

# **Medicaid Hospital Payment Commission**

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## **Meeting #1: Background and Introduction**

**Monday, October 18<sup>th</sup>, 2010**

# Ground Rules

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- ❖ All meetings shall be open to the public and will be conducted by the conveners. Conveners will determine under what circumstances non-members may participate.
- ❖ As the role of the Commission is advisory, meetings will be conducted in open, participatory style, inclusive of all members. Emphasis is placed on building a collaborative process -- consensus is sought but not required.
- ❖ The scope of work addressed by the Commission will be limited to Medicaid. The Commission will rely on existing datasets to support recommendations.
- ❖ The Commission will address a limited number of policy questions. A “parking lot” list will be created and maintained for issues outside the scope of the commission

# Why This Commission?

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- ❖ **Medicaid faces substantial short term budget pressures. Federal stimulus funds (ARRA) provided temporary relief – however, due to expire soon...**  
Elimination of ARRA match will “cost” Rhode Island over \$100 Million in general revenue funds in SFY 2012
- ❖ **...yet at the same time must look forward to implementation of federal reform and substantial increases in coverage and access.**  
Beginning in 2014, virtually all populations <133% FPL will be covered by Medicaid (excluding non-citizens).
- ❖ **Short term, we need a hospital payment policy that “fits” within our state budget constraints recognizing that ARRA and Article 20 are both due to expire.** ARRA was due to expire in October, 2010, but was extended through 2011 – however no additional extension is anticipated. Additionally, limitations on hospital payments established in Article 20 are set to expire in December, 2011.
- ❖ **Longer term, we need a hospital payment model that can support this broader role for Medicaid. Any strategies to contain Medicaid spending must include hospitals and must be financially sustainable for both the Medicaid program and the hospitals**  
We estimate that hospitals represent 28% of total Medicaid spending, accounting for over \$450 Million in spending in 2009. Correspondingly, Medicaid is a substantial payer for most Rhode Island hospitals.

# Commission Timeline

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*“...The director of the Department of Human Services shall report to the chairpersons of the House and Senate Finance Committees the findings and recommendations of the study commission by December 31, 2010.”*

❖ **October 18<sup>th</sup>: Background and Introduction**

Background, define the problem (conceptually and analytically), communicate the department’s proposed principles for hospital payment reform

❖ **November 5<sup>th</sup> : Introduce Medicaid Proposal(s)**

Review draft Medicaid hospital payment policy recommendations for SFY 2012

❖ **November 19<sup>th</sup>: Discussion and Alternatives**

Stakeholders “turn”. Continue to discuss/get stakeholder feedback on Medicaid policy recommendations, stakeholders bring alternative options to the table for discussion

❖ **December 17<sup>th</sup>: Outline set of options to consider going forward, clarify next steps**

Refine set of policy options to incorporate factors to consider as identified in discussion, clarify pros/cons, voice of stakeholders, clarify process of next steps toward legislative options.

Begin to identify longer term payment strategies, future opportunities for public/private partnerships

***Note: This is an aggressive schedule with a legislatively imposed deadline...will need to consider how best to continue some of the discussions that span a longer time horizon***

