



Georgia Medicaid Inpatient Prospective Payment System: Proposed Methodology Changes



Presentation to: Hospital Advisory Inpatient Payment Subcommittee
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Mission

The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

We are dedicated to A Healthy Georgia.

Overview of Inpatient Prospective Payment System (IPPS)



IPPS Reimbursement Overview

Georgia Medicaid and PeachCare reimburse inpatient hospital care through a Inpatient Prospective Payment System (IPPS).

- Georgia adopted the IPPS model in the late 1990s.
- Most states and Medicare use the IPPS model.
- Preference for model because payment rates are based on average resources used which rewards hospitals that are more efficient and cost effective.
- The IPPS model groups inpatient admissions that have similar characteristics and require similar resources into DRGs (or Diagnostic Related Groups). Each DRG has a payment weight assigned to it, based on the average resources used to treat patients in that DRG.

DCH spends about \$1.47 billion annually for inpatient care provided by hospitals under the Medicaid and PeachCare programs (includes both FFS and CMOs). This expense constitutes 15% of ALL Medicaid and PeachCare expenditures.

Current Georgia IPPS Methodology Components

- **As of April 1, 2014, the current payment is based on the Tricare Version 30 Grouper and financial data for 2011 and 2012.**
- **Hospitals are divided into 1 of 3 Peer Groups:**
 - *Statewide*
 - *Pediatric*
 - *Specialty*
 - *Each peer group has a base rate which is determined by hospital costs*
- **The base payment is calculated as the base rate times the DRG weight assigned to the inpatient case.**
- **Each claim receives a hospital specific per case add-on for Capital and Graduate Medical Education (if applicable).**
- **High cost claims may qualify for an Outlier Payment in addition to the base payment.**

IPPS Reimbursement Overview

DCH proposes to change the IPPS Reimbursement because:

- The current model components have been in place unchanged since the late 1990s. Grouper and cost updates have been infrequent.
- To be effective the methodology should be updated at least every 2 to 3 years to keep pace with industry changes and costs. Certain components must be updated annually. Updates are necessary to control overall costs to the state and ensure appropriate payment across hospitals.
- DCH has heard numerous concerns regarding the payment methodology from hospitals and internal/external subject matter experts.
- DCH has developed policy objectives and guidelines associated with Medicaid and PeachCare inpatient hospital payments. The current IPPS methodology does not address these policy objectives and guidelines. (*Note – policy objectives and guidelines are detailed on slide 10*).



IPPS Timeline and Update Process



ICD 10 Considerations for IPPS Timeline and Proposal

- On April 1, 2014, DCH updated the IPPS DRG version and hospital cost data for the first time since January 1, 2008.
- The April 2014 update was critical to comply with the federally mandated update to the International Classification of Diseases (ICD) 10 system.
- ICD 10 was originally scheduled to be effective October 1, 2014. The IPPS update was necessary as without it DCH could not pay claims on October 1, 2014 in an ICD 10 environment.
- While DCH successfully updated the IPPS on April 1, 2014, the ICD 10 transition was delayed until October 1, 2015.
- DCH will be able to pay claims under the current grouper in an ICD 10 environment. However, to mitigate potential ICD 10 fiscal liabilities, DCH will update to an ICD 10 native grouper (Tricare Version 33) as soon as feasible after October 1, 2015 (Tentative date is January 1, 2016).

IPPS Update Process and Timeline

DCH Current Proposal Update Process

- **DCH began discussing methodology issues and concerns with the hospitals in Spring 2014.**
 - DCH Hospital Advisory IPPS Subcommittee met to discuss hospital concerns and methodology suggestions on May 22, 2014.
 - Hospitals were given the opportunity to submit comments to DCH via email through June 2014.
 - In August 2014, DCH convened a small group of hospital representatives to preview the DCH proposal.

DCH Current Proposal will be implemented in 3 phases (*detail on phases presented in upcoming slides*):

- **Phase 1: Effective July 1, 2015**
- **Phase 2: Effective January 1, 2016**
- **Phase 3: Effective July 1, 2016**

A detailed timeline for each phase is presented on slide 37.

DCH Approach to IPPS Review and Proposal



IPPS Methodology: Guidelines and Policy Objectives

DCH proposes to change the Medicaid IPPS Methodology based on the following agency guidelines and policy objectives:

Guidelines:

1. Changes must be **budget neutral**.
2. Methodology must support **regular updates on a predictable schedule**.

Policy Objectives:

1. **Promote efficiency** in the delivery of services by:
 - Creating appropriate incentives to **reduce/control costs**; and
 - Better **match reimbursement with the services provided**.
2. Promote and support Governor's policy objective to **enhance the physician workforce through graduate medical education programs**.
3. **Focus payment methodology on service delivery for Medicaid members**.



