# Report to the Office of the Legislative Fiscal Analyst

## Reimbursement Alternatives for Inpatient Hospital Outlier Payments

Prepared by the Division of Medicaid and Health Financing

September 30, 2011

# EXECUTIVE SUMMARY

This report is submitted in response to the following intent language passed in Senate Bill 2, lines 868 through 878, by the 2011 Legislature:

> The Legislature intends that the Department of Health report by October 1, 2011 to the Office of the Legislative Fiscal Analyst on reimbursement alternatives for inpatient hospital outlier payments that would give the State more control over inflationary increases and/or move away from a reimbursement based on billed charges. The report also shall explain the measures the Department takes to verify the validity of outlier claims. This report should include a report on any other reimbursements based on billed charges that totaled over $1,000,000 total funds in FY 2011 and options for moving away from paying as a percentage of billed charges.

## Reimbursement Alternatives for Inpatient Hospital Outlier Payments That Would Give the State More Control

Staff researched several states and Medicare for outlier payment methodologies. All states researched pay a percent of charges when the outlier threshold is reached. The difference across programs relates primarily to how the claim is determined to have exceeded the threshold, and what percent of charges is paid.

Some states (MS, OK, PA,WA, OH, KY, and RI) determine whether the threshold is exceeded by estimating the costs of the claim, based on the hospital specific cost-to-charge ratio (CCR), and determining whether the costs exceed the base payment by a specified threshold. If the costs exceed the base payment by the predetermined threshold, some percentage of the estimated costs is paid.

Other states (NJ and TX), determine whether the threshold is exceeded by comparing total charges to the base payment. If the charges exceed the base payment by the predetermined threshold, they pay some percentage of charges based on the hospital specific CCR, and any other applicable reduction factors the state may have.

In some states (TX and PA), payment may also be made when the length of stay exceeds a predetermined outlier threshold. These generally pay a per diem that is set by using the average per diem rate (base DRG payment / avg. length of stay) and applying some adjustment factor to that amount. Texas does not allow for both a cost outlier and a length of stay (LOS) outlier payment. Pennsylvania, on the other hand, does allow for both simultaneously.

Some states (MS and RI) have a LOS outlier system in place only for inpatient hospital mental health related claims. In these cases, the LOS outlier payments take the place of the cost outlier payments.

Additionally, Medicare determines if the charges exceed the predetermined threshold and pays a percent of charges based on the hospital specific CCR.

| Administrator | Method |
|---|---|
| Mississippi | Pays 50% of costs exceeding base DRG payment when costs exceed outlier threshold |
| Oklahoma | Pays % of costs (based on hospital CCR) above outlier threshold |
| Pennsylvania (Costs) | Pays 100% of costs when costs exceed 150% of DRG base payment |
| Pennsylvania (LOS) | Pays 60% of per diem DRG rate when LOS exceeds LOS outlier threshold |
| Texas (Costs) | Pays 70% of charges exceeding outlier threshold |
| Texas (LOS) | Pays 70% of per diem DRG rate when LOS exceeds LOS outlier threshold |
| Washington | Pays 100% of costs when costs exceed 175% of DRG base payment |
| Ohio | Pays 100% of costs when costs exceed outlier threshold |
| New Jersey | Pays % of charges (based on hospital CCR) above outlier threshold |
| Kentucky | Pays 80% of costs exceeding the outlier threshold |
| Rhode Island | Pays 60% of costs above Base DRG Payment when costs exceed outlier threshold |
| Medicare | Pays % of charges (based on hospital CCR) above outlier threshold |

**Explanation of Measures the Department Takes to Verify the Validity of Outlier Claims**

Inpatient claims are reviewed by Program Integrity within the Office of Inspector General for Medicaid Services. Following are some pertinent provision in Rule:

> R414-1-12. Utilization Review.
> (1) The Department conducts hospital utilization review as outlined in the Superior System Waiver in effect at the time service was rendered.
> (2) The Department shall determine medical necessity and appropriateness of inpatient admissions during utilization review by use of InterQual Criteria, published by McKesson Corporation.
> (3) The standards in the InterQual Criteria shall not apply to services in which a determination has been made to utilize criteria customized by the Department or that are:
> (a) excluded as a Medicaid benefit by rule or contract;
> (b) provided in an intensive physical rehabilitation center as described in Rule R414-2B; or
> (c) organ transplant services as described in Rule R414-10A.

In these exceptions, or where InterQual is silent, the Department shall approve or deny services based upon appropriate administrative rules or its own criteria as incorporated in the Medicaid provider manuals.

R414-1-14. Utilization Control
(2) The Department may request records that support provider claims for payment under programs funded through the Department. These requests must be in writing and identify the records to be reviewed. Responses to requests must be returned within 30 days of the date of the request. Responses must include the complete record of all services for which reimbursement is claimed and all supporting services. If there is no response within the 30 day period, the Department will close the record and will evaluate the payment based on the records available.

**A report on any other reimbursements based on billed charges that totaled over $1,000,000 total funds in FY 2011**

Aside from the outlier payments for inpatient hospital stays, the only other Medicaid reimbursement methodology paying more than $1 million in FY 2011 was outpatient hospital reimbursement. As has been directed in previous legislative intent language, the Department of Health converted to a prospective payment system for outpatient hospital payments in FY 2012, but that had not been completed prior to the close of FY 2011.