



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Executive Office of Health and Human Services



Medicaid Hospital Payment Study Commission: Meeting #1 Minutes

DATE:

Monday, October 18th, 2010

TIME:

7:30am to 9am

LOCATION:

Neighborhood Health Plan of Rhode Island, 299 Promenade Street, Providence, RI 02908

ATTENDANCE:

Commission Membership:

Present:: Christopher Koller, David Gifford, MD, Gary Bubly, MD (designee for Newell Warde, MD), John J. Hynes, Linda Haley (designee for Sharon Reynolds), Mark Montella (designee for George Vecchione), Mark Reynolds, Matthew Harvey (designee for Peter Marino), Michael J. Ryan (designee for Francis Dietz), Michael Ryan (designee for John Fogarty), Nick Tsiongas, MD, Patrice Cooper, Robert Kalaskowski (designee for Marie Ganim), Rosemary Gallogy

Not Present : Al Kurose, MD, John Simmons, Linda Katz

Staff : Beth Cotter, David Burnett, Deborah Faulkner, Deborah Florio, Debra Stipcich, Elena Nicolella, Kevin Quinn, Kristin Sousa, Ralph Racca, Rick Jacobsen, Stacy Paterno, Stephanie Perreault, Thomas Pearson, Tricia Leddy

Public : No members of the public body

1. Welcome, Introductions, Commission Charter, Ground Rules, Why this Commission, Commission Timeline, and Commission Agenda

The meeting was called to order at 7:30am. Introductions were initiated by David Burnett and Elena Nicolella. David Burnett noted that these commission meetings are Open Meetings and are subject to RI General Laws 42-46. David Burnett then provided a review of the commission charter, ground rules, why the commission has been called, the time line of the commission and the agenda for the commission.



2. Presentation

Deborah Faulkner and Kevin Quinn provided a presentation on the total Medicaid program spending, populations who are being served, providers, Medicaid's role as a payer, the payer mix for each hospital, the business of each payer, a breakdown of Medicaid spending on hospitals, the Medicaid starting point for medical education and supplemental payments detailed by hospital.

The presentation was interactive and the commission members and staff engaged in dynamic discussion. A response to the commission's requests is included with these minutes.

3. Proposed Principles of Payment Reform and Key Policy Issues

Elena Nicolella reviewed the principles of reform stressing the importance of the client and the quality of the care provided. In addition, control of hospital spend, transparency, predictability and consistency were discussed. The adherence to federal and state law as well as encouraging access, efficiency, control over spending, purchasing clarity and administrative simplicity in any changes to payment methods must be taken into account.

Key policy issues that will be addressed in the proposal that will be put forth at the meeting on November 5th will include inpatient and outpatient rates for fee-for-service and managed care, medical education, and supplemental payments including; disproportionate share hospitals (DSH), upper payment limit (UPL) and uncompensated care payments (UCC).

4. Commission Questions

A response to the commission's requests is included with these minutes. Please refer to attachment.

5. Public Comments

No members of the public body were present.

6. Closing

David Burnett and Elena Nicolella closed the meeting with appreciation for the attendance, discussion and the host. A reminder that the next meeting will be on November 5th, 2010, 7:30am to 9am, UnitedHealthCare of New England, Inc., 475 Kilvert Street, Warwick, RI 02886 was announced. The meeting was adjourned at 9:05am.



Hospital Payment Commission: Meeting #1 Requested Information

| | |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. List of Invited Participants | Attached |
| 2. Medicaid Unit Costs (PMPM) by Population | <p>Page 7 of the presentation shows Medicaid Enrollment and Expense by Population. The corresponding unit costs are as follows:</p> <ul style="list-style-type: none"> • Elderly: \$2,104 PMPM • Adults with Disabilities: \$1,970 PMPM • Children and Families in Managed care: \$289 PMPM • Children with special health care needs: \$1,521 PMPM <p>Overall average: \$825 PMPM</p> <p>Note: The total Medicaid expenditure of \$1.7 billion includes \$12.7 million in crossover payments.</p> <p>Source: Claims extract March 8, 2010. ACS analysis. Excludes program administration.</p> |
| 3. State payments to health plans | The administration/contingency percent for the managed care contracts for 2009 was 8% |
| 4. Licensing Fee | Attached is SFY 2010 licensing fee by hospital |
| 5. Definitions | <p>DSH: Disproportionate Share Hospitals Federally matched state payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients</p> <p>UPL: Upper Payment Limit Federally matched state payments to hospitals, to account for differences between Medicaid and Medicare</p> <p>UCC: Uncompensated Care Payments State payments to hospitals for unqualified uncompensated care (state only funds – no federal match)</p> |
| 6. Final Report from the Community Hospital Task Force | <p>Link to OHIC web site</p> <p>http://www.ohic.ri.gov/documents/Committees/Final%20community%20hospital%20taskforce/CHTF%20Letter%20and%20Final%20Report.pdf</p> |
| 7. How other states reimburse | Attached |
| 8. Pay to cost ratios | Calculating refinement to pay-to-cost ratio analysis based on 2009 dataset. To be included as part of Meeting #2 discussion |
| 9. Where are payments to non-hospital facilities in our pie chart? | On page 8 of the presentation, the pie chart shows that hospital payments were 28% of total Medicaid spending in SFY2009. This does include a small amount (less than 1%) of payments to free standing dialysis and ambulatory surgical centers. |



