Employees Group Insurance Division

Office of Management and Enterprise Services

Inpatient Facility Reimbursement

February 12, 2014

3014

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 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 Medicare's relative weights.
- The Department of Corrections (DOC) utilizes HealthChoice's reimbursement methodology.

HealthChoice Inpatient Background

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- Historically, the base rate and outlier threshold have increased an average of 2.0% annually.
- Outlier claims are claims in which billed charges exceed the MS-DRG allowable plus the outlier threshold.
- The outlier thresholds effective 10/01/13 are $82,648/$64,256 for urban/rural with a marginal factor of 0.80.
- The current base rate/outlier combination results in overall high payment levels with the primary driver being outliers.
- HealthChoice established an inpatient task force in October, 2013 to provide feedback on the proposed reimbursement changes.

Objective of the Analysis

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- Primary Objective: Determine whether HealthChoice's reimbursement methodology and payment levels for inpatient facilities 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.
  - Review HealthChoice's current reimbursement levels and historical cost trends.
    - From 2009 to 2012, inpatient utilization has decreased by 17%. At the same time, average billed charges have increased 24% while the base rates increased 6%.

Objective of the Analysis

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- Assess reimbursement levels relative to charges, costs, Medicare and commercial payer ranges.
- Identify long-term objectives to include reimbursement methodology and payment level assessments 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 proposed changes to inpatient reimbursement are based on data analysis, its consultant's recommendations, and feedback from the task force.

Issue 1 – Urban/Rural Distinction

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Concern:

- The current urban/rural distinction does not adequately address the difference in facility characteristics such as size, cost structure, and service mix. There is a very large differential between urban and rural base rates.

Recommendation:

- Establish a four tier system for acute facilities:
  - Tier 1 – Network urban facilities with greater than 300 beds
  - Tier 2 – All other urban and non-network facilities
  - Tier 3 – Critical Access Hospitals (CAH), Sole Community Hospitals (SCH), Indian, Military and VA facilities
  - Tier 4 – All other network rural facilities

Issue 1 – Urban/Rural Distinction

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Recommendation:

- Annual updates to the base rate:
  - Tier 1 and Tier 2 – 100% of Medicare's full market basket percentage. (No productivity, ACA, etc. reductions)
  - Tier 3 – 50% of Medicare's full market basket
  - Tier 4 – Remain frozen
  - Tier 3 and Tier 4 base rates will be reevaluated annually.

Issue 1 – Urban/Rural Distinction

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Tier	# of Oklahoma Network Facilities	Average Operating and Capital Cost-to-Charge Ratio	Average Case Mix Index	Average # of Beds	Provider Type
1	8	.278	1.7568	513	0
2	35	.356	1.6055	76	0
3	27	.448	1.1771	65	8, 16, 17
4	20	.430	1.1405	66	0, 7

Source: 2014 IPPS Impact File for Oklahoma network providers; Provider Type 0 = IPPS; Provider Type 7 = Rural Referral Center (RRC); Provider Type 8 = Indian; Provider Type 16 = Sole Community Hospital (SCH); Provider Type 17 = SCH/RRC

Issue 1 – Urban/Rural Distinction

Rationale:

- A tiered reimbursement approach is responsive to task force recommendations to develop a categorical system.
- HealthChoice recognizes the important role that rural facilities play in Oklahoma's health system by providing access to residents in less populated areas.
  - Medicare reimburses 101% of costs to CAHs. Temporarily freezing base rates for larger rural facilities (Tier 4) and providing modest increases to Tier 3 facilities aligns with these policies.

Issue 2 – Urban Non-Outlier Claims

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Concern:

- The current urban base rate needs to be updated in order to provide a more appropriate level of payment for non-outlier cases.

Recommendation:

- Tier 1 – 13% increase in the base rate
- Tier 2 – 5% increase in the base rate

Issue 2 – Non-Outlier Claims

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Rationale:

- Tiered base rates are designed to account for differences in facility size, services and patient severity.
- Proposed adjustments to the base rates are estimated to result in payments that are well above costs for non-outlier cases.
- Proposed increases to the base rates are also well above Medicare's average base rates for each tier.
- Proposed base rate adjustments are estimated to result in payments for non-outlier cases that are within close range of other commercial payers in Oklahoma.

