TennCare Variation Background

In 2009, the THA board of directors agreed to support a hospital assessment for FY 2010-11 to fund the state share of cuts proposed by the Bureau of TennCare that would have negatively impacted TennCare providers and enrollees.

Among the proposed cuts was a cut to cap hospital payments at 100 percent of Medicare. The board agreed to replace state dollars to avoid this cut. However, the board raised two issues. The board was concerned that the state proposal created a ceiling or maximum for hospital reimbursement but it did not include a floor or minimum. Secondly, members of the board felt strongly that payments to hospitals from TennCare for the same or very similar services varied inappropriately across the state and replacing this cut was supporting the continuation of that variation.

The board, as a condition of supporting the assessment, directed THA to define the amount of variation in hospital payments from the TennCare MCOs and if that analysis found a level of variation that was inappropriate, to work with the state to develop a recommendation for reducing the variation.

After first reviewing and reporting results based on all data available to THA, the board directed THA to work with the state to engage Aon Hewitt, the actuarial firm that most recently completed the TennCare actuarial analyses, to analyze the claims data included in TennCare's data base.

Aon's initial work focused on defining the amount of variation that existed among hospital payments from the TennCare MCOs for the same or similar services. Aon segregated all TennCare hospital claims into four major groups: inpatient routine, inpatient high cost routine, inpatient specialized services and outpatient services.

Aon then benchmarked each hospital's TennCare reimbursement to the hospital's current Medicare reimbursement and expressed TennCare reimbursement as a percentage of Medicare reimbursement for each hospital.

In May 2011, Aon completed the analysis of the extent of variation and found the following level of variation in hospital reimbursement based on 2009 hospital TennCare claims data:

> The variation in reimbursement among hospitals ranged, in relation to Medicare rates, from a low of 20 percent of Medicare to a high of 109 percent for routine inpatient services and from less than 10 percent of Medicare to 179 percent for specialized inpatient services, i.e. burns, trauma, transplants, cardiac surgery, highest level of neonatal intensive care and HIV. For outpatient services, reimbursement ranged from a low of 60 percent of Medicare to a high of >180 percent.

The THA board concluded that the amount of variation in payments to hospitals for the same or similar services was inappropriate for a publicly funded program, and asked Aon to provide alternatives for reducing the variation in a budget neutral way for TennCare.

Aon provided a variety of alternatives and, ultimately in November 2011, the THA board proposed establishing a floor and ceiling for TennCare reimbursement, expressed as a percentage of Medicare, for each of the broad categories of hospital services.

The board's original recommendation was as follows:

1) For routine and high-cost routine inpatient service categories:

    a) For year one the minimum range will be 40-49% of Medicare and the maximum range will be 80-89% of Medicare. Hospitals currently paid more than 90% of Medicare for these inpatient services will be reduced to 90% of Medicare for those services. The monies generated by this reduction will be used to increase the rates paid to those below the 40% of Medicare floor.
    b) For year two the floor and ceiling will be a minimum range of 50-59% of Medicare and a maximum range of 70-79% of Medicare. Any hospital paid more than 80% of Medicare for these inpatient services will be reduced to 80% of Medicare for those services. The monies generated by this reduction will be used to increase the rates paid to those below the 50% of Medicare floor.

2) For the outpatient service category:
    a) For year one, move the ceiling to 125% of Medicare. All hospitals receiving more than 125% of Medicare will be reduced to 125% of Medicare. The floor would be 90%-99% of Medicare. Hospitals below that floor will be increased to the floor.
    b) For year two move outpatient to a ceiling of 104% of Medicare. The floor would be 100% of Medicare. Hospitals below that floor will be increased to the floor.

3) For the Specialized Services Category:
    Categorize specialized services into three groups, cardiac surgery, neonatal, and other specialized that includes burns, multiple significant trauma, transplants and HIV related services. The reimbursement ranges for these three categories of specialized services would be established to reflect the range of payments that currently exist or the following.
    a) Cardiac surgery – the floor will be 30%-39% of Medicare and the ceiling will be 70%-79% of Medicare.
    b) Specialized neonatal – the floor will be 0%-9% of Medicare and the ceiling will be 170%-179% of Medicare.
    c) Other specialized – the floor will be 30%-39% of Medicare and the ceiling will be 150%-159% of Medicare.

For the specialized services category, outliers will be considered separately and reimbursement for outliers will not be confined to these ranges. Working with Aon, TennCare should include a methodology for addressing outliers in all of the specialized services categories.

The impact will be to reduce the reimbursement for hospitals currently being reimbursed above the ceiling and to use the dollars saved to increase reimbursement for those hospitals below the floor in each category.

The THA board and TennCare agreed that the reduction in variation will be phased in over two years to minimize the initial impact on any one hospital or system, with

approximately one-third being addressed in the first year and the remainder being addressed in the second year.

Year 1 Implementation Band

Inpatient routine and high cost routine: 40% of Medicare to 93% of Medicare
Outpatient: 78% of Medicare - >150% of Medicare

Prior to implementing the Year 2 adjustment, Aon was asked to complete a more current analysis using claims data covering the period September 2010 to August 2011 and paid through November 2011, including an adjustment for non-emergency out-of-network rates. The results of this analysis are now being used to implement the variation reduction plan for hospitals. The final budget neutral ranges based on the claims data covering the period September 2010 to August 2011 and paid through November 2011 are as follows:

Year 2 (With the more current claims data referenced above)

Inpatient routine and high cost routine: 53.8% of Medicare to 80% of Medicare
Outpatient: 93.2% of Medicare to 104% of Medicare

Although no changes will be made to the specialized services rates, the ranges that existed in the reimbursement covering the period September 2010 to August 2011 and paid through November 2011 that will become the floor and ceiling for future negotiations between hospitals and MCOs are as follows:

Cardiac surgery:	32% of Medicare – 83% of Medicare
Neonatal services:	4% of Medicare – 174% of Medicare
Other specialized:	49% of Medicare – 164% of Medicare

All first-year changes were implemented effective July 1, 2012. Second year changes will be implemented effective July 1, 2013.