Acute Hospital Inpatient Rebasing and Service Intensity Weights (SIWs) Effective July 1, 2014

Philip Mossman, Deputy Director
OHIP – Division of Finance & Rate Setting (DFRS)

Michael Ogborn, Director
OHIP – DFRS - Bureau of Acute & Managed Care Rate-Setting

Janet Baggetta, Chief Health Care Fiscal Analyst
OHIP – DFRS - Bureau of Acute & Managed Care Rate-Setting

Presentation Outline

- Overview of July 1, 2014 Rebasing
- Derivation of DRG Payment Variables
- Derivation of Statewide Price Adjustments
- Derivation of Direct GME and Non-Comparable Rates
- Transition Policy and Payments
- Other July 1, 2014 Payment Provisions
- Future Actions
- Q&A

Overview of July 1, 2014 Rebasing

Acute Hospital Inpatient Rebasing Statutory Authority & Updated Cost Base

Statutory authority to update the base year operating costs for acute inpatient DRG rates:

- Section 2807-c(35)(c) of the Public Health Law indicates that the base period reported costs used for rate-setting for operating costs components shall be updated no less frequently than every four years and the new base period shall be no more than four years prior to the first applicable rate period that utilizes such new base period provided, however, that the first updated base period shall begin on or after April 1, 2014 but no later than July 1, 2014.

Updated cost base from 2005 to 2010

- 2010 audited base year data being used

Guiding Principles

Transparency

- Provide information for understanding of the rate calculation

Budget Neutral

- Targeted Medicaid Expenditures

Minimize Fiscal Redistribution

- Fiscal Stability

Provide for Transition

- Fiscal Stability

Acute Hospital Inpatient Payment Structure Prior to July 1, 2014

For Discharges On or After December 1, 2009 through June 30, 2014

Statewide Operating Price*
Adj. for WEF, IME%, PPNO%
(Rate Code 2946)

×

APR-DRG Weight

+

DGME Rate
(if applicable)
Adj. for PPNO%
(Rate Code 2589)

+

Non-Comparable Rates *(if applicable)*
Adj. for PPNO%
Plus Capital
(Rate Code 2990)

=

Payment Per Case

+

High-Cost Outlier Payment
(if applicable)

=

Total Payment Per Case

* There may be a further adjustment to the adjusted statewide operating price for transfer cases.

Acute Hospital Inpatient Payment Structure Effective July 1, 2014

For Discharges On or After July 1, 2014

Statewide Operating Cost-Based Price*
Adj. for **budget neutrality%**, WEF, IME%, **transition%,** PPNO%
(Rate Code 2946)

×

APR-DRG Weight

+

DGME Rate
(if applicable)
Adj. for **budget neutrality%**, **transition%**, PPNO%
(Rate Code 2589)

+

Non-Comparable Rates *(if applicable)*
Adj. for **budget neutrality%**, **transition%**, PPNO%
Plus Capital
(Rate Code 2990)

=

Payment Per Case

+

High-Cost Outlier Payment
(if applicable)
Based on budget neutral thresholds

=

Total Payment Per Case

* There may be a further adjustment to the adjusted statewide operating price for transfer cases.

Targeted Medicaid Operating Expenditures for Budget Neutrality

Expenditures for ***open*** hospitals based on:	2011 cases	Fee-for-service (FFS) claims and Medicaid managed care (MMC) encounters
	April 1, 2014 budget neutral statewide price	Adjusted for April 1, 2014 APR-DRG weights, WEFs, and IME adj.'s
	April 1, 2014 DGME and non-comparable rates	Based on 100% of 2005 costs
	Transfer rates	Lower of: adj. SW price, or adj. per diems Plus DGME rate
	Cost outlier payments	Based on April 1, 2014 APR-DRG-specific thresholds
Plus $42 million	60% of projected payments for closed hospitals	The other 40% was already used for supportive housing

Former Method of Acute Inpatient Rebasing: Ensure Budget Neutrality through the Statewide Price Only

Development of the Budget Neutral Statewide Price

Start with ***Total*** Targeted Medicaid Expenditures

Subtract

- DGME and non-comparable payments based on 100% of 2005 costs
- PPNO savings
- Cost outlier payments

Remainder

- Equals ***net*** targeted Medicaid expenditures

Continue with ***Net*** Targeted Medicaid Expenditures

Derive a statewide price so that:

- When that price per case is adjusted by the applicable APR-DRG weight, WEF, and IME%
- And when the adjusted price for each transfer case is determined
- Then the sum of the adjusted prices for all regular and transfer cases will = the net targeted expenditures

New Method of Acute Inpatient Rebasing: Ensure Budget Neutrality through the Statewide Price and the DGME/Non-Comparable Rates

Development of Budget Neutrality Factor (BNF)

