Hospital Payments and Quality Initiatives

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Today's Overview

How Ohio Medicaid pays hospitals

- Prospective Payment Methods
- Inpatient Hospital Payment System
- Outpatient Hospital Payment System
- Hospital Care Assurance Program (HCAP)
- Hospital Franchise Fee

Prospective Payment Methods

Developed in the late 1980s, Ohio Medicaid uses prospective payment methods to pay for inpatient and outpatient hospital services.

Inpatient Hospital – based primarily on the **All Patient Refined Diagnostic Related Grouping** (APR DRG) and prospectively determined Hospital Payment Rates

- A small number of hospitals are paid on a reasonable cost basis

Outpatient Hospital – based on prospectively determined fee schedules, with bundling of certain services.

Inpatient Payment System

Prior to 1984: Cost-based Hospital Inpatient Payments
- (Result = constantly increasing and unpredictable)

1984: Implemented APR DRG-based, prospective payment system
- a system of averages that improved predictability

1987: Rebased APR DRG payment system, reset case mix, and hospital rates

2000: Recalibrated APR DRG relative weights, reset case mix, and updated grouper

2006: Recalibrated APR DRG relative weights; reset case mix

July 2013: Implemented new APR DRG grouper, rebased hospital base rates with a 3 year Stop-Loss/Stop-Gain transition

Inpatient Payment Rate Setting

Patient Classification system

What are APR DRGs?

- All Patients Refined Diagnosis Related Groups (APR DRG) is a classification system that classifies patients according to their reason of admission, severity of illness (SOI) and risk of mortality (ROM)
- The patient characteristics used in the definition of the DRGs are limited to information routinely collected on hospital abstract systems
- There are a manageable number of DRGs that encompass all patients seen on an inpatient basis
- Each DRG contains patients who are similar from a clinical perspective
- Each DRG contains patients with a similar pattern of resource intensity

Inpatient Payment Rate Setting

Patient Classification system

How was APR DRG developed?

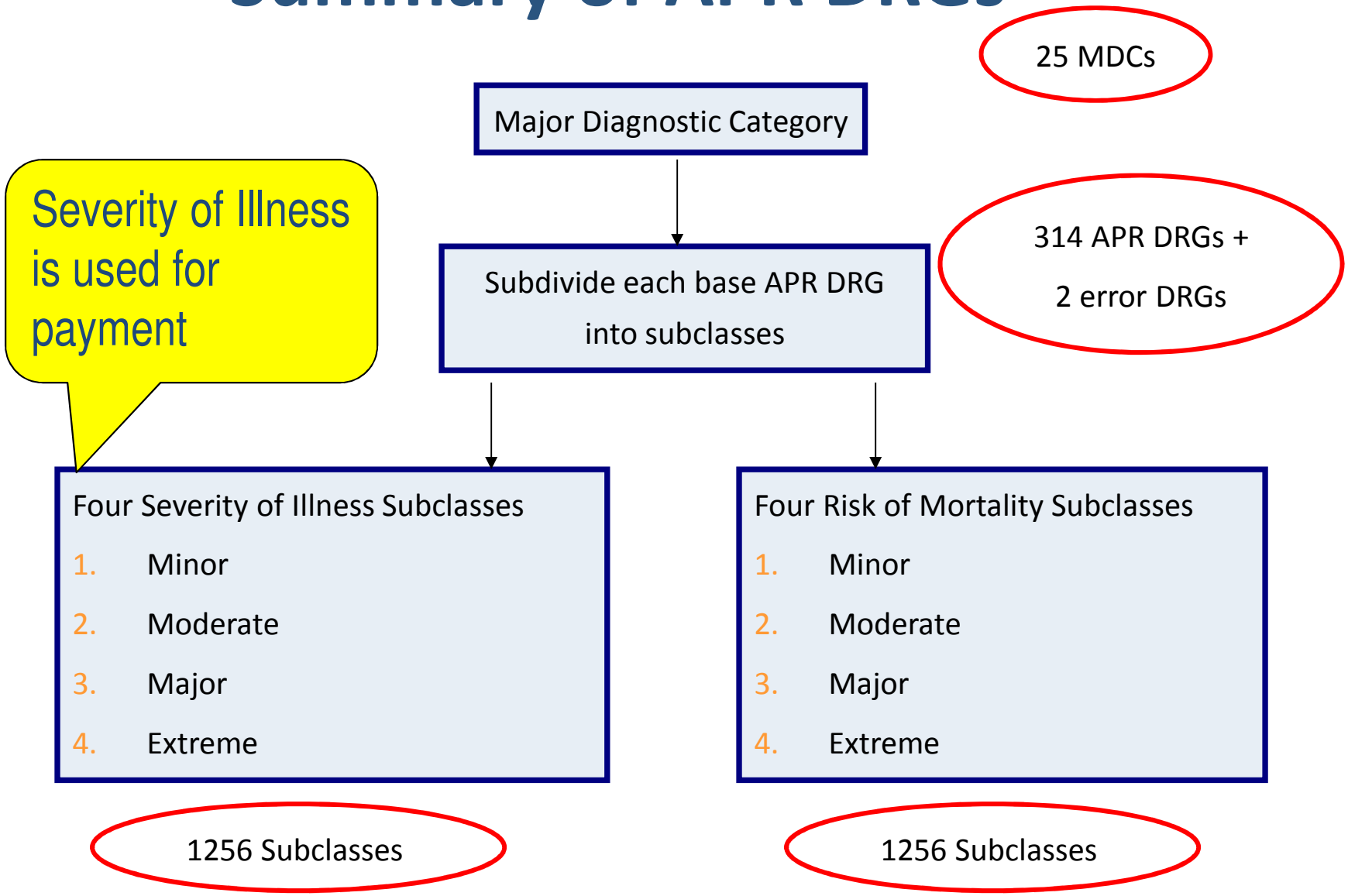
- Designed by a core panel of physicians from the National Association of Children's Hospitals and Research Institutes (NACHRI)
- Supplemented by specialists and subspecialists by body system
- Input from medical records specialists, nursing professionals, health services researchers and economics analysts
- Intensive peer review of all clinical logic processes
- Review and revisions based on data analysis

