SPARC
DRG Hospital

1. Is this a "Rate Change" or a "Method Change"?
   Method change

1b. Is this change an increase, decrease, or no impact?
   Decrease

2. Presentation of issue – Why is change being made?
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current methodology and reimbursement structure for DRG Hospital Payments.

   The Oklahoma Health Care Authority Board has taken action to reduce SoonerCare expenditures due to declining state revenues and increased program costs. As a result, OHCA recommends the following method change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

   Federal Requirements
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

   OHCA Finance staff has reviewed various provider payment types and services that are funded by state appropriations from the legislature to the OHCA. The proposed changes for DRG Payments to Inpatient Acute Care Hospitals and Critical Access Hospitals are outlined below.

3. Current methodology and/or rate structure.

New Methodology	Current Methodology
Reduce DRG Outlier payments by increasing the DRG threshold to $50,000. Costs (billed amount times hospital specific cost to charge ratio) on the claim must now be $50,000 (was $27k) greater than the DRG base payment to trigger a high cost outlier payment. The outlier calculation description: *Outlier Amount = (claim total amount billed) X (billing provider's CCR) - (DRG Weight X Peer Group Base Rate) – (threshold of $50,000) X (marginal cost factor 70%), or zero, whichever is greater.*	Currently, the DRG threshold is $27,000.
Pay the lesser of billed charges or the DRG amount. For DRG claims, the payment may not exceed billed charges.	Currently, payment is made at the DRG allowable amount.
Transfers pay lesser of transfer fee or DRG. In the case of a transfer, the Transfer Allowable	Currently, both the transferring facility and the receiving facility are paid at the DRG

Fee for the Transferring Facility shall be calculated as follows: *Transfer Allowable Fee = (MS-DRG Allowable Fee/Mean Length of Stay) X (Length of Stay + 1 day).* The total Transfer Allowable Fee paid to the transferring facility shall be capped at the amount of the MS-DRG Allowable Fee for a non-transfer case. No outlier payments will be made on transfer cases. Payment to the receiving facility, if it is also the final discharging Facility, will be at the DRG allowable.	allowable plus outlier if applicable.

4. New methodology or rate.
   See the new methodology in the table above.

5. Budget estimate.
   The estimated annual change is a decrease in the amount of $33,571,241.00 total dollars; $11,903,243.00 state share.

6. Agency estimated impact on access to care.
   This method change should not have a negative impact to access and quality of care to SoonerCare members.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the method change for the DRG Hospital payments.

8. Effective date of change.
   July 1, 2015.