



Massachusetts Council of Community Hospitals

Testimony Submitted 8-31-07

Sarah Iselin, Commissioner
Division of Health Care Finance and Policy
2 Boylston Street, 5th Floor
Boston, MA 02116-4734

Dear Commissioner Iselin:

RE: proposed 114.6 CMR 14:00

The Massachusetts Council of Community Hospitals (MCCH) is grateful for the attempt to create and begin to implement a standardized fee schedule to distribute UCP funding to hospitals and community health centers. We can appreciate the difficulties encountered in trying to conform to the intent of the law in such a short period of time. Unfortunately, our current interpretation of this proposed regulation falls short of what we had expected health reform to accomplish in controlling the costs to the uninsured population.

We saw in all past versions of payment schemes to distribute UCP funding such wide variations in payments to providers that it was not uncommon for one hospital to get paid \$2000 for an appendectomy while another hospital received \$7500 for the same procedure and yet the actual cost was probably \$3500. This led to situations where the UCP pool patient was, for some hospitals, paid better than Medicaid and their private pay contracts. The OIG reviewed this situation and noted in a recent report the many abuses that occurred as a result of the incentives built into the UCP coupled with the lack of regulatory oversight and accountability led some hospitals to take actions that maximized revenue and, in our view, avoid undertaking operational change to become more efficient. MCCH believes that universal insurance coverage is achievable but not without also addressing the cost of such care.

MCCH believed adoption of a Medicare fee schedule to distribute UCP funding was the most equitable way to distribute funding between providers. It had the advantage of rising or falling with the actual volume of services rendered. We thought that this aspect was particularly important since insurance take-up would likely vary significantly from provider to provider. In fact, we have heard since implementation of C58 this appears to be happening. A second advantage was that it automatically adjusted for case mix and thus we could minimize the variation in payments for the same services. Our hypothetical appendectomy in all hospitals would receive closer to the \$3500 and if in a teaching hospital a little bit more. If funding levels in the future led to pool underfunding then all providers would see an equal reduction in payment for that appendectomy. A third advantage was its prospective nature in a bundled DRG or APC rate. This aspect provided incentives to not only maintain quality but also to economically gain but adopting best practices that reduced inappropriate testing, careless handling of patients that led longer lengths of stay, reduction of hospital acquired infections for the same reason, etc. etc. There is little doubt that the continued financial viability of the Medicare system is a direct result of adoption of this payment system.

We now look at these regulations and have the following concerns:

1. The fee schedule should not produce financial outcomes that result in the free care patient being the best payer against all other payers for a particular provider. The overall objective is to have a strong incentive to not only enroll individuals into an insurance product but to continually restructure operations to deliver care as efficiently as possible for all payers. We see this regulation creating situations where the UCP patient for some hospitals will pay better than Commonwealth Care and Medicaid. A standardized fee schedule with little variation due to add-on's is the single most important action the Commonwealth could take to effectively address cost containment and accelerate the enrollment of more individuals into an insured product.
2. The concept behind the distribution of any proposed shortfall places the non-Dsh providers and especially the financially weaker community hospital sector as the payer of last resort. Every inefficiency or misjudgment regarding cost of care by either the insurer or provider or adverse selection in the subsidized products will eventually lead to backfilling the premium subsidies by drawing down on the pool funding. This means that payments to non-DsH providers automatically go down and theoretically can go to zero while the DsH providers have a protected floor at 85% of cost. There is no justification for this approach as we go into the future. You should not be creating conditions that lead to actions that disassemble the community hospital sector or pit DsH against non-DsH at a time we need to be all working together. It is egregious that should a shortfall in funding occur that results in a community hospital dropping needed services in order to adjust to the loss in funding. The regulations should allow for the hospital assessment to decline proportional to the reductions in pool usage. The assessment should be calculated based on net private pay revenue to recognize that many community hospitals have no leverage with the private payers to recover their assessment, remembering that Medicare and Medicaid do not recognize and thus do not pay for this assessment under any set of circumstances. The assessment should be extended to all providers of similar services to include clinical laboratories. Another more broadly funded source of funds must be utilized to insure there is not a shortfall in UCP payment.
3. "Transition" costs for DsH providers are, in the proposed regulation, distributed by a 25% add-on to ambulatory payment rates. We feel that this approach to distribute funding sends a potential signal to the provider community that there is a greater payoff to a particular provider to lobby for continuation of the transition add-on than to adjust operations to meet the actual reasonable costs of providing the service. There is adequate evidence already that a very significant amount of ambulatory care for this population is of a non-emergent nature better delivered in a community health center or physician office, at least for one very major provider. The transition payments should be distributed in a more directive way than that proposed and should sunset at a time certain. We believe that there will be more accountability of these public funds if they are separately distributed and more visible to the public and regulators rather than buried in an outpatient rate.
4. "Transition" payments should also not apply to only DsH providers. Many of our community hospitals are financially impaired and some more so than the DsH providers in the competition for clinical resources that lead to inappropriate use of emergency rooms and preventable admissions. Our community hospital based DsH providers may have an even greater need than the large urban providers for such transition payments. Recent extraordinarily high wage settlements in the teaching hospital sector are creating enormous pressures to attract and retain clinical resources that are compromising the ability of the community hospital sector to perform its mission. Establishing a set of characteristics that identify which providers need "transition" support would more likely

lead to a more rational distribution of funds as well as identify the actual level of funding required. The idea of continuing to give out blank checks without justification and accountability for results is, in my view, continuation of “big dig” thinking.

5. We feel that the Indirect Medical Education (IME) payment level is not justified. Medicare’s history of IME payments suggests that CMS found little evidence for its payment as part of the Medicare payment scheme. Rather it was justified to recognize the costs of large urban hospitals which had a high level of uninsured with no payment stream to support their cost. In Massachusetts there is a payment stream to support this cost for the teaching sector. Overall, there is little justification for the level of payment proposed for any of the add-ons. Especially since you departed so far from the Medicare payment DRG concept and toward the average SPAD concept since it appears to lead to potential payment levels beyond what would be expected for the same service in the private sector insurance products. What you don’t want to have in place are incentives to provide low cost of care services at inflated reimbursement rates. You want to force the right care, at the right place, at the right time.

We see the concept of a standardized fee schedule as well as regulation in general as a tool(s) for change at a time when the ability to implement coverage for almost all our population remains tenuous. It is actually a demonstration of leadership at a time when we all think we are doing the right thing. But all of us would acknowledge we need to change our behaviors not only as consumers of healthcare but employers and providers as well. While the UCP is not an insurance program per se it should have features that advance equity of payment, cost containment and quality of care standards which will facilitate the program recipients eventually transferring to legitimate insurance product. An effective program with public transparency will allow insurers to better target their programs since they will have an appreciation of the likely cost of care for those that remain in the pool. These potential advantages can only be realized if the fee schedule is calibrated rationally, the pool funded appropriately and our individual performance measured. We look forward to working with the Division in the future to advance the goals of health reform. We believed that the enabling legislation required consultation with MCCH prior to issuing regulations. We may have ideas that could prove helpful as you execute your responsibilities in the future. MCCH greatly appreciates the opportunity to comment on these proposed regulations.

Sincerely,

Donald J. Thieme
Executive Director