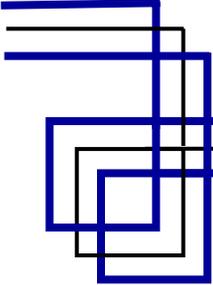


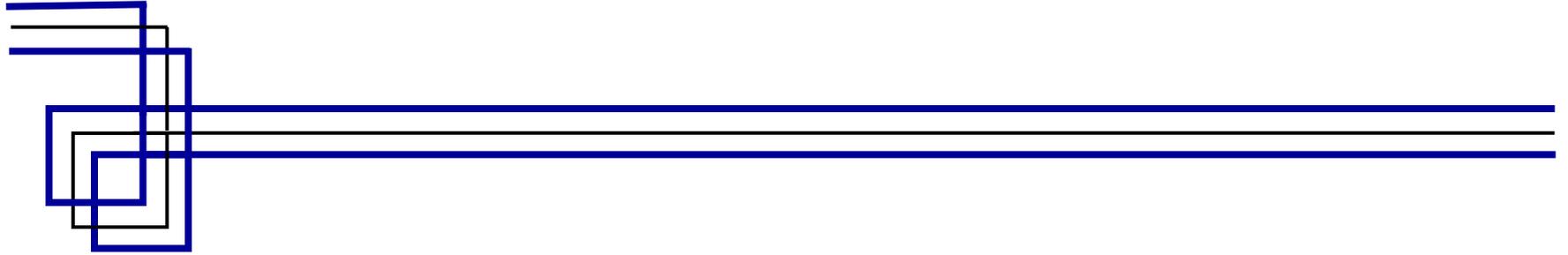
Medicaid Inpatient and Outpatient Hospital Reimbursement System

April 10, 2006

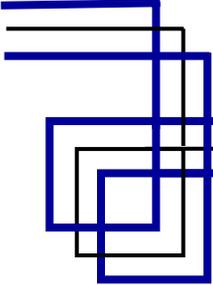


Agenda

- ❑ Introductions
- ❑ Objectives
- ❑ DRG Overview
- ❑ Phase I DRG Rebasing – October 2006
- ❑ Phase II DRG Implementation – July 2007
- ❑ Outpatient
- ❑ Discussion/Q&A

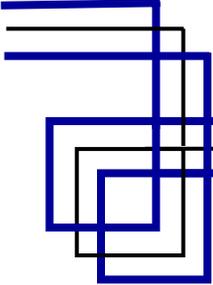


OBJECTIVES



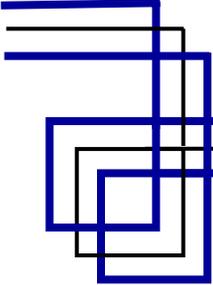
Original Objectives

- ❑ Align rates more closely to costs
- ❑ Move money from outpatient to inpatient
- ❑ Update DRG grouper to later version
- ❑ Cleanup/refine some reimbursement policies



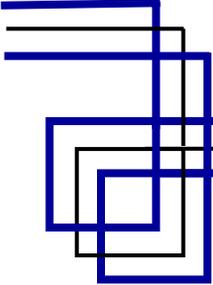
Issues and Considerations

- ❑ Timing – same as CMO rollout
- ❑ Baseline for calculating rates (fee-for-service population vs. CMO population)
- ❑ Budgetary constraints – must be budget neutral
- ❑ Resource considerations – how much can the Department realistically support
- ❑ Feasibility of moving forward on new outpatient system – potential benefits vs. the level of effort