# Commission Agenda

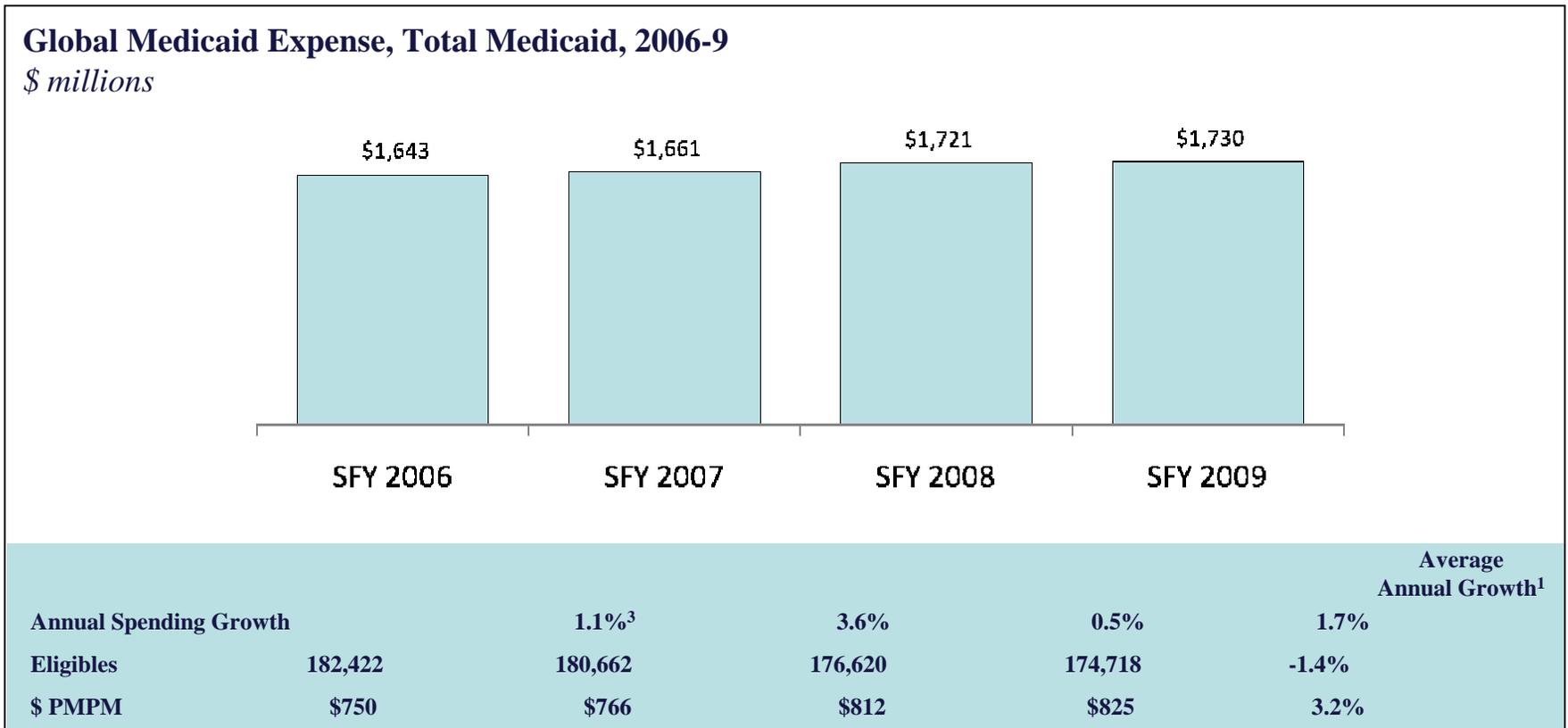
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Medicaid's proposal, to be discussed on November 5<sup>th</sup>, will address the following four elements of hospital payment

- ❖ Inpatient payment rates, including FFS and managed care
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- ❖ Supplemental payments, including DSH, UPL and UCC
- ❖ Treatment of Graduate medical education (GME)

# Total Medicaid Program Spending

RI Medicaid program expenditures totaled \$1.7 Billion in 2009, and has been limited to 1.7% average annual growth in spending over the past three years.

