Employees Group Insurance Division

Office of Management and Enterprise Services

Inpatient Facility Reimbursement

October 15, 2013

HealthChoice Inpatient Background

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- On 10/01/07, HealthChoice implemented Medicare Severity Diagnosis Related Groups (MS-DRGs) and changed the outlier formula by increasing the threshold and marginal cost factor.
- On 04/01/08 HealthChoice implemented an urban/rural distinction for inpatient in conjunction with an outpatient fee schedule reimbursement methodology.
- Base rates effective 10/01/13 are $8,417/$10,824 for urban/rural.
  - The MS-DRG allowable is the base rate applied to CMS relative weights.
- Historically, the base rate and outlier threshold have increased an average 2.0% annually.

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- The outlier thresholds effective 10/01/13 are $82,648/$64,256 for urban/rural with a marginal cost factor of 0.80.
- Outlier claims are claims in which billed charges exceed the MS-DRG allowable plus the outlier threshold.
- The Department of Corrections (DOC) utilizes HealthChoice's reimbursement methodology.

Objective of the Analysis

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- Primary Objective: Determine whether HealthChoice's reimbursement methodology and payment levels for inpatient hospital are in line with common industry practices.
- Analytical Steps:
  - Obtain external consulting services to assist in data analysis and identify options for reimbursement approaches that are consistent with industry practices.
  - Obtain Truven Health Reimbursement Benchmark database for 2011 Oklahoma commercial data by MS-DRG.
  - Review HealthChoice's current reimbursement levels and historical cost trends.
    - From 2009 to 2012, inpatient utilization has decreased by 17% but average billed charges have increased by 24% compared to only 6% increase in the base rate for market basket increases.
  - Compare current reimbursement levels to:
    - Allowed-to-Charge Ratio
    - Medicare rates
    - Commercial payer ranges

Objective of the Analysis

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– Identify both short-term and long-term objectives.
  - Short-term objectives are to adjust reimbursement to be within a close range of other Oklahoma commercial payers.
  - Long-term objectives include reimbursement methodology and payment levels for one-day stays and observations cases, mental health, rehabilitation, skilled nursing facilities, readmissions, Hospital Acquired Conditions (HAC), transfer cases, quality/outcomes, and bundled payments.

– HealthChoice's current proposed changes to inpatient reimbursement are based on data analysis and its consultant's recommendations.

– Establish a provider task force to obtain feedback on the analysis and recommendations.
  - 6 urban hospitals and 6 independent rural hospitals were identified by reviewing utilization to participate in the task force.

Issue 1 – Urban/Rural Distinction

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Issue:

- Rural base rate is 183% of the average Medicare base rate compared to the urban base rate of 139%.
- Over 36% of rural non-outlier claims have an allowable greater than billed charges indicating the rural base rate is too high.

Recommendation:

- Freeze the rural base rate at the current level until it is close to the urban base rate and then discontinue the distinction. This is anticipated to take 3-5 years.

Other Considerations:

- Medicare average rural base rate is lower than the urban base rate.
- Fewer independent rural hospitals.

Issue 2 – Urban Non-Outlier Claims

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Issue:

- Urban non-outlier claims are reimbursed at 91% of the Truven median.
- Actual weighted claim payments are 109% of Medicare.

Recommendation:

- A two-tiered base rate for urban hospitals:
  - 4% increase in the base rate for low intensity DRGs
  - 9% increase in the base rate for high intensity DRGs
    - DRGs with MCC, those with relative weights of 5 or greater regardless of CC/MCC, all transplants, and NICU (DRGs 790, 791 and 792).

Other Considerations:

- Average increase will be 4.7%
- Two-tiered approach increases payments to hospitals that have a higher severity case-mix.

Issue 3 – DRGs 793/794

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Issue:

- Currently, 52% urban claims and 100% rural claims for DRG 793 – Full Term Neonate w Major Problems have an allowable greater than billed charges.
- Currently, 85% urban claims and 95% rural claims for DRG 794 – Neonate w Other Significant Problems have an allowable greater than billed charges.

Recommendation:

- A MS-DRG fee will not be established for these two DRGs. HealthChoice will reimburse 60%/70% urban/rural of billed charges.