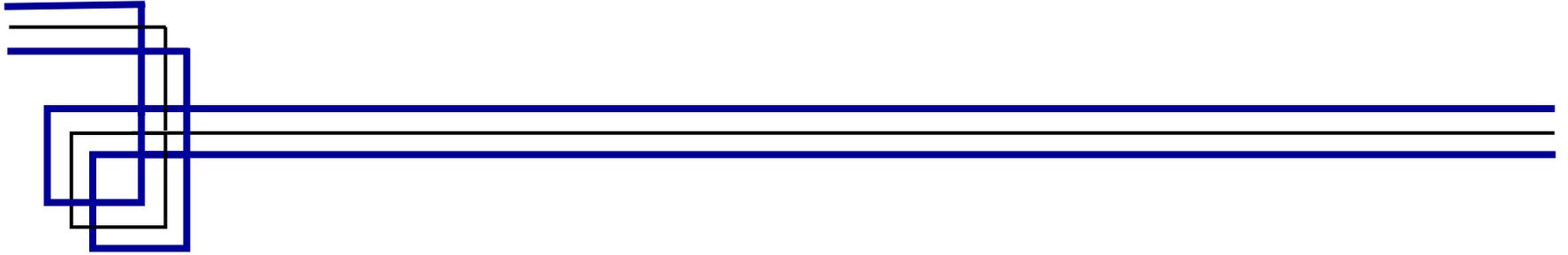
Where We Are Today

- ❑ Install latest version of DRG grouper
- ❑ Recalibrate relative weights and base rates using new grouper and 2003/2004 costs
- ❑ Minimize any changes to policies, procedures, systems, etc.
- ❑ Strengthen outpatient edits to improve data and provide options for future procedure-driven system

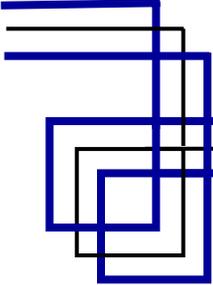


Implementation Strategy and Timeline

- ❑ Phase I Inpatient DRG – rebase DRGs October 2006
- ❑ Phase II Inpatient – rebase DRGs and cleanup/refine policies and methodology July 2007
- ❑ Phase I Outpatient – examine billing policies and implement edits to improve quality of data over next six months
- ❑ Phase II Outpatient – future procedure-driven system on hold

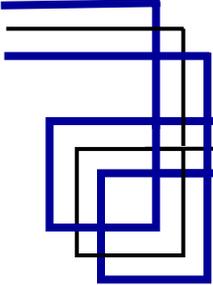


DRG OVERVIEW



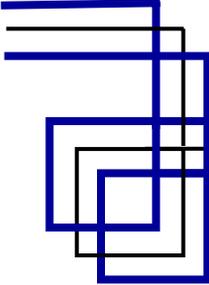
History

- ❑ Began development of Georgia DRG system in 1997
- ❑ Implemented DRG-based reimbursement in 1999
- ❑ Rebased DRG rates in 2002
- ❑ Have not looked at system really since 2002



The Rebasing Process

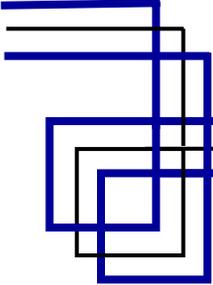
- ❑ Determine the base year for the claims
- ❑ Determine the base year for the cost reports
- ❑ Calculate the capital and GME add-ons
- ❑ Create the rate setting claims database
- ❑ Calculate the cost of the claims
- ❑ Identify and remove outliers
- ❑ Perform stability analysis
- ❑ Calculate relative 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.

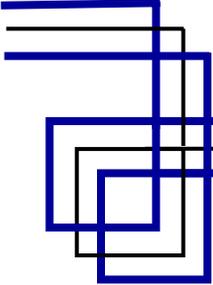
Current System	Rebased System
The base year used was State Fiscal Year (SFY) 2001	The base year will be SFYs 2004/2005
Claims data from July 1, 1998 to June 30, 2001 (SFYs 1999 through 2001 were used when necessary for low-volume DRGs)	Claims data from July 1, 2003 to June 30, 2005 (SFYs 2004 through 2005 will be used when necessary for low-volume DRGs)



Cost Report Base Year

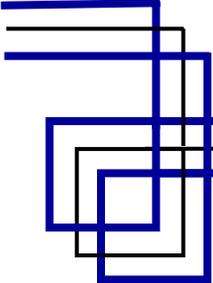
- ❑ Data from the cost reports will be used to calculate the operating cost-to-charge ratios, the capital add-on, and the GME add-on.

