

Overview of Changes to the Medicaid Inpatient and Outpatient Hospital Reimbursement System

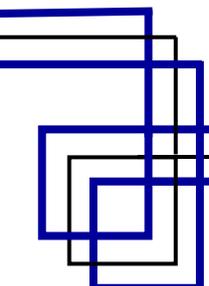
September 29, 2005

Rebasing the Inpatient System



Overview of the Process

The Rebasing Process



- ❑ Determine the base year for the claims
- ❑ Determine the base year for the cost reports
- ❑ Calculate the capital and GME add-ons
- ❑ Create the rate setting claims database
- ❑ Calculate the cost of the claims
- ❑ Identify and remove outliers
- ❑ Perform stability analysis
- ❑ Calculate relative weights
- ❑ Calculate the case-mix of each hospital
- ❑ Calculate the peer group base rates

The Base Year

- ❑ The base year is the year from which claims will be used to create the reimbursement system.

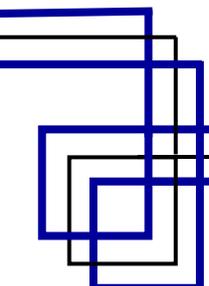
Current System	Rebased System
The base year used was State Fiscal Year (SFY) 2001	The base year will be SFY 2004
Data from July 1, 1998 to June 30, 2001 (SFYs 1999 through 2001 were used when necessary for low-volume DRGs)	Data from July 1, 2001 to June 30, 2004 (SFYs 2002 through 2004 will be used when necessary for low-volume DRGs)

Cost Report Base Year

- Data from the cost reports will be used to calculate the operating cost-to-charge ratios, the capital add-on, and the GME add-on.

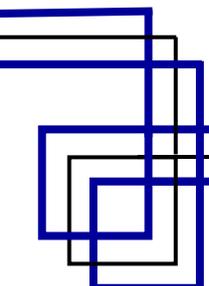
Current System	Rebased System
1999 audited cost reports or the most recently audited cost report prior to 1999 if 1999 was not audited are used.	The 2003 cost reports or the most recently submitted cost report prior to 2003 will be used.

Capital and GME Add-ons



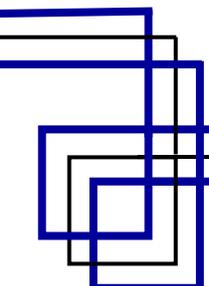
- ❑ Both the capital and graduate medical education (GME) add-ons will be calculated in the same manner as the current system.
- ❑ Capital:
 - Capital from the cost report is not inflated
 - A per case payment is calculated
- ❑ GME
 - GME from the cost report is inflated
 - A per case payment is calculated

Creating the Rate Setting Claims Database



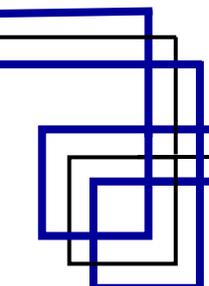
- ❑ In order to set the rates, a “clean” rate setting claims database is created. This ensures that the rates are set using typical claims.
- ❑ The following claims are removed to “clean” the data:
 - All claims except the final claim in a group of reprocessed claims
 - Claims with a net payment of zero
 - Interim claims
 - Next day readmissions with similar diagnoses

