Final Report:

Implementing a DRG Payment System for Oklahoma Medicaid
Acute Hospital Inpatient Care

February 24, 2006
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Executive Summary

Background

This report documents the implementation of a DRG payment system as designed and analyzed in prior studies presented to the Oklahoma Health Care Authority (OHCA) by APS Healthcare in December, 2003 and September, 2004. Those studies established the feasibility and expected impact of a change in hospital payment policy for both managed care and fee for service segments of the Oklahoma Medicaid client population.

The DRG payment system was originally launched by the Centers for Medicare and Medicaid Services in the early 1980’s. The system creates a method of predetermined fixed reimbursement for hospital care provided to inpatients. The payment consists of an amount to cover base hospital operating expense (Base Rate) multiplied by the case severity of the patient (DRG weight).

Data Summary

Fee for service (FFS) claims and managed care encounter records for the most recent (as of June, 2005) three calendar years (2002–2004) were extracted from the OHCA MMIS to use in the DRG rate-setting. Only acute inpatient hospital claims and encounters were used, and encounter records were adjusted for undercount (as described in a previous report). The CMS Healthcare Cost Report Information System (HCRIS current through March 31, 2005) was used to compute cost-to-charge ratios and to measure the hospital characteristics used to classify hospitals into one of five cost-related peer groups. The hospital-specific cost-to-charge ratios were applied to charges (billed amounts) on claims to compute costs, which were then adjusted for inflation over the three year period.

DRG Payment Calculation

In order to calculate the hospital payments under the DRG payment system – a global budget of $416 Million was used. This represents the projected total payments for the hospitals in the first year of DRG payments (October 2005 through September 2006).

DRG base rates were computed as the average cost per discharge for each hospital peer group, and DRG weights were calculated as the average cost per discharge for each patient diagnosis related group relative to the over-all average cost per discharge. A DRG with a weight of 2.0 is twice as resource intensive as the average discharge, while a DRG with a weight of 0.5 is one half as resource intensive as the average discharge. Each discharge was assigned to a DRG with the CMS Version 22 DRG Grouper, modified to include perinatal codes, which are prevalent in the Medicaid population. The DRG payment was then computed for each discharge as the product of the hospital peer-group base rate times the DRG weight. Discharges with exceptionally high costs receive an additional “outlier” payment to compensate.
DRG Payment Implementation

Prior to implementing the DRG payment system, OHCA sent notices to hospital administrators to verify their cost-to-charge ratio and peer-group assignment information. This review process led to revision of the inclusion criteria for fields from cost reports, and updated information for hospitals without cost reports or more current data since their last cost report was filed.

The DRG payment system for acute care hospitals went live on October 1, 2005. Payments were automatically adjusted following system upgrades that were implemented in November when the hospital CCR and peer-group data validation process was completed. Following initial implementation, the payment tables with information about hospital CCR, peer-group, and DRG weights will be updated annually.
I. Introduction

The purpose of this report is to document the data, methods, assumptions, and decisions that support the implementation of a diagnosis-related group (DRG) payment system for acute-care hospital discharges paid for by Oklahoma Medicaid.

Health-risk adjusted payment systems are being adopted by public and private payers across the country because they take advantage of electronic information technology to compensate hospitals for what is generally believed to be a more objective, accurate, and fair measure of surgical, medical, and nursing work effort, compared to traditional payment rates based on “customary and prevailing” charges or per diem payments based on historical costs. Additionally, DRG payments are made on a per discharge basis which encourages hospitals to operate more efficiently.