Start with ***Total***
Targeted Medicaid Expenditures

Continue with ***Net***
Targeted Medicaid Expenditures

Subtract

- ~~DGME and non-comparable payments based on 100% of 2010 costs~~
- PPNO savings
- Cost outlier payments

Remainder

- Equals ***net*** targeted Medicaid expenditures

Derive a BNF so that:

- When the adjusted statewide price **+ the DGME rate + the non-comp. rate** for each case, **all based on 2010 costs**, is multiplied by the BNF
- And when the budget neutral payment for each transfer case is determined
- Then the sum of the budget neutral payments for all regular and transfer cases will = the net targeted Medicaid expenditures

The budget neutrality factor is not a cut to the April 1, 2014 statewide price, but a reduction to all 2010 cost-based payments to keep total payments at the targeted Medicaid expenditure level.

Rationale for Major Change to the Acute Inpatient Rebasing Method

Derive and apply a budget neutrality factor:

- To the 2010 cost-based statewide price, and
- To each hospital's 2010 cost-based DGME and non-comparable rates

In order to provide the same margin for all costs

July 1, 2014 budget neutrality factor = -2.8704%

Derivation of DRG Payment Variables

- Service Intensity Weights (SIWs)
- Average Length of Stay (ALOS) for Transfer Payments
- Cost Thresholds for Outlier Payments

SIWs, ALOS, Thresholds

2014 weights, ALOS, thresholds have been posted on the NYSDOH public website

- They're based on v31 of the APR-DRG grouper
- They will ***not*** be retroactive to Jan 1, 2014
- They will be effective for discharges on/after July 1, 2014, ***but***
  - **For fee-for-service**, no implementation until Division of the Budget approves the July 1, 2014 rates
  - **For Medicaid managed care**, July 1, 2014 implementation to limit reconciliation; plans have been notified

SIW Development

Based on:

- 3 years of non-Medicare SPARCS cases (2009–2011)
- Charges reduced to cost using 2010 audited ICR (Exhibit 51) ratios of costs to charges (RCCs)

Hospitals excluded from weight development

- Flat rate hospitals (no ancillary charge master)
- Exempt hospitals (not paid using acute care rates)
- 15 hospitals with implausible RCC data

ALOS and Thresholds

ALOS

- Based on same 3-year non-Medicare SPARCS data as SIWs

Cost outlier thresholds

- Individual case charges reduced to cost with High Cost Charge Converter (HCCC)
  - HCCCs = ratio of ***overall*** inpatient costs to charges
  - HCCCs derived from ***2011*** ICRs
- Thresholds
  - Based on 2011 Medicaid claims data
  - Adjusted for budget neutrality to prior aggregate outlier payments

Derivation of Statewide Rate Adjustments

- Institution-Specific Adjustment Factor (ISAF) aka Wage Equalization Factor (WEF)
- Indirect Medical Education (IME) adjustment

WEF

Formula

- $\text{WEF} = \dfrac{1}{(\text{labor share} \times \text{wage index}) + \text{nonlabor share}}$

All components are hospital-specific

- Wage index
  - Based on 3-year average (2008–2010) Medicare occupational-mix-adjusted wages and hours
- Labor/nonlabor shares
  - Based on audited 2010 ICR data

IME

IME adjustment formula (no change)

- $\text{IME adjustment} = [(1 + \text{IRB})^{0.405} - 1] \times 1.03$
- Where IRB stands for ratio of Interns and Residents to Beds

Short-hand expression

- $0.405 \times 1.03 \times 10 = 4.2$
- Means the IME adj. is roughly 4.2% per 10% incremental in the IRB

Source of updated IRB

- 2010 IME survey for resident counts
- Exhibit 3 of the 2010 audited cost report for acute care staffed beds

Derivation of Direct GME and Non-Comparable Rates

- Non-Comparable Costs
  - Ambulance
  - Nursing Schools
  - Teaching Election Amendment (TEA)—payment for Part B costs, for which other hospitals bill directly

Payment for Direct GME and Other Non-Comparable Costs

Derivation of DGME and other add-ons

- Start w acute inpatient costs (all payer) from audited 2010 ICRs
- Multiply by *Medicaid cost percentage*
- Divide by 2011 Medicaid FFS/MMC cases

July 1, 2014 Medicaid cost percentages

- Medicaid FFS/MMC acute care days ÷ total acute care days
- Source of acute care days is also audited 2010 ICRs
- Cost Report Schedule 2 on Health Commerce System (HCS)

Change to Direct GME (DGME)

Add-on reflects only teaching cost centers (like Medicare)

- I&R Services – Salary & Fringes (cc 013)
- I&R Services – Other Program Costs (cc 033)
- Supervising Physician – Teaching (cc 014)

