03
630: Neonate, Birthwt >2499g, w/o Signif or Proc, w Other Prob	391: NORMAL NEWBORN	2,473	\$3,940,473.17
628: Neonate, Birthwt >2499g, w/o Signif or Proc, w Minor Prob	630: NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W OTHER PROB	1,005	\$5,474,644.32
628: Neonate, Birthwt >2499g, w/o Signif or Proc, w Minor Prob	627: NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MAJOR PROB	932	\$7,412,728.44
209: Major Joint & Limb Reattachment Procedures of Lower Extremity	544: MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	582	\$21,481,945.43
434: No Longer Valid	521: ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	506	\$4,969,780.19
627: Neonate, Birthwt >2499g, w/o Signif or Proc, w Major Prob	626: NEONATE, BIRTHWT >2499G, W/O SIGNIF OR PROC, W MULT MAJOR PROB	465	\$12,853,261.56
621: Neonate, Birthwt 2000-2499g, w/o Signif or Proc, w Other Prob	391: NORMAL NEWBORN	333	\$603,896.48
112: No Longer Valid	558: PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	333	\$11,267,135.15
483: No Longer Valid	541: ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	326	\$128,645,046.23
483: No Longer Valid	542: TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	234	\$55,003,819.68

Table 7
Overview of new DRGs by MDC

MDC	New DRG V23	Case	Covered Charge
01: Diseases and disorders of the nervous system	524: TRANSIENT ISCHEMIA	151	\$1,681,818.82
05: Diseases and disorders of the circulatory system	554: OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	208	\$8,520,675.76
	557: PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	250	\$10,883,910.02
	558: PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	342	\$11,620,104.25
08: Diseases and disorders of the musculoskeletal system and connective tissue	544: MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	582	\$21,481,945.43
20: Alcohol/drug use and alcohol/drug induced organic mental disorders	521: ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	563	\$5,256,126.08
More
Total (39 New DRGs) in Non-Medicare Claims of SFY 2005 Data		4,487	\$347,893,676

Calculation of outlier thresholds

DRG Outlier:

Using claims from SFY 2004 and 2005, a particular claim was considered to be a DRG outlier if it met both of the following criteria:

- a) The cost of the claim was greater than the DRG-specific mean plus three standard deviations, and
- b) The cost of the claim was greater than the overall mean of all claims (all DRGs) plus two standard deviations.

MDC Outlier:

Using claims from SFY 2005 only, a particular claim was considered to be a MDC outlier if it met both of the following criteria:

- a) The cost of the claim was greater than the MDC-specific mean plus one standard deviations, and
- b) The cost of the claim was greater than the overall mean of all claims (all MDCs) plus two standard deviations.

Table 8
Examples of claims and payments identified as outliers – v16 vs. v23

Hospital	Service Start Date	Covered Charges	DRG V16 and Paid Payment			DRG V23 and Projected Payment		
			DRG	Outlier/Inlier	Paid Payment	DRG	Outlier/Inlier	Projected Payment
Egleston Childrens (000000943A)	12/31/2004	\$84,417.50	292	Outlier	\$45,931.61	292	Inlier	\$20,674.48
	07/27/2004	\$86,083.50	124	Inlier	\$11,011.48	124	Outlier	\$37,344.99
	07/06/2004	\$167,753.50	103	Inlier	\$72,141.65	144	Outlier	\$69,936.91
	11/21/2004	\$92,528.25	627	Outlier	\$49,661.46	626	Inlier	\$12,421.22
Grady Memorial (000000855A)	07/24/2004	\$154,284.66	415	Outlier	\$58,648.72	415	Inlier	\$24,102.72
	11/27/2004	\$160,834.88	191	Inlier	\$13,424.34	191	Outlier	\$66,494.83
	09/25/2004	\$262,199.84	506	Inlier	\$8,968.87	504	Outlier	\$107,689.72
Shepherd Spinal Center (000248069A)	09/07/2004	\$97,305.33	002	Outlier	\$51,043.87	001	Inlier	\$44,257.58
	12/06/2004	\$73,216.63	477	Outlier	\$40,229.63	477	Inlier	\$25,374.61

Calculation of Relative Weights

- Inliers of DRG (SFY 2004 and 2005) or MDC (SFY 2005 only) with a valid sample size are used to calculate relative weights.
- DRG relative weight is calculated as: $\text{Average Cost per DRG} \div \text{Overall Average Cost}$
- MDC relative weight is calculated as: $\text{Average Cost per MDC} \div \text{Overall Average Cost}$
 - MDC-based relative weights are adjusted by complications.

Table 9
Case mix by hospital example – v16 vs. v23

Provider	SFY 2001 DRG v16			SFY 2005 DRG v23		
	Cost/Case	Case Mix	Case Mix Adjusted Cost/Case	Cost/Case	Case Mix	Case Mix Adjusted Cost/Case
Egleston Childrens	\$11,558	2.441	\$4,736	\$13,444	2.232	\$6,024
Grady Memorial	\$4,148	1.210	\$3,427	\$5,784	1.052	\$5,501
Shepherd Spinal Center	\$30,715	3.635	\$8,450	\$38,224	3.594	\$10,635

Hospital-Specific Case-Mix Factors calculation steps:

Step 1: The number of cases in each DRG (within each hospital) is multiplied by the relative weight of the DRG to obtain a factor for each DRG for SFY 2005 claim data.

Step 2: The resulting DRG factors from Step 1 are summed across all DRGs within each hospital.

Step 3: The summed factors from Step 2 are divided by the total number of cases within each hospital.

Table 10
Calculation of base rates

Peer Group Base Rates are calculated by summing the case-mix adjusted total costs for each hospital in the peer group and dividing this by the total number of claims in the peer group. Only SFY 2005 inliers are used for the calculation of base rates.

Peer Group	Base Rate
Pediatric	\$5,731.89
Statewide	\$5,096.13
Specialty	\$8,495.39

Peer Group Base Rate Formula:

$$\frac{\Sigma (\text{Provider Total Cost} / \text{Provider Case Mix})}{\text{Peer Group Claim Count}}$$

Table 11
Discussion of specialty hospital base rates

A much greater case-mix coefficient of variation in the specialty peer group is found in SFY 2005 data, indicating it is inappropriate to use the calculated peer base rate for this group.

Peer Group	SFY 2005 Case-mix Factor		
	Average	Std Dev	Coeff. of Variation
Pediatric	1.825	0.433	23.72%
Specialty	3.530	4.160	117.84%
Statewide	0.944	0.306	32.42%

Therefore, the hospital-specific rates are used for the specialty peer group. This table shows the base rates, the average length of stay (LOS), and the rate per day to compare across peer groups and across hospitals within the specialty peer group. Length of stay is based on SFY 2005 inliers only.

Peer Group	Base Rate	Avg. LOS	Rate/Day	Average Case-Mix	(Avg Case-Mix × Base Rate)/Day
Pediatric	\$5,731.89	6.0	\$959.62	1.825	\$1,743.21
Statewide	\$5,096.13	4.4	\$1,156.90	0.944	\$1,093.56
Specialty		22.1	\$383.77	3.530	\$1,356.97
Kindred	\$3,666.57	40.3	\$90.90	12.489	\$1,136.24
Walton Rehabilitation	\$6,567.78	12.9	\$509.31	1.334	\$678.98
Wesley Woods Geriatric	\$8,798.39	10.0	\$876.35	1.110	\$976.97
Shepherd Spinal Center	\$10,635.34	34.6	\$307.58	3.594	\$1,104.72
Roosevelt Warm Springs	\$12,917.47	27.9	\$463.12	1.424	\$659.21