The Oklahoma Health Care Authority (OHCA) commissioned APS and EDS to implement a DRG payment system for Oklahoma Medicaid. The report is presented in seven parts:

I. Introduction
II. Method
III. Discharge Data Collection and Adjustment
IV. DRG Weight Computation
V. Hospital Base-Rate Computation
VI. Payment System Implementation
VII. Conclusion and Recommendations

A concise overview of the tasks undertaken to implement the payment system is presented in Appendix 1. Additional details and supporting data are attached in the other Appendices:

1. DRG payment implementation for Oklahoma Medicaid
2. Claim fields and extract criteria
3. Cost-to-charge ratios
4. Updated grouper codes
5. Neonatal grouper codes
6. Oklahoma Medicaid DRG weights
7. Base-rate peer-groups
8. Absolute base rate calculation
II. Method

The DRG payment methodology is based on published guidelines that follow the system currently used by the federal Centers for Medicare and Medicaid Services (CMS) to compensate hospitals for services to Medicare patients.\(^1\)

The basic formula for a DRG-related payment per discharge can be written as:

\[
\text{Payment} = (\text{Hospital Base Rate}) \times (\text{DRG Relative Value Weight})
\]

Implementing this payment formula requires the computation of both a hospital base-rate and a DRG relative value weight. It is important to note that both of these factors must be known in order to compute an expected average payment: \textit{expected payments cannot be deduced from hospital base rates alone.}

The hospital base rate measures facility-related costs net of patient case-mix. These facility-related costs vary in proportion to combinations of facility characteristics, like size, location, teaching requirements, and critical access or sole provider designation. Total payments, however, do not necessarily vary in proportion to these base-rate facility cost factors, because the second factor in the payment formula – DRG weight – or case-mix, also varies greatly between different hospital types.

It is paradoxical that some hospitals have relatively low base rates, but relatively high payments. This is true whenever a facility benefits from a favorable operating or administrative cost structure (for example, economies of scale), but also receives a high proportion of patients with very complex conditions requiring high-cost procedures and patient care services. Therefore, it is not valid to conclude that a relatively low base rate will translate into a relatively low total or average payment.

The next section describes the hospital discharge data that were used to estimate the initial DRG payment formula for Oklahoma Medicaid.

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III. Hospital Discharge Data Collection and Adjustment

Three years of acute care, inpatient hospital claims and encounters with discharge dates of 1/1/2002 through 12/31/2004 (CY 2002, 2003, 2004) were extracted from the OHCA data warehouse and utilized for this analysis. The records included both fee-for-service claims and managed-care encounters. Indian Health Service and Children’s Hospital claims were excluded from the extract. Also, clients classified as “medically needy” and their corresponding hospital claims were not included in the dataset. Appendix 2 provides a detailed listing of claim fields and criteria used for the data extraction.

**Fee-for-Service Claim Data**

Claim codes were validated as meeting uniform billing specifications (no local codes specific to Oklahoma Medicaid were found). Claims were tested for uniqueness per discharge. It was found that there were cases where multiple claims existed for a single hospital discharge, which was verified by OHCA. These claims represent instances where hospitals submitted “interim bills” for an inpatient stay. A unique identifier was created for these multi-claim discharges, and all related claims were assigned the same identifier. All value fields from the multiple claims were aggregated for the unique claim.

Financial fields were tested for accuracy. Payments from the claim-header paid amount were adjusted for third-party coverage and co-payments. These adjusted actual payments were then compared to expected payments calculated on the basis of service location-specific per diem rates provided by OHCA. Detail service location per diem payment rates for each hospital were multiplied by claim detail allowed unit amounts (i.e. the length of stay for the discharge, measured in days) to calculate expected payment per discharge. A high correlation between adjusted actual payments and expected payments based on per diem rates and length of stay indicated that the claim header field contained reliable payment information. Overall, the total of actual payments and total calculated payments to all hospitals were also deemed reasonably accurate by OHCA.

**Managed-Care Encounter Data**

APS reviewed the managed-care encounter records included in the dataset to be used for setting DRG hospital base rates and relative payment weights. It was found that encounters tended to be under-counted and unevenly reported, so the number of encounters was estimated as 57% of the number of FFS claims. Encounter records were weighted so that the sum of weights equals 57% of the number of FFS claims. The effect of this correction is to smooth out the trend in MC encounters and total discharges throughout the baseline period. These re-weighted encounter records were then combined with FFS claims and the combined total was used to estimate the total revenue.
discharge volume, the percentage distribution of discharges over DRGs and providers, and changes in the distribution over time.

