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Joint Informational Hearing of the Senate and Assembly Health Committees

Hospital Reimbursement Mechanisms

**Friday, February 24, 2012, 10 a.m. to 1:00 p.m.
Broad CIRM Seminar Room
Keck School of Medicine of USC**

Overview

Reimbursement and payment policies can drive decision making in hospitals which can have consequences on patient health outcomes. The purpose of this joint informational hearing entitled “Hospital Reimbursement Mechanisms” is to provide a public forum on reimbursement and contracting issues for health plan network and out-of-network private hospitals, areas of dispute between hospitals and health plans over hospital reimbursement rates and practices, how these practices impact patients, and to provide a status update on the implementation of paying hospitals through a diagnosis-related group (DRG) methodology in Medi-Cal fee-for-service.

The hearing will begin with an overview of how hospitals are reimbursed by the various types of payors. Toby Douglas, Director of the Department of Health Care Services (DHCS), will then provide an overview of the requirement that DHCS shift from a per diem form of payment to DRGs in the Medi-Cal program, the status of implementation, and how DHCS intends to monitor utilization and expenditures following implementation of the DRG payment methodology.

Following the DHCS presentation, the Committees will hear testimony from health plans, hospitals, and other stakeholders, with a focus on payment issues in the marketplace between hospitals and third-party payors, areas that have given rise to disputes or concerns, and the effectiveness of the existing regulatory structure in resolving those disputes.

Hospital Reimbursement

The manner in which hospitals receive payment for the care they provide is highly complex. At the most basic level, hospital reimbursement differs by whether the payor is a public program such as Medicare or Medi-Cal, a private insurance or health plan, the type of contract negotiated with the private insurance or health plan, and whether the hospital has a contract at all with the payor.

Reimbursement methodologies by Medicare and Medi-Cal are discussed in detail in a later section. In the private insurance sector, the most common payment structures for hospitals with insurance contracts include:

- Per diem – a set payment per day of inpatient care. Per diem payments usually vary by type of care (maternity, general medical/surgical, intensive care, etc.). This methodology is by far the most common reimbursement system in California for inpatient care by private insurers.
- Diagnosis-related groups (DRGs) – a form of “per case” reimbursement methodology used by Medicare (and as discussed later, being adopted by Medi-Cal), that sets payment based on the type of diagnosis or procedure, regardless of length of stay or costs.
- Discounted charges – payments are based on a percentage discount off the hospital’s “chargemaster,” which is a lengthy list of the hospital’s “list price” for every single procedure and every supply item used during those procedures.
- Fee schedule – an agreed upon payment for a specific procedure or service. This is a common methodology for outpatient care, such as laboratory and radiology services, but not commonly used for inpatient care.

Hospital payment rates vary widely by geographic region, but the variation within geographic regions can be even more dramatic. According to one study, published in November of 2010, by the Center for Studying Health System Change (HSC), the average inpatient payment rate for the Los Angeles metropolitan market was 149 percent of Medicare, while average payment in the San Francisco market was 210 percent of Medicare. However, within those markets there was wide variation. In Los Angeles, the hospital payment rate at the 50th percentile was 118 percent of Medicare, while the single most expensive hospital (which was not identified) was paid 418 percent of Medicare. Similarly, in San Francisco, hospitals at the 50th percentile were paid 210 percent of Medicare, with the highest hospital payment coming in at 484 percent of Medicare.

The variation can partly be explained by the degree of hospital concentration in particular markets, and whether there are large hospital systems that dominate in a given market. Similarly, the concentration of health plans in the area has some impact as well. However, hospital reputation also plays an important role. According to the HSC study, in some markets, “certain hospitals are so highly regarded that consumers perceive any health plan network that excludes these ‘must-have’ hospitals as undesirable.” Other hospitals that are typically paid a premium include hospitals that provide a particular type of care unavailable elsewhere in the region, such as children’s specialty care or transplants.

One issue related to the bargaining strength of certain hospitals was highlighted when Blue Shield of California suspended its contracting relationship with UCLA Medical Center. UC negotiators were insisting that insurers contract with all five of their medical centers – a ‘take one, take all’ negotiating position. Blue Shield rejected that proposal, arguing that the negotiation over their contract with UCLA should not include other medical centers as a precondition to contracting. As teaching hospitals that offer a full range of services, including trauma centers and access to specialists, UC hospitals can demand higher reimbursement rates than many other hospitals in California.