Fundamental Principle of APR DRG Clinical Logic

- Severity of illness and risk of mortality are dependent on the patient's **underlying condition** (i.e., the base APR DRG)

- High severity of illness and risk of mortality are characterized by **multiple serious diseases** and the **interaction of those diseases**.

Summary of APR DRGs



Summary of APR DRGs - Examples

Major Diagnostic Category = 10

Endocrine, Nutritional & Metabolic Diseases & Disorders

Subdivide each base APR DRG into subclasses = DRG 420, Diabetes

Severity of Illness is used for payment

Four Severity of Illness Subclasses

1. Minor – Uncomplicated Diabetes 250.0x
2. Moderate – Diabetes with Renal Manifestation 250.4x
3. Major – Diabetes with Ketoacidosis 250.1x
4. Extreme – Diabetes with Hyperosmolar Coma 250.2x

Four Risk of Mortality Subclasses

1. Minor – Diagnosis 250.0x & 250.4x
2. Moderate – Diagnosis 250.1x & 250.2x
3. Major
4. Extreme

Sample APR-DRG List and Descriptions

MDC	APR-DRG	APR-DRG Name
	001	Liver transplant or intestinal transplant
	002	Heart or lung transplant
	003	Bone marrow transplant
	004	Tracheostomy w MV 96 hours w extensive procedure or ECMO
	005	Tracheostomy w MV 96 hours wo extensive procedure
	006	Pancreas transplant
01	020	Craniotomy for trauma
01	021	Craniotomy except for trauma
01	022	Ventricular shunt procedures
	023	Spinal procedures
01	024	Extracranial vascular procedures
01	026	Other nervous system related procedures
01	040	Spinal disorders injuries
01	041	Nervous system malignancy
01	042	Degenerative nervous system disorders exc mult sclerosis
01	043	Multiple sclerosis other demyelinating diseases
01	044	Intracranial hemorrhage
01	045	Cva precerebral occlusion w infarct

APR DRGs Characteristics

- APRs are transparent and statistically sound
- APRs have expanded payment categories to a total of 1,256
- Every secondary diagnosis and all procedures are evaluated for their impact on a case
  - Ohio Medicaid accepts 25 Diagnoses and 25 Procedures

DRG Assignment

Claims from the rate setting database were submitted to the grouper for classification using 3M's APR DRG algorithm

- 314 DRGs plus two error DRGs
- 4 Severity of Illness (SOI) levels under each DRG

314 DRGs x 4 SOI/DRG= 1,256 possible combinations for payment purposes

DRG Relative Weights

The **relative weight** is the measure of the resources (costs) of the discharges in the specific DRG/SOI (numerator) as compared to the average resources (costs) of all discharges in the system (denominator).