**Converting Charges to Costs**

Having established that hospital claims contain reasonably high-quality information on payment and lengths of stay per discharge, an adjustment was made to convert hospital charges (i.e. “billed amounts”) into hospital costs. Charges were multiplied by a cost-to-charge ratio (CCR) to more closely approximate the actual cost of providing services to Medicaid clients. Further computation of hospital base-rates and relative DRG weights are based on hospital costs, rather than charges or paid amounts.

CCR data were extracted from CMS’ Healthcare Cost Report Information System (HCRIS). HCRIS is a public-use file that contains a complete history of cost reports (CMS Form 2552-96). The first step is to link the OHCA provider identification number with the six-digit CMS Provider ID on the cost-report. It was difficult to make an accurate and complete linkage because no universal identifier will be available until CMS fully implements the “National Provider Identifier” in 2007. To detect and correct ID-number matching errors, OHCA chose to send a letter to each hospital administrator to verify their assigned CMS ID number.

CCR data were computed by this method:

1) Select data from worksheet B-1 column 27 (total cost) and worksheet C-1, columns 6 (inpatient charges) and 7 (outpatient charges).

2) Compute the CCR for each cost report according to the formula:
   a. Numerator (cost) = B-1, Col. 27, Line 95 minus sum of Lines 63 through 94, including subscripts.
   b. Denominator (charges) = (C-1, Col. 6, Line 101) plus (C-1, Col. 7, Line 101) minus (the sum of Col. 6 Lines 63 through 100, including subscripts), minus (the sum of Col. 7 Lines 63 through 100, including subscripts).
   c. Ratio (CCR) = Numerator / Denominator.

3) Compute the average CCR for each CMS ID over all their cost reports in the most recent three years.

4) Join the CCRs to OHCA providers using the CMS ID cross-walk, which results in three kinds of matches:
   a. OHCA providers with one CCR get the computed CCR.
   b. OHCA providers with more than one CCR get the average of all the CCRs for matching CMS ID numbers.
   c. OHCA providers with no CCR get the overall average of all similar providers (i.e. the default CCR) – Critical Access Hospitals (CAH) get the average of all CAH, and non-CAH get the average of all non-CAH hospitals.

A list of hospitals showing OHCA ID number, CMS Provider ID and final computed average CCR is attached as Appendix 3.
IV. DRG Weight Computation

Relative value weights for DRG categories were computed using hospital discharge data described in Part III above. This section describes the DRG weight computation procedures that were followed.

**Data Preparation for DRG Grouper**

Input files were created for the CMS Medicare Version 22 grouper. Lines containing detail ICD-9 procedure codes were transposed and attached to the claim header record to produce a single claim record per line. Historical diagnosis and procedure codes that are no longer valid and not recognized by the CMS Medicare Version 22 Grouper were updated to their replacement codes. Appendix 4 shows the invalid codes and their associated replacement codes.

Because the CMS Medicare grouper logic is based on the Medicare population, which has little or no perinatal experience, claims that were grouped into Major Diagnostic Category 15 “Newborns and Other Neonates with Conditions Originating in the Perinatal Period” were further grouped using the logic for neonates that is employed by the Wisconsin Medicaid program. This neonatal modification of the CMS Medicare grouping logic is shown in Appendix 5.

After processing claims with the grouper, the percent of ungrouped claims was 0.18% (about 150 claims). The reason codes for the ungrouped claims were investigated and verified. Most of these ungrouped claims were due to invalid diagnosis codes.

**DRG Weight Calculation**

DRG relative value weights were calculated in accordance with Medicare’s Inpatient Prospective Payment System. Claim charges were converted to cost using cost-to-charge ratios described in Part III above. The medical inflation rate was accounted for by inflating costs forward to the final quarter of the projected payment year using the Inpatient Hospital Prospective Reimbursement Index produced by Global Insight.

