



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Georgia Medicaid Inpatient Prospective Payment System: Phase 3 Proposed Methodology Changes



Presentation to: Hospital Advisory Inpatient Payment Subcommittee
Presented by: Department of Community Health

Date: August 30, 2016

Background to Proposed IPPS Changes

In April 2015, DCH proposed a 3 phase approach to changing and updating its Medicaid IPPS methodology.*

DCH proposed to update the IPPS Reimbursement because:

- The IPPS model components had been unchanged since the late 1990s. Grouper and cost updates were 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. This is necessary to control overall costs to the state.
- DCH heard numerous concerns regarding the payment methodology from hospitals and internal/external subject matter experts.
- DCH developed policy objectives and guidelines associated with Medicaid and PeachCare inpatient hospital payments. DCH determined its IPPS methodology did not address these policy objectives and guidelines.

*Refer to the “DCH IPPS Presentation to the HAC IP Subcommittee April 14, 2015” at <http://dch.georgia.gov/hospital-providers>



Background to Proposed IPPS Changes

Proposal was designed to promote 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.

**Phases 1 and 2 of the IPPS update were completed on July 1, 2015 and January 1, 2016.

Current IPPS Methodology

- Hospitals are divided into 3 Peer Groups, each with different base rates: Statewide, Pediatric, & Specialty.
- Tricare Version 33 to group claims into diagnostic related groups (DRG). (Phase 2 update)
- Base rates are adjusted for Medicaid Utilization and Indirect Medical Education with a stop loss stop gain. (Phase 1 update)
- Outlier claims are paid based on the difference between the cost of the claim and the inlier payment amount.
- Direct GME is paid out of a supplemental pool, separate from the IPPS claim. (Phase 1 update)



Phase 3 Proposal

Effective October 1, 2016 DCH proposes to:

- 1. Update cost data to a more recent year in order to rebase rates and model components.**
 - This is a budget neutral update. Update from 2011 to 2014 data.

- 2. Change Outlier Formula**
 - Base outlier payment on the difference between the estimated cost of the claim and the outlier threshold.

- 3. Reimburse Outliers on an Automated Basis***
 - Outliers considered Level 1 will be automatically reimbursed but subject to a post payment review (based on a sample of claims).
 - Outliers considered Level 2 will continue to have a prepayment review. However, this process will be quicker and easier – reducing the time between submission for outlier review and reimbursement to the hospital.

**Note: The more focused outlier review will allow DCH to expand the post-payment review of inlier claims. This should promote program integrity.*



Phase 3 Proposal (Cont'd.)

Effective October 1, 2016 DCH proposes to:

4. **Apply a Stop Loss/Gain of +/- 5.07% to mitigate the financial impact to individual hospitals.** (This adjustment does not apply to GME Pool payments.)
5. **Allocate funds from the Direct GME Pool based on a per resident amount.**
 - Proposal presented to hospitals in May 2016.
6. **Indirect Medical Education (IME) will no longer be paid as part of the inpatient claim. Funds will moved to the Graduate Medical Education Cost of Care (GMECC) Pool and be a flat grant amount to be paid quarterly.**
 - Proposal presented to hospitals in May 2016.

Phase 3 Proposal: Update Cost Data

DCH used the following updated financial data:

Financial Data Component	Source
Base Year for Claims	<ul style="list-style-type: none">• Claims Data for CY 2014
Cost to Charge Ratio Calculations	<ul style="list-style-type: none">• CY 2016 DSH Survey Data and• Cost Reports for Hospital Fiscal Year Ending in 2014 when DSH data not available
Medicaid Utilization	<ul style="list-style-type: none">• CY 2016 DSH Survey Data• Cost Reports for Hospital Fiscal Year Ending in 2014 when DSH data not available

Phase 3 Proposal: Outliers

DCH Concerns with Current Outlier Process:

- Manual process is inefficient and results in undue hurdles to reimbursement.
- Current payment formula creates an inappropriate incentive to reach the outlier threshold (\$1 in additional cost may trigger a payment exceeding \$30,000).
- There is overlap in reimbursement coverage between the DRG inlier payment and the outlier payment.
- Payment of 89.3% of cost of outliers is higher than for inliers.



Phase 3 Proposal: Outlier Automation Concept

1. Hewlett Packard Enterprises (HPE), via MMIS, continues to identify potential outliers using the 4399 edit and notifies the Hospital of the potential outlier.
2. The Hospital must notify the Medical Review Entity (MRE)* that it is requesting outlier reimbursement.
3. The MRE identifies Level 1 claims, to be reimbursed without prepayment review, and Level 2 claims, which are subject to a prepayment review process.
4. The MRE will notify Hospitals to submit supporting documentation. Documentation will be submitted electronically directly to the MRE, rather than to HPE.
 - Itemized Charges must be submitted for Level 1 claims.
 - Itemized Charges, Utilization Review Notes, and Medical Records must be submitted for Level 2 claims.
5. DCH/MRE will create with a standard format for submitting itemized charges.
6. HPE will continue to process payments, upon approval from the MRE, via MMIS.