Medicaid Hospital Payment Study Commission
Membership Listing

| Name | Designee | Organization |
|--------------------|--------------------|---------------------------------------------------------|
| Al Kurose, MD | - | Coastal Medical |
| Christopher Koller | - | State of RI Office of the Health Insurance Commissioner |
| David Gifford, MD | - | State of RI Department of Health |
| Francis Dietz | Michael J. Ryan | Memorial Hospital of Rhode Island |
| George Vecchione | Mark Montella | LifeSpan |
| John Fogarty | Michael Ryan | Charter Care |
| John J. Hynes | - | Care New England |
| John Simmons | - | RIPEC |
| Linda Katz | - | Poverty Institute |
| Marie Ganim | Robert Kalaskowski | State of RI Senate Policy |
| Mark Reynolds | - | Neighborhood Health Plan of RI |
| Newell Warde, MD | Gary Bubby, MD | Rhode Island Medical Society |
| Nick Tsiongas, MD | - | Health Right |
| Patrice Cooper | - | UnitedHealthCare of New England, Inc. |
| Peter Marino | Matthew Harvey | State of RI Senate Budget Office |
| Rosemary Gallogy | - | State of RI Department of Administration |
| Sharon Reynolds | Linda Haley | State of RI House Budget Office |



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Executive Office of Health and Human Services



Licensing Fee by Hospital

| Hospital | SFY 2010 |
|---------------------|-----------------------|
| CNE | \$ 27,866,496 |
| Women & Infants | \$ 15,824,541 |
| Kent | \$ 12,041,955 |
| Butler | \$ - |
| Lifespan | \$ 61,571,453 |
| Rhode Island | \$ 41,233,273 |
| Miriam | \$ 15,591,837 |
| Bradley | \$ - |
| Newport | \$ 4,746,343 |
| Independents | \$ 35,466,477 |
| Landmark | \$ 5,503,871 |
| Memorial | \$ 7,178,101 |
| Roger Williams | \$ 6,729,576 |
| South County | \$ 4,314,605 |
| St. Joseph | \$ 7,932,921 |
| Westerly | \$ 3,807,403 |
| Total | \$ 124,904,426 |

Note: Excludes Eleanor Slater

How Medicaid Pays for Hospital Care

Excerpt from a draft paper by Kevin Quinn and Connie Courts

October 13, 2010

A.2 Current Medicaid Methods for Inpatient Hospital Payment

Medicaid fee-for-service payment for inpatient hospital care was \$43 billion in 2006, growing by 8.2% a year since 2002. As shown in Figure A.2.1, the predominant payment methods are as follows.

- Payment per hospital stay using Diagnosis Related Groups.** The hospital is paid a fixed amount depending on the diagnoses and procedures reported on the claim, including complications and comorbidities (CC). Eight different DRG grouping algorithms, or groupers, are in current use. In all cases, the DRG payment equals a relative weight for the specific DRG times an overall DRG base price. For example, the current Medicare MS-DRG payment rates for pneumonia are:
 - DRG 195, pneumonia without CC: $0.7096 \times \$5,584 = \$3,963$
 - DRG 194, pneumonia with CC: $1.0152 \times \$5,584 = \$5,669$
 - DRG 193, pneumonia with major CC: $1.4796 \times \$5,584 = \$8,262$
- For DRG 195, for example, the relative weight of 0.7096 reflects the average nationwide hospital cost for DRG 195 relative to the average nationwide hospital cost for all DRGs. In general, hospital-specific costs and charges have no impact on the payment received. The chief exception is "outlier" payments for a few stays that are extraordinarily expensive.
- Cost reimbursement.** A few states continue to use the cost reimbursement method that prevailed in the 1970s under Medicare and Medicaid. When a claim is received, an interim payment is made at a percentage of charges. After the annual hospital cost report is submitted and reviewed, payment on the claim is retrospectively settled to a percentage of cost, with either Medicaid or the hospital making a payment to the other. This process can take up to several years.
 - Per diem.** Nine states pay hospitals per diem. Typically, the rates are specific to each hospital, and each hospital receives the same rate for every inpatient day. Rates are usually calculated from hospital cost reports. The rate may be prospective, meaning that once the rate is set then the per diem payment is final. Alternatively, the per diem payment may be subject to cost settlement, in which case the method would be described more accurately as cost reimbursement.