Areas of Dispute between Health Plans and Hospitals

Payment disputes arise most commonly when there is no contract between the hospital and the payor. This situation typically occurs in the provision of emergency care, because emergency care must be provided without regard to a patient’s ability to pay. In an emergency, a patient is

taken to the nearest hospital, whether or not the hospital has a contract with the patient's health insurance company.

Under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), and also under state law, hospitals are required to provide appropriate screening examinations to determine whether emergency medical conditions exist, regardless of patients' ability to pay. When emergency medical needs are identified, hospitals are required to provide care until the patient is stabilized. A patient is "stabilized" when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient.

Once a patient is stabilized, if the patient needs post-stabilization care, the hospital will typically seek more information about the medical history of the patient, including whether the patient has insurance. At this point, the patient could be transferred to another hospital for further care, depending on the circumstances.

If the patient's health plan has a contract with the hospital that provided the emergency care, billing is relatively straightforward. However, if there is no contract, the amount billed by the hospital and emergency room physicians may be more than the health plan believes is reasonable. Often, there is simply a lapse between contracts with the hospital and the health plan, and the bill may be held up just until a new contract is negotiated. If that is not the case, disputes over the amount the health plan is required to pay are resolved by applying the Gould Criteria.

AB 1455 and the "Gould Criteria"

AB 1455 (Scott), Chapter 827, Statutes of 2000, established requirements for prompt payment of provider claims by health plans, including a prohibition on health plans engaging in an unfair payment pattern. In regulations implementing this law, the Department of Managed Health Care (DMHC) defined what constituted appropriate reimbursement of a claim. In the case of providers with a written contract, the regulations require reimbursement at the agreed upon contract rate. For noncontracted providers, however, the regulations adopted what is known as the "Gould Criteria" (from *Gould v. Workers' Compensation Appeals Board, 1992*), which requires:

The payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration:

- (1) the provider's training, qualifications, and length of time in practice;
- (2) the nature of the services provided;
- (3) the fees usually charged by the provider;
- (4) prevailing provider rates charged in the general geographic area in which the services were rendered;
- (5) other aspects of the economics of the medical provider's practice that are relevant;
- and
- (6) any unusual circumstances in the case.

AB 1455 required all health plans to establish a "fast, fair, and cost-effective" internal dispute resolution system accessible to noncontracted providers to resolve billing and payment disputes.

In addition to the dispute resolution system required of each health plan, DMHC established a voluntary, non-binding Independent Dispute Resolution Process (IDRP) to afford noncontracted providers who deliver EMTALA-required emergency services a fast, fair and cost-effective way to resolve claim payment disputes with health plans concerning the “reasonable and customary” value under the Gould Criteria. To be eligible for the IDRP, the provider must have first gone through the health plan’s own dispute resolution process. However, possibly because of the voluntary, non-binding nature of the program, the IDRP program has been rarely used.

Battle over Balance Billing Led to Limits on Post-Stabilization Billing

Until it was prohibited by the California Supreme Court in January of 2009 (*Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*), the practice of hospitals and physicians “balance billing” health plan enrollees for emergency services was the subject of several legislative battles. Patients with health coverage complained of being billed by physicians and hospitals for amounts in addition to the deductibles, co-payments and co-insurance provided for under their health insurance. Out-of-network providers were seeking to bill patients the balance of an emergency care bill that the patient’s health insurance plan was refusing to pay.

One of the legislative attempts to address this issue was AB 1203 (Salas), Chapter 603, Statutes of 2008. Under AB 1203, a noncontracting hospital is prohibited from charging a patient or his/her health plan for post-stabilization care unless certain requirements are met. Health plans are required to provide 24-hour access for noncontracting hospitals to obtain authorization for post-stabilization care, and hospitals are required to contact the health plan to provide the plan with information about the patient.

Emergency Rooms as a Source of Revenue?

Beginning in October of 2010, the Center for Investigative Reporting’s California Watch began publishing a series of articles on Prime Healthcare Services (Prime), which operates 14 hospitals, primarily in Southern California. The first article focused on unusually high rates of patients diagnosed with septicemia, an infection of the blood, which has a high reimbursement rate from Medicare compared to other infections. Subsequent articles raised questions about high rates of a rare malnutrition disorder known as Kwashiorkor among Prime’s Medicare patients, again raising concern of possible Medicare fraud.

One of the concerns raised by the allegations contained in these articles is the issue of “upcoding.” Upcoding is billing for a higher paying service or procedure than what was actually provided. The federal Health and Human Services Inspector General and the California Attorney General are both investigating the hospital chain’s billing practices.