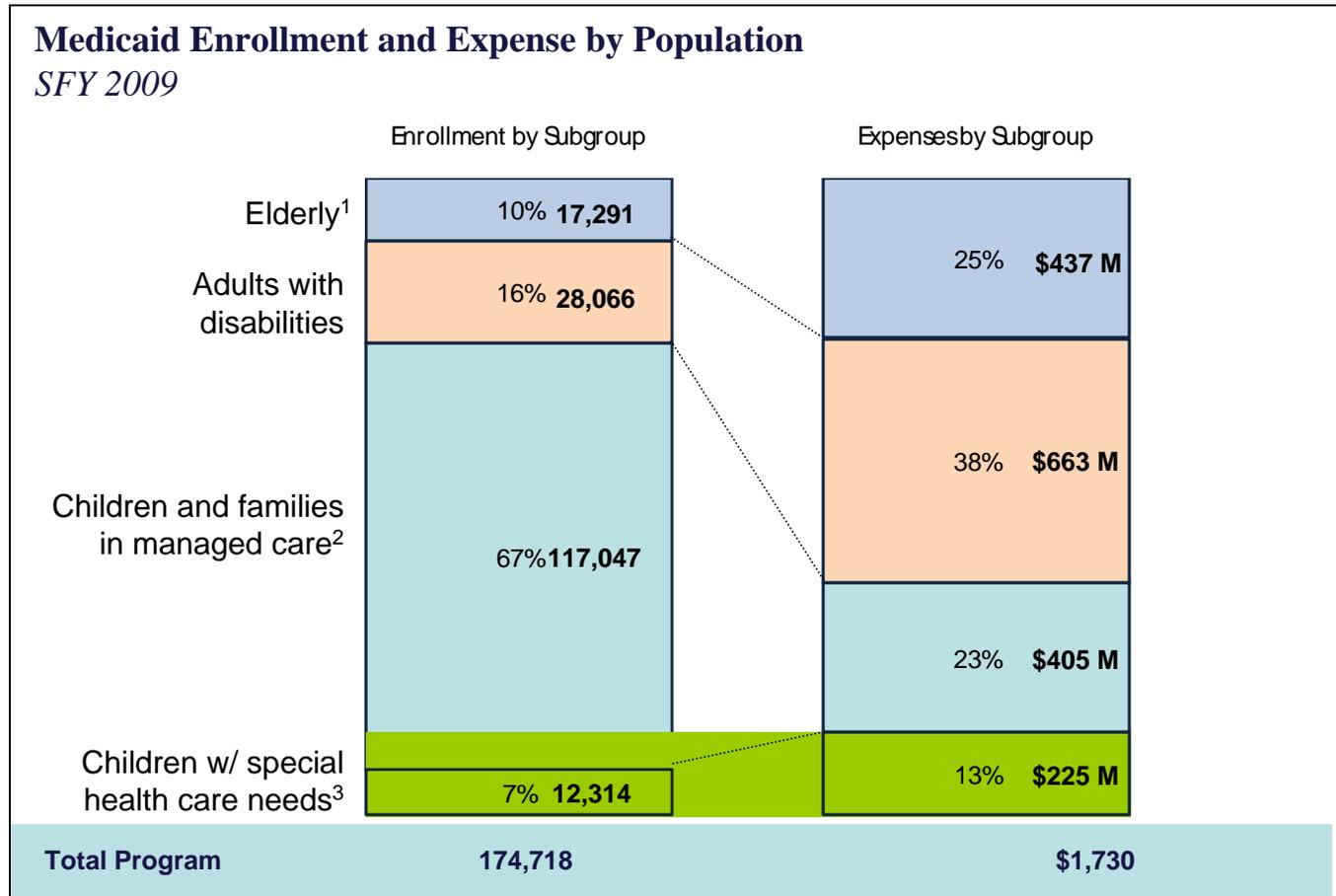


<sup>1</sup>Calculated as compounded annual growth rate (CAGR) over period 2006-2009 as shown.

Source: K. Booth analysis of claim data (MedicaidGlobal20100308xls-1,) extracted March 8, 2010. Excludes program administration.

# Populations Served

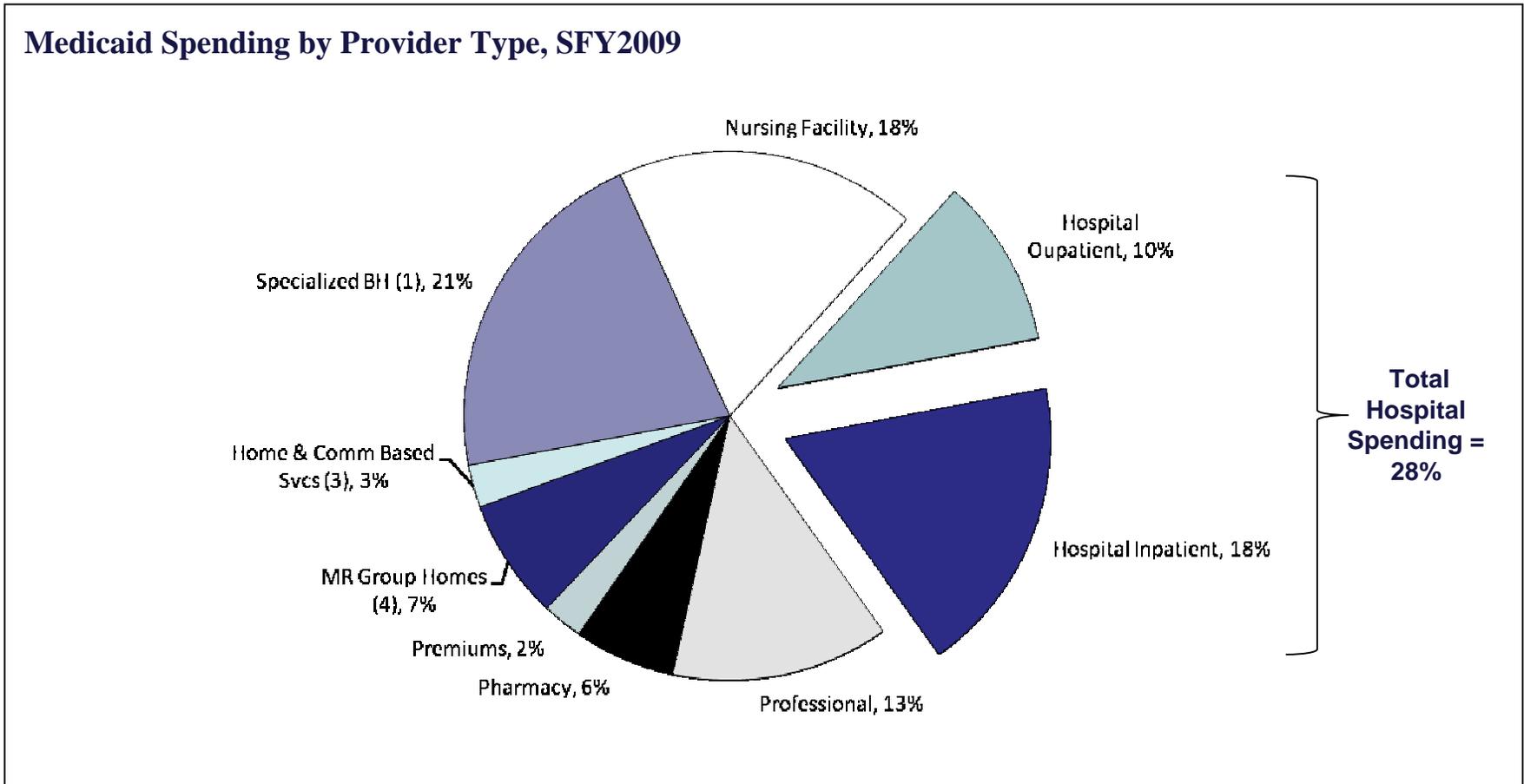
RI Medicaid program serves 175,000 Rhode Islanders, including elderly adults, adults with disabilities, children and families in managed care, and children with special health care needs