The average relative weight of all discharges in the rate setting database is 1.0.

Denominator calculation

- Compute the average inflated cost per case for all discharges in the database
- Remove abnormally low and high costs cases (+/- 2 std dev from mean)

Numerator calculation

- Same process as above, but low/high cost outliers are determined for each of the 1,256 DRG/SOI subclass separately

Example of Costing Claims

Data provided by Hospital ABC on JFS 02930

	Hospital Cost Reports	
Schedule C, Column 5 (Per Diem)	12/31/2009	12/31/2010
25. Adults and Peds	820.18	838.92
26. Intensive Care Unit	1320.43	1334.67
Schedule D, Column 1 (Ratio)	12/31/2009	12/31/2010
37. Operating Room	0.4614	0.4569
41. Radiology- Diagnostic	0.2629	0.2596
55. Medical Supplies	0.5701	0.5498

Two Identical Claims Submitted by Hospital ABC
Charges by Revenue Code

	Date of Discharge	
	12/12/2009	1/6/2010
Rev Code 110, Covered Days = 3	$1,654.00	$1,654.00
Rev Code 200, Covered Days = 2	$4,690.00	$4,690.00
Rev Code 360	$8,620.00	$8,620.00
Rev Code 320	$1,200.00	$1,200.00
Rev Code 270	$800.00	$800.00
Total	$16,964.00	$16,964.00

Cost Out the Claims
For Date of Discharge 12/12/2009

	Days/Charges		Per Diem/CCR		Cost
Rev Code 110	3	*	820.18	=	$2,460.54
Rev Code 200	2	*	1320.43	=	$2,640.86
Rev Code 360	$8,620.00	*	0.4614	=	$3,977.27
Rev Code 320	$1,200.00	*	0.2629	=	$315.48
Rev Code 270	$800.00	*	0.5701	=	$456.08
					$9,850.23

Cost Out the Claims
For Date of Discharge 1/6/2010

	Days/Charges		Per Diem/CCR		Cost
Rev Code 110	3	*	838.92	=	$2,516.76
Rev Code 200	2	*	1334.67	=	$2,669.34
Rev Code 360	$8,620.00	*	0.4569	=	$3,938.48
Rev Code 320	$1,200.00	*	0.2596	=	$ 311.52
Rev Code 270	$800.00	*	0.5498	=	$ 439.84
					$9,875.94

Inpatient Payment Rate Setting

Setting Hospital Base Rates

Peer groups are created to merge hospitals with similar cost structures to set base rates.

- The primary formula in the DRG system is *Base Rate x DRG Relative Weight*.
- All current peer groups were examined to determine their appropriateness under the rebased system.
- Possible considerations for peer group definitions and/or hospital assignment to a peer group include:
  - Bed size
  - Urban/rural location (or CBSA)
  - Academic medical center program
  - Unique populations served (e.g., children, psych, rehab)
  - Similarity in cost structure

Inpatient Payment Rate Setting

Hospital Base rates developed?

Assigning Base Rate Values – **Peer Group Level**

- Decision made to retain current OMA Peer Groups with 7/1/13 rebase
- **Base Rate for a Peer Group** = (Total Inflated Costs of Cases in the Peer Group) / (Sum of Total Cases in the Peer Group)
- Discharges used in the calculation were from 10/1/08 – 9/30/10, FFS and managed care combined

Inpatient Payment Rate Setting

How are Relative Weights and Hospital rates developed?

