RHRI Advisory Workgroup

Final Recommendation to Oregon Health Authority

March 20, 2014

Oregon Health Authority

HB 3650 Language *(Paraphrased)*

- *Based upon an evaluation by an actuary retained by the authority, on and after July 1, 2014, the authority may, on a case-by-case basis, require a CCO organization to continue to reimburse a rural hospital determined to be at financial risk, fully for the cost of covered services based on cost-to-charge ratios.*

Workgroup Process and Progress

- OHA convened an advisory workgroup made up of stakeholders from Type A/B hospitals (through OAHHS), Office of Rural Health (ORH), Coordinated Care Organizations (CCO), and Oregon Health Authority (OHA).

- The workgroup has met six times between September, 2013 and March, 2014.

- **First Key Deliverable:** Develop a recommendation to OHA Administration for each Type A/B hospital as to maintaining cost based reimbursement (CBR) or moving to an alternative payment methodology (APM).

Workgroup Process and Progress

- OHA retained Optumas as the actuarial firm to review and validate the foundational work and to develop a tool to evaluate the hospitals against. The tool will be hierarchical in nature and will quantify the risk (to hospital, to community, to CCO) associated with each hospital.

- Through an iterative process with the workgroup, Optumas developed a hierarchical decision tree that has received broad consensus by the workgroup.

- **Second Key Deliverable:** Optumas has reviewed and supports the recommendation.

Workgroup Recommendation and Implementation Proposal

- OHA will utilize the Decision Tree developed by Optumas and endorsed by the workgroup to determine which hospitals will move off of CBR.
- OHA will consider and address the financial risk to the CCOs (associated with those hospitals remaining on CBR) as a component of the decision and implementation process.
- OHA Director will make a decision no later than April 15, 2014 identifying which hospitals will transition off of CBR.
- OHA will re-evaluate, using the Decision Tree, every two years using the most current data available, starting two years post implementation.

Oregon Health Authority

Implementation Proposal

- OHA will encourage hospitals and CCOs to enter into good faith negotiations for contracts to be effective January 1, 2015.
- For hospitals transitioning off of CBR, discounted charges with a limit on the annual payment increase (rate cap) and a volume adjustment system would be used as a starting point for hospital/CCO negotiations.
- OHA will evaluate and determine a risk corridor for the volume adjustment. This should be on a hospital specific basis.
- OHA will determine when the volume adjustment might sunset. This should also be on a hospital specific basis.
- CCOs and hospitals are encouraged to negotiate alternative payment methodologies and incentives beyond the starting point.
  - Creates a glide path for hospitals to PPS and aligns incentives with the state, CCOs and hospitals

