Georgia Inpatient DRG Weight Setting Process, FY 2014

Parameter to be Addressed	Current Methodology	Updated Methodology	Reasoning
Grouper Software:			
Medicaid DRG Version	Tricare Version 24	Tricare Version 30	Most recent version available at time of data processing.
Determination of Claim Set:			
Date Range for Claims Set	1-year local claims set for initial weights; 2-year local claims set for fallback weights	1-year claims set only, includes FFS and CMO claims, dates of discharge 7/1/2011 - 6/30/2012	In order to ensure the relative weights reflect current best practices from Georgia Medicaid providers recommendation was made to use the most current 1 year claims set . This along with the changes in statistical stability count discussed below expands the number of Georgia Medicaid based weights.
Exclusions from Claims Set - Weight Setting versus Fiscal Impact	Claims temporarily removed for weight setting but included in fiscal impact: Closed Providers, Out-of-State providers, Zero-Paid Claims, Ungroupable claims, Low-Charge Claims except certain DRGs, Same-DRG Transfers, Readmissions or Early Discharges within 3 days for same DRG and same provider, Same-Day or One-Day Discharges except for death or false labor or Normal Newborn, Border Providers, Excluded Hospitals	Include CMO claims in weight setting and fiscal impact models. Remove following types of claims prior to weight setting or fiscal impact: All claims from providers without cost reports (including Closed and Out-of-State), Zero-Paid FFS Claims, Ungroupable claims, Excluded Hospitals, Undischarged Patients, FFS claims with TPL > 25% of total payments. Exclude from weight setting but include in fiscal impact: Low-cost claims, all transfers, Same-Day Discharges (but not 1-day discharges) except for death or false labor or normal newborn.	Reimbursement based on Georgia Medicaid program and providers moving forward.
Low-Cost/Charge Claims	Claims with charges < $500 and not certain newborns or maternal diagnoses and not deaths are temporarily removed from weight setting but included in fiscal impact	All claims with cost < $350 and below 10% of average DRG claim cost are removed from weight setting but included in fiscal impact	Changing low cost limit to $350 to ensure less expensive nursery cases included while 10% lower limit for higher cost DRGs excludes problematic claims data.
Combined Interims	Combine interim bills that have same PCN, provider number, and contiguous dates of service (maximum 1 day between dates of service).	**{Current Methodology Will Be Used}**	
Claims Costing:			
Cost Estimation of Claims	Claim cost is determined using operating per diems and cost-to-charge ratios from cost report. DRG weight is based on operating cost with capital cost applied from survey data only for rate setting.	**{Current Methodology Will Be Used}**	
Medical Education Costs	Direct Medical Education is not included in calculation of operating cost-to-charge ratios. DME surveys are used to calculate total DME cost to add to the rates at qualifying faculties. Indirect Medical Education is not removed from claim costs.	**{Current Methodology Will Be Used}**	
Inflation Method	Total cost of each claim is inflated to common date based on claim discharge date.	Component cost of detail line items are inflated to common date, specific to routine or ancillary items. Routine revenue codes are inflated from mid-point of cost report period. Ancillary revenue codes are inflated from claim discharge date. Common inflation endpoint date will be 12/31/2013.	More accurate representation of inflation.

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DRG Weight Setting:			
High-Cost Outlier Claims	Excluded from DRG weight setting	Included in DRG weight setting, capped at preliminary outlier threshold	Non-outlier portion of DRG claim included as a high cost case to provide more accurate average cost for DRG. Costs above outlier threshold are excluded from weight setting since they are reimbursed under outlier program.
DRG Outlier Thresholds	Calculated threshold is maximum of statewide average DRG cost + 2 standard deviations or specific DRG average cost + 3 standard deviations OR average DRG cost of MDC + 3 standard deviations for fallback weights	**{Current Methodology Will Be Used}**	
Statistical Stability Count	DRG must have minimum claim count to yield 90% confidence interval that mean is within 10% of true mean.	DRG must have minimum claim count to yield 75% confidence interval that mean is within 15% of true mean.	One of the Department's goal is to reimburse as many claims as possible based on actual historical GA Medicaid claims. This approach allows more DRG weights to be based on GA Medicaid claims data and better matches reimbursement with provider costs instead of MDC based weights.
Secondary / External Weight Sources	Weight source for unstable DRGs using 1-year claims set is weights based on 2-year claims set. If DRG weight is still unstable, use 1-year MDC average weight.	Weight source for unstable DRGs is based on regional all-payer claim set from similar state data (HCUP). If secondary DRG weight is still unstable, use national Tricare DRG weight.	With change in statistical stability count more DRG weights are already based on historical GA Medicaid claims. All payor sample based on regional states. Approximately 2.5% of total claims reimbursed using these alternative weight sets.
Anomalous Weights for Pairs & Triplets	Anomalous weights are equated to calculated weight of higher-priority or higher-complexity DRG, e.g. use 1-year DRG mean above 2-year DRG mean and 2-year DRG mean above MDC mean.	Anomalous weights are equated by weight-volume equally among DRG weights, regardless of source, such that total weight of claims remains equal before and after adjusting, i.e. weight favors DRG with more claims.	Weighted average results in zero fiscal impact.