Issue 3 – Neonatal

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Concern:

- The Medicare MS-DRG relative weights for neonatal DRGs do not appear to be appropriate for HealthChoice's population. As a result, the allowed amount is almost always more than the billed charges for neonatal DRGs.

Recommendation:

- MS-DRGs 789-794 will be reimbursed at 70% of billed charges for all tiers.
- MS-DRG 795 (Normal Newborn) will receive the allowable for each tier.

Rationale:

- Paying a percentage of billed charges for neonatal care provides a consistent approach for all types of facilities across tiers.

Issue 4 – Outlier Claims

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Concern:

- HealthChoice's **charge** based outlier formula is susceptible to higher outlier payments compared to other payers, particularly for facilities with relatively high billed charges.
  - Medicare's outlier policy is **cost** based.

Issue 4 – Outlier Claims

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Recommendation:

- Establish thresholds for each tier based upon Medicare's current IPPS impact file average Operating CCR and Capital CCR for Oklahoma network providers and Medicare's published threshold.
- The threshold will be updated each year with implementation of a new MS-DRG version.

Threshold	Tier 1	Tier 2	Tier 3	Tier 4
Medicare V31 Threshold	$21,748	$21,748	$21,748	$21,748
Proposed Threshold	$78,228	$61,090	$48,542	$50,586
Current Threshold	$82,648	$82,648	$64,256	$64,256

Issue 4 – Outlier Claims

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Recommendation:

- Establish a marginal factor for each tier based upon Medicare's current IPPS impact file average Operating CCR and Capital CCR for Oklahoma network providers.
- Establish a phase-in period for the marginal factor.
- The marginal factor will be updated each year with implementation of a new MS-DRG version.

Marginal Factor	Tier 1	Tier 2	Tier 3	Tier 4
Current marginal factor	.80	.80	.80	.80
Initial phase-in (06/01/14 to 09/30/14)	.67	.68	.72	.71
Second phase-in (10/01/14 to 09/30/15)	.54	.56	.64	.62
Estimated Full phase-in marginal factor (10/01/15)	.42	.45	.56	.54

Issue 4 – Outlier Claims

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Rationale:

- A tiered approach to the outlier methodology along with tiered base rates considers both the costs and charges for similar facilities within each tier.
- The proposed tiered thresholds are based upon Medicare's fixed loss (cost) threshold and the charge-to-cost ratio for each tier and result in lower thresholds than the current methodology.
- Payments under the proposed outlier formula are estimated to be well above Medicare payment levels.

Impact of Proposed Changes

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- 71% of urban facilities would experience a modest increase in reimbursement.
- 74% of rural facilities would experience no change in payments.
  - Decreases experienced by rural facilities are due to proposed change to neonatal MS-DRGs, i.e., payments will be made at 70% of billed charges rather than amounts greater than billed charges.
- Payments for outlier, non-outlier, and neonatal claims are estimated to be well above costs and Medicare payment levels, and within close range of other commercial payer payments.
- Payments for non-outlier cases for all urban facilities would increase.
- Payments for outlier cases would be reduced for all facilities.
  - Urban facilities with substantial outlier volume would experience larger reductions.

Proposed Time Line

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- Public Meeting Notice on HealthChoice's website – 01/22/14
- Public Meeting – 02/12/14
- Public Meeting Written Comments Due – 02/21/14
- HealthChoice's Responses Posted – 03/26/14
- Fee Schedule Notice to Providers – No later than 04/01/14
- Implementation Date – 06/01/14

Conclusion

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- The current base rate/outlier combination results in overall high payment levels with the primary driver being outliers.
- The proposed base rate/outlier combination will bring HealthChoice's urban payments within close range of other Oklahoma commercial payers and substantially above Medicare rates.
- HealthChoice's rural payments will continue to be above Medicare and commercial payer ranges for several years.