Oregon Association of Hospitals and Health Systems

OREGON ORH OFFICE OF RURAL HEALTH

March 20, 2014

Tina Edlund
Acting Director
Oregon Health Authority
500 Summer St.
Salem, Oregon 97301-1097

Sent electronically

Dear Tina,

We are writing you today to thank you for your assistance and leadership, with the assistance of both Kelly Ballas and Jeff Fritsche, in guiding the Oregon Health Authority's Alternative Payment Methodologies for Type A/B Hospitals Advisory Group toward a constructive and agreeable recommendation to transition hospitals off cost-based reimbursement and to communicate how the resulting implementation and transition period should work.

The advisory group – comprised of Coordinated Care Organization representatives, hospital association representatives, the Oregon Office of Rural Health representatives and State representatives – has met six times since September 2013 and has considered and recommended a model integrating the following factors, which are supported by Oregon's rural hospitals:

1. A baseline actuarial analysis that assessed the payment relative to expected cost risk of adopting a prospective payment system (PPS);
2. The Medicaid relevance in relationship to the hospital's entire book of business;
3. The Financial Strength Index of each hospital; and
4. Demographic/community characteristics of each hospital.

The sum of these factors was then used as the basis for the actuarial evaluation, and as noted, we believe this is a sound approach.

The final advisory group product is a decision tree, developed by the actuarial services firm Optumas, to assess the financial risk of moving away from cost-based reimbursement (CBR). It combines the four factors from above into an overall actuarial test to determine which hospitals are recommended to move off CBR.

Now that we are at a point in the process of making a determination and recommendation to the director of the OHA, our attention has shifted to considering the path that the identified Oregon hospitals will follow to transition Medicaid reimbursement off CBR to a prospective payment methodology. The following is a summary of our implementation proposal and reflects our recommendation for the OHA director.

1. As proposed by the advisory group, the Oregon Health Authority should run the actuarial test in March or April 2014 using the most current year of data available, (likely CY 2013).

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2. Per the recommendations of the advisory group, this test should be re-run every two years with the option of moving on or off cost-based reimbursement as the decision tree determines. We also understand and appreciate that you would like to consider this as part of your overall decision and might also include critical access status and if a hospital is close to the "bubble" and what that impact may have on local health care access.

3. We recommend that rural hospitals be given the option to wait to negotiate with CCOs until after this test has been run, with the goal of completing the transition from CBR to prospective payment by Jan. 1, 2015 (when the new PPS rates would likely go into effect). The OHA would outline a timeline for adoption of a new alternative payment methodology and provide guidance for mutual success of the CCOs and rural hospitals.

4. We strongly recommend that the alternative payment method –"Discounted Charges with a Volume Adjustment System (VAS)" (which as you know was thoroughly discussed with advisory group members both as a group and individually with each CCO) be the default option for rural hospital-CCO contracting to move off CBR, with hospitals also able to negotiate another payment model with CCOs as a secondary option.

   This is important because, as discussed, this identified payment methodology meets the primary goals of the State in transitioning hospitals to PPS in that it: 1) adds to payment stability by basing initial payment rates on a hospital's historical costs; 2) is consistent with the limitations of the overall Medicaid Demonstration; 3) aligns incentives with the CCOs' need to reduce inpatient volumes, and; 4) poses moderate financial risk to the hospitals.

   We believe that a straightforward methodology and set of guidelines can be developed to facilitate implementation of this alternative model, which is important given the short timeframe for this transition. Selecting an appropriate payment alternative to CBR was part of the scope of the advisory group, and we believe the use of the Discounted Charge approach with a VAS would fulfill this obligation. We are prepared to assist the state, through the work of the RHRI, in implementing this payment methodology.

5. Finally, we suggest that given the profound change in the incentives facing rural hospitals transitioning to a PPS, these hospitals be afforded some reasonable additional (and temporary) funding for technical assistance to help them through this transition. This funding could be provided through the initial prospective rates established with a CCO (with commensurate reductions to remove these funds in future years) or directly from the State. In a previous meeting there was some discussion as to whether technical assistance funds of this nature might be available through the State SIM grant. Given the highly innovative nature of this work, we imagine that the Centers for Medicare/Medicaid Innovation (CMMI) may be predisposed to authorize the use of SIM funds for this purpose. One example that was highlighted in our conversations with CCOs was the technology challenges this transition will pose to these hospitals in the short term.

Lastly, we believe it is important to reiterate an important OHA principle or "guidepost" for the advisory committee's work which was that: *"… the implementation of this model is not intended to have immediate (day one) cost saving implications, but rather to address future costs and to align incentives."* We believe that the recommendations of the advisory group along with our recommendations regarding an orderly transition to PPS for the identified rural hospitals, is fully consistent with this key principle.

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In conclusion, after more than two years of work, this endeavor is a significant step toward transforming payment for Oregon's rural hospitals. It is our sense that the work that we have accomplished in the context of the RHRI in facilitating rural hospitals' transition to PPS is "cutting edge" from a policy perspective nationally. This once again illustrates the leadership role the State has taken to advance Oregon health reform and at the same time take into consideration the views of key stakeholders.

However, we need to look at this as step one in a transition process and not the final destination. Moving too quickly could undermine our fragile rural delivery system and put critical access to health care services at risk. This has to be avoided through thoughtful implementation of this work. This policy framework aims to achieve our shared goals, and at the same time build on the consensus of the OHA advisory group. Thank you again for the opportunity to work collaboratively on this important process.

Sincerely,

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