A3 Report

Title: MPIP Hospital Payment Recalculation
Date started: Sept 2017 **Current Date: 12/21/2017**

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LEANOhio

P1: Why Change is Needed

Why are we doing this: The Ohio Department of Medicaid administers the Medicaid Electronic Health Record Incentive Program, known in Ohio as the Medicaid Provider Incentive Program (MPIP). MPIP incentive payments are 100% federally funded and administration of the program is funded at 90/10 enhanced federal match. Incentives are available for eligible hospitals and eligible providers. In 2013, the Federal Office of the Inspector General (OIG) initiated an audit of MPIP. The over several years of back and forth between the OIG and ODM, it was determined that data provided by eligible hospitals to calculate aggregate incentive payments during the attestation and review phase of the program were inaccurate and that this was largely due to a timing issue. In order to comply with the OIG audit findings, and to prevent the OIG from enforcing their original findings, ODM agreed to go back and review all aggregate hospital payments issued via the MPIP program.
This review starts with evaluating the original payment and ends with one of the following determinations: (1) no further action is needed by the hospitals, (2) hospital overpayment or (3) hospital underpayment.
The pain point is determining the most accurate numbers, specifically Charity Care, to use to calculate the aggregate payment.

P2: Current State

Problem: We have to recalculate all hospital payments and there are too many bottle necks and moving pieces in our current process. The hospital calculation process is written in statute and is very complicated to understand. Each hospital may have a different interpretation of the calculation and financial statements are fluid and subject to change. In addition, even if an audited financial document is being used in the calculation, the specific line item required for the incentive payment calculation may not have been audited. Also, a document that worked for one hospital may not work for another, so it makes creating an operational process very challenging. Lastly, the ODM PM is a bottle neck because all hospital correspondence flows through her.
Our current process has 5 delays and a continuous loop back between hospital and CGI. The MPIP PM is responsible for three of the 5 delays. The delay at the hospital could result in ODM not being able to perform the review.

P3: Future State

Future State: The end goal is to determine the aggregate calculation in the most standardized way possible across all hospital payments without additional burden being put on the hospital and ODM staff.

P4: Analysis

Analysis: The issue we come across is that "audited financial data" that was used to process the original payment typically came from an audited document but the particular data element may not have been tested. This resulted in overpayments or in some instanced underpayments based on the OIG onsite audit findings.

Why is the charity care on the old Medicare cost report unreliable?
- Because hospitals didn't allocate resources to auditing that line item
- Because Medicare auditors didn't audit that line item
- Because that line item wasn't tied to a Medicare payment prior to HITECH

P5: Potential Solutions

Potential Solutions:
- Reach out to all hospitals and have them submit program year one charity care to ODM for review.
- Have an auditor review all current documentation and determine if additional review is needed.
- Have CGI reach out to each individual hospital and go back and forth until a final number is agreed on and then send that final number to auditors for review.
- **Use the audited uncompensated care number certified for hospital DSH payments as a proxy for charity care ******

D6: Action Plan

Action item:	Assigned to:	Due Date
Develop new process		
Get buy in from leadership	Emma	1/1/2017
Have CGI do test run	Rebecca	5/1/2017
Request Myers and Stauffer #s from Hospital policy	Emma	6/1/2018
Discuss key players with overall team	Emma	7/1/2017
Start process	Rebecca	9/1/17
Report out to CMS	Emma	1/1/2018

C7: Check Results

Process Map	Before	After	%Change	
Steps/Yellow:	24	19	-21%	
Decisions:	3	4	33%	
Delays:	5	0	-100%	
Loops:	1	0	-100%	
# of People	5	4	-20%	

C7: Check Results

We were able to accomplish the following in our process:
- Eliminate all delays
- Eliminate all continuous loopbacks
- Decrease the number steps
- Decrease the number of people involved
- Increased the number of decisions*. In this case, increasing the number of decisions eliminated a continuous loop back and delay. It also simplified our current process by eliminating CGI's interaction with a hospital.

A8: Follow-up Action

This process went live in September 2017 per our agreement with the OIG. We have completed the first part of the process for 2011. We decided to use the audited Myers and Stauffer's DSH payment uncompensated care number as a proxy or test for determining if a provider needed an additional review from program integrity. As of 12/21/2017, we have completed 57 reviews of 161 and send 19 to program integrity for additional review.
Some providers may prefer to use a data source other than the M&S number for uncompensated care. To account for that, we notify providers that if there is no findings associated with their payment, but they would like an additional review of different documentation, they can request a Program Integrity review.
I anticipate that there may be a learning curve when audit findings are issued and recoupment by SURS because this is the first time MPIP has utilized SURS for recoupment of MPIP payments.