Report to the Social Services Appropriations Subcommittee and the Office of the Legislative Fiscal Analyst

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Payment Methodology to Rural Hospitals

October 2020

UTAH DEPARTMENT OF HEALTH

Statutory Requirement

This report is submitted in response to the following intent language passed in HB 2 during the 2020 General Session of the Utah State Legislature:

> *The Legislature intends that the Department of Health work with rural hospitals to propose options to the Office of the Legislative Fiscal Analyst by October 1, 2020 for a new reimbursement methodology for rural inpatient hospital billing that gives the State of Utah more control over the annual inflationary increases and keeps the total funding close to previous levels that could start with FY 2022.*

Definitions

CMS – Centers for Medicare and Medicaid Services

DOH – Utah Department of Health

DRG – Diagnosis Related Group

PRISM – The Provider Reimbursement Information System for Medicaid is the system currently being developed for DOH to replace the legacy claims adjudication system

Rural Hospital – Hospitals located in counties outside of Cache, Davis, Salt Lake, Utah, Washington and Weber

Introduction

This is a challenging topic as any changes would need to be carefully considered to ensure rural providers remain viable entities. Any option considered has pros and cons which deserve thoughtful consideration. While the fiscal impact of regular charge master increases may be small to the State's budget, they may be large to a small rural hospital struggling to keep its doors open to serve the local population. In some cases, a rural hospital may be the only means of obtaining care for some persons in the community.

Reviewing past audits[1] of Disproportionate Share Hospital payments, one may see the majority of rural hospitals have uncompensated care costs for services provided to Medicaid members. Accordingly, caution in making changes to Medicaid's reimbursement to these hospitals is even more warranted.

[1] https://medicaid.utah.gov/stplan/inpatientdsha/

Unfortunately, most reimbursement methodologies do not necessarily control for annual inflationary increases resulting from hospitals updating their charge masters. Some methods employed in other states primarily include variations of DRG reimbursement (e.g., MS-DRG, APR-DRG) and percent of cost variations (e.g., 101% of costs for Critical Access Hospitals).

Reimbursement Options for Rural Hospitals

The Utah Department of Health worked with rural hospitals and the Utah Hospital Association (UHA) to identify options to consider. UHA suggested the following three options:

1. Existing program remains unchanged
    a. This would result in no disruption to the rural hospitals and continues to allow payments to adjust based on the complexity of the services provided.
    b. Maintaining the existing payment methodology will help ensure no rural provider or community is adversely impacted.
2. Reduce the percent of charges paid
    a. Adjust the percent paid from 89% to some amount resulting in a budget neutral policy.
    b. Any annual increases could be approved by the legislature (e.g., the industry would need to lobby for their increase).
    c. Hospitals don't have the same charge master increases annually, therefore a uniform adjustment factor will impact each hospital differently.
    d. Determining the appropriate reduction may be problematic as it would impact hospitals differently depending on their changes in complexity of services provided.
3. Freeze the percentage of charge payment levels as of a specific year
    a. Attempt to target, with consideration of changes in volumes of services and complexity of care, a fixed amount of reimbursement.
    b. Any annual increases could be approved by the legislature (e.g., the industry would need to lobby for their increase).

Some other methodologies used around the country, although not necessarily able to control for inflationary changes in the hospitals' charge masters include:

1. Pay using a DRG
    a. Rural hospitals would be paid using the same methodology as Urban Hospitals.
    b. Increases administrative burden on rural providers.
    c. A factor could be implemented in the payment calculation to offset annual inflationary increases.
    d. This change would require updates to both legacy and PRISM claims adjudication systems.
    e. This change would require an update to the Utah State Plan and CMS approval.

f. This methodology was reviewed in January 2020. At the time, a move to DRG reimbursement would have resulted in approximately a 40% reduction in payments. Given CMS' reaction to rate cuts in the past, it is unlikely such a change would be approved.
g. This methodology does not directly control for charge master increases

2. Pay using a percentage of cost methodology
    a. In some States, critical access hospitals (CAH) are paid 101% of costs.
    b. This does not specifically control for inflationary increases in a hospital's costs; however, it would equally reimburse hospitals at least their costs.
    c. This change would require updates to both legacy and PRISM claims adjudication systems.
    d. This change would require an update to the Utah State Plan and CMS approval.
    e. Cost settlements increase the administrative burden for both the state and rural providers.

Other Information

The Utah Hospital Association provided this additional background of the rural hospital environment in Utah:

> The Utah Department of Health, the Utah Hospital Association and the Utah State Legislature have worked collaboratively over many years to assure access to hospital care in rural communities. Urban hospitals, in particular, have consistently supported policies that recognize the fragility of rural providers. In approximately 1995, in collaboration with the Utah Department of Health, urban Utah hospitals took a minor cut in payments so that money could go to pay rural hospitals a better inpatient rate. This policy has basically been the policy since that time. At that time, the rural hospitals were paid 100% of billed charges for Medicaid inpatients. This not only helped the patients and the hospitals but the local communities as rural hospitals are always one of the top three employers in rural Utah counties. Twice since that time, the Legislature has reduced rural Medicaid inpatient payments. The first reduction was to 93% of billed charges and the second, which is the current rate of 89% of billed charges. Overall, this has still been one of the best ways that the Utah Legislature has ensured that rural Medicaid patients get access to quality care as required by federal law. In addition, this helps maintain and improve the rural healthcare infrastructure in Utah
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> Utah has been fortunate that we have not had a rural hospital close for at least 30 years. This is due largely to the partnership between those hospitals, the Utah Hospital Association, the Utah Legislature, the Utah Department of Health and other state and federal officials working together to ensure the financial health and

stability of these crucial hospitals. We have had at least four rural hospitals over the past thirty years within days or weeks of closure, but this collaboration has helped keep them open for their rural residents. There is ample evidence that a rural hospital closure impacts the health of its surrounding citizens as well as compromising the economy of the rural area.

Other states have not been so fortunate and have seen significant rural hospital closures due to increasing financial pressures. Nationally, 130 rural hospitals have closed since 2010 while none have closed in Utah. The focused commitment of the legislature, the Utah Department of Health, and the hospital community to rural hospitals has clearly been successful at maintaining access. Following is a link to recent list of rural hospital closures: https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-130-rural-hospital-closures.html