

Department of Community Health Hospital Status Report

Presentation to
HOMETOWN HEALTH – Spring Conference
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CARIE SUMMERS, CHIEF FINANCIAL OFFICER

Topics

- Medicaid Rate Enhancements
 - Fee-for-Service
 - CMO
- Impact of DRG Rebasing
- Trauma Funding
- Federal Regulations
- Status of Disproportionate Share Hospital payments



Medicaid Rate Enhancements

- Fee-for-Service Increases (July 1, 2008)
 - INPATIENT
 - Increase in current DRG base rate by 3.68% for Trauma Hospitals in Levels I - III; 2.77% for all other hospitals
 - No change to Grouper or update to base rates



Medicaid Rate Enhancements

- Fee-for-Service Increases (July 1, 2008)
 - OUTPATIENT
 - Rebase interim CCR's to project for FY 2009
 - Cost coverage in interim CCRs and settlement for non-CAH's to increase from 85.6% to 90.7% for Trauma Hospitals (Levels I - III) and 85.6% to 88.3% for all others
 - CAH's continue at 101% of cost (considered for interim CCR's and at cost settlement)
 - Triage fee for non-ER use of ER from \$50 to \$60
 - Outpatient cap increases with inpatient increase



Medicaid Rate Enhancements

Other 7/1/08 Budgetary changes that can impact hospitals

- Coverage for digital mammography at 80% of 2007 RBRVS
- Physician RBRVS reimbursement to move to 80% of 2007 RBRVS (with some exclusions)
- Ambulance reimbursement 86% of 2007 Medicare
- Nursing Homes to receive increase in per diem for capital costs (move to Fair Rental Value System) and additional 1% increase in per diem for facilities meeting quality incentive program criteria
- Medicaid coverage of foster children up to age 21



Medicaid Rate Enhancements

- Services paid by CMO's (July 1, 2008)
 - HB 990 (Appropriations Act) requires CMO's to increase their current per unit reimbursement by amounts comparable to the percentage increase in FFS if CMO reimbursement not linked to Medicaid FFS

EXAMPLE:

Inpatient Hospital base rate in FFS increasing 2.77% for non-trauma hospitals. CMO's would have to increase their inpatient hospital reimbursement 2.77% if not linked to Medicaid.



Medicaid Rate Enhancements

- Services paid by CMO's (July 1, 2008)
 - HB 990 requires CMO's to pay CAH's at Medicare critical access rate of 101%
 - Supported by HB 1234 (discussed on Tuesday's agenda)
- DCH to audit CMO's to ensure rate increases made
 - Added to Myers and Stauffer CMO audit programs
 - Feedback from providers
 - DCH contracts with CMO's amended to reflect required rate increases

Impact of DRG Rebasing

- Effective January 1, 2008
- Update to new base rates and new grouper

Question: How will rate increases be offset by DRG rebasing?

- Budgeted to be cost neutral in the aggregate
- Expected increases or decreases on a hospital specific basis

Too soon to tell actual impact...inpatient hospital claims data only available through March 2008 but not complete given time periods that providers have to bill.



Trauma Funding

- \$53 million appropriated to DHR in Amended FY 2008 budget
- For trauma centers, trauma physicians, and EMS providers
- Funding must be obligated by 6/30/08
- Trauma Commission considering allocation methodologies
 - To be determined by mid May
- Funding to go to trauma centers who will share some of the funding with their trauma physicians and EMS providers (as determined by the Trauma Commission allocation)
- No appropriated funding for FY 2009



Federal Regulations

- CMS May 2007 regulation
 - clarifies definition of non-state governmental providers (i.e., public providers);
 - adds cost based limitations to public provider Medicaid reimbursement;
 - defines what constitutes a legitimate IGT;
 - under Congressional moratorium for implementation until May 25, 2008.



Federal Regulations

- States required to survey providers to determine governmental status
 - DCH Survey on DCH Website (Under “Providers” and “2008 Survey...”)
 - Training available to help providers complete the survey
 - HTH Webinar
 - Being conducted and results compiled by Myers and Stauffer
- Assuming moratorium ends, state will use results to determine future UPL and DSH payments and determine whether reimbursement must be limited to cost. Results will also help ID who can still provide IGTs.



DSH Status

- Requested funding received for private hospitals eligible for DSH in Amended FY 2008 budget and now available
- DCH waiting on CMS approval of state plan amendment
 - On 2nd 90 day clock; CMS must decide by June 5
- If CMS approval not received in time to make payments before May 25, DCH may withdraw SPA and make DSH payments using FY 2007 methodology
 - Necessary to preserve ability to IGT before moratorium ends May 25
 - Assumes most hospitals convert to private status and can no longer IGT

Questions?

Contact me:

1. Through Jimmy and HomeTown Health
2. Directly at csummers@dch.ga.gov or 404-657-4859

