

**PUBLIC MEETING OF THE  
HOSPITAL RATE-SETTING  
TECHNICAL ADVISORY COMMITTEE**

**October 22, 2008  
10:30 a.m. – 1:30 p.m.**

**AGENDA**

- 1. 10:30 a.m. – 10:45 a.m. Opening Remarks**
  - Commissioner Richard Daines
  - Senator Kemp Hannon
  - Assemblyman Richard Gottfried
  
- 2. 10:45 a.m. – 12:30 p.m. Presentation by Department of Health Staff on Medicaid Costs, Payments and Options**
  - Review options for modernizing Medicaid Fee for Service inpatient reimbursement
  - Review Commissioner's preliminary recommendations
  - Identify future policy issues
  
- 3. 12:30 p.m. – 1:30 p.m. Questions & Answers & Discussion**

# Health Care Reform

Hospital Rate-Setting Technical Advisory Committee

October 22, 2008

# Agenda for Today

- Review options for modernizing Medicaid Fee For Service inpatient reimbursement
- Review Commissioner's preliminary recommendations
- Identify future policy issues

# Purpose of the Technical Advisory Committee (TAC)

- Evaluate inpatient reimbursement methodology, including a review of the data which demonstrates how much inpatient revenue exceeds Medicaid inpatient costs
- Examine the impact of proposed methodological changes on hospitals
- Examine the role of hospitals in delivering ambulatory care services to Medicaid beneficiaries
- Commissioner to issue findings and recommendations this November.

# Reform Principles

## Medicaid Rates should:

- Be transparent
- Promote high value, quality driven health care services
- Pay for Medicaid patients
- Not cross-subsidize non-Medicaid payers
- Encourage care in the right setting
- Reinforce health system planning and advance state health care priorities
- Be updated periodically
- Comply with Federal Medicaid rules
- Be consistent with Budget constraints



# Modeling Options for A New Methodology

# Medicaid Inpatient Overpayment Analysis

## (Acute Care Only – Excluding Exempts)

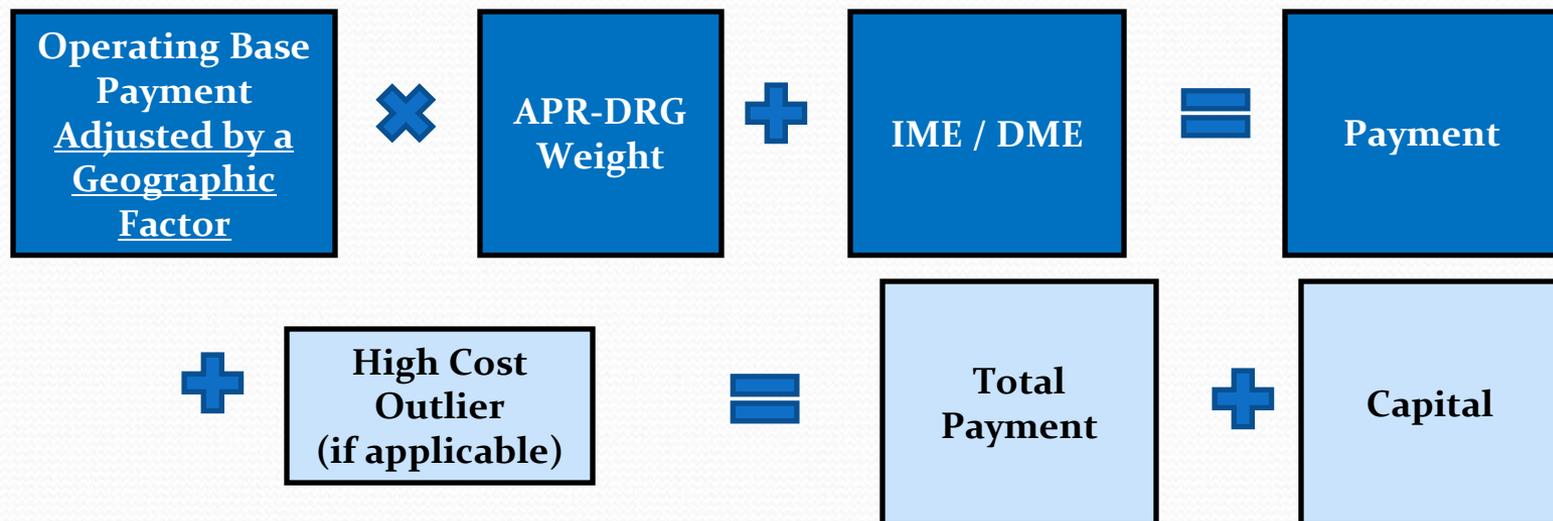
Description		
2007 Costs (2005 RCC based - trended to 2007 using CPI)	\$	2,501,345,000
2007 payments under current methodology	\$	3,259,919,000
Payment over Costs (Overpayment)	\$	758,574,000
<b>Less Adjustments since 2007:</b>		
Rebasing Adjustment (2008-09 Final Budget)	(\$	154,000,000 )
Detox Reduction – Full Implementation (2008-2009 Final Budget)	(\$	55,697,000 )
1.3% reduction on final 2008 Trend (August Special Session)	(\$	97,149,000 )
Reduce 2009 Trend by 1% (August Special Session)	( \$	34,696,000 )
<b>Adjusted Overpayment:</b>	( \$	417,032,000 )
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<b>Plus Adjustments not in Gap:</b>		
2007-08 Legislative Adds	\$	158,000,000
<b>Net Adjusted Overpayment:</b>	\$	575,032,000
		<hr/> <hr/>