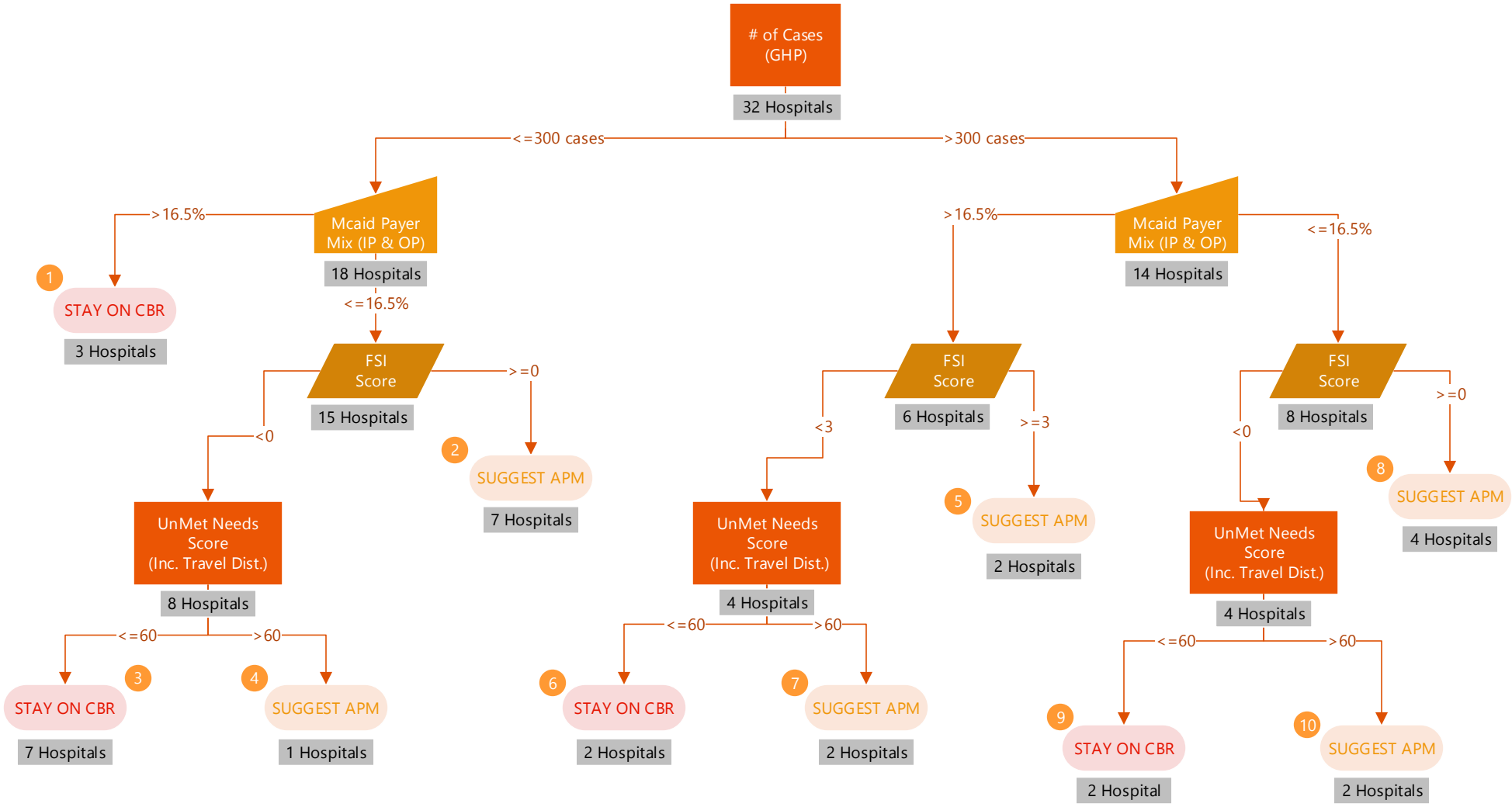
Implementation Proposal

- OHA will identify any available resources that could be provided to the CCOs and to the hospitals to assist with the transition off of CBR (within budgetary constraints).

Communication

- Consensus achieved by the advisory workgroup on March 20, 2014.
- Recommendation sent to OHA Acting Director, Tina Edlund for a final decision.
- Request for OHA to release a final decision by April 15, 2014.
- OHA will commit to hosting two webcasts by the end of April addressing the decision and implementation steps.
  - One will be with the hospitals
  - One will be with the CCOs that have rural hospitals
- OHA will develop any rules necessary to implement the final decision and provide guidance for compliance by the CCOs and the hospitals.

OR Rural Health Reform Initiative Hierarchy



Criteria	Source	Data Used
# of Cases	COMPDATA	2011 - 2012 2-year average
Mcaid Payer Mix (IP & OP)	Databank	2011 - 2013 3-year average
FSI Score	Hospital Financial Data	Most recent 3-year average
Unmet Needs Score	2014 Unmet Needs Report	Varies, typically 3- to 5-year average

	Hospital Profile		Recommendation	Hospital Count
1	Medicaid Case Load:	Small	STAY ON CBR	3
	Medicaid Relevance:	High		
	Financial Strength:	N/A		
	Community Need:	N/A		
2	Medicaid Case Load:	Small	SUGGEST APM	7
	Medicaid Relevance:	Low		
	Financial Strength:	Strong		
	Community Need:	N/A		
3	Medicaid Case Load:	Small	STAY ON CBR	7
	Medicaid Relevance:	Low		
	Financial Strength:	Weak		
	Community Need:	Unmet		
4	Medicaid Case Load:	Small	SUGGEST APM	1
	Medicaid Relevance:	Low		
	Financial Strength:	Weak		
	Community Need:	Met		
5	Medicaid Case Load:	Large	SUGGEST APM	2
	Medicaid Relevance:	High		
	Financial Strength:	Excellent		
	Community Need:	N/A		
6	Medicaid Case Load:	Large	STAY ON CBR	2
	Medicaid Relevance:	High		
	Financial Strength:	Not Excellent		
	Community Need:	Unmet		
7	Medicaid Case Load:	Large	SUGGEST APM	2
	Medicaid Relevance:	High		
	Financial Strength:	Not Excellent		
	Community Need:	Met		
8	Medicaid Case Load:	Large	SUGGEST APM	4
	Medicaid Relevance:	Low		
	Financial Strength:	Strong		
	Community Need:	N/A		
9	Medicaid Case Load:	Large	STAY ON CBR	2
	Medicaid Relevance:	Low		
	Financial Strength:	Weak		
	Community Need:	Unmet		
10	Medicaid Case Load:	Large	SUGGEST APM	2
	Medicaid Relevance:	Low		
	Financial Strength:	Weak		
	Community Need:	Met		

Recommendation	Hospital Count
STAY ON CBR	14 Hospitals 28% of Medicaid IP & OP Charges
SUGGEST APM	18 Hospitals 72% of Medicaid IP & OP Charges