

# **Medicaid Hospital Payment Study Commission**

---

**Meeting #2: Medicaid Proposal**

**Meeting Date: Friday, November 5<sup>th</sup>, 2010**

# Agenda

---

- ❖ Medicaid Hospital Payment Proposal
- ❖ Impact Assessment
- ❖ Backup documentation

# Principles of Reform

---

- ❖ **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
- ❖ Medicaid must **control hospital spending** in coming years, in both fee-for-service and managed care
- ❖ **Transparency and predictability** in payment methods and payment levels is important
- ❖ **Consistency:** Medicaid payment methods should pay similarly for similar care
- ❖ Medicaid payment methods and levels must **adhere to federal law**, e.g., upper payment limits
- ❖ Any changes in payment methods should **encourage access, efficiency, control over spending, purchasing clarity, and administrative simplicity**

# Longer-term Objectives

---

## **Where we want to get, by SFY2013, prior to federal reform implementation**

- ❖ Base Payment rates are transparent, predictable and consistent, meeting principles of reform stated on prior page. New outpatient payment method implemented for outpatient fee-for-service.
- ❖ All Rates (inpatient and outpatient, Fee-for-service and Managed Care) increase annually consistent with CMS hospital market basket and/or Medicare rates
- ❖ DSH payments are transparent, set in accordance with new federal guidelines
- ❖ Outpatient payment rates meet or exceed Medicare rates without UPL

# Where we are: Medicaid Perspective

---

- ❖ **Medicaid hospital payment trends experienced SFY2006-09 were not sustainable**  
Medicaid payments to RI hospitals between 2006 and 2009 increased by 10% a year on average
  
- ❖ **We estimate that initiatives put in place for SFY2010 resulted in hospital payment trend of approximately 4% between SFY2010 and SFY2011**  
This is more in line with realistic state budget constraints; however some of these initiatives are set to expire in SFY2012.
  
- ❖ **We have proposed a Medicaid purchasing approach for hospital based services, which specifically addresses the following six elements:**
  1. What happens to Medicaid managed care payment rates to hospitals, once Article 20 expires?
  2. How should Medicaid fee-for-service payment rates to hospitals be updated?
  3. Should Medicaid pay for medical education?
  4. How should Medicaid Disproportionate Share Hospital payments (DSH) be adapted to meet new federal guidelines?
  5. Are UPL payments (federally matched state payments to hospitals, to account for differences between Medicaid and Medicare) still appropriate given new outpatient payment methods?
  6. Should Medicaid continue to pay for unqualified uncompensated care (i.e., should UCC continue)?

# Medicaid Proposal: Page 1 of 2

	Issue	Current Status	For Discussion	Proposal
Inpatient	1. Fee-for-Service	<ul style="list-style-type: none"> <li>New payment method based on APR-DRGs implemented 7/1/10.</li> <li>Rates were set to be budget neutral relative to what the previous payment method would have paid, with transition adjustment</li> <li>Rates held at 7/1/10 rates through SFY11 (thru Jun11)</li> </ul>	<i>How should inpatient rates change for SFY12 and beyond?</i>	<ul style="list-style-type: none"> <li>SFY11 (Jul10-Jun11): No change</li> <li>SFY12 (Jul11-Jun12): No change in method, budget neutral transition adjustment eliminated</li> <li>SFY13 (Jul12-Jun13) and beyond: Trend rates based on the CMS hospital market basket</li> </ul>
	2. Managed Care	Legislated caps in place <ul style="list-style-type: none"> <li>1/1/11-12/31/11: rates capped at 90.1% of 6/30/10 rate</li> <li>1/1/12-12/31/12: rate increase must not exceed hospital market basket</li> </ul>	<i>What happens to managed care inpatient payment rates once legislated caps expire?</i>	<ul style="list-style-type: none"> <li>SFY11 (Jul10-Jun11): no change – legislated cap in place</li> <li>SFY12 (Jul11-Jun12): extend rate cap (90.1% of 6/30/10 rate) for 6 months until end of state FY (6/30/12)</li> <li>SFY13 (Jul12-Jun13) and beyond: Extend existing legislated cap on trend, not to exceed hospital market basket, with no legislated end date</li> </ul>
	3. Medical Education	<ul style="list-style-type: none"> <li>Hospital medical education cost (as of 1994) implicitly included in previous payment methods.</li> <li>No specific payment for medical education under DRGs</li> </ul>	<i>Should Medicaid make specific payment for medical education?</i>	<ul style="list-style-type: none"> <li>No Medicaid payment specifically for medical education</li> </ul>
Outpatient	4. Fee-for-Service	<ul style="list-style-type: none"> <li>New payment method based on APCs implemented on 10/1/09 on an interim basis</li> </ul>	<i>How should outpatient rates be updated? What method should be used, longer term?</i>	<ul style="list-style-type: none"> <li>SFY11 (Jul10-Jun11): no change</li> <li>SFY12 (Jul11-Jun12): Increase rates to achieve 100% of Medicare rates, effective July 1, 2011, with annual adjustment going forward</li> <li>SFY13 (Jul12-Jun13) and beyond: Develop new payment method for implementation in SFY2013</li> </ul>
	5. Managed Care	Legislated cap in place <ul style="list-style-type: none"> <li>1/1/11-12/31/11: rates capped at 100% of 6/30/10 rate</li> </ul>	<i>What happens to managed care outpatient payment rates once legislated caps expire?</i>	<ul style="list-style-type: none"> <li>SFY11 (Jul10-Jun11): no change – legislated cap in place</li> <li>SFY12 (Jul11-Jun12) and beyond: Legislated cap in place thru Dec11. Trend at market basket rates beginning Jan 1, 2012</li> </ul>

