

# **Pennsylvania's Medical Assistance Program: Recommendations for Hospital Policy Reform**

## **Presented by the Safety-Net Association of Pennsylvania**

The Commonwealth of Pennsylvania has not taken a close look at its Medical Assistance program and the policies that shape, govern, and regulate that program since the early 1990s. Since that time, major changes have taken place in almost every aspect of the health care system, from the manner in which care and Medical Assistance services are delivered to the need and demand for government-supported health care throughout the state.

The Safety-Net Association of Pennsylvania (SNAP) believes that the time has come to take a closer look at the Medical Assistance program and to work with state officials to bring that program into the twenty-first century. Medical Assistance policy is important to SNAP because the organization represents the interests of private, acute-care hospitals that play the leading role in caring for the poor, the disadvantaged, and the uninsured residents of the commonwealth. Safety-net hospitals are the 25 percent of acute-care hospitals in Pennsylvania that care for the highest combined proportion of uninsured patients, Medical Assistance recipients, and Medicare SSI recipients and that therefore constitute the state's health care safety net. SNAP provides the following policy recommendations with which to frame such a future public discourse on behalf of these safety-net hospitals – and on behalf of the low-income Pennsylvanians they serve and who count on them for access to vital health care services.

Our approach to presenting the issues to be addressed, and our recommendations on those issues, is divided into five distinct discussions:

- governance of the Medical Assistance inpatient hospital program
- fee-for-service program issues
- supplemental payment issues
- outpatient fee-for-service issues
- managed care program issues

First, though, we would like to introduce the concept of “safety-net hospitals” and the significant role they play in caring for low-income Pennsylvanians.

### **Safety-Net Hospitals and the Health Care Safety Net in Pennsylvania**

Poor, uninsured, and disadvantaged Pennsylvanians rely to a significant degree on the state's health care safety net for medical services. In the absence of public hospitals – Pennsylvania is the largest state in the nation without any public hospitals – the health care safety net in the commonwealth today consists, in large part, of the 25 percent of the state's acute-care hospitals that bear the largest share of responsibility for caring for the poor as measured by the combined proportion of care they provide to Medical Assistance, Medicare SSI, and uninsured patients.

Pennsylvania's 48 safety-net hospitals are located throughout the commonwealth in both urban and rural areas and in 21 of the state's 67 counties. They are large and small, teaching and non-teaching.

Collectively, they are the providers of last resort for low-income Pennsylvanians who often have few choices regarding how and where they receive health care services, proportionally treating three times as many Medical Assistance recipients as non-safety-net hospitals and serving two-thirds more uninsured patients.

The ability of these safety-net hospitals to function in the current environment has been affected by a number of major changes in government health care reimbursement, including the introduction of prospective payment systems, such as DRGs, and increased use of managed care.

Safety-net hospitals also are severely underpaid. Today, Pennsylvania's Medical Assistance program pays them only 74 cents on the dollar for their costs. This, in turn, contributes to safety-net hospitals seeing only 92 percent of their total costs covered by total patient revenue; non-safety-net hospitals in Pennsylvania receive 97 percent.

In SNAP's view, these special challenges necessitate special solutions – solutions that may, at times, involve treating safety-net hospitals differently than other hospitals in the state. Pennsylvania's safety-net hospitals are, in effect, state government's partners in caring for the poor, and considering the different situations these hospitals face and the different role they play in the state's health care safety-net, we believe it is entirely fitting that these hospitals have a different relationship with the state. Among our recommendations below, we will note a number of areas in which we feel that different treatment of safety-net hospitals by the commonwealth may be in order.

## **Governance of the Medical Assistance Fee-for-Service Program**

### **Issue: The Manner in Which the Medical Assistance Inpatient Hospital Program is Administered**

#### ***Background***

Since the early 1990s, the Pennsylvania Department of Public Welfare (DPW) has administered the Medical Assistance inpatient hospital program through a series of limited-term inpatient rate agreements between the commonwealth and the hospital industry. Each rate agreement, once entered into, has then served as the governing legal document for inpatient fee-for-service payments.

These rate agreements have become a surrogate for public policy – a surrogate that focuses very narrowly on just one aspect of Medical Assistance policy. Under these agreements, for example, hospitals have been required to forfeit their right to appeal DPW policies and decisions on a broad range of issues. This, in turn, has made it very difficult – and in some cases, even impossible – to address, let alone resolve, legitimate policy issues that are not addressed in the rate agreements. As the years pass and one rate agreement leads to another, the rate negotiation process has become increasingly contentious, essentially degenerating into a fight over percentage increases in payments. Lost in efforts to address immediate concerns such as rates has been any meaningful consideration of broader policy issues that affect providers, the patients and communities they serve, and the commonwealth.