1. The elderly includes all adults over age 65. Adults with Disabilities includes all adults under age 65.
2. Children and Families includes low income children, parents and pregnant women who meet specific asset and income requirements.
3. Children with Special Health Care Needs includes children in Substitute (Foster) Care, Individuals eligible for SSI under 21, Katie Becket children, and Adoptive Subsidy children.

# Medicaid Providers

Hospitals are the largest single category of providers. As such, any initiative focused on Medicaid expenditures must include hospitals



<sup>1</sup> Specialized BH reflects professional services provided through MHRH, DCYF, DHS BH (BH, Cedarr, CIS), NonInstitution/NonWaiver.

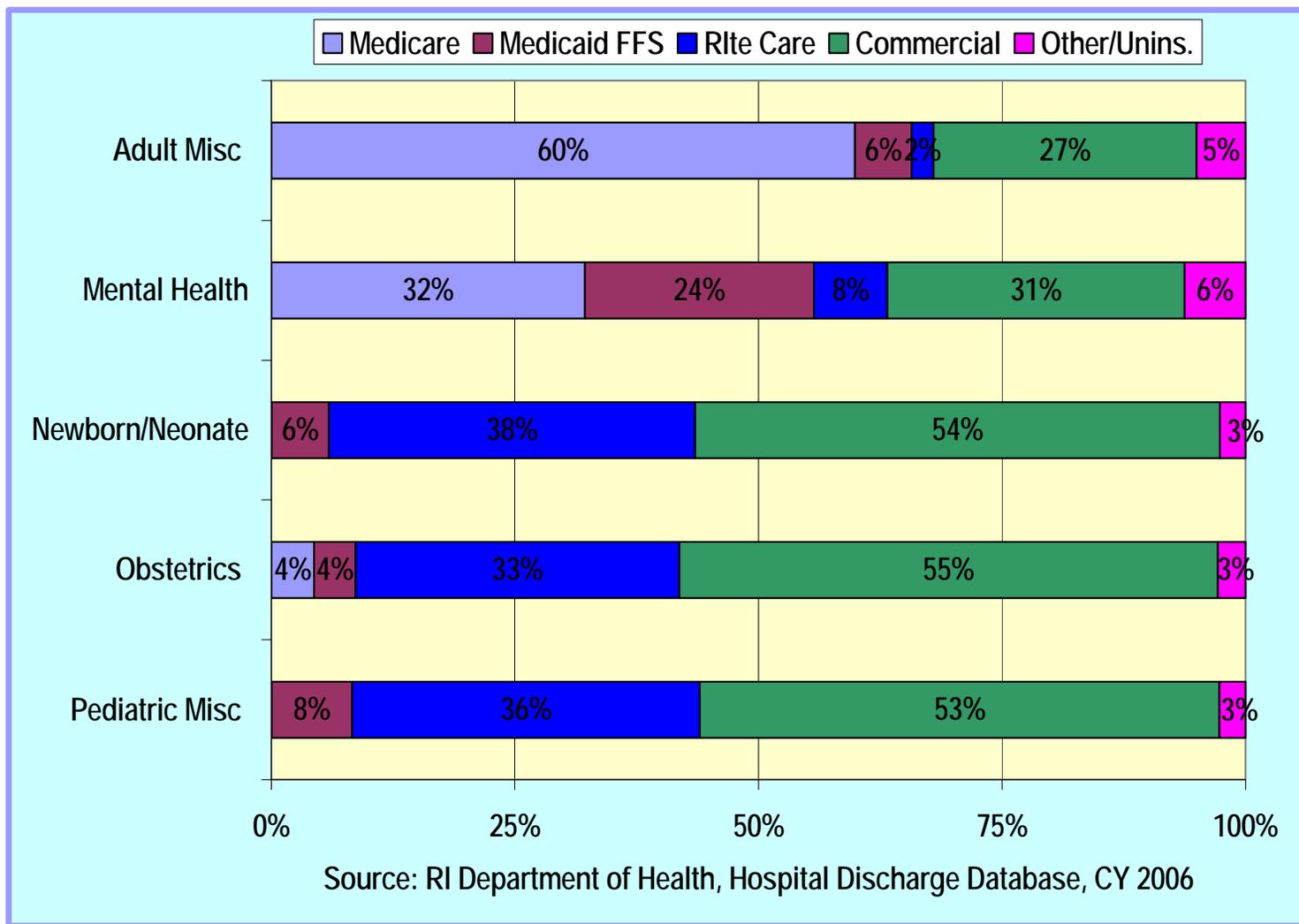
<sup>2</sup> Specialized BH Institutions include Slater, Tavares and Zambarano. These are specialized facilities for severely disabled adults or children.