Average cost per discharge was computed for all claims, and the average cost per discharge within each DRG was also calculated. Claims with costs and costs per day that were outside of three standard deviations from the geometric mean (i.e. exponential mean of the log distribution) within each DRG were excluded from the weight calculation. This is consistent with the CMS methodology. The final DRG weight is thus the average cost per discharge for each DRG category, excluding extreme outliers. The Oklahoma Medicaid specific DRG weights are provided in Appendix 6.
V. Hospital Base-Rate Computation

The DRG hospital payment system covers a total of 571 hospitals. This large number of hospitals may be reduced to a smaller number of hospital classes, or “peer groups” in order to simplify the DRG payment formula.

Using hospital base-rate peer groups in the payment formula is a compromise between the complexity of using a unique hospital-specific rate for every single provider, and the over-simplification of using one single rate for all hospitals. To find an optimal balance between simplicity and complexity, multivariate statistical methods are used to construct exhaustive and mutually exclusive categories that minimize cost variance within categories, and maximize cost variance between categories.

This section explains the method used to classify hospitals into base-rate peer groups, and to compute a relative base-rate common to all hospitals within each peer group. Hospitals and their peer group assignments are shown in Appendix 7.

Classification Variables

Actual costs vary from one discharge to another for several different reasons: patients may have different burdens of illness or severity, lengths of stay may vary, and hospitals may have different capital structures, different costs related to graduate medical student training, and different operating costs related to wages determined by labor markets across different geographic localities. Public concern with access to care, and equitable reimbursement, justify additional consideration for special situations, such as critical access and sole community hospitals.

Multiple regression analysis was used to partition discharge cost variance into distinct parts due to the various contributing factors. The SPSS software regression procedure was applied to regress actual costs for each discharge on patient diagnostic case mix (DRG) and length of stay, and five hospital classification variables (taken from the most recent CMS Form 2552-96 cost reports available in the HCRIS Hospital Data Set):

a. Teaching Hospital (Worksheet S2: for non-CAH, Line 25: for CAH, Line 30.04)

b. Urban or Rural Hospital (for cost reports with FY ending before March 2004, Worksheet S2, Column 1, Line 21: for cost reports with FY ending after Feb 2004, Worksheet S2, Column 1, Line 21.03)

c. Sole Community Hospital (Worksheet S2, Line 26, Column 1)

d. Critical Access Hospital (Worksheet S2, Line 30)

e. Large Hospital (Worksheet S3-1, Column 1, Line 1 > 200 beds)

Because these variables depend on accurate linkage between OHCA hospital ID numbers and CMS ID numbers, accurate cost reports, and accurate software, OHCA decided to verify the assigned classification variables with a letter to hospital administrators.
V. Hospital Base-Rate Computation

Hospital Classification

There are 32 possible combinations of the five classification variables, so every hospital is one of the 32 hospital types. The regression equation was used to compute a predicted value (the adjusted average cost) for each of the 32 hospital types (holding case-mix and length of stay constant). The hospital types were then sorted in ascending order of predicted average costs, and divided into five intervals of approximately equal width. Hospitals within an interval form a cost-related “peer group” because they have approximately the same level of expected costs given their combination of characteristics, and costs vary significantly from one interval to another.

Peer-Group Base Rates

Base rates for the DRG payment formula were calculated from the predicted average costs for each of the five hospital peer groups. The base cost for all types of hospital in a peer group is measured as the average cost for each type of hospital in the group, weighted by the number of discharges for each type of hospital in the group. These weighted averages for the five hospital peer groups are then divided by the over-all weighted average cost to compute the relative peer-group base-rate for the five hospital cost classes. The relative rate is thus the ratio of group cost to overall average cost.