Creating the Rate Setting Claims Database



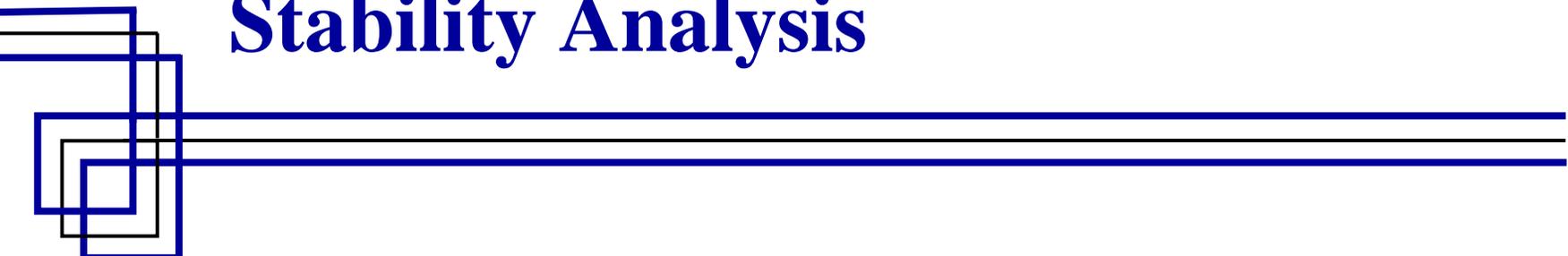
- The following claims are removed to “clean” the data: *(continued)*
 - Transfers
 - Out-of-state hospital claims
 - Claims from Georgia hospitals that did not have cost-to-charge ratio data (either closed or no cost report)
 - Same-day discharges
 - Readmissions
 - One day stays for certain DRGs
 - Low charge claims for certain DRGs

Calculating Costs



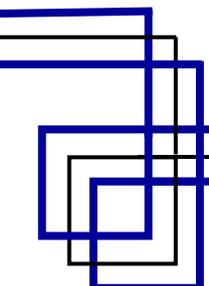
- ❑ An operating cost-to-charge ratio is calculated for each hospital using data from the cost reports.
- ❑ Charges from the claims are converted to operating costs by multiplying the charge on the claims by the hospital specific operating cost-to-charge ratio.
- ❑ The operating costs of the claims are inflated forward to a common point in time.

Stability Analysis



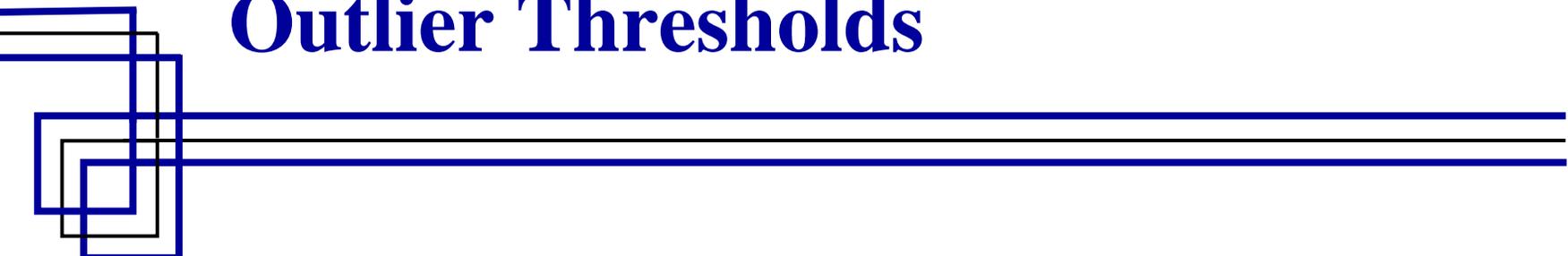
- ❑ When setting the rates for a DRG system, it must be determined if the number of cases falling into each DRG is adequate for accurate and statistically reliable rate setting.
- ❑ If rates are set on a DRG with an inadequate number of cases, financial risk will result from the fact that the cases used to set the rates may not be representative of future cases.

Stability Analysis *(continued)*



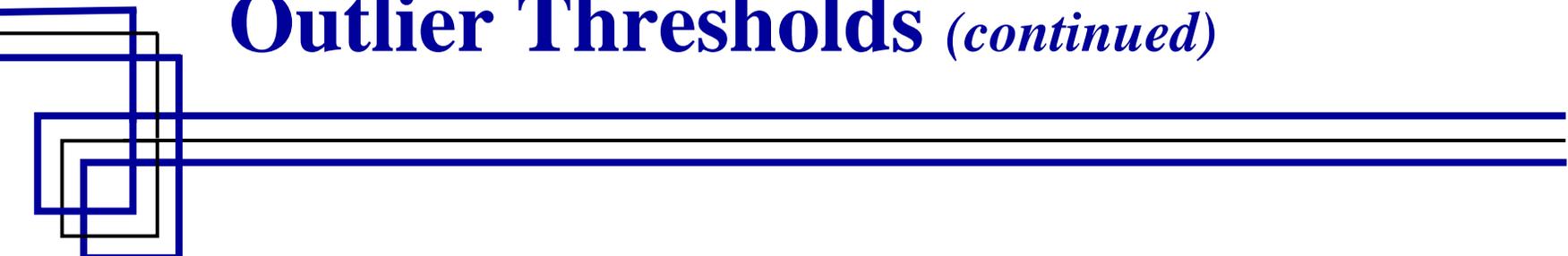
- A DRG sample is considered to be statistically reliable if:
 - there are enough claims at the 90 percent level of confidence and if the coefficient of variation (the standard deviation divided by the mean) is less than 100 percent, **or**
 - there are enough claims at the 95 percent level of confidence regardless of the coefficient of variation.