<sup>3</sup> Home and Community Based Services (HCBS) are services provided as an alternative to more costly nursing home/institutional options, such as personal care, assisted living, case management. <sup>4</sup>MR Group Homes include both public and private facilities.

Source: K. Booth analysis of claim data (MedicaidGlobal20100308xls-1,) extracted March 8, 2010. Excludes program administration.

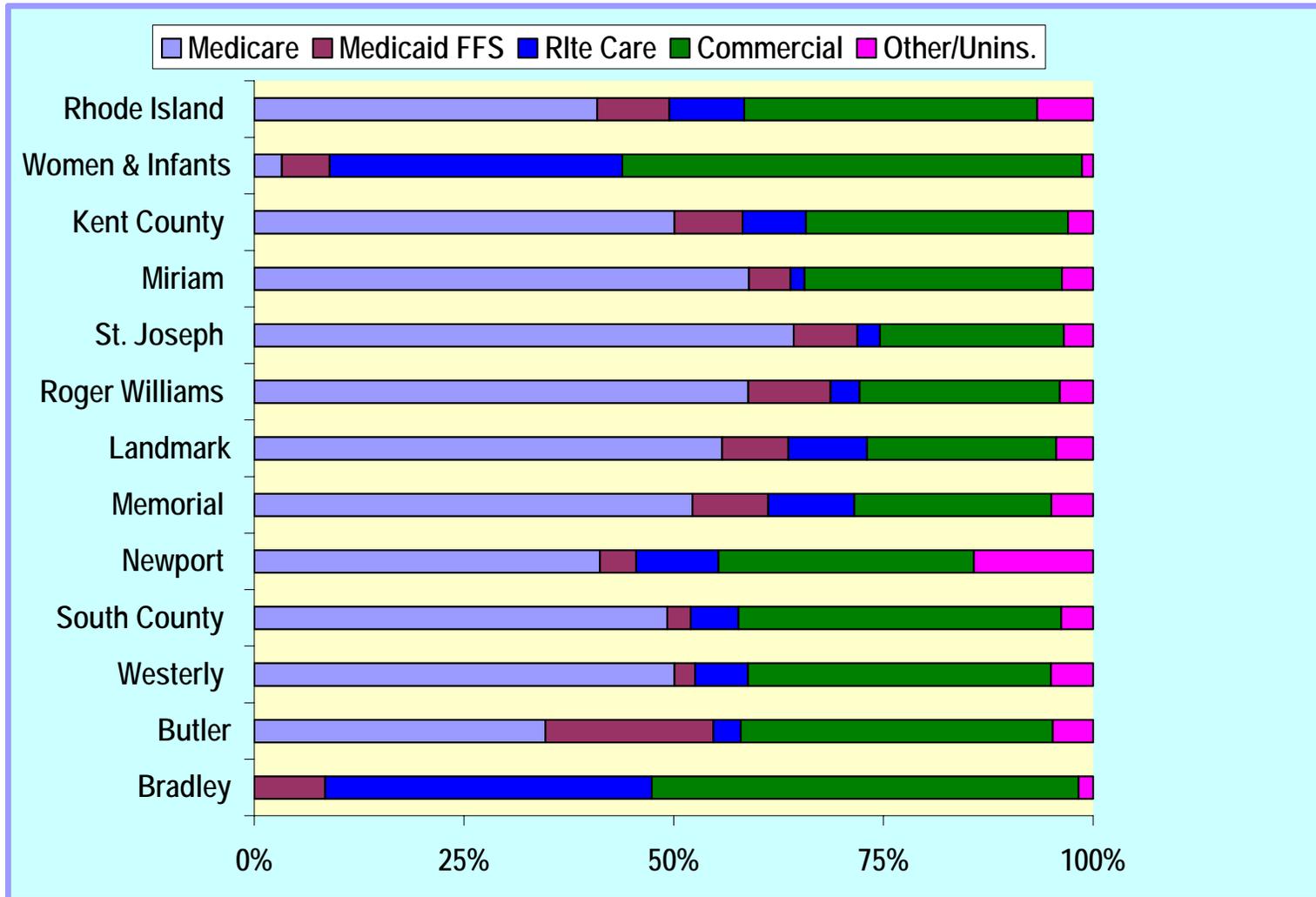
# Medicaid's Role as a Payer, 2006

Correspondingly, Medicaid is also a substantial payer for most hospital services, especially Mental Health, obstetrics, newborn/neonate and pediatrics...