Current IPPS Methodology Components Reviewed

DCH reviewed and/or is proposing changes to the following 4 IPPS methodology components that constitute the basis for the current methodology:

1. Peer Groups
2. Capital Reimbursement
3. Graduate Medical Education (GME)
4. Outlier Payments

DCH is proposing 2 new methodology changes to address agency policy objectives.

Peer Groups

IPPS Methodology: Peer Groups

Current Approach:

1. Hospitals are divided into 1 of 3 Peer Groups:
 - **Statewide** – Covers 144 hospitals
 - **Pediatric** – Covers 3 hospitals
 - **Specialty** – Covers 5 hospitals
2. Operating or base rates are assigned to the statewide and pediatric peer groups based on the average cost of each peer group.
3. The specialty peer groups receive a hospital specific base rate. This is because of the variation in specialty across the 5 hospitals in the group.
4. Each peer group receives the same discount factor to maintain overall budget neutrality.

DCH Concerns:

The current peer group approach does not reflect actual variation across hospitals on a cost and acuity basis.

DCH Revised Methodology:

DCH is unable to address peer group concerns at this time because of the fiscal impact on individual hospitals. DCH will evaluate peer groups in the future.

Capital Reimbursement



IPPS Methodology: Capital Reimbursement

Current Approach:

1. DCH reimburses capital expenditures by using a hospital specific add-on based on hospital cost.
2. Approach uses hospital cost report information (Worksheet A) and hospital surveys at the time of rebasing. **Capital reimbursement is set at 100% of cost.**

DCH Concerns:

1. **Does not appropriately match reimbursement with services provided.** By reimbursing at 100% of cost, current approach **puts emphasis on bricks and mortar as opposed to service delivery.**
2. Due to budget neutrality requirement, to **maintain the 100% capital reimbursement, the cost must come out of the hospital base rate.**
3. Emphasis on capital **disadvantages smaller markets and slower growing communities** that cannot support capital intensive projects.



IPPS Methodology: Capital Reimbursement

DCH Revised Methodology (Effective July 1, 2015):

1. Capital costs will be **included in the base rate** and subject to the same **budget neutrality factor** as other operating costs.
2. Capital costs will be **rebased every 2 to 3 years** along with all hospital operating costs.
3. Use Worksheet B as source information.

Adherence to DCH Policy Objectives:

1. Promotes **efficiency** by more **appropriately matching reimbursement to services delivered**.
2. **Removes inappropriate incentive** for hospitals to maximize capital costs.



Graduate Medical Education



IPPS Methodology: Graduate Medical Education

Current Approach:

1. DCH reimburses Graduate Medical Education (GME) through a hospital specific add-on based on GME program costs. GME reimbursement is set at 100% of cost.
2. The GME add-on is only adjusted during rebasing periods.

DCH Concerns:

1. Current GME **reimbursement is utilization driven** and may not reflect costs appropriately across participating hospitals.
2. Due to budget neutrality requirement, to **maintain the 100% GME reimbursement, the cost must come out of the hospital base rate.**
3. **Indirect Medical Education is not currently reimbursed** by GA Medicaid. *IME is an adjustment that factors in the higher costs of teaching hospitals.*
4. **Timeliness of GME payments tied to CMO claims.** Currently, DCH makes these payments but there is a lag in reimbursement due to timing of DCH receiving and processing CMO encounter data.



IPPS Methodology: Graduate Medical Education

DCH Revised Methodology (Effective July 1, 2015):

1. **Reimburse GME outside of the IPPS claims payment process by establishing a Medicaid GME Payment Pool.**
2. Pool will be **funded at \$41.6 million** (based on current IPPS model estimated expenditures) and allocated based on the percentage of each hospital's GME expenditures.
3. DCH will make **quarterly payments from the Medicaid GME Payment Pool beginning September 30, 2015.**
4. Reimburse Indirect Medical Education. See Slides 27 - 29 for detail.

IPPS Methodology: Graduate Medical Education

DCH Revised Methodology (Effective July 1, 2015):

5. Approach for Covering New Hospital GME Programs:

- 19 hospitals currently receive GME.
- Over the next few years the State, through the Board of Regents, plans to provide startup funds for a significant number of new GME programs.
- Once these new programs are established, the associated costs will be funded out of the Medicaid GME Payment Pool.
 - *New programs will receive Medicaid GME funds once their filed annual cost reports include the costs of the filled residency slots.*
- DCH's intent would be to request the necessary funds to support the Pool through the annual Appropriations Process, so that the Pool increases as GME programs grow.