Absolute Base Rate

To convert the relative base rate for each group into an absolute dollar-denominated rate, the relative rate must be multiplied by the average projected payment per discharge, which is equal to the projected total hospital payment budget, divided by the total projected volume of discharges. However, since DRG case-mix also varies from one peer-group to another, the final base rate determination must account for case-mix variation. This was done in three steps.

The first step was to project the volume and case-mix of hospital discharges for the payment year (October 2005 through September 2006) and pro-rate the projected total hospital payment budget to projected discharges. This gives a budget-neutral average payment amount per discharge.

The second step multiplies this average by the relative peer-group base rates. This gives a first approximation to absolute base rates. These approximate peer group base rates, DRG weights, and outlier adjustments were used to compute a payment for each discharge. These computed payments were summed over all discharges.

The third step compares the sum of computed payments to the total projected budget. The base rates were adjusted by the ratio of total projected budget to the sum of computed payments. This ensures that the sum of computed payments is equal to the projected total hospital payment budget. Appendix 8 shows the conversion of relative hospital peer group base costs to absolute hospital peer group base payment rates.
VI. Payment System Implementation

The billing and payment system is designed and maintained by EDS. The transition to DRG payment rates from per diem payments occurred on October 1, 2005.

Payment Tables

The payment system uses three tables that are updated each year according to the procedures described in Parts III, IV, and V above:

1. Hospital CCR and Peer Group Assignment Table
2. Peer Group Base Rate Table
3. DRG Weight Table

To ensure the accuracy of hospital CCR and peer-group assignments, OHCA decided to send this hospital-specific information to each hospital administrator for review, prior to payment system implementation. Several inaccuracies were identified through this review process, including:

- Critical Access hospitals are not required to submit cost data on Worksheet C-1, so Worksheet B1 was used instead of C-1.
- The cost-to-charge ratio formula omitted some cost centers that OHCA had intended to include, so the computer routines were revised to include these cost centers.
- Cost report format for rural/urban designation changed in March 2004, so computer routines were revised to retrieve data from the correct location on cost reports submitted after February 2004.
- Some hospitals had more current information than was available on their most recent cost report recorded in HCRIS, so OHCA worked with the providers to correct the data on a case-by-case basis.

The payment tables were updated with the verified and corrected information in November, and claims submitted prior to the update were automatically re-priced with the new tables.

Pricing Formula

This DRG pricing formula is used to compute the payment for a hospital discharge:

\[ \text{Reimbursement} = (\text{DRG Weight}) \times (\text{Provider Peer Group Base Rate}) + (\text{Outlier Amount}) - (\text{Applicable co-payments or TPL}) \]

Co-payments are based on length of stay ($3 per day). The adjustment for high-cost outliers is applied if the provider cost exceeds a threshold of $50,000 and the DRG
Weight X Base Rate is less than provider cost. The outlier amount is 70% of provider cost in excess of $50,000. Outlier amount is computed with this formula:

\[
\text{Outlier Amount} = (\text{claim total amount billed}) \times (\text{billing provider’s CCR}) - (\text{DRG Weight} \times \text{Peer Group Base Rate}) - (\text{threshold of $50,000}) \times (\text{marginal cost factor 70%}), \\
\text{or zero, whichever is greater.}
\]

The DRG pricing formula does not include amounts payable for Disproportionate Share or Graduate Medical Education – these are handled separately. The DRG payment system also does not cover discharges from psychiatric, rehabilitation, residential treatment centers, or Indian clinic hospitals – these continue to be paid at *per diem* rates.
VII. Conclusion and Recommendations

Implementation of the DRG payment system went fairly smoothly, largely due to extensive advanced preparation. Feasibility and impact studies helped to foster a wide-ranging stakeholder discussion, which ultimately resulted in broad-based support for the authorizing legislation.

Technical difficulties were resolved fairly rapidly with cooperative working relationships that had already been established between the providers (represented by Oklahoma Hospital Association), OHCA, and its consultants and contractors. These difficulties were encountered during the case-by-case validation of hospital-specific data. Several errors in computer software programming, as well as inaccurate or outdated data in some cases were detected and corrected within six weeks of the planned implementation date.