Other Considerations:

- Medicare relative weights for these two MS-DRGs are probably not appropriate considering Medicare utilization
- An increase in the urban base rate would continue to exacerbate an allowable greater than billed charges.

Issue 4 – Outlier Claims

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Issue:

- Urban outlier claims are reimbursed at 230% of the Truven mean.
- Outlier claims are only 4% of the total claims but nearly 30% of payments compared to 10% for commercial payers and 5% for Medicare.

Recommendation:

- Decrease the marginal cost factor from 0.80 to 0.39.
  - Based on the average operating and capital Cost to Charge Ratio (CCR) for Oklahoma hospitals published by CMS's 2014 Final Rule IPPS Impact file.
- Increase outlier threshold.
  - Urban Threshold = [Medicare cost threshold/urban CCR] * multiplier tied to average base rate markup over Medicare [$21,748 / .34] * 1.55 = $99,145
  - Rural Threshold = [Medicare cost threshold/rural CCR] * multiplier tied to average base rate markup over Medicare [$21,748 / .45] * 1.55 = $74,910

Other Considerations:

- HealthChoice's **charge**-based formula results in high outlier payments when hospitals have high charges. Medicare's outlier formula is **cost**-based.
- 90% of outlier payments are made to 20 hospitals.
- Over 60% of outlier payments are concentrated in 25 MS-DRGs including transplants, cardiac procedures and spinal fusions.
- Commercial payer outlier polices vary considerably including cost-based outlier formulas similar to Medicare's approach, day outlier, and charge based outlier.

Impact of Proposed Changes

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- Impact analysis and comparison to Truven was based upon 2011 data.
- Increased payments for non-outlier cases for all urban hospitals.
- Reduced outlier payments for all hospitals, particularly for hospitals with relatively high charges.
- The majority of urban hospitals, especially those that do not have many outlier claims, would experience a modest increase.
- Most rural hospitals would experience no change in payments.

Impact of Proposed Changes

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- Urban hospitals with substantial outlier volume would experience larger reductions.
  - Prior to adjustment, aggregate outlier payments > 400% of Medicare.
  - Modeled outlier payments are > 200% of Medicare.
  - Charge patterns for hospitals with substantial outlier volume indicate that billed charges are substantially higher compared to national, state, and a national sample of institutions that have similar bed size, resident-to-bed ratios and disproportionate share (DSH) percentages from CMS Medicare Provider Analysis and Review (MEDPAR) inpatient data.
  - Although there is a significant reduction in HealthChoice's outlier payments, HealthChoice represents approximately 2% of the hospitals' total inpatient billed charges.
  - Comparing historical cost to charge data from 2005 to 2011, one particular hospital's charges increased 30% more than costs.

Long-Term Considerations

- Future Redesign Opportunities
  - Many commercial payers are either implementing or considering more innovative approaches to hospital reimbursement as costs continue to increase.
  - Hospitals are providing care to more patients who are older and/or have chronic conditions such as diabetes and congestive heart failure.
  - Commercial plans are seeking to decrease costs while improving quality, mostly through measurement and management of hospital admissions, readmissions and outcomes.
    - Quality measurements and enhancement
    - Medical Homes/ACOs
    - Bundled payments
    - Frequent users/care management

Proposed Time Line

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- Meeting with Hospital Task Force - 10-15-13
- Written Task Force Comments – 10-25-13
- Meetings with Individual Providers, if Requested – Week of 10-28-13
- Public Hearing Notice – Week of 11-04-13
- Public Hearing – Week of 12-09-13
- Public Hearing Written Comments – 12-17-13
- HealthChoice's Responses Posted – 12-20-13
- Fee Schedule Notice to Providers – No later than 01-01-14
- Implementation Date - 03-01-14

Conclusion

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- The current base rate/outlier combination results in overall high payment levels relative to Oklahoma commercial benchmarks with the primary driver being outliers.
- The proposed base rate/outlier combination will bring HealthChoice's urban payments in line with other Oklahoma commercial payers and significantly above Medicare rates.

	Current	Proposed
% of Truven	110%	100%
% of Medicare	159%	143%

- The rural payments will continue to be above Truven during the phase-in period.