# Medicaid Proposal: Page 2 of 2

	Issue	Current Status	For Discussion	Proposal
Other	1.DSH	<b>DSH structure and levels proposed by HARI and approved by DHS/ CMS</b>	<i>How should DSH payments be adapted to meet new federal requirements</i>	<ul style="list-style-type: none"> <li>• SFY11 (Jul10-Jun11): no change – DSH payments established and approved</li> <li>• SFY12 (Jul11-Jun12) and beyond: New DHSled determination of qualified DSH payments, consistent with federal requirements.</li> </ul>
	2.UPL	Payment level proposed by HARI and approved by DHS/ CMS	<i>Are UPL payments still appropriate given new outpatient payment methods</i>	<ul style="list-style-type: none"> <li>• SFY11 (Jul10-Jun11): no change – UPL payments established and approved</li> <li>• SFY12 (Jul11-Jun12) and beyond: No UPL payments</li> </ul>
	3.UCC	These are unqualified uncompensated care payments that are not federally matched (state only funds) and are in no way related to Medicaid services or beneficiaries	<i>Should this payment continue?</i>	<ul style="list-style-type: none"> <li>• SFY11 (Jul10-Jun11): no change – unqualified UCC payments established and approved</li> <li>• SFY12 (Jul11-Jun12) and beyond: No unqualified UCC payments</li> </ul>

# Medicaid Proposal: Year by Year Summary

		SFY 2011 <i>Jul10-Jun11</i>	SFY 2012 <i>Jul11-Jun12</i>	SFY 2013 (and beyond) <i>Jul12-Jun13</i>
Inpatient	FFS	<b>No change</b> Retain APR-DRG rates effective July 1, 2010	<b>No change</b> Budget neutral transition adjustment eliminated	<b>Proposal</b> Trend rates based on the CMS hospital market basket (ongoing)
	Managed Care	<b>No change</b> Rates capped at 90.1% of 6/30/10 rates	<b>No change</b> Rates capped at 90.1% of 6/30/10 rates through December 2011 <b>Proposal</b> Extend rate cap (90.1% of 6/30/10 rates) for 6 months through end of state FY (6/30/12)	<b>No change</b> Rate increase not to exceed CMS hospital market basket through December 2012 <b>Proposal</b> Extend cap on allowable annual increase -- not to exceed CMS hospital market basket (ongoing)
	Med Ed	<b>No change</b> No payment	<b>No change</b> No payment	<b>No change</b> No payment
Outpatient	FFS	<b>No change</b> Retain APC rates effective 10/1/09	<b>Proposal</b> Annual rate adjustment effective 7/1/11 to achieve 100% of Medicare rates	<b>Proposal</b> Annual rate adjustment effective 7/1/12 to achieve 100% of Medicare rates. New payment method implemented.
	Managed care	<b>No change</b> Rates capped at 100% of 6/30/10 rates	<b>No change</b> Rates capped at 100% of 6/30/10 rates through December 2011 <b>Proposal</b> Rate increases not to exceed CMS hospital market basket beginning January, 2012	<b>Proposal</b> Rate increases not to exceed CMS hospital market basket (ongoing)
Other	DSH	<b>No change</b>	<b>No change</b>	<b>Proposal</b> New DHS led determination of qualified payments, consistent with federal requirements (ongoing)
	UPL	<b>No change</b>	<b>Proposal</b> No UPL payment	<b>Proposal</b> No UPL payment
	UCC	<b>No change</b>	<b>Proposal</b> No unqualified UCC payments	<b>Proposal</b> No unqualified UCC payments

# Backup Documentation

---

# Hospital Spending Growth

Medicaid spending growth on hospitals in recent years has challenged state program efforts to “fit” within state budget constraints

## Medicaid Spending on Hospitals, SFY2009

	Hospital	SFY 2009 Medicaid Spend (\$M) <sup>1</sup>	% of SFY2009 Spend	Annualized Spending Growth (CAGR) 2006:09
<b>Care New England</b> SFY 2009 Spend: \$113M % of total: 32% CAGR: 13%	Women & Infants	\$75	18%	13%
	Kent	\$28	7%	8%
	Butler	\$10	3%	37%
<b>LifeSpan</b> SFY 2009 Spend: \$158M % of total: 45% CAGR: 9%	Rhode Island	\$113	27%	8%
	Miriam	\$20	5%	13%
	Newport	\$8	2%	6%
	Bradley	\$18	4%	13%
<b>Independents</b> SFY 2009 Spend: \$83M % of total: 24% CAGR: 7%	Landmark	\$17	4%	9%
	St. Joseph	\$21	5%	4%*
	Memorial	\$23	6%	14%
	Roger Williams	\$15	4%	4%
	Westerly	\$3	1%	6%
	South County	\$5	1%	4%
<b>TOTAL</b>		<b>\$355</b>	<b>100%</b>	<b>10%</b>

\* St. Joseph CAGR based on 2007-2009 to avoid anomaly in spending data in 2006. Overall CAGR calculations use St. Joseph 2007 spend as proxy for 2006.