### ***SNAP's Policy Recommendation***

SNAP believes that the current process of setting rates is cumbersome, ineffective, and inappropriate as a surrogate for developing public policy. It has proven to be an impediment to making policy, reviewing, updating, and modernizing the Medical Assistance program, and resolving legitimate disagreements between DPW and the providers upon whom it depends to care for Medical Assistance recipients. It also has led to an inappropriate and unfortunate focus on *what* Medical Assistance pays providers, as opposed to *how* it pays them. Administering Medical Assistance solely through rate agreements also overlooks the basic reality that there is more to the Medical Assistance program than rates: it is a program that needs purpose, direction, policy, and regulation – none of which it has experienced during the past decade under the current approach.

Consequently, SNAP recommends that future Medical Assistance policy-making – including much-needed Medical Assistance reform – be pursued through a formal policy-development process and not through rate agreements. It is time to look at the entire Medical Assistance program, not just the rates it pays to providers, and this is the best way to start.

### **Inpatient Fee-For-Service Program Issues**

The Medical Assistance inpatient fee-for-service program, as distinguished from the managed care program, has not been reviewed or evaluated for many years. Many key aspects of this program would benefit from a broad re-examination of their purpose, how they are currently executed, and how they might best be carried out in light of the changes in health care delivery and reimbursement technology and practice in recent years.

In particular, SNAP would like to focus on five aspects of the Medical Assistance fee-for-service program:

- DRG rates
- the recalibration of relative weights
- the DRG system
- capital payments
- outliers

While growing parts of the commonwealth's Medical Assistance population are in the process of being moved into the HealthChoices managed care program, all providers still have a significant stake in fee-for-service issues for two reasons: first, all continue to serve at least some fee-for-service Medical Assistance recipients; and second, fee-for-service rates tend to be used by participating managed care plans as the basis for Medical Assistance managed care rates.

## **Issue: DRG Rates**

### ***Background***

The current Medical Assistance DRG rates for individual hospitals were developed based on the cost structure of those individual facilities in 1987. This means that 1987 was the base year for Medical Assistance rates – and it remains the base year for those rates today, 16 years later.

For most hospitals, today's Medical Assistance rates do not cover their costs for treating Medical Assistance recipients. Over the years, the rate increases that DPW has given to hospitals for Medical Assistance have not kept pace with overall health care inflation. In 2001, a report commissioned for the Pennsylvania General Assembly's Legislative Budget and Finance Committee by Lewin Associates, a prominent health policy consulting firm, found that on average, Pennsylvania's Medical Assistance fee-for-service program reimburses providers for only about 85 percent of the inpatient costs they incur caring for Medical Assistance recipients. Consequently, the more Medical Assistance recipients a hospital serves and the higher the proportion of that number to that hospital's overall patient population, the more money the hospital loses. This has contributed significantly to the troubled financial condition of safety-net hospitals across the commonwealth.

### ***SNAP's Policy Recommendation***

One way to address the problem of inadequate Medical Assistance rates would be to rebase those rates, but SNAP opposes such an approach. The purpose of a prospective payment system – such as the current Medical Assistance DRG system – is to give hospitals an incentive to keep down their costs and manage them effectively. Consequently, rebasing would penalize hospitals that have succeeded in keeping down their costs by reducing their rates while rewarding those that have been less cost-conscious by increasing their rates. Such an approach would remove the incentive to be cost-conscious that is so critical a part of the DRG prospective payment system, and SNAP believes this would constitute bad public policy.

Instead, SNAP believes that DPW should assure the adequacy of future Medical Assistance rates. We believe that annual Medical Assistance rate increases should include a realistic inflation factor geared specifically to the increase in health care costs. If, for budgetary reasons, the commonwealth concludes that it cannot afford such across-the-board rate increases for all hospitals every year, it should ensure that at least its safety-net hospitals receive realistic annual adjustments for inflation. This is necessary because of the special role that these hospitals play in caring for the uninsured and underinsured in Pennsylvania. Other hospitals – those that care for fewer Medical Assistance and uninsured patients as a proportion of their overall patient population – may be able to get by with more modest increases because their higher proportion of insured patients enables them to compensate for their Medical Assistance losses. Pennsylvania's safety-net hospitals have no such opportunity to compensate for lost revenue because they have far fewer privately insured patients and consequently have a far greater and more justifiable need for full health care inflation annual rate increases.