We conclude with the following recommendations for further action:

1) Update the payment tables of hospital CCR, peer group, base rates and DRG weights on an annual basis.
2) Initiate the hospital administrator CCR and peer group data validation cycle earlier in the process to allow for any corrections to be made prior to final payment table delivery.
3) Continue to work with providers to resolve remaining concerns or recommendations for modifications to the payment method.
4) If payment method modifications are agreed upon, revise payment computation software and Medicaid State Plan Amendment accordingly.
Appendix 1 - DRG Payment Implementation for Oklahoma Medicaid

**Purpose:** APS will support EDS implementation of DRG payment system in Oklahoma by producing the base-rate and DRG-weight tables necessary to compute a DRG payment for acute-care general medical and surgical hospital inpatient discharges.

**Project 1:** Re-calibrate the absolute base-rate using existing relative weights and new total budget. Supply the existing peer-group cross-walk, DRG weight table, and recalibrated absolute base rates to EDS prior to July 1 for testing purposes.

**Project 2:** Reconstruct the peer-group cross-walk and relative base rates using a new year of data (CY2004). Reconstruct the DRG weights with a new year of data and a more current grouper (CMS Grouper Version 22). Supply the reconstructed peer-group crosswalk, reconstructed DRG weights, and recalibrated absolute base rates to EDS prior to Oct 1 implementation.

<table>
<thead>
<tr>
<th>Project 1 Step Number</th>
<th>Step Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Obtain from OHCA the approved annual acute hospital inpatient payment budget.</td>
</tr>
<tr>
<td>2</td>
<td>Calculate hospital specific payments for the base year and test for budget neutrality.</td>
</tr>
<tr>
<td>3</td>
<td>Adjust base rates so payments are budget neutral and report re-calibrated base rates to OHCA &amp; EDS.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project 2 Step Number</th>
<th>Step Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Extract all header and detail claims data for the analysis. Limit the extraction to acute care hospitals. Also exclude specified Children's Hospitals and Indian Health Service hospitals, free-standing rehab &amp; free-standing psych. Limit the FFS claims to a status of different from denied.</td>
</tr>
<tr>
<td>2</td>
<td>Reconcile existing database of claims and adjusted encounter records with new claims data for CY 2004. Make reasonable &amp; necessary adjustments to smooth data discontinuities associated with the termination of managed care encounter reporting.</td>
</tr>
<tr>
<td>3</td>
<td>Search claims data sets for interim billed claims. Create a temporary link between header and detail claim data sets for interim billed claims. Create a single claim with a unique ICN for interim billed claims.</td>
</tr>
<tr>
<td>4</td>
<td>Review historical claims to update procedure and diagnosis codes that are invalid for current grouper software. Apply neonatal grouper enhancement to grouper software. Use enhanced grouper software to assign DRGs to discharges from claims and encounters for the previous three calendar years (1/1/02-12/31/04).</td>
</tr>
</tbody>
</table>
VIII. Appendixes