# Payer Mix for Each Hospital, 2006

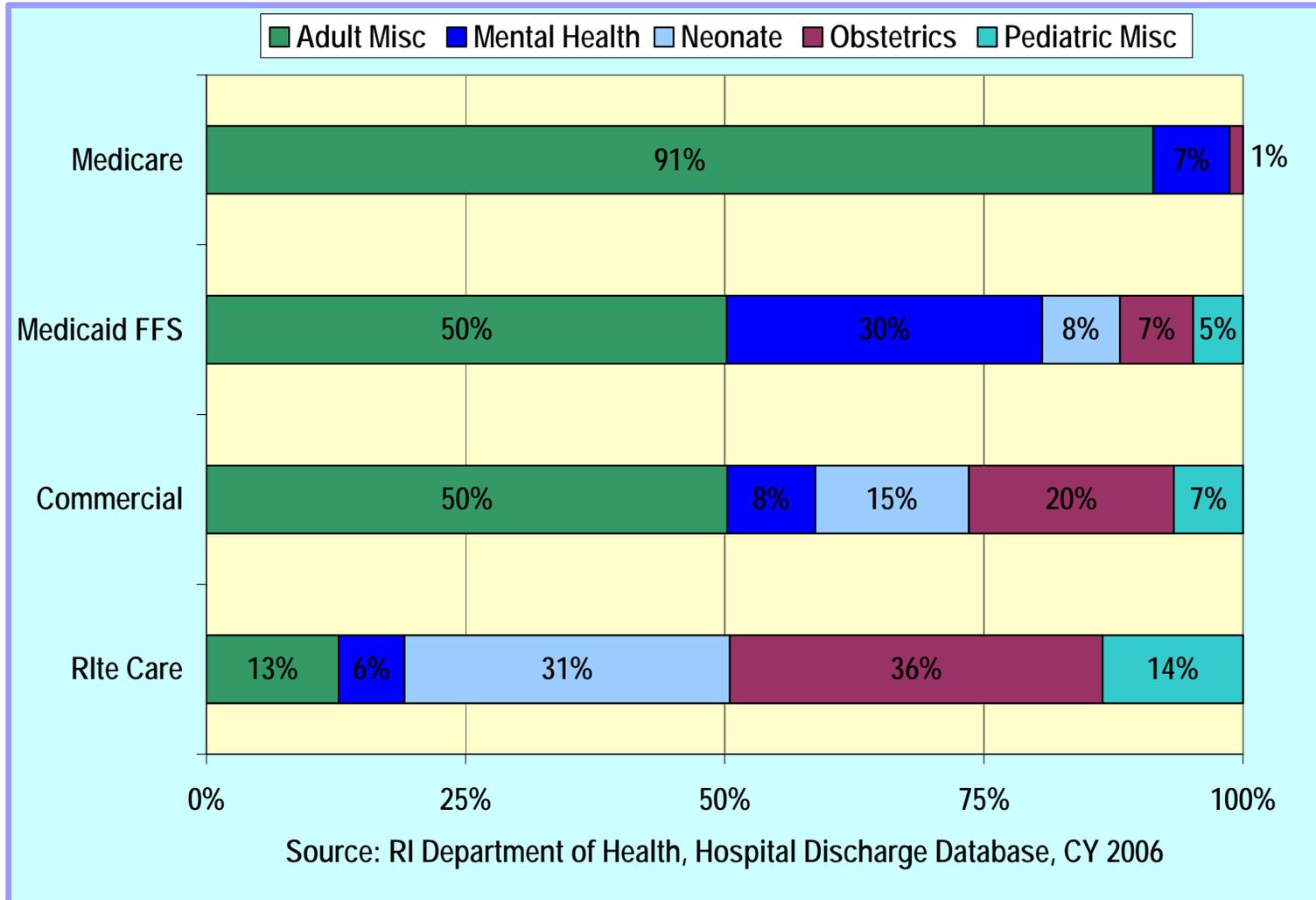
Medicaid is also a substantial payer for most hospitals. Thus, any initiative focused on hospital payment must also consider the impact on hospital financial performance.



Compared with 2006, Medicaid managed care probably now represents a larger share of each hospital's volume and Medicaid FFS a smaller share (except probably at W&I)