**Current MRE vendor is Georgia Medical Care Foundation (GMCF).*

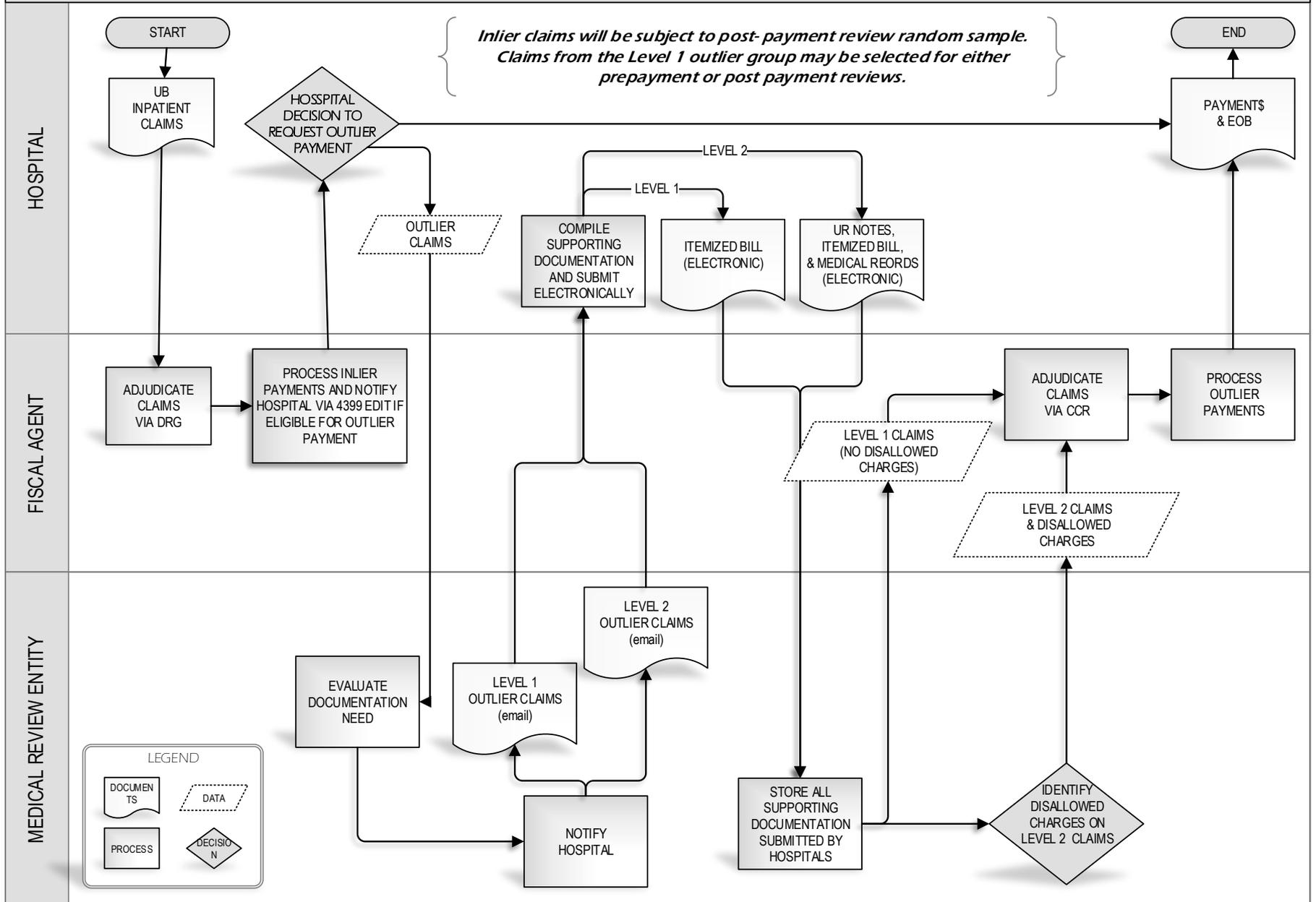
Phase 3 Proposal: Outlier Automation Concept (Cont'd.)