Assigning Relative Weight Values

- Ohio hospital claims (FFS and encounters) used with Ohio hospital cost report data that matched the claims period
- Costs assigned to cases using cost centers as reported on the hospital cost reports
- Stability test done on each DRG/SOI to ensure a stable weight assigned
- In some DRG/SOIs, weights from NY Medicaid were used to impute an SOI weight within a DRG or were used as a substitute weight (approx 0.2% of all cases in the dataset).
- In 18 DRGs, some SOIs were adjusted since the progression of weights was illogical with each higher SOI. Often, the average of two adjoining SOIs was used to apply as a weight to both SOI levels.

Inpatient Payment System

For the typical inpatient case the payment is calculated as follows:

Total Inpatient Payment =

(Hospital Base Rate x DRG/SOI Relative Weight)

+ Capital Add-on

+ (Graduate Medical Education Rate x DRG Relative Weight) (if applicable)

Inpatient Payment System *(continued)*

Medical Education Add-on: recognizes a portion of a hospital's costs by virtue of having a Graduate Medical Education (GME) program.

- ***Direct MedEd*** – recognizes costs related to the actual training of interns and residents.
- ***Indirect MedEd*** – recognizes facility costs related to hospitals running a teaching program (does not include Direct MedEd costs).
- It is case-mix adjusted

Capital Add-on: recognizes costs associated with hospitals' buildings and equipment.

- It is not case-mix adjusted

Inpatient Payment System

Outlier Payments

- Fixed Outlier Threshold varies, either DRG or peer group specific
  - For Neonate and Tracheostomy DRGs, threshold = $42,900 (cost)
  - For non-Neonate/Trach cases for Teaching/Children's Peer Groups = $54,400 (cost)
  - For non-Neonate/Trach cases other Peer Groups = $68,000
- Outlier Payment Percentage = 90%
- Eligible Outlier Costs = (Cost of Case – Outlier Threshold)
- Outlier Threshold = (Base Payment + Fixed Outlier Threshold)

Inpatient Payment System *(continued)*

Outlier Payments *(continued)*

Example: Inpatient claim with charges of $200,000 and the cost-to-charge ratio for the hospital is 0.75. The DRG/SOI has a relative weight of 1.2, the hospital base rate is $2,500, MedEd rate is $1,000, and a capital add-on of $200.

Step 1: Calculate the cost of the case – $200,000 x 0.75 = $150,000

Step 2: Calculate the amount over the outlier threshold – $150,000 – [($2,500 x 1.2) + $68,000] = $79,000

Step 3: Calculate 90% of outlier cost difference – $79,000 x 0.90 = $71,100

Step 4: Calculate total payment – ($2,500 x 1.2) + (1,000 x 1.2) + $200 + $71,100 = $75,500

Adjustments to Base Rates

Assigning Base Rate Values – **Hospital Level**

- In order to not have a fiscal shock on any one hospital the base rates were phased through adjustment
- Starting Point for assignment of the base rate is the hospital's Peer Group base rate (termed the "natural" base rate)
- A stop loss/stop gain was applied, however, depending on peer group. If a hospital's fiscal impact showed payment change outside the corridor, the hospital's base rate was forced to be a rate to fit the hospital's payments within the corridor.
- The adjustments will be phased out over time

Inpatient Payment Rate Setting

Assigning Base Rate Values – **Hospital Level** (continued)

- If the hospital is in one of ODM's Rural Peer Groups (11, 12 or 20) or is in an ODM MSA Peer Group but has Critical Access Hospital designation by Medicare, then there is no Stop Gain cap. Each hospital's base rate was forced to be equal to payments that are calculated to equal a floor of 70% of the hospital's costs.
- If the hospital is in an ODM MSA Peer Group and is not a Critical Access Hospital, then the Stop Loss limit is -3.0% and the Stop Gain limit is +3.0%.
- If the hospital is in the ODM Teaching Peer Group, then the Stop Loss limit is 0.0% and the Stop Gain limit is +3.0%. (All hospitals in the peer group are at 0.0%, however.)
- If the hospital is in an ODM Children's Peer Group, then the Stop Loss limit is -5.0% and the Stop Gain limit is +5.0%.