Source: K. Booth analysis of claim data (MedicaidGlobal20100308.xls-1,) extracted March 8, 2010. Excludes program administration.

# Hospital Payment Summary

**Highly Preliminary  
Estimates**

We estimate that initiatives put in place for SFY2010 resulted in hospital spending trend of approximately 4% between SFY2010 and SFY2011. This is more in line with realistic state budget constraints; however some of these initiatives are set to expire in SFY2012.

	<b>2009 Dataset Oct'08-Sep'09 (with transition)</b>	<b>SFY2010</b>	<b>SFY2011</b>	<b>Trend SFY2010- SFY11</b>
Inpatient	\$218	\$233	\$242	4%
IP Fee for Service	\$82	\$85	\$87	2%
IP Managed Care	\$135	\$149	\$155	4%
Outpatient	\$112	\$118	\$126	7%
OP Fee for Service	\$17	\$15	\$15	3%
OP Managed Care	\$95	\$103	\$111	7%
<b>Subtotal IP &amp; OP</b>	<b>\$330</b>	<b>\$351</b>	<b>\$368</b>	<b>4.6%</b>
Supplemental	\$130	\$140	\$144	3%
UCC	\$4	\$0	\$8	NA
UPL	\$21	\$25	\$18	-29%
DSH	\$106	\$115	\$118	3%
<b>Total RI Hospitals</b>	<b>\$460</b>	<b>\$491</b>	<b>\$512</b>	<b>4.1%</b>

*Note: Excludes Rehab, Out of State and Out of Network hospital payments*

## Inpatient Data Notes:

- 2009 Inpatient Mgd care dataset is from K. Quinn APR-DRG implementation analysis of RY (Sept to Aug). 2010 and 2011 are SFY (Jul-Jun). Trend for 2009 to 2010 is 75% of full year trend to adjust for this difference. 2009 Inpatient managed care data includes \$13m in transitional payments that were actually paid through FFS in 2009. That same \$13m is NOT included in the 2009 IP FFS totals.
- 2010 & 2011 IP Managed Care data is projected using cost trend of 7.1% and utilization trend of 5.6%, adjusted for impact of Article 20. Source for trend assumptions: HC analytics, RC Core SFY12 estimate.
- 2010 & 2011 Inpatient FFS data is projected as the simulated DRG-based payment for 2009 claims with a 2.5% annual utilization trend increase.

## Outpatient Data Notes

- 2009 outpatient data based on hospital-level payments for 2009 generated May 2010. OP Managed Care data includes an increase of 5% to account for transition population.
- OP managed care cost trend: 8.4%, OP utilization trend: 2.8%. Source: HC analytics, RC Core SFY12 estimate.
- 2010 OP FFS data is 2009 data adjusted for the ratio of simulated before APC to after APC payments from K. Quinn analysis of April-September 2008 payments
- 2011 OP FFS uses 2.5% utilization trend and no cost trend.

## Supplemental Notes

UCC payments for SFY2010 were actually paid in SFY2011 and are shown here in SFY2011 along with the SFY 2011 payments.

# CMS Market Basket Rates

## Source

<http://www.cms.gov/MedicareProgramRatesStats/downloads/mktbskt-actual.pdf>

- Actual regulation market basket updates as published in the "Federal Register"
- Current history and forecasts of the market baskets
- Latest update reflects the GII 2010Q1 forecast with historical data through 2009Q4.

### Actual regulation market basket updates

#### Inpatient Hospital PPS

	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>FY 03</u>	<u>FY04</u>	<u>FY05</u>	<u>FY06</u>	<u>FY07</u>	<u>FY08</u>	<u>FY09</u>	<u>FY10</u>
Market Basket Update	2.9	3.4	3.3	3.5	3.4	3.3	3.7	3.4	3.3	3.6	2.1

1. Inpatient Hospital PPS went into effect October 1, 1983.

2. Beginning in FY 2007, hospitals that provide the required quality data will receive the full market basket increase.

### Actual regulation market basket updates

#### Outpatient Hospital PPS

	<u>CY 01</u>	<u>CY 02</u>	<u>CY 03</u>	<u>CY 04</u>	<u>CY 05</u>	<u>CY 06</u>	<u>CY 07</u>	<u>CY 08</u>	<u>CY 09</u>	<u>CY 10</u>
Market Basket Update	3.4	3.3	3.5	3.4	3.3	3.7	3.4	3.3	3.6	2.1

1. Outpatient Hospital PPS went into effect August 1, 2000.