Figure A.2.1
How Medicaid Pays for Hospital Inpatient Care (September 2010)

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Per Stay -- CMS-DRGs CO*, IA, IL, KS**, KY, MN, NC**, ND*, OH, PA*, SC, UT, VT, WI**, WV** * Moving to APR-DRGs ** Moving to MS-DRGs | Per Stay -- AP or Tricare DRGs DC, GA, IN, NE, NJ, VA, WA |
| Per Stay -- MS-DRGs MI, NH, NM, OK, OR, SD, TX* * Moving to APR-DRGs | Per Stay -- Other DE, MA*, NV, WY * Casemix adjustment based on APR-DRGs |
| Per Stay -- APR-DRGs MT, NY, RI | Per Diem AK, AZ, CA, FL, HI, LA, MO, MS, TN |
| Cost Reimbursement AL, AR, CT, ID, ME | Other (Regulated Charges) MD* * Casemix adjustment based on APR-DRGs |

Notes

- CMS-DRGs=CMS Diagnosis Related Groups (used by Medicare until 10/1/07); MS-DRGs=Medicare Severity DRGs (used by Medicare since 10/1/07); AP-DRGs=All Patient DRGs; APR-DRGs=All Patient Refined DRGs; Tricare DRGs=DRGs used by the military health care system
- Source: Authors, based on information from individual states, Ingenix and 3M Health Information Systems.
- Updates and corrections are welcome and may be sent to kevin.quinn@acs-inc.com.
- Neither the authors nor their employer has a financial interest in any DRG grouping algorithm.

A.3 Current Medicaid Methods for Outpatient Hospital Payment

Medicaid fee-for-service payment for outpatient hospital care was \$12 billion in 2006, growing by 4.2% a year since 2002. The distinctions among payment methods are less clear than for inpatient care. These methods can be categorized into four broad approaches, as shown in Table A.3.1.

- **Cost reimbursement.** As with inpatient cost reimbursement, outpatient claims are first paid at a percentage of charges and then settled to a percentage of cost a year or two later. Lab services are an exception; these services are typically paid using Medicare’s clinical lab fee schedule, without settlement. A state may also carve out other services that are paid using fee schedules.
- **Other fee schedule.** If a state uses fee schedules extensively, the table categorizes it as “other fee schedule,” even if some services are reimbursed based on cost. A state may develop its own fees for ambulatory surgeries, imaging, therapy, clinic visits, or ER visits or it may adopt them from another source. An example is Medicare’s previous fee schedule for ambulatory surgical centers.
- **Ambulatory payment classification (APC) groups.** Medicare implemented its APC-based method in 2000. It is essentially a fee schedule, with thousands of procedure codes each assigned to one of 838 APCs. Each APC has a relative weight that is multiplied by an APC conversion factor (analogous to the DRG base price) to arrive at a fee. Unlike DRGs, a single visit may include multiple APCs and multiple separate payments. Payment for a chest pain patient seen in the emergency room, for example, might be as follows:
 - CPT 99284, ER visit →APC 615, Level 4 ER visit →3.311 x \$67 = \$223
 - CPT 71010, chest x-ray →APC 260, Level II plain film → 0.666 x \$67 = \$45
 - CPT 93005, EKG →APC 099, EKG → 0.394 x \$67 = \$26

Some states, such as Montana, have closely followed the Medicare model, which also includes various rules regarding modifier use, “composite APCs,” “conditional packaging” and other topics. Other states, such as Rhode Island, use an “APC fee schedule,” which is a simplified method without composite APCs, conditional packaging, and other complexities.

- **Enhanced Ambulatory Patient Groups (EAPGs).** EAPGs take a more bundled approach than APCs, that is, fewer ancillary services are separately payable. EAPGs also use diagnosis to categorize medical visits. The patient above, for example, would be assigned to APG 604 (chest pain) and a single payment would cover the ER evaluation, the chest x-ray and the EKG. Each EAPG has a relative weight that is multiplied by a conversion factor to yield a payment rate.

