Reducing Variation in TennCare Hospital Payments

November 14, 2013

Goals of the Webinar

- Explain why THA and TennCare have worked to reduce variation in hospital payments
- Provide an understanding of the scope and impact of the variation analyses
- Show hospitals the overall impact of the payment adjustments
- Describe the process for implementing the Year 2 rate changes

Why are Variations in Hospital Payments Being Addressed?

- In 2010, the THA board agreed to support the hospital assessment to avoid $660 million in TennCare reductions
  - Cuts included all special payments to hospitals as well as a 1 percent rate cut to providers and benefit limits for enrollees
- Members of the THA board conditioned their support for the hospital assessment on THA and TennCare working to reduce the variation in hospital payments for essentially the same services from the MCOs

How Were Variations in Hospital Payments Addressed?

- THA Board approved using Aon Hewitt, the state's actuary, to complete analyses to define existing variation and recommend a solution
  - Aon has extensive experience with TennCare claims data
  - Aon worked with the TennCare rate variation task force to define the existing variation and to model potential solutions to reduce variation
  - Services were grouped into 4 major categories
    - Specialized services that are typically provided in a small subset of hospitals, such as transplants, neonatal intensive care and level 1 trauma.
    - High cost routine services that are provided at many or most hospitals, but are higher than average in cost, such as strokes and spinal surgery.
    - Routine services that are provided at many or most hospitals in the state, such as mastectomy and broken hips.
    - For outpatient services, claims were assigned to 16 categories of service, such as Level 1 Emergency Room visits and Cardiac Catheterization. These were not categorized as specialized or routine.

- Ultimately task force asked Aon to create a "budget neutral" proposal to move hospitals within bands of acceptable variation agreed on by the THA board

Implementation

- TennCare agreed to move hospitals within the bands over 2 years
- Year 1 changes effective July 1, 2012
  - Year 1 bands adjusted for budget neutrality were as follows
    - Routine and high cost routine inpatient- 40% to 93% of Medicare
    - Outpatient – 78% to >150%% of Medicare
    - Specialized services
      - Cardiac surgery – 32% to 83% of Medicare
      - Neonates – 4% to 174% of Medicare
      - Other - 49% to 164% of Medicare
- Initial year would represent smaller portion of total dollars to move in order to test the implementation

Year 2 Modifications

- The THA board asked Aon to make minor adjustments before implementing Year 2
  - Re-evaluate hospitals that were out of network in the initial analysis and hospitals that had contract adjustments necessary to bring MCO contracts into compliance in Year 1
  - Add St. Jude to the analysis
- Aon completed the adjustments in late October

Modeling of the Impact of Reducing Variation in TennCare Payments Across Hospitals As Requested by THA

Webinar November 14, 2013

AON Hewitt

Aon Hewitt

- Aon Hewitt is a division of Aon Corporation, one of the top 250 US-based companies on the Fortune 500 list and a world leader in actuarial services, risk management and human capital consulting services.
- 6,800 consultants in 98 offices with expertise in actuarial services, managed health care, public policy, data analytics and strategy development.
- 7+ years working with TennCare as their Medicaid Actuaries, Data Analysts and Consultants
- 50+ years team experience with health care claim data analytics

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Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments – Rate Variation Project Background

- Phase 1: January 2011 – May 2011: Aon was engaged to conduct a study of the variation in TennCare payments to hospitals for similar services
  - Study designed to segregate hospital services between higher cost services typically performed at a smaller subset of hospitals and all other "routine" services
  - Variation was measured using both Medicare and Cost benchmarks
  - Study concluded that significant variation did exist for routine IP and OP services

- Phase 2: June 2011– November 2011: Using the dataset developed for the variation study, Aon worked with THA to model different approaches to reduce variation
  - Final methodology was approved by THA Board in November 2011
    - Established ranges based on Medicare benchmarks for IP Routine and Outpatient Services
    - Hospitals outside of these ranges would be moved to either the floor or ceiling over a two year period
    - Impacts overall were designed to be budget neutral, based on the total dollars in the modeled dataset
    - Specialized services ranges were established to reflect the range of payments that existed in model

Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments – Rate Variation Project Background