Outlier Thresholds



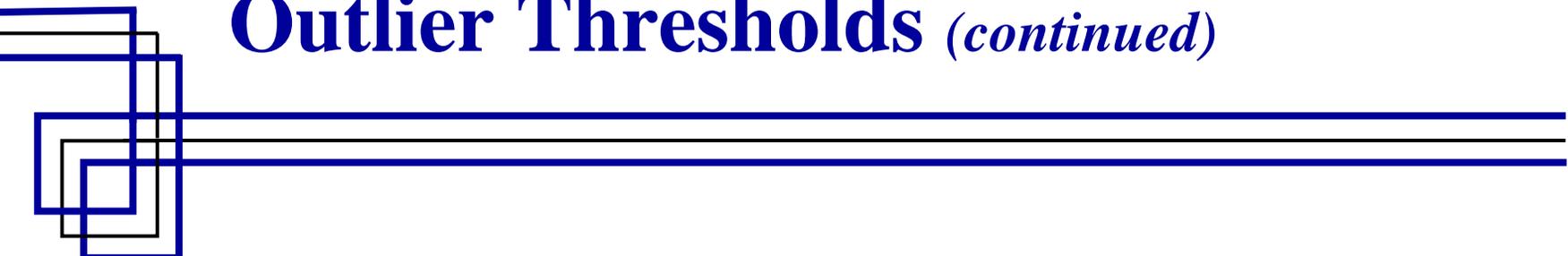
- ❑ In developing a DRG system, claims that have similar diagnostic and resource need characteristics are grouped together for reimbursement purposes.
- ❑ In any system, there will be claims that are similar based on diagnosis but fall outside of the cost range of most claims with the same or similar diagnosis. These claims are considered outliers.

Outlier Thresholds *(continued)*



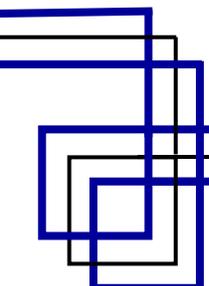
- For claims that meet the stability analysis criteria at the DRG level, a claim is identified as an outlier if it meets both of the following criteria:
 - The cost of the claim is greater than the DRG-specific mean plus three standard deviations; and
 - The cost of the claim is greater than the overall mean of all claims (all DRGs) plus two standard deviations.

Outlier Thresholds *(continued)*



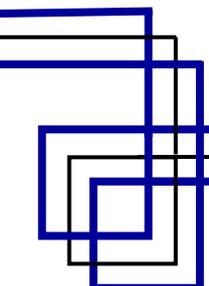
- For claims that do not meet the stability analysis criteria at the DRG level and are thus grouped to an MDC, a claim is identified as an outlier if it meets both of the following criteria:
 - The cost of the claim is greater than the MDC-specific geometric mean plus one standard deviation; and
 - The cost of the claim is greater than the overall mean of all the MDC-level claims plus two standard deviations.

Relative Weights



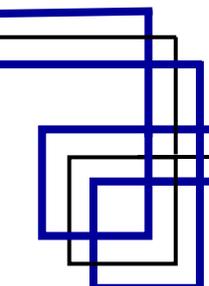
- ❑ The relative weight is a measure of the relative intensity of services within a DRG when compared to the average intensity of services across all cases.
- ❑ The DRG system contains several pairs of DRGs that are different only in that one member of the pair specifies “with complications or co-morbidities,” (w/CC) while the other member specifies “without complications or co-morbidities” (w/o CC).
- ❑ If the relative weight for the DRG without complications was higher than the DRG for the DRG with complications, the relative weight of one of the DRGs is adjusted to make them equal.

