

Community Hospital Task Force II  
Meeting #2 Notes  
November 27, 2007  
Rhode Island Quality Partners  
235 Promenade Street, 5th Floor, Providence, RI

Commissioner Koller called the meeting to order at 5:04pm. He asked the task force members to identify themselves as the task force was connected via video conference with the Medicare Acute Care division of the Center for Medicare and Medicaid Services. Koller reviewed the meeting's agenda and announced that he and co-chair Director of Human Services Gary Alexander have invited Lifespan to select a board member of a Lifespan member hospital to join the Task Force.

**Goal of 2nd Meeting:** Review Medicare's payment methodology and understand its principles. Recommend principles that should guide the RI Medicaid hospital inpatient payment methodology.

**Explanation of Medicare's inpatient payment methodology (Miechal Lefkowitz and team from CMS)**

Commissioner Koller introduced Miechal Lefkowitz of CMS to give a brief overview of Medicare's payment system. Lefkowitz used the previously distributed MedPAC summary of Hospital Acute Inpatient Services Payment System as a reference to facilitate understanding of the basic information about Medicare's case-based payment system.

Important Points made in the CMS presentation:

- Case-Based Payment Methodology has been used for 24 years (implemented in 1983).
- Policy principle for the payment methodology is explicit stated in the MedPAC document - "The IPPS payment rates are intended to cover the costs that reasonably efficient providers would incur in furnishing high quality care, thereby rewarding providers whose costs fall below the payment rates and penalizing those with costs above the payment rates."
- When the payment methodology was introduced, the stated reason for shifting to this method was to incentivize efficient behavior and cost controlling.
- CMS changed from the original CMS-DRG system to the new MS-DRG system recently and has thus recently spent significant resources determining the framework for this new DRG system to implement. Important factors in the decision was the appropriateness to the Medicare population and the openness of the DRG system (whether providers would need to purchase the grouper from a vendor or if it was available for free).

Questions and Comments from the Task Force

- One of the policy adjusters in Medicare is for "bad debt". The MedPAC report states that CMS will reimburse a hospital for 70% of a Medicare patient's bad debt after "reasonable" attempts to collect the debt was made. The task force requested a definition of "reasonable attempts." CMS stated that they did not have that information at hand but would attempt to locate it.
- Does CMS consider the DRG system a success? CMS stated that no one ever stated that they liked the DRG system until there were attempts made to change it -at this point it received fairly strong support.

- How does CMS pay for outpatient procedures for a Medicare patient if the procedure takes place in an inpatient setting? Outpatient payments are made on a completely separate and different system than inpatient payments, but the payment systems are based on the same principles.
- What will the effect of the MS-DRG system be on teaching hospitals, since there is currently a policy adjuster that provides teaching hospitals with a higher payment because they provide medical education? MS-DRG's will likely continue the success of high severity hospitals with teaching programs because they get more money because of case mix. However, CMS is currently examining the indirect medical education (IME) adjustment because there have been reports that CMS overpays these programs for their costs. Some estimates show that CMS overpays \$1 billion per year.
- Were any DRG's not examined for the Medicare system change? CMS did not look at DRG's for newborns, pregnancies and children under 17, as they are not a factor in the Medicare population.
- How do the DRG weights get set and changed? CMS completes an annual survey process that examines the DRG weights and makes changes as needed. The process is complicated and based partly on data pertaining to hospitals' costs.
- The new MS-DRG's will require a better documentation system to ensure that coding is done properly to facilitate proper payment for the hospitals.

### **Task Force member discussion on inpatient payment principles (Tom Miller, Ph.D., Facilitator)**

Commissioner Koller introduced Tom Miller, a faculty member at Providence College with significant experience working with hospital boards, as the facilitator for a discussion on what principles Rhode Island's Medicaid inpatient payment system should be built upon. Miller began the discussion with a list of potential principles.

### **Potential Principles**

- The preferred case-based payment system should reward the efficient use of hospital resources for inpatient health care services at a given standard of care (*efficiency*).
- The preferred case-based payment system should be relatively simple compared to alternatives; minimizing additional complexity and the costs associated with implementation (*simplicity*).
- The preferred case-based payment system should reward the provision of quality inpatient care (*value-based purchasing*).
- The preferred case-based payment system should result in similar payment for similar care (*fairness*).
- The preferred case-based payment system should result in payment calibrated to the expected use of resources (*resource-based*).
- The preferred case-based payment system should accommodate the infrequent but significant variation in the resources required to care for patients with similar diagnoses (*outlier recognition*).
- The preferred case-based payment system should, in general, reflect approaches that

are accepted and used in one or more other states (*acceptability*).

- The preferred case-based payment system should help support hospitals providing exceptional community benefit (*mission supporting*).
- The preferred case-based payment system should include all inpatient health care services except long-term and skilled nursing facility care (*comprehensiveness*).

Discussion of the Principles by Task Force (discussion is summarized to combine similar points were made by multiple discussants)

- Definition of Simplicity - Should the simplicity principle be split into two statements: Simplicity of Operation and Simplicity of Implementation? Should the simplicity of administration at a regulatory level be considered as well?
- Mission Supporting Principle - Does the description of "community supporting" mean that hospitals with higher level of uncompensated care will receive higher payments from Medicaid? How would this principle affect DSH payments? Should we be creating a payment system based on a principle of supporting hospitals that provide uncompensated care? The task force voted to remove mission supporting as a principle from the list - seemingly due to a lack of consensus on what this would mean and a perception that it would be cumbersome to apply.
- Other principles the task force discussed were consistency of payment, aligned incentives, inflation adjusted, and an adjustable system.
- The principle of "transferability to other payers" was added to acceptability.

The task force ranked the remaining principles as follows:

<b>Potential Principles for a Case-Based Medicaid Payment System</b>			
Principle		Allocation	
4. Fairness		25.2	
3. Quality/VBP		24.7	
1. Efficiency		16.7	
7. Acceptability / transferability to other payers		14.6	
5. Resource-based		14.5	
2. Simplicity		12.0	
6. Outlier recognition		7.7	
8. Comprehensiveness		7.5	

### **Summary of discussion and connection to next meeting's agenda (Commissioner Koller)**

Commissioner Koller introduced Kevin Quinn, a consultant with ACS, which has a contract with the Department of Human Services and has, under this contract, created a discussion paper talking about Rhode Island making the shift to a case-based payment system for Medicaid. Quinn encouraged the task force to carefully read the document for discussion at the next task force meeting.

### **Public Comment**

David Balasco from Lifespan thanked the chairs for the invitation to a Lifespan representative and requested that the task force consider a complete approach when discussing a new payment system. He recommended that outlier adjustments, payment for teaching, case mix adjustment, capital funds and trauma centers should be considered in the deliberations of the group.

Commissioner Koller adjourned the meeting at 7:15pm.