DCH will convene a committee consisting of DCH, hospitals, GBPW and Regents to identify criteria for future Medicaid GME participation and to determine the payment allocation approach.

IPPS Methodology: Graduate Medical Education

Adherence to DCH Policy Objectives:

1. **More appropriately matches reimbursement to services.**
 - Ensures that utilization increases do not result in unanticipated payments.
2. Promotes and support Governor's policy objective to **enhance the physician workforce through graduate medical education programs**
3. An established pool of funds, independent of the IPPS claims and linked to the State's physician workforce and graduate medical education programs **may make it easier to secure necessary funding increases through the Appropriations Process.**



Outlier Payments



IPPS Methodology: Outliers

Current Approach:

1. DCH makes outlier payments to **mitigate hospital risk associated with unusually high cost cases.**
 - DCH reimburses a higher payment when costs exceed the DRG-specific outlier threshold.
 - Each case must be first reviewed/approved by DCH prior to reimbursement.
This review is a manual process.
2. The **outlier payment is 89.3% of the difference between the estimated cost of the claim and the allowed inlier payment for the DRG.**



IPPS Methodology: Outliers

DCH Concerns:

1. The current process is **resource intensive and time consuming** for both DCH and hospitals and **creates time delays for actual payment.**
2. The current outlier formula results in **duplicate payments for a portion of the claim** (which allocates funds away from operating payments):
 - Outlier payments are **generally based on the difference between the estimated claim cost and the outlier threshold** with the allowed inlier payment covering all costs up to the outlier threshold.
 - However, the **GA Medicaid outlier payment is calculated on the total allowable cost back to the first dollar rather than being calculated on the cost in excess of the outlier threshold.**
 - *A claim that is \$1 over the outlier threshold may result in a payment \$30,000 or greater than a claim that is \$1 below the outlier threshold.*
3. Outlier percent of payment at **89.3%** is much higher than what is normally seen in other programs and exceeds the inlier cost average. Typical percent of payment is between 70-80%.

IPPS Methodology: Outliers

DCH Concerns (continued):

In summary, the DCH current outlier system:

- Process is inefficient and results in **undue hurdles to reimbursement.**
- **Creates an inappropriate incentive to reach the outlier threshold (\$1 in additional cost may trigger a payment exceeding \$30,000).**
- Results in an **overlap in reimbursement coverage** between the DRG inlier payment and the outlier payment.
- Percent of Payment at 89.3% is higher compared to other outlier programs.

IPPS Methodology: Outliers

DCH Revised Methodology (Effective July 1, 2016 – not July 1, 2015):

- 1) **Automate** outlier payments.
- 2) Base **payment** on the **difference between the estimated cost of the claims and the outlier threshold**.
- 3) Change in the **statistical outlier formula to the maximum of \$35,000 or average cost plus 1.96 standard deviation**.
- 4) Perform **post payment audit** of all payments considered high risk and a sample audit of lower risk payments.

Adherence to DCH Policy Objectives:

- 1) An automated outlier payment process, with a post payment audit, should **promote DCH and hospital efficiency by reducing administrative costs associated with the current manual review and approval process**.
- 2) The redirection of a small number of high payment outliers cases to an increased number of low payment outlier cases **creates the proper incentives for the hospitals to increase cost control on outlier cases**.

Indirect Medical Education (IME) Factor (New Component)



Indirect Medical Education Calculation (New)

DCH has historically reimbursed teaching hospitals for the direct cost of residents but payments have not reflected the higher indirect costs incurred by teaching hospitals.

- To recognize these higher costs, an **Indirect Medical Education (IME) rate factor** will be applied to the base rate.
- Reimbursement for IME would be carved out of the overall program expenditures to maintain budget neutrality.

The IME adjustment adheres to the DCH policy objective to promote and support the Governor's efforts to enhance the physician workforce through graduate medical education programs.

IME supports GME programs by leveling cost discrepancies between teaching and non-teaching hospitals and targets reimbursement toward the additional costs associated with teaching programs that serve Medicaid.

The IME adjustment will be implemented on July 1, 2015.



Indirect Medical Education (IME) Calculation

DCH Revised Methodology (continued):

An **Indirect Medical Education (IME) rate factor** will be applied to the base rate. Reimbursement for IME will be carved out of the overall program expenditures to maintain budget neutrality.

