Inpatient Facility Reimbursement

February 12, 2014
HealthChoice Inpatient Background

• 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

• 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

• **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

– 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

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

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

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

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

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
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

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.
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.
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.

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
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<tbody>
<tr>
<td>Medicare V31 Threshold</td>
<td>$21,748</td>
<td>$21,748</td>
<td>$21,748</td>
<td>$21,748</td>
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<tr>
<td>Proposed Threshold</td>
<td>$78,228</td>
<td>$61,090</td>
<td>$48,542</td>
<td>$50,586</td>
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<tr>
<td>Current Threshold</td>
<td>$82,648</td>
<td>$82,648</td>
<td>$64,256</td>
<td>$64,256</td>
</tr>
</tbody>
</table>
Issue 4 – Outlier Claims

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.

<table>
<thead>
<tr>
<th>Marginal Factor</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
</tr>
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<tbody>
<tr>
<td>Current marginal factor</td>
<td>.80</td>
<td>.80</td>
<td>.80</td>
<td>.80</td>
</tr>
<tr>
<td>Initial phase-in (06/01/14 to 09/30/14)</td>
<td>.67</td>
<td>.68</td>
<td>.72</td>
<td>.71</td>
</tr>
<tr>
<td>Second phase-in (10/01/14 to 09/30/15)</td>
<td>.54</td>
<td>.56</td>
<td>.64</td>
<td>.62</td>
</tr>
<tr>
<td>Estimated Full phase-in marginal factor (10/01/15)</td>
<td>.42</td>
<td>.45</td>
<td>.56</td>
<td>.54</td>
</tr>
</tbody>
</table>
Issue 4 – Outlier Claims

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

• 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

- 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

• 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.