An article published on July 23, 2011, by California Watch, looked at an increase in emergency room admission rates at Prime hospitals, again focusing on Medicare, but this time also describing a conflict regarding emergency room admissions with Kaiser Permanente. In the article, California Watch described an allegation from Kaiser that Prime had failed to give them an opportunity to care for Kaiser patients after an emergency situation had stabilized. According to the article, “Kaiser accused Prime of using improper medical criteria to ‘capture’ its patients, treating them without authorization and performing unneeded tests to create hefty bills.” In the same article, California Watch describes Heritage Provider Network, another managed care plan, as making similar allegations against Prime. According to the article, “Heritage claims Prime is engaging in racketeering when it ‘mislabels’ Heritage members as too sick to be transferred back to the managed care network.”

The claims of both Kaiser and Heritage are part of lawsuits between the health plans and Prime. Prime has denied the allegations.

The allegations raised by Kaiser and Heritage hinge, to some extent, on the determination of when a patient is stable for transfer. As described above, current law requires hospitals to provide emergency care to anyone who walks in the door of an emergency room, regardless of ability to pay. Accordingly, current law requires health plans to pay a noncontracting hospital the “reasonable and customary value” for that emergency care provided to their enrollees. But both of these requirements generally stop as soon as the patient has been stabilized. In the case of an out-of-network health plan enrollee, once he or she has been stabilized, AB 1203 prohibits the noncontracting hospital from charging the patient’s health plan for post-stabilization care without first getting authorization from the health plan, with some exceptions.

There are two areas of possible contention in this scenario. First, what is considered “reasonable and customary” for the legally required payment of emergency care up to the point of stabilization? For this question, the Gould Criteria is applied, and each health plan must have a dispute resolution process available for the noncontracting hospital. If it is not resolved between the plan and the hospital, these disputes can eventually be resolved in court. The second area of possible dispute is determining when the patient is stable enough to be transferred back to the patient’s contracted hospital. While there is a definition of “stabilization” in statute, it is ultimately determined by the treating physician.

Medi-Cal Hospital Reimbursement Methodology Changing

Inpatient hospital costs are a significant portion of federal and state health care expenditures. For example, in the 2011-12 fiscal year, an estimated \$8.5 billion in total funds were paid to community (non-county) hospitals in the fee-for-service Medi-Cal program for inpatient acute care.

Traditionally based on a per diem rate, the health budget trailer bill of 2010, SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, requires DHCS, subject to federal approval, to develop and implement a Medi-Cal methodology based on DRGs to reimburse hospitals for inpatient care. Last year’s health budget trailer bill, AB 102 (Committee on Budget), Chapter 29, Statutes of 2011, required the implementation date of the DRG reimbursement methodology to be July 1, 2012, or the date upon which the DHCS director executes a declaration certifying that all necessary federal approvals have been obtained and the methodology is sufficient for formal implementation, whichever is later.

Medicare has reimbursed most hospitals since the early 1980s on the basis of DRGs. Under DRGs, every inpatient hospital stay is assigned to a single DRG using a computerized algorithm that takes into account the patient’s diagnoses, age, major procedures performed, and discharge status. Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that DRG relative to the hospital resources needed to take care of the average patient.

In November 2011, DHCS indicated it was delaying implementation of DRG payments from July 1, 2012, until January 1, 2013, to allow additional time for DHCS to work with hospitals to finalize the analytical dataset, to provide additional time to run simulations on the data, and to understand the fiscal impact of the new payment methodology. DHCS stated the development of the DRG system will require a major system change which will take months to complete, and the additional six months will also allow hospitals more time needed to prepare for the new payment methodology.

The DRG reimbursement methodology will replace the current fee-for-service Medi-Cal reimbursement methodology of paying most hospitals. For private hospitals, that reimbursement methodology varies depending upon whether the hospital contracts with the state. Hospitals that contract with the state are paid on the basis of negotiated per diems (a per diem is a payment rate for each day a patient is in the hospital). Noncontract hospitals are reimbursed on the basis for their allowable costs.