IME expenses will be reimbursed using the Medicare IME calculation formula:

- If the hospital is an approved teaching hospital, it receives a percentage adjustment to the operating rate for each case. This percentage varies by hospital, depending on the ratio of residents to beds.
- The IME formula multiplier is 1.35 for discharges occurring during FY 2015
- Medicare IME formula = $1.35 * ((1 + \text{ratio of residents to beds})^{0.405} - 1)$

Residents: CR Worksheet S-3, Part I, Column 9, Line 27

*Beds: CR Worksheet S-3, Part I, Column 2, Line 14 [Hospital Beds] +
CR Worksheet S-3, Part I, Column 2, Line 16 [Subprovider IPF
Beds] + CR Worksheet S-3, Part I, Column 2, Line 17 [Subprovider
IRF Beds]*



Medicaid Utilization Adjustment Factor (New Component)



Medicaid Utilization Adjustment Factor (New)

DCH Proposal

In order to promote the policy objective to **focus inpatient reimbursement on service delivery for Medicaid members**, DCH is proposing a **“Utilization Adjustment” factor based on each hospital’s Medicaid inpatient utilization rate (MIUR)**.

- Source data for the MIUR will be the Disproportionate Share Hospital (DSH) survey.
- Based on a hospital’s MIUR, DCH will apply an adjustment factor to the hospital base rate.

In future years, based on the MIUR update, hospitals could receive increased reimbursement if they provided care for more Medicaid members.

Medicaid Utilization Adjustment Factor (New)

Medicaid Utilization Band Rate Adjustment Factor						
Medicaid Utilization Band	0 - 10.9%	11 - 20.9%	21 - 30.9%	31 - 40.9%	41 - 50.9%	51+%
Rate Adjustment Factor	0.0%	2.0%	4.0%	6.0%	8.0%	10.0%
# of Hospitals	17	15	52	42	16	10

The Utilization Adjustment will be implemented on July 1, 2015.



Stop Loss/Gain Factor (New Component)



Stop Loss/Stop Gain Factor (New)

DCH Proposal

- In order to mitigate the impact of the proposed IPPS methodology changes to individual hospitals, **DCH will apply a stop loss/stop gain factor of 8.2% for the loss and 10% for the gain.**
- The stop loss/stop gain will be in **effect for July 1, 2015 through June 30, 2016.**

Proposed Methodology Impacts



Proposed Methodology Impacts

Summary of Proposed Methodology Impacts:

- No change to current peer group alignment.
- Restructures capital reimbursement to be included in the base rate.
- Reimburses GME through a new stand alone pool of funds instead of as an add-on payment to the claim.
- Automates the outlier payment process, eliminates duplicate payments and updates the outlier formula.
- Applies a new Indirect Medical Education (IME) factor to recognize the higher indirect costs incurred by teaching hospitals.
- Includes a new Medicaid Utilization Adjustment Factor that reflects the variability among hospitals in terms of serving Medicaid patients.
- Uses a Stop Loss/Stop Gain factor to moderate the fiscal impact on hospitals related to changes in Phase 1 IPPS methodology.



Implementation Timeline

Phase 1 – Effective Date July 1, 2015

- Eliminates Capital and GME Add-on Payments.
- Updates Hospital Cost to Charge Ratio (CCRs) – this will be an ongoing annual update.
- Establishes Medicaid GME Payment Pool. *GME will no longer be paid as an add-on to the IPPS claim. Quarterly payments begin September 30, 2015.*
- Incorporates new IME and Medicaid Utilization Factors into the base rate calculation.
- Applies a Stop Loss/Stop Gain through June 30, 2016.

Phase 2 – Effective Date January 1, 2016

- Update the Tricare DRG Version from 30 to 33 in order to mitigate the ICD 10 fiscal impact.

Phase 3 – Effective July 1, 2016

- Annual Update to Hospital Cost to Charge Ratio (CCRs).
- Update Cost Data.
- Change Outlier Formula.
- Pay Outliers on an Automated Basis.

Phase 1 Implementation Next Steps

- DCH will send each hospital their Phase 1 Medicaid inpatient rates that are effective July 1, 2015. Hospitals will receive this information by April 21, 2015.
- Hospitals may submit comments and questions to DCH by May 12, 2015.
- DCH will issue written responses to Hospital Comments and Questions by May 27, 2015.
- DCH will post the initial public notice at the May 14, 2015 Board Meeting.
- DCH will submit IPPS SPA to CMS for approval in June 2015 upon Board approval of the public notice.

Questions and Comments

DCH will address questions and comments during the current meeting. Hospitals may also send questions and comments in writing to DCH at:

- mwyatt@dch.ga.gov
- Questions and comments must be received by close of business Tuesday, May 12, 2015.

Today's presentation will be posted on the DCH website.