<table>
<thead>
<tr>
<th></th>
<th>Obtain current HCRIS cost report database files from CMS. Implement SAS database management system to access and retrieve relevant information from cost reports.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Calculate hospital-specific inpatient cost-to-charge ratio using the OHCA formula and data from cost reports in HCRIS. Convert claim charges to cost using the cost-to-charge ratio.</td>
</tr>
<tr>
<td>7</td>
<td>Develop or acquire from OHCA a quarterly index for inflating historical claims. Inflate claim cost forward to most recent quarter in claim set so that analysis is based on real cost, adjusted for inflation.</td>
</tr>
<tr>
<td>8</td>
<td>Calculate DRG weights by dividing the average (arithmetic mean) cost for each DRG by the average cost for all DRGs. Exclude outliers per Medicare methodology.</td>
</tr>
<tr>
<td>9</td>
<td>Retrieve the five hospital-specific variables used to classify hospitals into base-rate peer groups from HCRIS. (<em>Per OHCA's request, the in-state/out-of-state variable will be omitted.</em>)</td>
</tr>
<tr>
<td>10</td>
<td>Recalculate the relative hospital peer-group base rates using the updated data sets for discharge costs and hospital grouping variables.</td>
</tr>
<tr>
<td>11</td>
<td>Reclassify hospitals according to new base rate formula and produce provider-to-peer group cross-walk table with default assignment for unmatched provider IDs.</td>
</tr>
<tr>
<td>12</td>
<td>Obtain from OHCA the approved annual acute hospital inpatient payment budget.</td>
</tr>
<tr>
<td>13</td>
<td>Calculate hospital specific payments for the base year and test for budget neutrality.</td>
</tr>
<tr>
<td>14</td>
<td>Adjust base rates so payments are budget neutral and report the re-calibrated base rates, provider/peer-group crosswalk table, and reconstructed DRG weights, to OHCA &amp; EDS.</td>
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</table>
Appendix 2 – Claim Fields and Criteria for Data Extraction

Header Data Elements

- ICN
- Adjusted ICN
- Claim Status Code
- Claim Type Code
- Facility Provider ID
- Client ID
- Date of Birth
- Sex Code
- Admit Source
- Admit Type
- Patient Status Code
- Admission Date
- First Date of Service
- Last Date of Service
- Provider County Code
- Indian Provider Indicator
- Provider Name
- Admit Diagnosis Code
- Diagnosis Code 1
- Diagnosis Code 2
- Diagnosis Code 3
- Diagnosis Code 4
- Diagnosis Code 5
- Diagnosis Code 6
- Diagnosis Code 7
- Diagnosis Code 8
- Specialty
- Header Billed Amount
- Header (Warrant) Amount
- Header Patient Liability Amount
- Header State Share Amount
- Header Total Reimbursement Amount
- Header TPL Amount
- Header Encounter Amount
- Covered Days
- Non Covered Days
- Total Days
Detail Data Elements

- ICN
- Adjusted ICN
- LOC Pricing
- Revenue Code
- Detail From Date of Service
- Detail Last Date of Service
- Detail Amount Billed
- Detail Amount Allowed
- Detail Co-Pay
- Detail TPL
- Detail Quantity Units Allowed
- Detail Quantity Units Billed
- Days Covered

ICD-9 Surgical Procedure Code Elements

- ICN
- Adjusted ICN
- Surgical Procedure Code
- Surgical Procedure Code Date

Extraction Conditions

- Claim Type Code = “I”
- Last Date of Service Between 7/1/2000 and 6/30/2003
- Final Issue Warrant Date Between 7/1/2000 and 6/30/2004
- Indian Provider Indicator = “X”
- Claim Status Code Different from “D”
- Excluded Hospitals = JD McCarty, George Nigh, The Childrens’ Center
- Excluded “Medically Necessity Clients”
## Appendix 3 – Hospital Cost-to-Charge Ratios

<table>
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<th>OHCA ID</th>
<th>Name</th>
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Appendix 4 – Procedure and Diagnosis Code Updates

Note: No procedure code updates for Grouper Version 22

Diagnosis Code Updates

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Appendix 6 – OHCA DRG Weights for Calendar Years 2002-2004
(based on FFS claims and managed-care encounter data)