In enacting the DRG provision in existing law, the legislature stated its intent that the new Medi-Cal inpatient hospital reimbursement methodology should be based on DRGs that more effectively ensure all of the following:

- Encouragement of access by setting higher payments for patients with more serious conditions;
- Rewards for efficiency by allowing hospitals to retain savings from decreased length of stays and decreased cost per day;
- Improvement of transparency and understanding by defining the "product" of a hospital in a way that is understandable to both clinical and financial managers;
- Improvement of fairness so that different hospitals receive similar payment for similar care and payments to hospitals are adjusted for significant cost factors that are outside the hospital's control;
- Encouragement of administrative efficiency and minimizing administrative burdens on hospitals and the Medi-Cal program;
- Payments based on data that has high consistency and credibility;
- Simplification of the process for determining and making payments to the hospitals;
- Facilitation of improvement of quality and outcomes;
- Facilitation of implementation of state and federal provisions related to hospital-acquired conditions; and
- Support of provider compliance with all applicable state and federal requirements.

DHCS states about two-thirds of state Medicaid programs use DRGs, as do many commercial payors, and that DRGs are a better payment methodology for several reasons. DHCS states DRGs enable a greater understanding of the services being provided and purchased by Medi-Cal, and because payment does not depend on hospital-specific costs or charges, DRGs reward hospitals for improving efficiency. In addition, because DRGs for sicker patients have higher payment rates, this method encourages access to care across the full range of patient conditions. DHCS also argues that DRGs are a more transparent payment methodology than the current California Medical Assistance Commission per diem negotiation process. Finally, DRG payment rewards hospitals that provide complete and detailed diagnoses and procedure codes on claims, thereby giving payors and data analysts better information about the services provided.

When the DRG-based payment method is implemented, DHCS indicates that, for at least one year, and possibly additional years, the DRG-based payment method will be phased in. Claims will be paid using the DRG payment methodology, but some hospitals will see DRG base prices that are higher or lower than they otherwise would have been. DHCS' intention is that individual hospitals will not experience sharp changes (either up or down) in payment levels. The transitional DRG base prices would be set so that statewide payments would be budget-neutral relative to what they otherwise would have been.

In January 2012, the California Hospital Association wrote to DHCS requesting the implementation of the DRG payment system be put on hold until the state can have adequate time to work with hospitals on the best payment methodology for a generally homogenous

narrow group of patients (pregnant women and newborns) who will remain in fee-for-service Medi-Cal due to implementation of the expansion of Medi-Cal managed care.

DHCS Utilization Controls

To monitor utilization and control expenditures under Medi-Cal's existing fee-for-service payment methodology, DHCS uses Treatment Authorization Requests (TARs). According to DHCS, it employs 49 nurse evaluators and 2 physicians at a cost of \$6.6 million total fund (\$1.8 million General Fund) through its Utilization Management Division (UMD) who review all acute inpatient days (except for obstetrical admissions) and, if appropriate, authorize Medi-Cal reimbursement based on medical necessity. When DHCS shifts its Medi-Cal hospital payment methodology to DRGs, its method of cost and utilization control will also need to shift. Under the fee-for-service per diem rate methodology, hospitals have an incentive to admit patients and to have a longer length of stay, as a hospital is reimbursed for each day a patient is in a hospital. Under a DRG payment methodology, hospitals are paid a flat amount for each condition irrespective of the length of stay, so hospitals' financial incentive is to discharge patients early and avoid long lengths of stay. Because of the different incentives in the new methodology, DHCS will need to monitor inpatient claims to ensure that claims are not "upcoded" to a higher paying DRG.

DHCS indicates that once DHCS begins reimbursing hospitals through DRGs, instead of reviewing each hospital day for authorization, UMD staff will be looking at the medical necessity for the admission. DHCS indicates emergency aid codes will also continue to require daily TARs in order to ensure that only medically necessary emergency care is authorized for payment.

Summary

Both at the federal level, with the Patient Protection and Affordable Care Act, and here in California, there is a broad effort to move toward a governing structure that improves health outcomes by incentivizing the efficient management of health care. Medi-Cal's adoption of DRGs is one step in this direction, as it rewards efficient and effective treatment of conditions. Other efforts include widespread adoption of medical technology such as electronic medical records, advancing the concept of "medical homes," and supporting the development of Accountable Care Organizations.

Given the rapidly escalating cost of health care, California policymakers have a strong interest in crafting a policy environment that supports a healthy and competitive marketplace between insurers and providers, and one that aligns fiscal incentives with the best interest of the patient. This hearing is an opportunity to examine, in the area of hospital reimbursement, the progress California is making in this regard, and to investigate whether alleged abuses in the area of hospital reimbursement have exposed flaws in the regulatory structure.