- Level 1 outlier claims will be reimbursed within an estimated 2 weeks of hospital request/itemized charges submission. Level 2 outlier claims within an estimated 1 to 2 months.
 - Current reimbursement time is 4 to 6 months for outliers.
- DCH will periodically perform prepayment and/or post-payment review on a sample of Level 1 claims. In addition, the more focused review of outliers will allow DCH to expand the post-payment review of outlier claims.
- Training on New Process: Alliant GMCF will post training and reference materials related to the administrative simplification process for outliers to the Provider Education section of the MMIS Web Portal. These training materials will be posted before 10/1/2016, and will include a prerecorded WebEx session as well as a user reference manual.

DRG OUTLIER REVIEW PROCESS

DRAFT 4.0

Inlier claims will be subject to post-payment review random sample. Claims from the Level 1 outlier group may be selected for either prepayment or post payment reviews.



Phase 3 Proposal: Follow-Up on GME

Direct GME:

- Comments from Hospitals:
 - Recommendations on alternative Medicaid Allocation Ratio (MAR) calculation methodologies
 - Recommendations on additional incentivized residency programs (i.e.- Internal Medicine)
 - Requests for utilization of different data sources for various elements of the calculation
- DCH assessed the impact of the suggested changes and decided to implement the Direct GME funding model as it was originally proposed.

GMECC:

- Comments from Hospitals:
 - GMECC funding should be available to new GME programs upon the start of the program, rather than when the residents appear on the hospitals' Medicare Cost Reports.
- DCH assessed the impact of the suggested change and decided to provide GMECC funding to new GME programs upon the start of the program. However, because new programs have been added to the pool, this change results in \$10.5M in unmet need for the GMECC pool for SFY 2017. So, GMECC allocations to all hospitals will be prorated downward based on available funding.



Phase 3 Proposal: Overall Impact

1. Updating rates to reflect more recent hospital cost data **ensures that Medicaid payments are reflective of the actual cost and mix of services** provided by each hospital.
2. **While the Phase 3 update is budget neutral, individual hospitals may experience either an increase or decrease in payment.** DCH has included a stop loss/gain of +/- 5.07% to mitigate the impact to individual hospitals.
3. **The change in outlier formula moves funds into the hospital base rates which benefits all hospitals** – not just those with proportionally more outliers.
4. Carving out Indirect Medical Education (IME) will result in a reduction to the base rate payments to teaching hospitals. Instead, teaching hospitals will receive a flat grant for IME from the GMECC pool. This change is necessary to protect payments to non-teaching hospitals and provide a mechanism to request additional funding to support growing programs. **As Georgia's Graduate Medical Education program grows, IME payments will also grow. Without a separate GMECC pool, in a budget neutral environment, funds for IME growth would come from the base rates of non-teaching hospitals.**



Phase 3 Proposal: Impact Across Hospitals (Includes GME/GMECC*)

IPPS Proposal Impact Across Hospitals FY 2017 Compared to FY 2016*			
Average Decrease = -3.81%		Average Increase= 3.41%	
% Change in Payment	# of Hospitals with a Decrease	# of Hospitals with an Increase	Total
0%	4		4
0 - 2%	17	24	41
2 - 4%	14	22	36
4 - 6%	45	17	62
> 6%	1	5	6
Total	77	68	149
% Total	52%	46%	100%

IPPS Proposal Impact Across Hospitals FY 2017 Compared to FY 2016*			
Average Decrease = (\$323,680)		Average Increase= \$395,159	
% Change in Payment	# of Hospitals with a Decrease	# of Hospitals with an Increase	Total
\$0	4		4
\$0 - \$100K	55	36	91
\$100K - \$500K	12	18	30
\$500K - \$1M	0	8	13
\$1M - \$5M	4	5	9
> \$5M	1	1	2
Total	77	68	149
% Total	52%	46%	100%



Phase 3 Proposal: Medicaid Inpatient Utilization Rate (MIUR) Distribution

Medicaid Utilization Band Rate Adjustment Factor						
Utilization Band	0-11%	11-21%	21-31%	31-41%	41-51%	51% +
Rate Adjustment Factor	0.00%	2.00%	4.00%	6.00%	8.00%	10.00%
# of Hospitals SFY 2016	20	15	51	40	14	9
# of Hospitals SFY 2017	20	37	51	32	4	5

Phase 3 Proposal: Next Steps

- DCH will send each hospital its Phase 3 Medicaid inpatient rates (effective October 1, 2016) by September 6, 2016.
- DCH will address questions and comments during the current meeting. DCH will also accept written comments during the Public Notice comment period.

Next Steps for DCH:

- September 8, 2016: Issue Public Notice for all Updates to the IPPS Methodology.
- Draft and Submit Medicaid State Plan Amendment (SPA) to CMS for review and approval.