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<td>Cardiac congenital &amp; valvular disorders age &gt;17 w cc</td>
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<td>Rectal resection w/o cc</td>
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<td>G.I. obstruction w/o cc</td>
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<td>Esophagitis, gastroent &amp; misc digest disorders age &gt;17 w cc</td>
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<td>Other digestive system diagnoses age &gt;17 w/o cc</td>
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<td>Pancreas, liver &amp; shunt procedures w cc</td>
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<td>Pancreas, liver &amp; shunt procedures w/o cc</td>
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<tr>
<td>193</td>
<td>Biliary tract proc except only cholecyst w or w/o c.d.e. w cc</td>
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<td>Biliary tract proc except only cholecyst w or w/o c.d.e. w/o cc</td>
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<td>Cholecystectomy w c.d.e. w cc</td>
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<td>Hepatobiliary diagnostic procedure for non-malignancy</td>
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<td>Cirrhosis &amp; alcoholic hepatitis</td>
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<td>Disorders of liver except malig,cirr,alc hepa w cc</td>
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<td>Disorders of liver except malig,cirr,alc hepa w/o cc</td>
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<td>Disorders of the biliary tract w/o cc</td>
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<td>Major joint &amp; limb reattachment procedures of lower extremity</td>
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<td>Hip &amp; femur procedures except major joint age &gt;17 w cc</td>
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<td>Hip &amp; femur procedures except major joint age &gt;17 w/o cc</td>
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<td>Hip &amp; femur procedures except major joint age 0-17</td>
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<td>Amputation for musculoskeletal system &amp; conn tissue disorders</td>
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<td>Biopsies of musculoskeletal system &amp; connective tissue</td>
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<td>217</td>
<td>Wnd debrid &amp; skn grft except hand,for muscskelet &amp; conn tiss dis</td>
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<td>Lower extrem &amp; humer proc except hip,foot,femur age &gt;17 w cc</td>
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<td>Lower extrem &amp; humer proc except hip,foot,femur age &gt;17 w/o cc</td>
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<td>Lower extrem &amp; humer proc except hip,foot,femur age 0-17</td>
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<td>Major shoulder/elbow proc, or other upper extremity proc w cc</td>
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<td>Shoulder,elbow or forearm proc,exc major joint proc, w/o cc</td>
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<td>Foot procedures</td>
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<td>Soft tissue procedures w cc</td>
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<td>Major thumb or joint proc,or oth hand or wrist proc w cc</td>
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<td>Hand or wrist proc, except major joint proc, w/o cc</td>
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<td>Local excision &amp; removal of int fix devices of hip &amp; femur</td>
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<td>Arthroscopy</td>
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<td>Other musculoskelet sys &amp; conn tiss O.R. proc w cc</td>
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<td>Fractures of hip &amp; pelvis</td>
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<td>Sprains, strains, &amp; dislocations of hip, pelvis &amp; thigh</td>
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<td>Osteomyelitis</td>
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<td>Bone diseases &amp; specific arthropathies w cc</td>
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<td>Non-specific arthropathies</td>
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<td>Fx, sprn, stm &amp; disl of forearm, hand, foot age &gt;17 w cc</td>
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<td>Fx, sprn, stm &amp; disl of uparm,lowleg ex foot age &gt;17 w cc</td>
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<td>Subtotal mastectomy for malignancy w cc</td>
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<td>Cellulitis age &gt;17 w/o cc</td>
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<td>Prostatectomy w/o cc</td>
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<td>Major male pelvic procedures w cc</td>
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<td>Menstrual &amp; other female reproductive system disorders</td>
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<td>Vaginal delivery w sterilization &amp;/or D&amp;C</td>
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<td>Signs &amp; symptoms w/o cc</td>
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## Appendix 7 – Base Rate Peer Groups

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## Appendix 8 – Absolute Base Rate Calculation

### Step 1. Average Payment per Discharge Calculation

| A = Projected Total Payment (Outlier Adjusted) | $416,235,745 |
| B = Projected Discharges | 105,098 |
| Projected Payment per Discharge = A/B | $3,762 |

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### Step 3. Budget-Neutral Adjustment to Base Rates

| Projected Total Payment | $416,235,745 |
| Sum of Case Mix Adjusted Payments | $388,090,267 |
| (over)/under Budget | $28,145,477 |
| Percent (over)/under Budget | 7.49% |
| Base Adjustment Factor | 1.0749 |

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<td>$4,895</td>
</tr>
</tbody>
</table>