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 and 2004 cost reports. “As-filed” cost reports will have historical adjustment applied for nonallowable charges



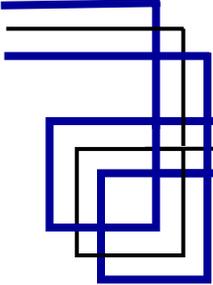
Capital and GME Add-ons

- ❑ 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 latest capital survey is not inflated
 - A per case payment is calculated
- ❑ GME
 - GME from the cost report is inflated
 - A per case payment is calculated



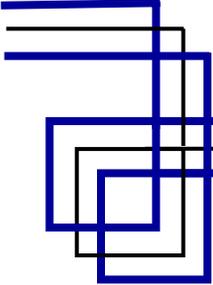
Calculating Costs

- ❑ 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



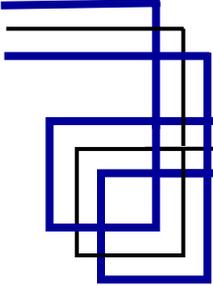
Outlier Thresholds

- ❑ Outliers are claims that are similar based on diagnosis but fall outside of the cost range of most claims with the same or similar diagnosis
- ❑ 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



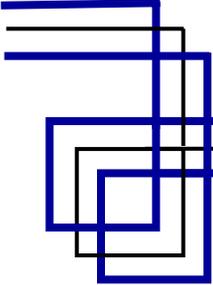
Relative Weights

- 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



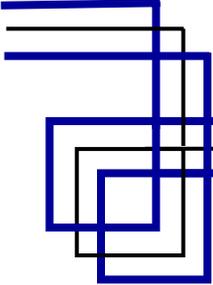
Case-Mix

- 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.



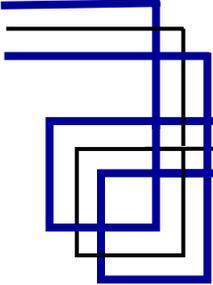
Peer Group Base Rates

- ❑ 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



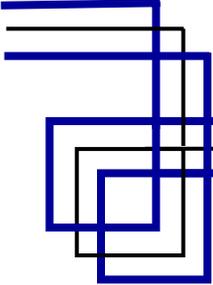
Impact Analysis and Budget Neutrality

- ❑ Model the impact of the new rates and compare to the current rates to determine the increase/decrease
- ❑ Apply adjustments to the base rate and the capital add-on factors to achieve budget neutrality
- ❑ Test the cost coverage for “reasonableness”



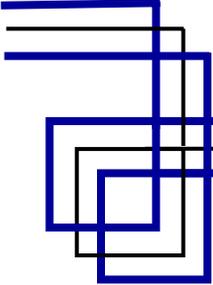
Future Changes to the Inpatient System

- ❑ Alternative methods to outliers, reimbursement of transfers, readmissions, and short stays will be reviewed
- ❑ Calculate population-based rates (fee-for-service vs. CMO)



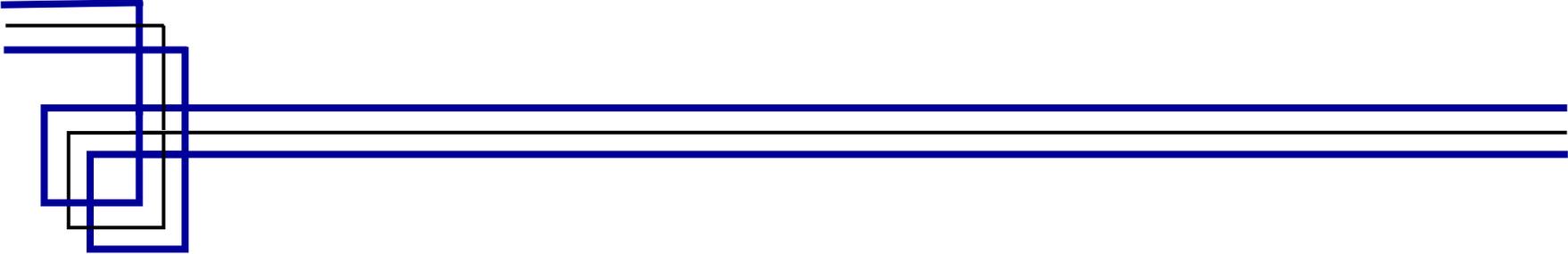
Next Steps for Phase I

- ❑ Verification of hospital-specific data
- ❑ Finalize specific assumptions/issues
- ❑ Calculation and rollout of final rates
- ❑ Post public notice by 1st of September
- ❑ Implementation of TriCare Version 23 grouper
- ❑ Implementation of new rates October 1st

