Appendix 8.4: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 4: Reimbursement and Payment

Subcommittee Charge

The Reimbursement and Payment Subcommittee of the New Jersey Commission on Rationalizing Health Care Resources will undertake a review of the following issues and report back to the full Commission in the fall of 2007. Among the issues the Subcommittee will review are:

1. The long term viability and adequacy of the Charity Care payment system
2. The adequacy of the current Medicaid payment rates, to both general acute care hospitals and to physicians including recommendations for potential changes. The Work Group will address the recommendation of the NJHA proposal for the establishment of a Medicaid Commission to review the performance of the Medicaid Managed Care companies operating in New Jersey and overall payment rates for Medicaid Services.
3. Review with the Department of Banking and Insurance current policy regarding Medical Loss Ratio's of private health insurers in New Jersey and other issues related to the adequacy of private insurer payment rates to general acute care hospitals.
4. Assess and quantify the loss of Medicare outlier payments to the State of New Jersey in light of recent Medicare changes.
5. Identify the potential impact to New Jersey hospitals of proposed Medicare changes to GME and DSH payments.
6. Propose a plan of work for a robust forecast of likely impacts of payment changes over the next several years to the financial state of hospitals in New Jersey.
7. As appropriate the Work Group will solicit the views from a wide range of stake holders on the items listed in 1 – 6 above.

Subcommittee Membership

See Appendix 8.4A for a list of the subcommittee members

Overview of Subcommittee Process

The Subcommittee met three times during the summer of 2007. In addition to the meetings, members were provided with materials related to issues listed in the subcommittee's charge. These included data on state payments to hospitals (subsidies and Medicaid reimbursement) and white papers on some of the issues (NJHA paper on freestanding ambulatory surgery centers and RWJ Hospital paper on NJ Subsidy Programs).

The meetings generally involved a review of materials provided by subcommittee members, then discussion of the various issues included in the subcommittee's charge. Although the subcommittee looked at all issues listed in the charge, members felt that some were beyond either the subcommittee's or the commission's ability to make a difference (e.g. Medicare reimbursement issues). Because the subcommittee did not want to get ahead of DOBI's planned initiatives to improve transparency in the payment claims process, it did not develop any recommendations on this issue. Limits on time and resources also led the committee to focus on three primary topics – how hospital closures can make existing reimbursement "go farther," leveling the playing field with respect to freestanding ambulatory surgery centers, and more effective distribution of state subsidies.

Key Findings

Distribution of charity care subsidies

The subcommittee was persuaded that there are many flaws in the current methodology for distributing charity care subsidies. Based in part on a white paper prepared by John Gantner, CFO at the Robert Wood Johnson University Hospital the subcommittee found that:

1) by not taking into account efficiency, some subsidies are rewarding inefficient hospitals;
2) by not taking account profitability, some subsidies are going to hospitals that do not need them to be financially viable;
3) lags in data collection and hold harmless provisions prevent the subsidies from truly following the patients;
4) the documentation requirements encourage hospitals to spend money on documenting charity care rather than pursue collection procedures;
5) hospitals often have to use a portion of their subsidies to pay for physician services for charity care patients; and
6) the delivery of charity care is totally unmanaged.

As a result, there appears to be little correlation between the distribution of the charity care subsidies and county wide poverty rates.

The subcommittee believes that part of the problem is that the state has never really settled on whether the subsidies are support to institutions that serve a particular population or an insurance plan for individuals meeting a certain eligibility tests. On the one hand, there are the documentation requirements and the specific calculations to determine the number of charity care patients seen by each hospital that make it look like an insurance program. On the other hand, the legislative earmarks and hold harmless provisions make it look like an institutional support plan.

The subcommittee recognizes that no supplemental funding is available at this time to expand the various state subsidies. Therefore, the subcommittee discussed two alternative approaches to distributing charity care subsidies.

1. Refine the existing methodology to factor in efficiency and/or profitability.

The Benchmarks Subcommittee has identified a number of efficiency criteria, including measures such as cost per adjusted admission, full-time equivalent staff per adjusted admission, case mix adjusted average length of stay, and days in accounts receivable (a complete list is included in Appendix 8.4B). Charity care subsidies could be adjusted based on an evaluation of hospitals using these or other efficiency measures.

Similarly, the subsidies could be limited to hospitals below certain profitability levels. Calculation of profitability should exclude subsidies because some hospitals with positive operating and/or profit margins would be losing money without the subsidy dollars. The limits could be based on absolute cutoffs or graduated reductions. For example, one approach would be to say that any hospital with an operating margin above x % would be ineligible for a subsidy; an alternative would be to reduce the subsidy for each dollar the hospital was above that target.

Separately or together, these refinements would funnel the subsidies to an arguably more deserving set of hospitals. However, it would still leave issues related to time lags and documentation.

2. Incorporate charity care and other subsidy funding into the Medicaid rates

This proposal is based on the belief that there is a high correlation between a hospital's Medicaid and charity care patient loads. In other words, the subsidy dollars would go to the hospitals provided the bulk of charity care. Such an approach would also eliminate the need to spend millions documenting charity care and the problems associated with data lags.