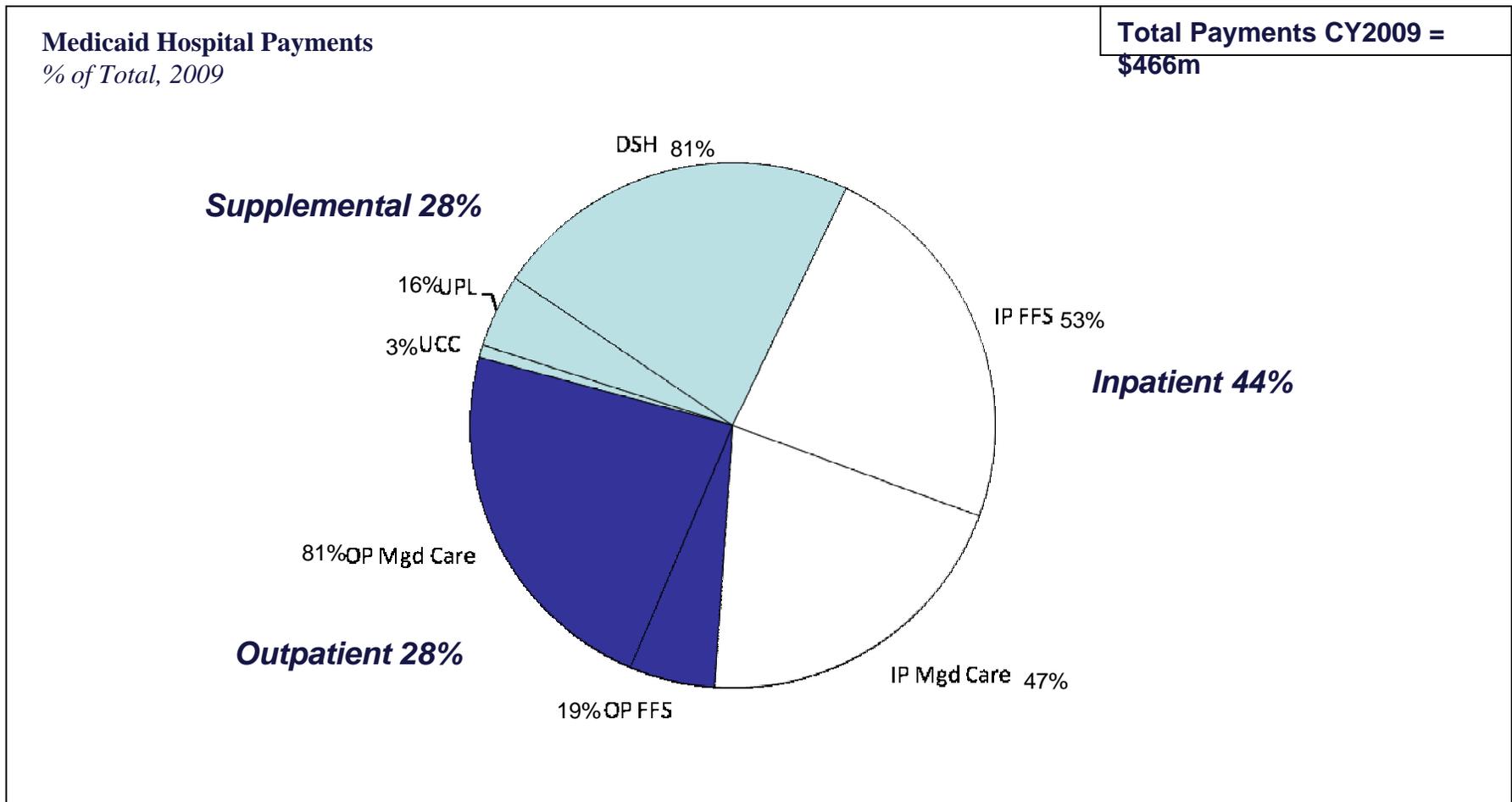
# The Business of Each Payer, 2006

Additionally, Medicaid's serves a very different mix of hospital patients as compared to Medicare or Commercial.



# Breakdown of Medicaid Spending on Hospitals

There are three major categories of Medicaid spending on hospitals: Inpatient care (44%); outpatient care (28%) and supplemental payments (28%).



# Medical Education: Medicaid Starting Point

- ❖ Medical Education represents about 6% of the cost of hospital care in Rhode Island.<sup>1</sup>
- ❖ If FFS Medicaid paid for Med Ed , about \$5 million a year would be redistributed to hospitals with Med Ed programs from other hospitals.<sup>2</sup>
- ❖ Before 7/1/10, FFS Medicaid paid for Med Ed to the extent that these costs were included in hospital-specific costs as of 1994 (and then trended forward).
- ❖ Under current DRG payment and managed care payment, there is no payment explicitly for Med Ed.
- ❖ Federal law is silent on whether states should pay for Med Ed.<sup>3</sup>
- ❖ As of 2009, 41 states pay for Med Ed, a decrease from 48 in 2009. Another nine have recently considered ending Med Ed payments.<sup>4</sup>

*Notes:*1. From ACS analysis of 2008 Medicare cost reports 10/6/10. The figure refers only to direct costs, not any “indirect” costs associated with being a teaching hospital. 2. In a June 14, 2010, simulation, ACS estimated that in FY 2011 fee-for-service payments under DRGs would be \$86.4 million and industry cost \$79.4 million, with industry cost defined to exclude about \$5 million in medical education. If Medicaid were to pay for medical education, payments presumably would be about \$5 million, with a corresponding reduction being made in DRG payments. 3. Charles Luband, *Reimbursement for Graduate Medical Education under Medicaid* (Ropes and Gray LLP, n.d.) 4. Tim. M. Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (Washington, DC: Association of American Medical Colleges, 2010), p. 3. Rhode Island is counted as paying for medical education in 2005 but not in 2009.