Projected Cost Coverage from APR DRG Implementation

	Expected Payment to Cost
TOTAL	*82.3%*
Urban	75.4%
Rural	86.6%
Teaching	91.7%
Children's	93.5%

Inpatient Payment Rate Setting

ODM will continue I/P payment reforms. These include the following:

- Phase out the Stop Loss/Stop Gain corridors over time
- Changes to peer groups (fewer peer groups, reassign some urban/rural status hospitals)
- Bring current DRG Exempt hospitals into the DRG payment system
- Payment considerations for distinct part rehab units
- Payment reform for readmissions
- Payment reform for medical education
- Implement quality-based payments into the system

Due to the large impact just for the changes made for July 1, 2013 it was decided to migrate the policy changes stated above, or other changes, in over time after initial implementation has been completed.

Outpatient Payment System

Prior to 1989: Cost-based Hospital outpatient payments
(Result = constantly increasing and unpredictable)

1989: Implemented prospective CPT code based fee payment system, that improved payment predictability

- *However, payment for many codes remained cost based or paid percent of billed charges*

2012: Final transition from cost-based payments starts

2014: The remaining cost based codes were moved to fixed fee schedule amounts except for Chemotherapy services;

- Evaluation of new O/P prospective payment system begins. Will use patient diagnosis and procedures performed to group O/P services using 3M's Enhanced Ambulatory Patient Grouping System (EAPG).

Outpatient Payment System

ODM reimburses most hospitals for outpatient services using prospectively determined fee schedules.

- Based upon the Physician's Current Procedural Terminology (CPT) coding and local level (HCPCS) codes.
- For emergency room, clinic and surgery services, ODM pays for the episode of care (bundle of services) for each date of service.
- Example: The surgery payment is payment in full for the medical supplies, pharmaceuticals, anesthesia, pre-op care, etc., as well as the surgical procedure itself.

Outpatient Payment System

Examples of Outpatient Bundling

- **Example**: Patient with a broken foot goes to a hospital-based clinic. They get an x-ray, pain medication, and fitted for a "boot" and crutches. The medication, boot, and crutches are bundled into the payment for the clinic visit, while the x-ray is separately payable.

- **Example**: Patient is seen in the Emergency Department and treated with stitches and pain medication. The stitches and medication are considered bundled into the ED payment.

Outpatient Payment System

Outpatient Annual Rate Setting

Annually, the American Medical Association and CMS create new CPT & HCPCS codes or reconfigure existing codes.

- Staff analyze these codes to set coverage rules and rates

- Staff target rates to a benchmark of 76% to 80% of Medicare rates, but limit specific code rates to rates for ‘similar’ services on the fee schedule

- This year CMS released these codes on 11/7/2014, leaving staff with 4 weeks to analyze , make coverage recommendations, set rates, draft emergency rules and do systems implementation work for a 1/1/2015 effective date.

Outpatient Payment System

What are EAPGs?

EAPGs are a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. Patients in each EAPG have similar clinical characteristics and similar resource use and cost.

EAPGs were developed to encompass the full range of Ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics.

EAPGs developed to represent ambulatory care across all payers, not just Medicare.

Outpatient Payment Reform

Rationale for Use of EAPG for Payment

- EAPGs are superior to Medicare's APCs especially for Medicaid programs
- Designed for an all-patient rather than for just a Medicare population
- Cover all outpatient services rather than aligning with Medicare payment policy that uses fee schedules for certain services (e.g., therapies, clinical labs, chemotherapy drugs)
- Classify medical outpatient visits based on diagnoses-not E&M codes matching payment to need and permitting service site neutrality of payment
- Bundling features create incentives for efficiency

Outpatient Payment Reform

EAPG Based Payment System

- Each EAPG has an associated relative weight for payment
- Weights indicate the relative resource utilization among all ambulatory services
- Resource intensive services have higher weights
- Incentive for efficient use of routine ancillary services is created by significant procedure consolidation and by the packaging of routine ancillaries into base visit payment
- No incremental payment for routine, low cost ancillaries (blood chemistry, chest x-ray, EKG, etc.)