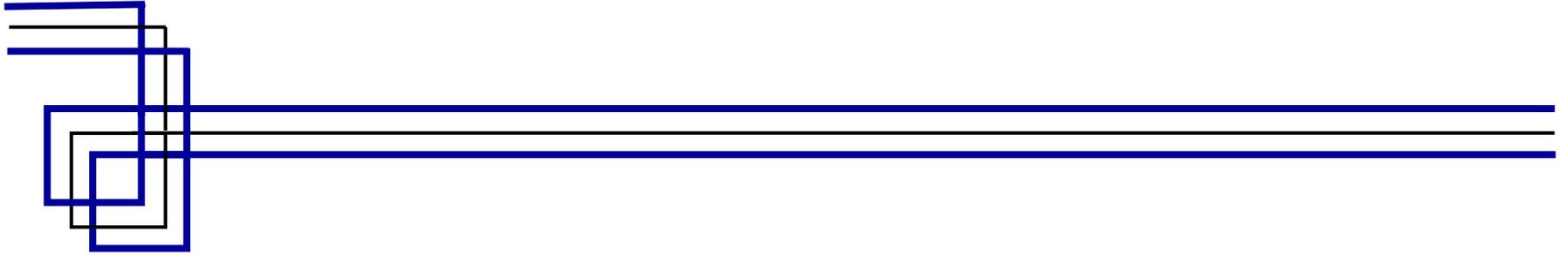


Phase II Refinement of DRGs

- ❑ Targeted for July 2007
- ❑ Will address fee-for-service vs. combined CMO/FFS rates
- ❑ Some areas for potential refinements
 - Outliers
 - Same day/one day stays
 - Transfers
 - Readmissions
- ❑ Evaluate need to implement later version of grouper

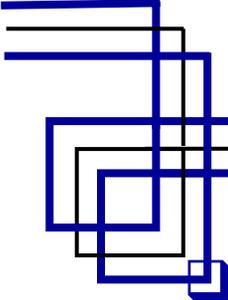


Outpatient System



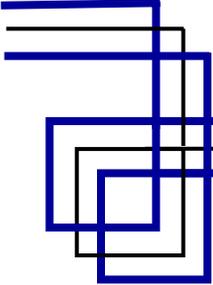
Discussion

Questions and Answers



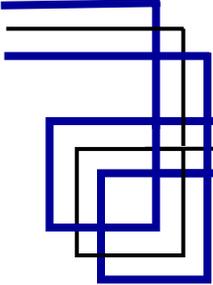
The Need for Change

- 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.
- 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 as well as to better predict expenditure.



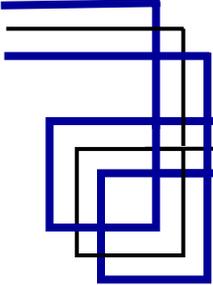
Feasibility Analysis

- ❑ Evaluated several models from other states
- ❑ Built a model based on a “Medicare like” system
- ❑ Developed some initial rates base on “costing” the claims using CCRs from latest cost reports
- ❑ Analyzed historical claims data required to support development of rates
- ❑ Calculated the impact at a high level to determine if approach would yield savings in outpatient payments that could potentially be moved to inpatient DRG



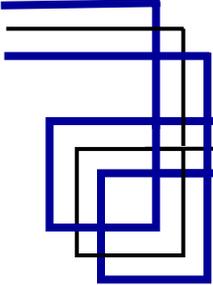
“Medicare Like” System

- ❑ Based on general Medicare OPPS system but modified to meet a state’s Medicaid agency’s needs
- ❑ 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
 - Reimbursing laboratory and radiology on a fee schedule (as is currently already done in Georgia)