- Phase 3: December 2011 – October 2012: Implementation for Year 1
  - Year 1 hospitals impacted were finalized (New dataset modeled using 3M software)
  - TennCare worked with MCOs to modify contracts for Year 1 impacts effective July 1, 2012

- Phase 4: October 2013 – March 2014: Implementation for Year 2
  - Year 2 hospitals impacted finalized
  - Year 2 contract changes will be effective July 1, 2013

Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments – Claims Used for Final Year 2 Analysis

- TennCare hospital claims incurred Sept 2010 - Aug 2011 paid thru Nov 2011
  - Same core dataset used for Year 1 adjustments to ensure consistency in budget neutrality
  - Data was reconciled against current MCO networks and significant contract changes
  - Data is reflective of current reimbursement levels

- Excluded:
  - Claims from hospitals not paid under a Medicare PPS (e.g., CAH)
  - Claims from hospitals outside of Tennessee
  - Claims for patients over age 64 and dual-eligibles
  - Claims paid as out of network for a MCO
  - Inpatient claims with payment under $100 per day
  - Outpatient claims with payment under $25 for emergency room , surgery, cath, cardiology or observation; or under $5 for other outpatient services
  - Inpatient claims for which a DRG could not be assigned
  - Outpatient claims without a CPT/HCPCS code

Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments – Service Categories

- Inpatient claims assigned to service categories by MS-DRG (v29), with some additional processing for neonates
  - Routine: Inpatient services that are provided at many or most hospitals in the state, such as mastectomy and broken hips (70% of payments)
  - Specialized: Inpatient services that are typically provided in a small subset of hospitals, such as transplants, neonatal intensive care and level 1 trauma (30% of payments)
- Outpatient Services assigned to one service category

Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments – Medicare Benchmark Definitions

- Medicare benchmark amounts determined by 3M Medicare Software
  - IP Grouper and Pricer tables
    - Enhancements to IP data to better identify transfers, interim bills, and newborns billed under mom's records resulted in only 6 IP claims not priced
  - OP Grouper and Pricer tables
    - Each priced or bundled claim line included
    - Made broad assumptions to override claims edits where MCO data does not contain all required claim fields such as modifiers, condition codes, bill types

- Medicare payment benchmarks included hospital-specific payment factors (DSH, wage index, etc), except IME and pass through amounts which were excluded

- Medicare payment determined by date of claim
  - IP based on discharge date
  - OP based on service date

- Outlier payment amounts were included

Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments – Inpatient Data Used for Year 2

Excluded Data

		IP Data used for Year 2	
Record Category		**IP Claims**	**TennCare Paid**
Age 65 or Greater	Patients age 65 and greater and Other Duals	1,209	$ 7,639,488
Out-of-Network	Claims paid out-of-network for the MCO	3,494	$ 23,663,561
Low Cost Outliers	TennCare payment < $100 / day	435	$ 275,791
Ungroupable	No DRG could be assigned	6	$ 16,278
Use	Data used for analysis	134,425	$ 730,898,839
Total	Total	**139,569**	**$ 762,493,957**

Payments as a Percent of Medicare (MCR)

	IP Data used for Year 2					
	TC Paid	MCR	Admit Count	Paid / Admit	% of Total Inpatient	Paid as a % of Medicare
Routine	$ 509,449,717	$ 787,657,639	127,250	$ 4,004	70%	65%
Specialized - Cardiac Surgery	$ 28,428,758	$ 46,874,899	1,450	$ 19,606	4%	61%
Specialized - Neonates	$ 163,052,918	$ 160,432,032	4,772	$ 34,169	22%	102%
Specialized - Other	$ 29,967,446	$ 30,749,701	953	$ 31,445	4%	97%
Total	**$ 730,898,839**	**$ 1,025,714,270**	**134,425**	**$ 5,437**	**100%**	**71%**

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Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments – Outpatient Data Used for Year 2

Excluded Data

		Outpatient Data used for Year 2	
Record Category		**OP Claims**	**TennCare Paid**
Age 65 or Greater	Patients age 65 and greater and Other Duals	9,058	$ 2,915,803
Out-of-Network	Claims paid out-of-network for the MCO	63,662	$ 18,485,852
Low Cost Outliers	TennCare payment < $25 per claim for ER, Surg, Cath, Cardiology, Observation; < $5 for all other	27,723	$ 263,440
Ungroupable	Only Revenue Codes on Claim Lines; Medicare pricing can't be determined	116,757	$ 23,891,631
Use	Data used for analysis	1,513,462	$ 504,961,421
Total	**Total**	**1,730,662**	**$ 550,518,147**