Case-mix



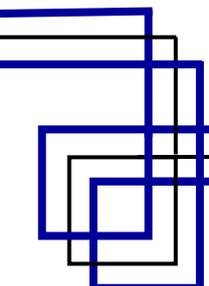
- The case-mix factor serves two important purposes:
 - It measures the overall intensity of cases for each hospital.
 - It adjusts hospital base rates by their case-mix factors to obtain a case-mix adjusted standardized base rate.
- Hospital-Specific Case-Mix Factors are calculated as follows:
 - Step 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.
 - 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.

Peer Group Base Rates



- Calculating the peer group base rates is a two-step process
 - Step 1:** The hospital-specific base rates (also referred to as the case-mix adjusted cost per case) are calculated for each hospital by dividing the average cost per case for the hospital by the hospital-specific case-mix factor.
 - Step 2:** The 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.
- Specialty hospitals are allowed to use the greater of the hospital-specific base rate or the peer group base rate.

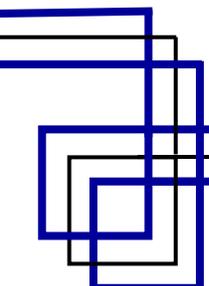
Future Changes to the Inpatient System



- ❑ Alternative methods to outliers, reimbursement of transfers, readmissions, and short stays will be reviewed.

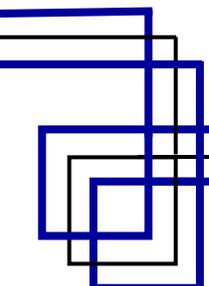
- ❑ The review will examine other systems such as methodologies used by:
 - Other states
 - Medicare
 - Private payers

The Outpatient System



Moving Forward Examining Reform

The Need for Change



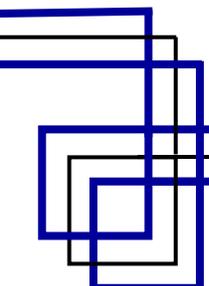
- ❑ With the implementation of the Medicare Outpatient Prospective Payment System (OPPS) in 2000, there has been considerable interest from Medicaid agencies to adopt this methodology or one that is based on the principles of a prospective fee-based system.
- ❑ The Department needs to provide better predictability of outpatient costs, especially with the increasing volume of services provided in this setting.
- ❑ Fee-based methodologies allow states to more equitably provide payment across all hospitals, which is a critical flaw in a CCR-based or other retrospectively-based system.

Alternative Systems



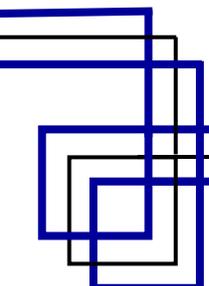
- ❑ EP&P completed an examination of how other state Medicaid agencies pay for outpatient hospital services through our work with Arizona's Medicaid program.
- ❑ EP&P is working with the Department to develop a prospectively based fee schedule methodology.
- ❑ Alternatives include:
 - Medicare OPPS
 - A “Medicare like” system
 - A Medicaid specific system

Medicare OPPS



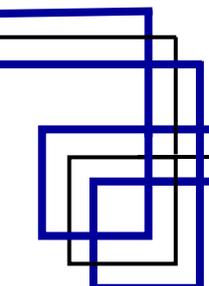
- ❑ While the system is tested and well known there are issues with using it for Medicaid. For example:
 - Differences in the populations served between Medicare and Medicaid
 - Some services utilized in Medicaid programs that are not specifically addressed in the OPPS
 - The level of effort that a state Medicaid agency would want to undertake with respect to ongoing maintenance of the fee schedule versus the level that Medicare takes