## **Issue: The Recalibration of Relative Weights**

### ***Background***

DRG payments are computed by multiplying a hospital's base DRG rate by the "relative weight" of a particular DRG. These relative weights are a measure of the cost of treating a specific medical problem in relation to an average case, and they are calculated by averaging the total state-wide costs of *each* DRG and comparing it to the state-wide average cost for *all* DRGs to calculate a ratio. That ratio is commonly known as a relative value or relative weight.

Developments in health care technology often lead to changes in the cost of treating some medical problems. Those changes, in turn, should affect the cost of a particular DRG. For example, there could be a medical problem that required major surgery and a 10-day hospital stay in 1987 that today requires comparatively minor surgery and only a three-day hospital stay. Such cases cost much less to treat than they did 16 years ago. Conversely, something that was impossible to treat 16 years ago might be treatable today, necessitating hospital care that years ago would have been unnecessary.

Today, Pennsylvania's Medical Assistance DRG system is based primarily on relative weights that were calculated in 1987, when the DRG system was introduced. Since that time, DPW has not recalibrated relative weights in response to changing medical technology for any DRGs that existed when it performed its initial calibration of relative weights, in 1987. DPW only calibrates relative weights for new DRGs, and it only does that once – when it adds those new DRGs to its system. These new relative values, moreover, are estimates of the relative cost of new DRGs and could be inaccurate. This means that many payments made through the DRG system could significantly underpay or overpay providers for certain aspects of the care they deliver to Medical Assistance recipients.

### ***SNAP's Policy Recommendation***

Payments to hospitals should accurately reflect the cost of the care they provide; they should neither overpay nor underpay hospitals for their efforts. Consequently, SNAP believes that DPW should recalibrate the relative weights of its DRG system at least every five years to ensure that they reflect changes in medical technology and treatment protocols and compensate providers fairly and accurately for the care they deliver.

## **Issue: The Diagnosis-Related Group Patient (DRG) Classification System**

### ***Background***

The classification software that DPW currently uses to sort medical cases among the various DRGs is often referred to as the "Medicare grouper" or "HCFA grouper." This Medicare grouper was originally designed in the 1960s as a management tool for monitoring utilization of hospital services and quality of care, and it was based almost entirely on data from Medicare claims. Medicare began using this grouper as a component of its prospective payment (DRG) system in 1983. DPW followed suit in the mid-1980s, modifying the system to reflect that Medicaid serves a very different population than Medicare.

The Medicare Payment Advisory Commission (MedPAC), a federal agency that advises Congress on Medicare reimbursement issues, recently concluded that the Medicare grouper does not adequately account for the severity of illness among patients within individual DRGs and recommended replacing it in Medicare with another grouper called “All-Patient Refined DRGs” (APR-DRGs). The “refined” aspect of APR-DRGs is that within each DRG, it includes multiple levels that correspond to the many varying degrees of illness or injury that patients within that DRG may suffer and the resulting varying levels of resources that hospitals must expend to treat them; the current DRG system has just one level that is applied to all cases within a given DRG, regardless of the severity of the patient’s illness or injury. This signifies MedPAC’s belief that payments made through Medicare DRGs do not sufficiently distinguish and recognize the potentially significantly different amounts of resources that may be required to treat patients when they are more or less severely ill than “typical” patients. This means that using the HCFA grouper results in the systematic overpayment of hospitals that generally see less-severely ill patients and the systematic underpayment of hospitals that treat more-severely ill patients. The APR-DRG system, MedPAC concluded, recognizes those differences and moves away from a “one-size-fits-all” approach and attempts to tie hospital reimbursement more closely to the actual resources that hospitals expend treating an individual case based on the severity of illness or injury of the patient.

### ***SNAP’s Policy Recommendation***

SNAP believes that DPW should switch to the APR-DRG system because it would lead to reimbursing hospitals more accurately and more appropriately for the services they provide. It would not over-reimburse hospitals for some care and under-reimburse them for other services, as the current system does; instead, it would pay them far more fairly on a case-by-case basis.

## **Issue: Capital Payments**

### ***Background***

DPW supplements Medical Assistance prospective payments to hospitals with an additional sum to help hospitals with their capital costs. The current capital add-on is 5.92 percent of each hospital’s prospective payment rate, and this amount has not been raised since 1996. Because the state’s DRG rates have not kept pace with increases in hospitals’ input costs, the capital add-on is only nominally an add-on. The only way it would be a meaningful amount is if DRG rates actually covered hospitals’ costs of providing care.