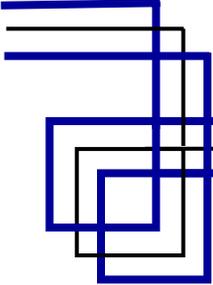
“Medicare Like” System *(cont.)*

- ❑ 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



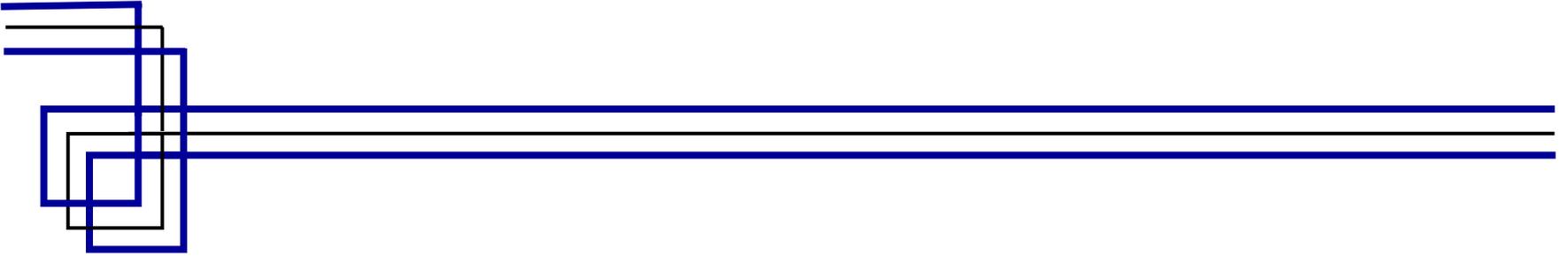
Findings

- ❑ Many claims data issues that could affect the setting of reliable rates
 - Missing procedure codes
 - Invalid procedure/revenue code combinations
 - Unreliable units
- ❑ Current outpatient reimburse has features that appear to be effective in controlling expenditures
- ❑ Moving to OOPS-like system is a major change that would require a significant effort to implement both on the part of the hospitals and on the part of the state

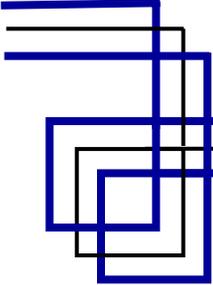


Conclusion on Outpatient

- ❑ Potential for moving dollars to inpatient is limited and does not seem to warrant the effort at this time
- ❑ Consequently, decision is to:
 - Work on improving the data
 - Put the project on hold at this time
 - Revisit sometime in future

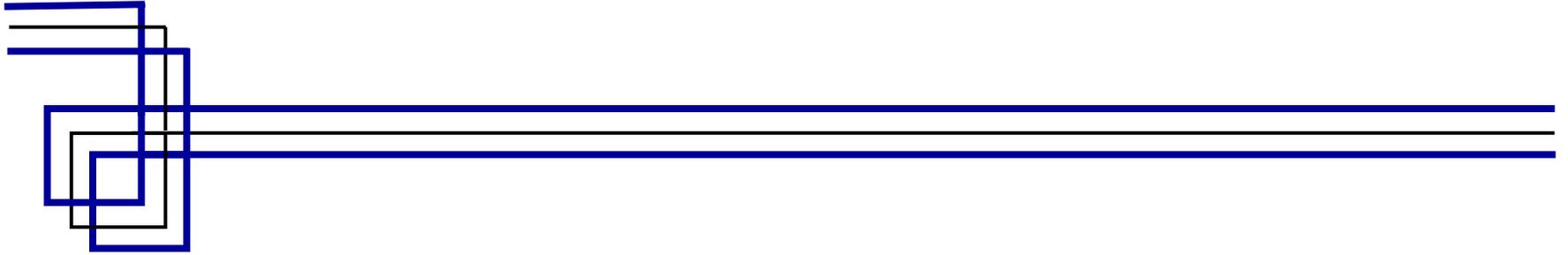


Next Steps for Outpatient



Improve Data

- ❑ Enhance existing edits
 - Require CPT/HCPCS on specific revenue code line items
 - Validate of revenue code/procedure code relationships
 - Test units for reasonableness on certain procedure codes
- ❑ Update billing policies as required
- ❑ Monitor effectiveness of edit/policies



Discussion

Questions and Answers