# Supplemental Payments – Detail by Hospital, SFY2010

	SFY 2010			Total	% of Total
	DSH	UPL	UCC		
			<i>pd in SFY2011</i>		
<b>CNE</b>	<b>22,797,085</b>	<b>4,607,791</b>	<b>800,000</b>	<b>28,204,876</b>	<b>20%</b>
Women & Infants	14,343,245	2,716,029	-	17,059,274	12%
Kent	8,445,012	1,891,762	800,000	11,136,774	8%
Butler	8,828	-	-	8,828	0%
<b>Lifespan</b>	<b>57,016,296</b>	<b>12,480,429</b>	<b>1,600,000</b>	<b>71,096,725</b>	<b>49%</b>
Rhode Island	44,326,157	9,211,731	-	53,537,888	37%
Miriam	8,534,180	2,428,027	1,600,000	12,562,207	9%
Bradley	80,093	-	-	80,093	0%
Newport	4,075,866	840,671	-	4,916,537	3%
<b>Independents</b>	<b>34,806,709</b>	<b>8,298,778</b>	<b>1,250,000</b>	<b>44,355,487</b>	<b>31%</b>
Landmark	6,862,743	2,344,207	-	9,206,950	6%
Memorial	8,346,204	2,478,771	-	10,824,975	8%
Roger Williams	7,874,985	1,399,519	-	9,274,504	6%
South County	2,982,861	528,650	500,000	4,011,511	3%
St. Joseph	6,121,718	1,289,078	-	7,410,796	5%
Westerly	2,618,198	258,553	750,000	3,626,751	3%
<b>Total</b>	<b>114,620,090</b>	<b>25,386,998</b>	<b>3,650,000</b>	<b>143,657,088</b>	<b>100%</b>

Source: Ralph Racca, DHS

Note: SFY2010 UCC was actually paid in SFY2011 along with additional UCC payments for SFY2011. Only payments attributed to 2010 shown here.

# Proposed Principles of Payment Reform

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- 1) **The patient comes first.**  
Medicaid exists to improve the health of its clients by funding access to quality care. Hospitals are essential partners in meeting the needs of Medicaid beneficiaries.
- 2) Medicaid must **control hospital spending** in coming years, in both FFS and Managed Care.
- 4) **Transparency and predictability** in payment methods and payment levels is important.
- 5) **Consistency:** Medicaid payment methods should pay similarly for similar care.
- 6) Medicaid payment methods and levels must **adhere to federal law**, e.g., upper payment limits
- 7) Any changes in payment methods should **encourage access, efficiency, control over spending, purchasing clarity, and administrative simplicity.**

# Key Policy Issues

Segment	Current Status	For Discussion: SFY 2012 and beyond
Inpatient Rates	<ol style="list-style-type: none"> <li>1. <b>Fee for service:</b> New payment method based on DRGs implemented 7/1/10</li> <li>2. <b>Managed care:</b> Legislated caps in place:               <ul style="list-style-type: none"> <li>o 1/1/11–12/31/11: payment rates must not exceed 90.1% of 6/30/10 rate</li> <li>o 1/1/12–12/31/12: rate increases must not exceed hospital market basket</li> </ul> </li> <li>3. <b>Medical education:</b> Hospital cost (as of 1994) implicitly included in previous payment methods. No specific payment under DRGs.</li> </ol>	<ol style="list-style-type: none"> <li>1. <b>Fee for service:</b> SFY 2011 rates under APR-DRGs were set to be budget-neutral relative to what the previous payment method would have paid. How should rates change for SFY 2012 and after?</li> <li>2. <b>Managed care:</b> What happens to managed care rates once legislative caps expire?</li> <li>3. <b>Medical education:</b> Should Medicaid make specific payment for medical education?</li> </ol>
Outpatient Rates	<ol style="list-style-type: none"> <li>4. <b>Fee for service:</b> New payment method based on APCs implemented 10/1/09.</li> <li>5. <b>Fee for service:</b> RI APC rates initially set at 100% of Medicare rates</li> <li>6. <b>Managed care:</b> Legislated cap in place.               <ul style="list-style-type: none"> <li>o 1/1/11-12/31/11: payment rates must not exceed 100% of the 6/30/10 rate</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>4. <b>Fee for service:</b> New method was introduced 10/1/09 on an interim basis. What method should be used long-term?</li> <li>5. <b>Fee for service:</b> How should rates be updated?</li> <li>6. <b>Managed care:</b> What happens to managed care rates once legislative caps expire?</li> </ol>
Supplemental Payments	<ol style="list-style-type: none"> <li>7. <b>DSH (inpatient):</b> DSH structure unchanged</li> <li>8. <b>UPL (outpatient)</b></li> <li>9. <b>Uncompensated care</b></li> </ol>	<ol style="list-style-type: none"> <li>7. <b>DSH (inpatient):</b> How should DSH be adapted to meet new federal requirements?</li> <li>8. <b>UPL (outpatient):</b> Are UPL payments still appropriate given new outpatient payment method?</li> <li>9. <b>Uncompensated care:</b> Any changes to UCC?</li> </ol>

# For Further Information

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**Any questions? Please contact:**

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