“Medicare Like” System



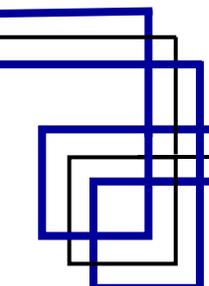
- ❑ These types of systems use parts of the OPPS system but are modified to meet a state’s Medicaid agency’s needs.
- ❑ The systems are fee schedule based but include major features that are similar to the Medicare OPPS:
 - Grouping procedures into Ambulatory Payment Classifications (APCs) for ratesetting purposes
 - Grouping items that bundle with surgery and ED claims for pricing purposes

“Medicare Like” System *(cont.)*



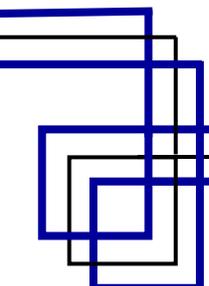
- ❑ Data used to set fees can be from hospital-specific Medicare Cost Reports and claim/encounter data.
- ❑ Each cost-based fee derived can be compared to the comparable Medicare fee.
- ❑ If there was not sufficient cost data from hospitals for a given procedure, then the Medicare fee for the procedure can be used as the default fee.

Medicaid Specific System



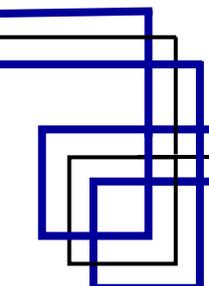
- ❑ The Department has also tasked EP&P with identifying fee schedule methodologies used by Medicaid agencies that are not based on the Medicare OPPS
- ❑ These may include payment of some services by a flat fee for all details on a claim or a piece-meal summation of payments of all details on a claim with a not-to-exceed amount

Data Analysis



- ❑ In order to make a recommendation, the current outpatient claims data must be examined.
- ❑ EP&P has conducted preliminary analysis of the claims data and has assessed that there is sufficient stable data to evaluate different fee-based options.

Key Items

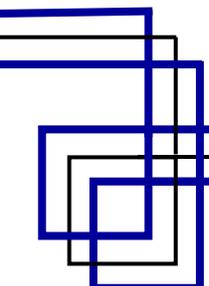


The following are key items that must be addressed and will determine the type of system that can be implemented:

Data Related

1. The base year of costs to set fees on—state fiscal vs. hospital-based year
2. Identifying noncovered charges on outpatient claims

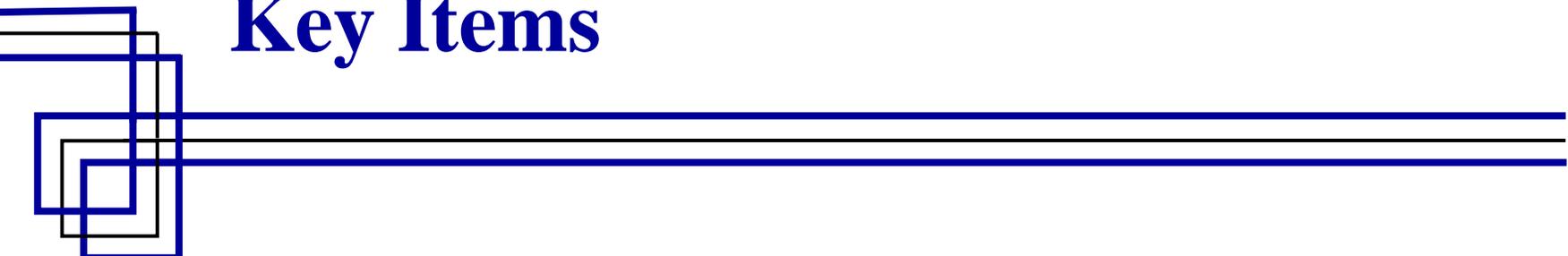
Key Items



Data Related (continued)

3. Identifying criteria to exclude certain claims from the ratesetting dataset that could artificially skew rates
4. Identifying the source and calculating the amount of inflation to apply to costs
5. Identifying the logical mappings of procedures to revenue codes in an effort to test the validity of the data (e.g. are the ER procedures always billed on a detail with a 45x revenue code?)

