

Community Hospital Task Force II
Meeting #6 Notes
January 22, 2008
Rhode Island Department of Administration
Conference Room A, One Capitol Hill, Providence, RI 02908

Commissioner Koller began the meeting and thanked the members for attending at the new time. The meeting was moved to account for the governor's state of the state.

Commissioner Koller reviewed the work plan for the task force and the agenda for the meeting.

Lou Giancola commented that the Task Force was formed to address the issues of community hospitals, but that now it is being asked to make administrative changes at Medicaid.

First-Cut Simulation of Medicaid Fee-For-Service Payments Under DRG Payment

Kevin Quinn of ACS was introduced. He cautioned that the results are not recommendations, but illustrative of how a simulation would work. Simulation presented as budget-neutral. Offered that technical questions can be answered at any time.

Simulation begins with overview of Medicaid and of prospective payment systems. [Please refer to slides for details.]

Kevin discussed the dataset that ACS used for the simulation and general data about the Rhode Island Medicaid Fee for Service payments.

Kevin discussed the simulation by care category. In responding to questions about interpreting the data, he commented that this simulation compares simulation data to the current payment method and illustrates the effect on payments for certain care categories. A more beneficial slide would be a comparison of the percent of costs covered by payment under the current method vs. in simulation.

What does this simulation tell us? That the APR-DRG redistributes the payments by care category. Does that mean we are currently paying too much in some categories and not enough in others? No, because we are not comparing the payments (present and simulation) to cost.

Next simulation was by hospital. Shows that teaching hospitals increase and that community hospitals decrease. Is that what we want? That is a policy question for the task force.

Next Kevin showed the results of a simulation with a policy adjuster affecting Adult and Pediatric Mental Health, Rehab, Neonates, and Normal Newborns designed to increase payment.

Question raised – why would you set up a new payment system to then try to pay hospitals for services at similar amounts as they are paid currently? Response – you would use a policy adjuster for areas that are important to Medicaid with regard to preserving patient access.

Do more things than payment methodology affect access? Yes, Medicaid payments do not really drive hospital decisions.

Discussion by Task Force

“Vanilla” DRG (no policy adjusters) will reduce payment levels to community hospitals from their current payment level. Will Task Force have to make policy judgment to redistribute funds from teaching/tertiary-level hospitals to community hospitals?

Is a policy adjuster a better way to compensate or a new base price? Well, if we want to centralize neonates, than we should be a policy adjuster because a base rate change may not incentivize a particular type of care.

What are the core services for which we would want to make incentives for the community hospitals to provide, and what protections would we put in place for community hospitals if we do not pay them enough for the services we want them to provide?

Should we add a policy adjuster without knowing what services we want to pay more for? Well, what do you want where?

Patient choice drives some of the things. Community hospitals can give a lot of care, except for the most complex. Primary care physicians can help to drive patients to the right places.

There is no determination of what the needs of the state are for what they need. What will the state need in hospital care in 10 years or 20 years? How can we make the determination of what to pay for without the information?

This discussion parallels what happened to primary care physicians. It is not whether the community hospitals are important, but rather in what areas are the community hospitals important? And what do we want to give the hospitals incentives to do?

In addition to look at the strategic direction and mechanics, one concern is the constitution of the Task Force. The farther we get into the details, the more important that the CEO's and the CFO's get into the discussion.

8 of the top 10 DRG's that are shown are neonate or mental health.

Kevin commented that he is open to hearing from all hospitals. Further analyses are to look at cost, mental health stays, and additional simulations.

Kevin then explained the Appendix in the slides that describes the dataset used in simulations.

By Feb 27, we want to have direction around the policy adjusters to add to Medicaid and the add-ons. That is the chance for the Task Force to affect payment to the community hospitals.

Discussion of draft preliminary report

Chris Koller introduces the draft report, which was also sent to Task Force in advance of meeting. The draft includes as many changes as could be incorporated per requests from TF members.

Tom Miller facilitates.

The purpose of the report is to communicate the Task Force's sense that Medicaid FFS should adopt a case-based method of payment for hospital inpatient services.

Comment that it is important to discuss the fact that Medicaid fee-for-service is a small amount of the payments for community hospitals and therefore there may be a minimal effect on community hospitals. Why the interim report? What is the value?

There may be a movement to prepare a minority report as this report does not meet the charge.

Without a real idea of what services should be provided at community hospitals, how can we be comfortable in providing direction to the state on how to pay?

First Task Force said "let's align incentives using the same type of method, that will work to drive efficiencies at hospitals." That is not the same as "similar method of payment." By specifying a specific case based method, we remove innovation and what hospitals want.

What core services are important for community hospitals to have? How do we incent those? How do we drive access to these services and how do we deal with their costs? Need a plan for this.

What are the measurable benefits of the change in the Medicaid payment methodology?

Addressing one small part of the hospitals' challenges at a time will not make real changes happen.

Bruce Tucker made a statement (see handout)

- Gov and LG ask us to examine and recommend the changes to protect the core services provided by the community hospitals to protect their future.
- Need to look at demographics and core services needed by population.
- Can't accept or reject proposal on what commercial payers should do
- Interim report is too broad.

Chris Koller suggested that the report be submitted by the co-chairs and not the whole Task Force.

Chris commented that it sounds like members of Task Force wanted to continue the first charge instead of the second charge. He pointed out that the proposed merger is a big issue that could exacerbate the problems faced by community hospitals, and highlights the need for system-wide planning. Medicaid will continue this work and would like the Task Force to continue to give feedback to Medicaid.

Report will be tabled.

Public Comment

Ed Quinlan read statement. (See separate handout.)

Adjourned at 6:03