This proposal carries with it several implications. First, it is in part driven by the notion that current Medicaid rates are low. Second, there would be a shift in the administration of the charity care funding from the Department of Health and Senior Services to Medicaid,

within the Department of Human Services. Third, since some Medicaid managed care rates are linked to Medicaid fee-for-service rates, the State would have to adjust payments to the managed care companies. Fourth, putting the entire amount of the charity care subsidies into Medicaid rates would cause the State to exceed the Medicaid upper payment limit. This problem could be addressed by distributing the subsidies based on the distribution of Medicaid reimbursement (fee for service and managed care) without actually folding the subsidies into the Medicaid rates.

Freestanding ambulatory surgery centers

Subcommittee members found two significant problems created by freestanding ambulatory surgery centers (ASCs). While most of the discussion in this area was in the context of ASCs, subcommittee members noted that many of the same issues applied to other types of freestanding outpatient facilities as well.

First, the ASCs are not legally obligated to take Medicaid and charity care patients while hospitals are bound by law to accept such patients. For the hospitals, the ASCs represent an economic threat to their financial viability by taking some of the most profitable patients out of the hospitals.

Payers benefit from the lower unit cost at freestanding centers, which makes the ASCs the providers of choice for some plans. However, they also recognize that in rate negotiations, the hospitals attempt to recover the lost reimbursement that results from this adverse selection.

The subcommittee discussed requiring that ASCs serve all payer classes but doubts that such a proposal is workable. Another approach is to deny licenses to new ASCs unless they are partnered with a hospital. Many doubted that this was possible and noted that if only applied to new facilities, it could only have a limited affect at best.

There was more consensus within the subcommittee on the need to level the playing field with regard to regulations and data reporting. Currently, ASCs are not subject to certificate of need requirements, facilities with a single operating room are not licensed by the Department of Health and Senior Services, and reportable events for ASCs are not consistent with reporting requirements for hospitals. The state has little data beyond the number of freestanding facilities; other information on volumes, revenues, and quality is not routinely reported.

If the Commission accepts the need for more consistency, the steps to cure the situation are complex and will require either new regulation and/or additional legislative authority. The subcommittee was in agreement that all operating rooms should be regulated for quality and data reporting regardless of the setting or the number at a particular location. The subcommittee also agreed that, as has been the case in New York State (which recently passed a law imposing new oversight authority for operating rooms in physicians' offices), that it is most likely merely a matter of time before a significant medical error would occur in an office-based operating room. Therefore, reportable events should be same, regardless of the setting. Finally, the subcommittee (with the Medical Society of New Jersey dissenting) recommended that the licensure exception for facilities and offices with a single operating room should be removed.

Incentives to encourage hospital closings

The subcommittee has strongly articulated the view that the "hospital system" would be financially stronger if a subset of hospitals closed. The argument is essentially that the reimbursement that follows the patients to the remaining hospitals will exceed the marginal costs of treating those patients, resulting in improved operating margins for the remaining hospitals. An ancillary benefit of such closures could be improved quality as well, given that the closed hospital was struggling financially and may not have had sufficient volume to ensure high quality of care.

The state could create a pool of funds to pay some or all of the costs of closing, which could include the outstanding debts, covering losses during a wind down period, and costs to transition the facility to other uses.

The pool need not be funded solely with State monies. Surviving hospitals in the region might be required to contribute to the fund since they would be expected to see a financial boost from the closure of a competitor. Using a simplified model in which the costs of closing were assumed to be net liabilities plus 6 months of operating losses at a rate of 15%, the cost of closing eight hospitals currently in severe financial distress was about $150 million. On the other hand, the model suggests that closing those eight hospitals would generate an additional $160 million in operating gains for surviving hospitals in the first year after closure.

A core issue here is pacing: Should the State avoid market intervention and allow hospitals to wither away at their own pace or should the process be expedited, through intervention, in an effort to restructure the market in favor of essential hospitals? Subcommittee members suggested that a slow process could create quality of care concerns and increase the costs of the eventual workout.

Appendix 8.4A
Reimbursement and Payments Subcommittee Members

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Horizon NJ Health

Michael D'Agnes
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Appendix 8.4B

Efficiency Measures
prepared by the Benchmarking for Efficiency and Quality Subcommittee

Indicators	Available for All Hospitals*	Source	Comments
FTE per adjusted occupied bed	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Labor expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Non-labor expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Total expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Case mix adjusted ALOS	Yes	DHSS B-2 Forms and UB-92 data	Use APR-DRGs to calculate case mix index
Occupancy (maintained beds)	Yes	DHSS B-2 Forms	Licensed beds are fixed in short run but maintained beds can be adjusted.
Days in accounts receivable	Yes	DHSS/NJHCFFA Financial data base	Measures efficiency of revenue cycle management.
Average payment period	Yes	DHSS/NJHCFFA Financial data base	Measures efficiency of revenue cycle management.
Denial rate	No	Voluntary reporting from hospitals	Will not calculate statewide benchmark but will use as additional information to evaluate revenue cycle management

* Yes indicates that the measure may be calculated based on existing data.