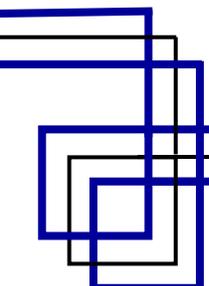
Key Items



Data Related (continued)

6. How to handle claims with missing procedures, nonvalid procedures, and details where the unit value was zero
7. Criteria for identifying new procedures and those that changed service definition as well as the data source to use for their costs

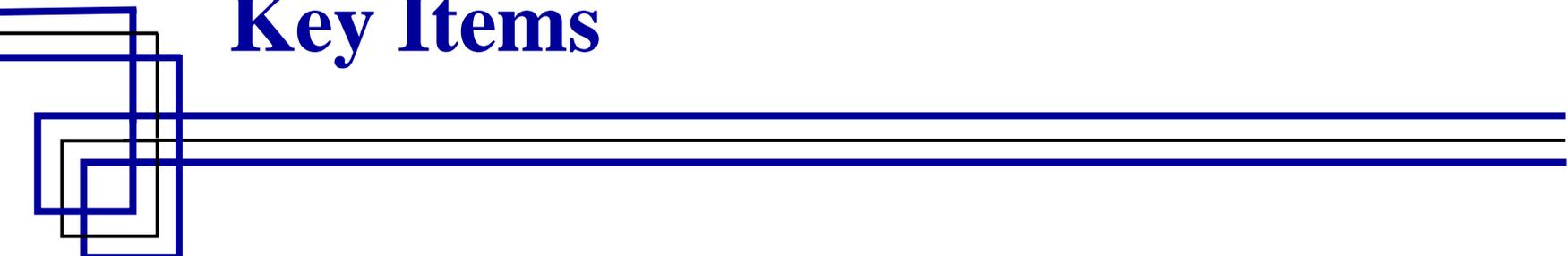
Key Items



Policy Decisions

1. Under what conditions could/should Georgia default to a Medicare fee
2. Under what conditions to default to another published fee
3. Under what conditions should a CCR be used instead of a flat fee

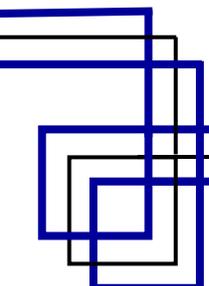
Key Items



Policy Decisions (continued)

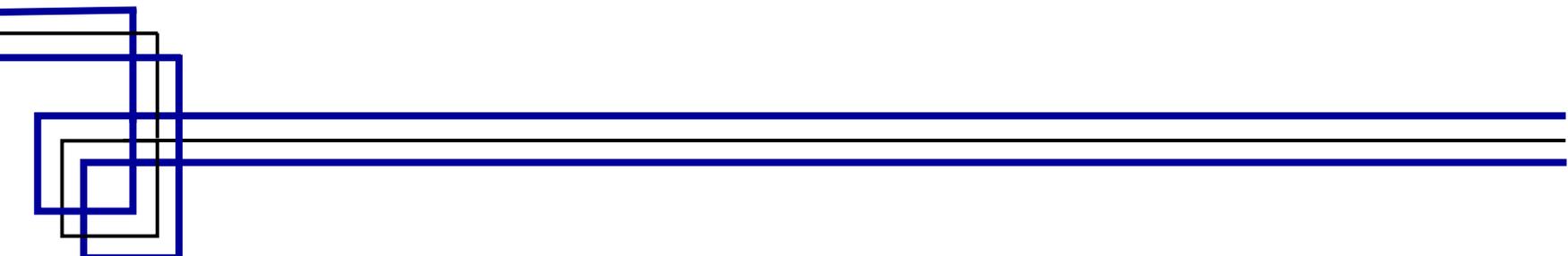
4. Which methodology features from the Medicare OPPS system should be adopted in the development of fees and payment of procedures in the new system:
 - Creating bundled rates for primary procedures such as surgery
 - Adopting Medicare’s Ambulatory Payment Classification (APC) methodology to group costs in setting rates
 - Creating pricing methodology for procedures where a modifier is required, e.g. claims with multiple surgery procedures present
 - Whether or not an outlier policy should be implemented in the new system

Key Items



Policy Decisions (continued)

5. Whether or not the fee schedule will be statewide or vary by peer groups
6. How often to make adjustments or to rebase the new fee schedule



Questions and Answers