DGME Policy for New Teaching Hospitals and Displaced Residents

Section 2807-c(35)(b)(x) provides an appeal mechanism for *New Teaching Hospitals* and *Displaced Residents*

- New Teaching Hospitals: change in status from non-teaching to teaching
- Displaced Residents: due to closure of a teaching hospital

Appeal process has been posted to NYSDOH's public website

- Policy document with templates for required data to be submitted
- Timeframes for appeals
  - New Teaching Hospitals: Oct. 1, 2014 for changes to Jan. 1 and July 1, 2014 rates
  - Displaced Residents: Oct. 1, 2014 for changes to July 1, 2014 rates

Ambulance/Transportation Rates

Even if the 2010 cost report showed ambulance costs, there will be no add-on if, per the July 2013 ambulance survey, the hospital does not provide the service

The ambulance reimbursement policy is currently under review

Transition Policy and Payments

Transition Policy Goal

Cap losses from Apr. 1, 2014 method at:

- 2.0% from July 1, 2014 through Dec. 31, 2015
- 2.5% for 2016
- 3.5% for 2017

Applies to Medicaid FFS and managed care

Financing for Transition Payments

1. Repurpose $42 million from closed hospitals

- Requires a 0.8% across-the-board decrease to initially-derived payments

2. Cap most* gains at roughly:

- 4.1% from July 1, 2014 through Dec. 31, 2015
- 6.8% in 2016
- No limit on gains in 2017

**** Gains from increased residents are excluded from the cap. Excluded gains = new residents × the derived Apr. 1, 2014 payment per resident***

Transition Adjustment

Estimated hospital-specific dollar amount*

- Sum of:
  - Decrease of 0.8% (across-the-board) to repurpose savings from closed hospitals
  - Decrease due to capped gains, if any
  - Increase to limit losses, if any
- Estimated dollar amount will ***not*** be subject to reconciliation or appeal

Transition adjustment

- Dollar amount divided by the sum of all inlier payments
- Will be applied to statewide price and all add-on rates
- Rate Schedule 7 provides details

Advantage of percentage adjustment instead of pool allocation

- Enables adjustment to FFS and managed care payments
- Eliminates need for retroactive claims processing

* The sum of the hospital-specific amounts is zero in each year.

Other July 1, 2014 Payment Provisions

- Adjustments for Potentially Preventable Negative Outcomes (PPNOs)
- Capital payments
- Workers' Comp./No Fault payments

PPNO Adjustments

PPNO statute

- Save $51 million annually
- Amount can be lowered if statewide PPR/PPC rates decrease

July 1, 2014 adjustments

- Prior dollar amounts stay the same, but percentages change

Will review updated PPNO adjustments in 2014

- More information will be provided at a future date

Capital Payments

Current methodology

- Initial add-on based on budgeted capital derived from annual surveys
- Payments reconciled to actual, audited capital expenditures

July 1, 2014 capital add-ons

- Unchanged from April 1, 2014 add-ons

Considerations for the future

- Evaluating need for retroactive reconciliation to actual expenditures
- Potential recommendations from Capital Workgroup

Workers' Compensation/No Fault (WCNF) Payments

July 1, 2014 WCNF Rates

- Based on the Medicaid July 1, 2014 rates, with modifications:
  - Per Section 2807-c(b-1), WCNF rates not subject to Medicaid budget cuts
    - Trend factor applied to statewide rate, DGME rates, and non-comparable rates
    - PPNO adjustment not applied
  - Transition adjustment factor also not applied
- Rate sheet release on HCS no later than July 25, 2014

Rates released to Workers' Comp. Board when the Division of the Budget approves the Medicaid fee-for-service rates

Future Actions

Rate-Setting

Acute inpatient system

- ICD-10 implementation effective October 1, 2015
- January 1, 2015 rates
  - DOH considering no SIW update
    - To provide stability in payments through December 31, 2015
    - Permitted b/c Statute requires update only every 4 years (like rebasing)
  - Will require budgeted capital update
- 2014–2015 research
  - Alternative way to calculate SIWs to reduce burden on DOH and hospitals
  - New short stay policy due to OSC Audit
    - Challenged full payment when death occurs w/in 24 hours of admission

Rebasing other service rates

- Exempt unit rates as of April 1, 2015; outpatient rates as of July 1, 2015

Inpatient Rate Revisions

Actual capital rates

- Reconciliation for Dec. 1, 2009 through Dec. 31, 2012
- Based on:
  - 2009 certified cost report
  - 2010–2012 audited cost reports
- Resubmissions of 2012 cost reports due to audit revisions were due July 2, 2014

Transition II pool rates

- Update for Oct. 1, 2010 through March 31, 2014

Contact Information

- **Contact Information**
  - *HospFFSUnit@health.state.ny.us*
- **Questions?**