Outpatient Payment Reform

EAPGs vs. DRGs

- DRGs
  - Describes an inpatient admission
  - Uses discharge date to define code sets
  - Based on Diagnosis and Procedure codes
  - Each admission assigned only 1 DRG

- EAPGs
  - Defines ambulatory visit
  - Uses from date to define code sets
  - Based on Diagnosis and Procedure codes
  - Multiple EAPGs may be assigned per visit – meaning more than a single line item receives payment

Outpatient Payment Reform

EAPG Based Payment Rate Development: Next Steps

- Group FFS & MCP O/P claims (1/1/2011-13/31/2013) using EAPG Grouper
- Like I/P, assign costs to each EAPG, using cost center method
- Calculate associated relative weights for payment of each EAPG
- Like I/P Set and assign Hospital Peer Group base rates
- Evaluate and make needed policy decisions
- Conduct fiscal analysis modeling
- Constant engagement with & education of stakeholders
- Constant engagement with HP for systems implementation
- Go Live: **1/1/2016**

Hospital Care Assurance Program

The Hospital Care Assurance Program (HCAP) is Ohio's version of the federally required Disproportionate Share Hospital (DSH) program.

- **HCAP** compensates hospitals who provide a disproportionate share of care to indigent patients (Medicaid consumers, people below poverty, and people without health insurance).
- Funds are distributed to hospitals using policy pools that account for Medicaid shortfall, uncompensated care, critical access and rural hospital and children's hospital status
- Distributes approx. $594 M in SFY 2015 to Acute Care General Hospitals.
- ACA Mandated cuts to Federal DSH funds to hospitals delayed until FFY 2017.

Hospital Care Assurance Program (HCAP)

- Hospitals receive payment based on policy payment pools.
- Pool payment is based on a hospital's proportion of a measuring factor to all other hospitals eligible in each pool.
- Total payment to hospital is limited to the lessor of: sum of payment in each pool or the hospital-specific disproportionate share limit (sum of Medicaid shortfall (FFS & MMC) plus the cost of care to the uninsured.
- 157 of 201 hospitals receive a payment

Current HCAP Distribution

Policy Pools	Percent of Total	Allocation	Number of Hospitals	Measuring Factor
High Fed DSH :	7.85%	$46,633,173	13	Total Medicaid Costs
Medicaid Indigent Care Payment Pool:	20.40%	$121,186,844	157	Medicaid Shortfall
Uncompensated Care Below Poverty Pool:	61.12%	$363,085,290	154	Uncompensated Care Below Poverty
Uncompensated Care Above Poverty:	5.24%	$31,128,385	155	30% of Uncompensated Care Above Poverty
Critical Access Hospitals:	1.30%	$7,722,691	13	Medicaid Shortfall
Rural Access Hospitals:	2.76%	$16,395,867	50	Remaining DSH Limit
Children's Hospital Payment Pool:	1.33%	$7,900,907	5	Remaining DSH Limit
Total Allocation	100.00%	$594,053,157		

Proposed for FFY 2014 HCAP Distribution

Policy Pool	Percent of Total	Allocation	Hospitals Paid	Measuring Factor
High Fed DSH :	12.00%	$71,286,379	13	Total Medicaid Costs
Medicaid Indigent Care Payment Pool:	60.38%	$358,689,297	157	Remaining DSH Limit
Uncompensated Care Pool:	16.88%	$100,276,173	155	Uncompensated Care Below Poverty
Critical Access Hospitals:	3.40%	$20,197,807	33	Remaining DSH Limit
Rural Access Hospitals:	5.36%	$31,841,249	30	Remaining DSH Limit
Children's Hospital Payment Pool	1.98%	$11,762,253	5	Remaining DSH Limit
Total Program Payments	100.00%	$594,053,158		
Statewide DSH Limit		**$1,605,173,041**		

Hospital Franchise Fee

The Hospital Franchise Fee Program (HFF) was originally enacted as part of Ohio's 2010 - 2011 Biennial Budget bill (Am. Sub. H. B. 1 of the 128th General Assembly)

- The program was continued in the SFY 12/13 Biennial Budget bill (Am. Sub. H. B. 153 of the 129th General Assembly) and the SFY 14/15 budget.

- The HFF is assessed on all hospitals that meet the conditions in Sections 5168.20 to 5168.28 of the Ohio Revised Code.

Hospital Franchise Fee

The franchise fee generated $513.5 M in SFY 2014

$213.45 M used to offset GRF spending for Medicaid.

Remaining HFF revenue supports reimbursement vehicles (hospital Upper Payment Limit program, MCP incentive payments to hospitals and rate increases) to Hospital Industry.

Questions