Hospital Reimbursement Methods
August 2010

Background

During the 2010 special session, the Legislative Assembly issued a budget note in House Bill 5100 directing the Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP) to work with hospitals, Oregon Health Plan (OHP) managed care plans and other stakeholders to study hospital reimbursement methods under OHP. The budget note directs the division to assess how the current reimbursement method could be modified to create a common reimbursement mechanism among a variety of payers and better contain hospital costs. It also directs the division to report results of the study to either the Interim Joint Committee on Ways and Means or Emergency Board by September 30, 2010, as well as to appropriate legislative policy committees and the Oregon Health Policy Board.

Results in brief

Individuals representing approximately 25 hospitals, MCOs, and Oregon Association of Hospitals and Health Systems joined DMAP for three meetings. Our goal was to determine what reimbursement methodologies are used by in paying hospitals, which are most common, and to build some consensus on what would be a good standard for the future. Currently, there is general agreement between OHP managed care organizations (MCOs) and hospitals about the method by which MCOs reimburse hospitals[1] for inpatient care, both with hospitals for which a contract is in place as well as for non-contracted hospitals. In most cases, the hospital contracts with the MCO and usually agrees to reimbursement based on

[1] In this paper, hospitals are grouped into three broad categories. As defined by Oregon law, a Type A hospital is a small and remote hospital that has 50 or fewer beds and is more than 30 miles from another acute inpatient care facility. A Type B hospital is a small and rural hospital that has 50 or fewer beds and is 30 miles or less from another acute inpatient care facility. A "DRG hospital" means a hospital that is not aType A or Type B hospital and that receives Medicare reimbursement based upon diagnostic related groups.

Medicare's Diagnostic Related Group (DRG) rates. In those cases where hospitals and plans cannot agree on rates for inpatient care, they follow current DMAP rule requiring plans to pay non-contracted DRG hospitals using Medicare DRG methodology. These rates are set in statute. DMAP has established a rate for the plans to pay each Type A and B hospital.

However, there is not agreement on a standard methodology for outpatient hospital reimbursement methodology. Many MCOs and hospitals do not use the methodology on which Medicare bases its rates for outpatient care, called Ambulatory Payment Classification (APC)[2]. While hospitals follow Medicare's dictate to use APC to bill Medicare, many do not purchase the APC software to verify Medicare's billing. Through stakeholder discussions, we found that only a few MCOs and hospitals have purchased the necessary software to use the APC methodology.

Since March 2008, administrative rule requires MCOs to reimburse hospitals outside of their care networks based on the Medicare method, which is APC for outpatient care. Due to the change in rule, DMAP no longer publishes an alternative rate schedule for outpatient hospital at DRG-based hospitals. Type A and B hospitals continue to be paid for both inpatient and outpatient care at a rate that is determined to be cost. This is calculated by DMAP and based on the hospitals' cost-to-charge ratios – a ratio of what they charge for a service versus what it costs to provide the service. DMAP continues to publish inpatient and outpatient rate tables for them.

Most DRG-based hospitals bill charges and most MCOs reimburse at a percentage of the hospital's charges. This is unacceptable to many plans because it does not allow them to estimate expenditures accurately, and it does little to contain health care costs. Hospitals increase their charges at least once annually, and when the charges increase, so does the level of reimbursement.

While many options were discussed, the organizations are far from consensus on the question of outpatient reimbursement and believe more study is warranted given the level of work, cost, and changes that must be implemented to move to a standard with which no one is yet familiar.

[2] Services in each APC are similar clinically and in terms of the resources they require. These similar services are "bundled" together and a payment rate is established for each APC.

Discussion: Outpatient payment methodologies

As noted earlier, hospitals and MCOs are largely satisfied with the current reimbursement methodologies for inpatient care. Thus, the majority of the focus has been exploring options for outpatient hospital payment methods. Stakeholders raised the issue of a standard methodology for outpatient rates for contracted MCO payments to hospitals. However, there was no general consensus among stakeholders about whether DMAP should require MCOs and hospitals to use a specific payment methodology. Some stakeholders stated that DMAP should not require a specific methodology or rate, leaving the negotiation of rates to the parties involved. Some acknowledged that establishing a standard for fee-for-service and non-participating hospital rates can be useful in facilitating mutually agreeable contract terms. There was general concensus, however, that many MCOs and hospitals dislike the Medicare methodology dictated in rule, which is APC for outpatient care.

DMAP and the stakeholders researched other possible methodologies that could be used for billing and pricing outpatient hospital services. Vendors provided demonstrations of Medicare's APC, Enhanced Ambulatory Patient Groups (EAPG), and a Resource-Based Relative Value Scale (RBRVS) system specifically for outpatient hospital services. Each of these systems factors efficiency and quality into reimbursement, rewarding hospitals for better, more cost-effective care. All of these systems have been used by other payers across the nation, including some Medicaid agencies, and each has some features that the MCOs and hospitals determined were useful. However, there was no agreement among MCOs or hospitals about which system to adopt.