Payments as a Percent of Medicare (MCR)

	Outpatient Data used for Year 2				
	TC Paid	Claim Count	Paid / Claim	% of Total Paid	% MCR
OP Total	**504,961,421**	**1,513,462**	**334**	**100%**	**97%**

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Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments – THA Board Recommendation

- Modeled the Original THA Board Recommendations
  - Year 1 :
    - 40% - 90% of Medicare – Inpatient Routine Services
    - 90% - 125% of Medicare – Outpatient Services
  - Year 2 :
    - 50% - 80% of Medicare – Inpatient Routine Services
    - 100% - 104% of Medicare – Outpatient Services
  - Specialized IP Services ranges established based on actual ranges
  - Adjustments to the floor to maintain budget neutrality
- THA worked with TennCare on an implementation approach to move all hospitals within the recommended ranges over a two year period
  - Year 1 ranges were adjusted to reduce the number of hospitals being impacted in Year 1
  - Year 2 ranges are based on the original recommendations and all hospitals outside of these ranges will be impacted

Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments – Modeling Results and Relative Impact

Year 2 Adjustment

Service Classification	THA Board Range Min	THA Board Range Max	THA Board Range Adjusted for Budget Neutrality Min	THA Board Range Adjusted for Budget Neutrality Max	Final Range Min	Final Range Max	Relative Impact ($)	Total $ in Model	Relative Impact (%)
Routine	50%	80%	54%	80%	54%	80%	$ 13,760,111	$ 509,449,717	2.7%
Specialized - Cardiac Surgery	30%	80%	32%	83%	32%	83%	$ -	$ 28,428,758	0.0%
Specialized - Neonates	0%	180%	4%	174%	4%	174%	$ -	$ 163,052,918	0.0%
Specialized - Other Claims	30%	160%	49%	164%	49%	164%	$ -	$ 29,967,446	0.0%
Outpatient	100%	104%	93%	104%	93%	104%	$ 35,569,045	$ 504,961,421	7.0%
Total*							**$ 47,402,521**	**$ 1,235,860,260**	**3.8%**

Total Adjustment

Service Classification	THA Board Range Min	THA Board Range Max	THA Board Range Adjusted for Budget Neutrality Min	THA Board Range Adjusted for Budget Neutrality Max	Final Range Min	Final Range Max	Relative Impact ($)	Total $ in Model	Relative Impact (%)
Routine	50%	80%	54%	80%	54%	80%	$ 14,642,361	$ 509,449,717	2.9%
Specialized - Cardiac Surgery	30%	80%	32%	83%	32%	83%	$ -	$ 28,428,758	0.0%
Specialized - Neonates	0%	180%	4%	174%	4%	174%	$ -	$ 163,052,918	0.0%
Specialized - Other Claims	30%	160%	49%	164%	49%	164%	$ -	$ 29,967,446	0.0%
Outpatient	100%	104%	93%	104%	93%	104%	$ 49,938,438	$ 504,961,421	9.9%
Total*							**$ 62,551,131**	**$ 1,235,860,260**	**5.1%**

* Hospitals with offsetting gains and losses between Routine and Outpatient are included in totals as net gain or loss

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Modeling the Impact of Variation Reduction in Ratio of TennCare to Medicare Payments

- **Questions?**

Implementation Next Steps

- In the coming week, impacted hospitals will receive a letter from THA with target percentages which represent the Year 2 movement as percent of Medicare to bring a hospital into the corridor.
- The Bureau is contacting MCOs to share their list of hospitals and target percentages for each facility that needs to be adjusted.
- The Bureau's expectation is that hospitals will be contacted by MCOs to acknowledge the need for an adjustment before the end of November.
- The target date to complete all adjustment amendments is March 30, 2014. Completion on this schedule will allow for adjustments to go back to July 1, 2013.
- No MCO will be allowed to pay the adjustments until all hospitals have signed contracts reflecting the Year 2 target adjustments.
- THA and Bureau staff can provide technical assistance where there are questions about the process and the development of targets.
- Questions may be sent by email to rate.variation@tn.gov.