# Four Key Rate Setting Components

1. Base price: Statewide vs. Peer Group
  - 2005 costs trended
2. Recognition of differences in wage and energy costs (Wage Equalization Factor (WEF) and Power Equalization Factor (PEF))
3. Patient Classification/Case Mix Weights- All Patient (AP) vs. All Patient Refined (APR)
4. Updated Graduate Medical Education formulas (DME and IME)

# Model of Medicare-like Rate

- An operating base price is set on a statewide basis and then adjusted for differences in wage and energy costs. That base rate is then multiplied against an individual patient's severity weight. To the extent applicable the payment is further adjusted by GME, outliers and capital costs



# Component 1: Base Price

## Comparison Statewide vs. Peer Group

Peer Group	Statewide Price	Peer Group Price
Upstate Non-Teaching (< 100 beds)	\$3,751	\$3,392
Upstate Non-Teaching (> 100 beds)	\$3,751	\$3,661
Upstate Teaching	\$3,751	\$3,125
Downstate Non-Teaching	\$3,751	\$3,279
Downstate Teaching	\$3,751	\$3,633
Major Academics	\$3,751	\$4,117
Major Publics	\$3,751	\$4,188

Applicable base price excludes GME and capital and is labor, power and case mix (APR) neutral.

## Component 2: Wage Equalization Factor (WEF) and Power Equalization Factor (PEF)

- The **Wage Equalization Factor** is the mechanism to equalize hospital salary and fringe benefit costs to account for differences in the price of labor among hospitals and groups of hospitals.
- The **Power Equalization Factor** is the mechanism to equalize hospital utility costs to account for the differences in the price of power, electrical and gas costs among hospitals and groups of hospitals.
- The **Geographic Adjustment Factor (GAF)** is the combination of WEF and PEF adjustments applied as a proportional relationship to labor and power costs.

## Component 2: Regional Determination for Wage Equalization Factor (WEF) and Power Equalization Factor (PEF)

<u>Scenario</u>	<u>Facility</u>	<u>Neutralized Base Price</u>	<u>WEF/PEF Adjustment</u>	<u>Adjusted Base Price</u>
Hospital Specific WEF/PEF	XYZ	\$3,751	1.1779	\$4,418
Regional WEF/PEF	XYZ	\$3,751	1.0554	\$3,959

- The adjustment of the Statewide Base Price on a hospital specific basis is most reflective of each individual hospital's labor and power costs versus the averaging that occurs on a regional basis.

# Component 3: Case Mix Comparison

(All Patient vs. All Patient Refined)

	AP	APR
<b>Peer Group</b>	<b>CMI</b>	<b>CMI</b>
Upstate Non-Teaching (< 100 beds)	0.8319	0.8893
Upstate Non-Teaching (> 100 beds)	1.0455	1.1164
Upstate Teaching	1.4261	1.5098
Downstate Non-Teaching	1.2185	1.1890
Downstate Teaching	1.5404	1.4659
Major Academics	2.1917	2.1548
Major Publics	1.4825	1.4819
<b>TOTAL</b>	<b>~ 1.50</b>	<b>~ 1.50</b>