The hospitals and MCOs did agree on the elements that should be present in any outpatient hospital payment standard methodology that DMAP could adopt in collaboration with hospitals and MCOs. The methodology should:

1. Align with federal health care reform goals and objectives to promote quality and cost effectiveness;
2. Encourage simplicity and transparency. Complex reimbursement methodology is difficult to bill and pay accurately, expensive to set up, and complicates verifying and auditing payment accuracy;
3. Minimize cost of implementation for hospitals and MCOs;

4. Not primarily be adopted as a mechanism to reduce funding for services; and
5. Facilitate budgeting and projection of expenditures, contain costs and minimize the randomness of increases in charges.

Recommendations

The department, with stakeholder agreement, recommends further study. In addition to the work already undertaken, participants in the meetings to discuss hospital reimbursement methods would like to add proof of concept and a thorough analysis of fiscal impact to DMAP, MCOs and hospitals before adopting any of the various options under consideration.

Conclusions

The department expects MCOs and hospitals to continue to use the Medicare-based DRG for inpatient services at most hospitals (and the cost-based systems and published rates for Type A and B hospitals) to guide reimbursement standards for inpatient services. The department also anticipates that systems and technologies, like APC, EAPG and others that group charges for related care, will contain costs by bundling similar services and rewarding quality and cost effectiveness.

Department staff will undertake or oversee thorough study and analysis of multiple options for billing and payment of outpatient hospital services, using the recommended elements described by stakeholders as well as the direction of reform at the federal and state level as guiding principles. However, the fee-for-service claims and managed care encounter data currently being collected do not contain adequate data for analyzing outpatient costs under an APC, EAPG or RBRVS system.

DMAP believes that collecting and analyzing the data needed to evaluate other billing and reimbursement systems will take approximately 18 months and will involve changing rules and training providers. The general agreement around the five principles outlined here should smooth the way for eventual general consensus, which can then lead to successfull implementation.

Oregon
Theodore R. Kulongoski, Governor

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September 23, 2010

The Honorable Senator Peter Courtney, Co-Chair
The Honorable Representative Dave Hunt, Co-Chair
Emergency Board
900 Court Street NE
Salem, OR 97301-4048

Re: Hospital Reimbursement Methods

Dear Co-Chairpersons:

NATURE OF REPORT

During the 2010 special session, the Legislative Assembly issued a budget note in House Bill 5100 directing the Oregon Department of Human Services, Division of Medical Assistance Programs (DMAP) to work with hospitals, Oregon Health Plan (OHP) managed care plans and other stakeholders to study hospital reimbursement methods under OHP. The budget note directs the division to assess how the current reimbursement method could be modified to create a common reimbursement mechanism among a variety of payers and better contain hospital costs. It also directs the division to report results of the study to either the interim Joint Committee on Ways and Means or Emergency Board by September 30, 2010, as well as to appropriate legislative policy committees and the Oregon Health Policy Board.

REPORT SUMMARY

While hospitals and Managed Care Organizations (MCOs) are largely satisfied with the current reimbursement methodologies for inpatient care, there were fewer points of consensus for outpatient payment

methodologies. Stakeholders raised the issue of a standard methodology for outpatient rates for contracted MCO payments to hospitals, but there was no general consensus among stakeholders about whether DMAP should require MCOs and hospitals to use a specific payment methodology. Some acknowledged that establishing a standard for fee-for-service and non-participating hospital rates is useful in facilitating mutually agreeable contract terms. Many MCOs and hospitals dislike the Medicare methodology dictated in rule, which is Ambulatory Payment Classification for outpatient care.

DMAP and the stakeholders researched other possible methodologies that could be used for billing and pricing outpatient hospital services. Vendors provided demonstrations of Medicare's APC, Enhanced Ambulatory Patient Groups (EAPG), and a Resource-Based Relative Value Scale (RBRVS) system specifically for outpatient hospital services. Each of these systems factors efficiency and quality into reimbursement, rewarding hospitals for better, more cost-effective care.

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4. Not primarily be adopted as a mechanism to reduce funding for services; and
5. Facilitate budgeting and projection of expenditures, contain costs and minimize the randomness of increases in charges.

The department, with stakeholder agreement, recommends further study of outpatient payment methods. In addition to the work already undertaken, participants in the meetings to discuss hospital reimbursement methods would like to add proof of concept and a thorough analysis of fiscal impact to DMAP, MCOs and hospitals before adopting any of the various options under consideration.

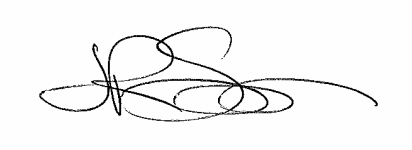
ACTION REQUESTED

The department requests the committee's acceptance of the attached report.

LEGISLATION AFFECTED

The attached report responds to the budget note in HB 5100.

Sincerely,



Jim Scherzinger
Deputy Director of Finance

cc: Judy Mohr Peterson
House Health Care Committee
Senate Health Care Committee