## Component 3: Selected Service Line Case Mix Comparison (All Patient vs. All Patient Refined)

Service Line	Acute Cases	AP-CMI	APR-CMI	% Change
Cardiovascular Surgery - less invasive (i.e., pacemaker, stents, etc.)	3,306	3.056	3.860	26.3%
Neonatology	43,085	0.938	0.982	4.7%
Neurological Surgery	1,216	6.404	5.951	-7.1%
Obstetrics/Delivery	34,073	0.696	0.848	21.7%
Major Cardiovascular Surgery (i.e., open heart surgery, bypass, valve, etc.)	1,294	8.859	8.268	-6.7%
Transplant Surgery	181	22.328	15.587	-30.2%
Trauma	1,513	4.452	4.676	5.0%

# Component 3: Comparison of MS-DRG and APR-DRG

- In its public comments, CMS stated that MS- DRG weights were specifically developed and tailored to the Medicare population and are not suitable for a non-Medicare population (i.e. children's services and newborns)
- Hospitals currently run more than one grouper.

# Component 3: Comparison of MS-DRG and APR DRG for Newborns (MDC 15)

	MS-DRG	APR-DRG
Number of DRGs	7	28
Severity Levels	None	4 levels within each DRG
Recognition of Birth Weight in DRGs	No	7 birth weight ranges
Separate Surgical DRG	No	Yes

# Component 3: Comparison of MS-DRG and APR DRG (Continued)

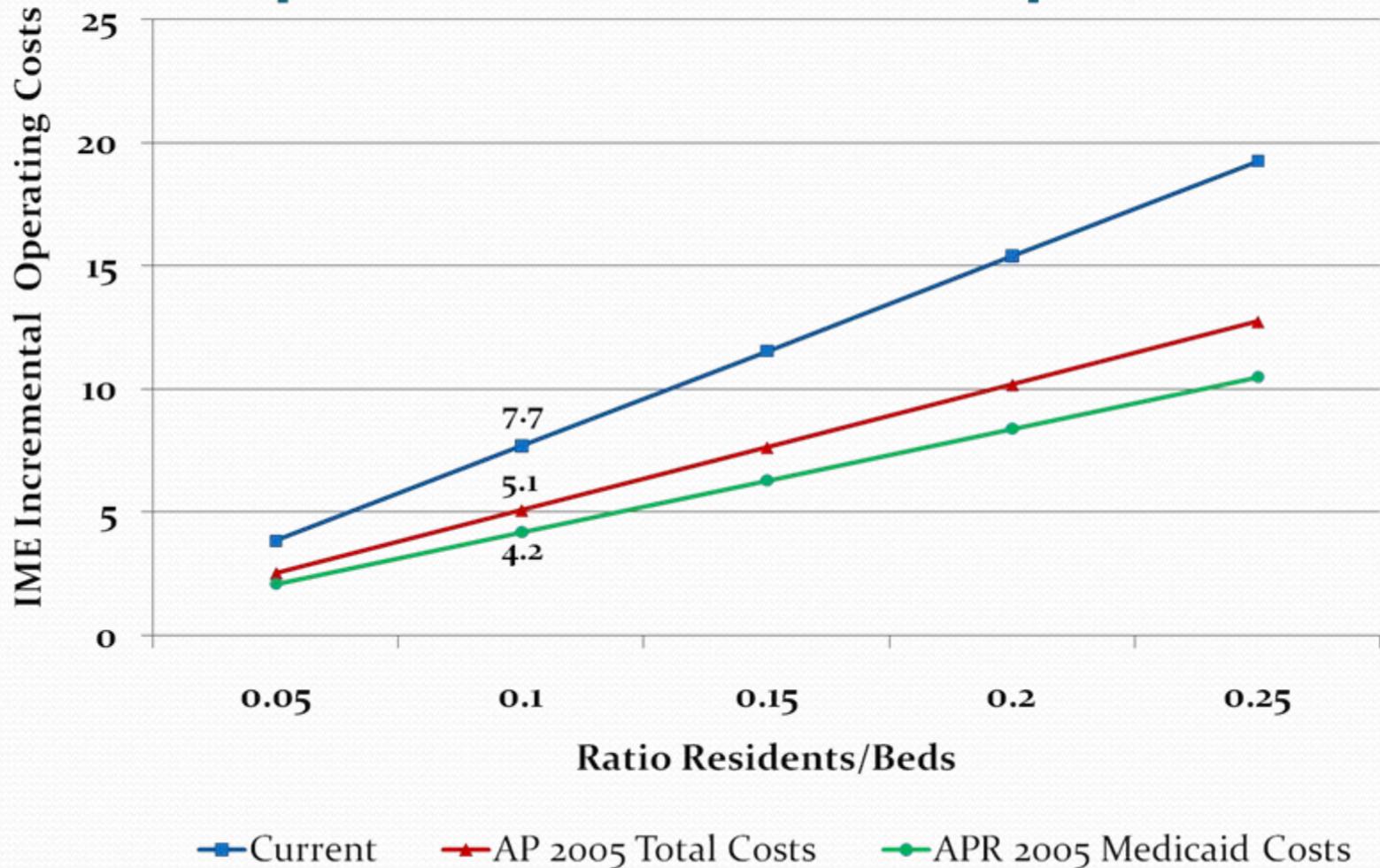
APR-DRG addresses MS-DRG deficiencies:

- All APR DRGs have 4 severity levels
- Patient age is used in severity leveling
- Significant pediatric and adult problems have a separate APR-DRG

# Component 4: GME Formula Update

- Direct Medical Education (DME) – identified on hospital's annual cost report and covers training expenses for resident salaries, teaching faculty and overhead. Proposing to update costs from 2001 to 2005.
- Indirect Medical Education (IME) – covers less tangible expenses attributed to higher patient care costs unique to teaching hospitals (i.e., longer treatment stays, increased testing associated with training residents), which are not readily identifiable from cost reports
  - Derived from an updated statistical analysis (reflects new costs and case weighting) which measures correlation between change in operating costs and teaching intensity factor (ratio of Interns/Residents to beds)
  - Current IME adjustment factor is based on a Medicare proxy and has not been updated since 1988.
  - Medicare has significantly reduced this factor over time with updates to their methodology based on changes in empirical data.

## Component 4: Impact of IME Formula Update



# Preliminary Model Option

- Statewide Base Price
  - 2005 Medicaid FFS costs inflated
- APR DRGs and case weights
- Facility Specific WEF/PEF adjustments
- Updated IME/DME formula
- Reinvest \$300M in Ambulatory Care Services

# Inpatient Update/Ambulatory Care Reinvestment Scenario

PEER GROUP	Inpatient Impact	Ambulatory Care Investment	Difference
Upstate Non-Teaching (< 100 beds)	(\$5.3M)	\$8.8M	\$3.5M
Upstate Non-Teaching (> 100 beds)	(\$29.8M)	\$32.0M	\$2.2M
Upstate Teaching	(\$9.0M)	\$23.6M	\$14.6M
Downstate Non-Teaching	(\$4.3M)	\$15.1M	\$10.8M
Downstate Teaching	(\$138.4M)	\$88.9M	(\$49.5M)
Major Academic	\$8.3M	\$50.7M	\$59.0M
Major Publics	(\$121.5M)	\$80.9M	(\$40.6M)
<b>TOTAL</b>	<b>(\$300M)</b>	<b>\$300M</b>	<b>\$0</b>

**\* Overpayments above \$300M remain available and could be used to address policy decisions regarding outlier policy, exempt units, HHC EMS costs, and/or physician reimbursement.**

# Summary of Recommendations

- Move forward with Medicaid reimbursement reform. The current economic crisis makes it all the more imperative that we bring down health care costs and bring up health care quality -- building a high performing health care system for the 21st Century.
- Replace the current, outdated, All-Patient Diagnostic Related Group (“AP-DRG”) payment methodology for reimbursing inpatient Medicaid services with a risk adjusted methodology – APR-DRGs.

# Summary of Recommendations

- Adopt a statewide base price to promote simplicity, transparency and advance value-driven care. Adjust statewide base price hospital specific wage and power costs.
- Update and refine GME adjustments to more accurately capture both direct and indirect costs associated with teaching programs.
- Consider how to use the APR-DRG system to advance quality considerations, notably potentially preventable complications and readmissions.

# Summary of Recommendations

- Continue to reallocate Medicaid dollars from inpatient rates to outpatient rates, most especially comprehensive primary and preventive care models that meet State and national primary care standards.
- Evaluate phase-in of inpatient/outpatient reform, balancing need for a smooth transition with need to increase primary care access and reduce unnecessary and costly hospital admissions and need to reduce Medicaid spending and improve quality.
- Ensure the timely and accurate collection of cost and quality data.

# Next Steps: Major Issues

- ✓ Outlier policy
- ✓ Exempt Units: Psychiatry, Medical Rehab, Chemical Dependency, Children & Cancer Hospitals, Critical Access Hospitals
- ✓ Capital
- ✓ Other adjustments: HHC EMS Costs, physician reimbursement
- ✓ Transition approach for changes to methodology