Capital costs pose a special problem for Pennsylvania’s safety-net hospitals. Because of the special challenges caused by their underpayment by Medical Assistance and the relatively high proportion of uninsured patients they serve because of where they are located,<sup>1</sup> the financial condition of safety-net hospitals is typically not strong. Lenders understand this and make it difficult for safety-net hospitals to borrow money to improve their facilities. Some safety-net hospitals have no access to capital at all, and others can get it only at interest rates that are higher — often, much higher — than they are for non-safety-net hospitals and other borrowers that enjoy greater financial health. Higher borrowing costs, in turn, increase overall costs at safety-net hospitals, making it still-more difficult for them to

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<sup>1</sup> For further information about these financial and other operational issues, see SNAP’s 2003 report entitled *The Challenges Facing Safety-Net Hospitals in Pennsylvania*.

operate on a sound financial basis – or they make necessary borrowing, and the improvements that capital investments bring, impossible.

### ***SNAP's Policy Recommendation***

SNAP believes that the Commonwealth of Pennsylvania should establish a capital pool from which safety-net hospitals could borrow at market or below-market rates. Because of the conditions that create the need for this pool, only safety-net hospitals should have access to these funds and the favorable interest rates for borrowing.

## **Issue: Outliers**

### ***Background***

When DPW developed the DRG system, it recognized that while DRGs would capture and appropriately pay for the care of most patients, there would sometimes be especially ill Medicaid recipients for whom the DRG system would inadequately compensate providers for the care they delivered because the cost of caring for such patients would fall too far outside the statistical averages upon which DRGs are based. For this reason, DPW provides extra payments, known as “outlier” payments, for patients whose care is extraordinarily costly. These payments are made in addition to the usual DRG payments. There are two types of outlier payments: day outliers and cost outliers. Day outliers are determined based on the length of a patient’s hospitalization; cost outliers are determined based on the cost of care delivered.

The day outlier system was based on the assumption that while hospitalization for especially sick patients is longer and more costly than hospitalization for other Medical Assistance patients, it costs far more to treat these patients during the earlier periods of their hospitalization and much less toward the end of their hospital stay. Consequently, the system applies a discount to the cost per day, to reflect the declining cost of care as the hospitalization continues.

### ***SNAP's Policy Recommendation***

When DPW created its day outlier policy, Medical Assistance payments covered nearly all hospital costs for caring for patients. Now, they no longer do: in Pennsylvania today, these payments cover only about 80 percent of the cost of services delivered. As a result, the discounting of the daily rate is no longer appropriate because by paying only about 80 percent of costs, DPW is already taking its “discount” before the day outlier system’s actual discount is calculated.

SNAP recommends that DPW pay hospitals for all outliers on a cost outlier basis. Through such an approach, the state and hospitals would share appropriately and fairly in the cost of unusually long and costly hospital stays; today, hospitals are bearing too much of this cost, and for safety-net hospitals, this is a burden that they simply cannot afford to shoulder on their own without potentially jeopardizing access to care for others in their communities.

It should be noted, moreover, that implementation of the APR-DRG system, recommended above, would significantly reduce the number of outlier cases in Pennsylvania because this system captures a

far broader range of severity of illness within each DRG, leaving far fewer cases that require special outlier compensation.

## **Supplemental Payment Issues**

### **Issue: Inpatient Disproportionate Share Payments**

#### ***Background***

Congress created the Medicaid inpatient disproportionate share program to require state Medicaid programs to provide supplemental payments to hospitals that care for especially large proportions of low-income patients. These payments were designed to help compensate hospitals for the tendency of states to underpay hospitals for providing Medicaid services and to reflect that this underpayment imposes a particularly heavy burden on hospitals that care for especially large proportions of Medicaid recipients. Secondly, Medicaid inpatient disproportionate share payments were directed to these same hospitals to reflect the general recognition that hospitals that care for especially large proportions of Medicaid recipients probably also care for especially large proportions of patients with no health insurance at all.

#### ***SNAP's Policy Recommendation***

DPW's current formula for determining Medicaid inpatient disproportionate share eligibility and calculating payments dates back to the early 1990s and, SNAP believes, no longer appropriately identifies the hospitals that truly provide the greatest proportion of care to low-income patients.

SNAP believes that Medicaid inpatient disproportionate share payments should be paid to hospitals that provide the highest proportional levels of service to low-income Pennsylvanians. In 2001, the commonwealth explored how to measure this level of service to low-income people when it needed to decide how to distribute a portion of its revenue from the national tobacco settlement agreement. After a great deal of discussion and debate, state officials agreed to identify hospitals that provide the highest proportional levels of care to low-income Pennsylvanians through what was called a "low-income variable" that consists of a hospital's combined proportion of Medical Assistance, Medicare SSI, and uninsured patients. DPW calculated low-income variables for all Pennsylvania's hospitals and then divided its tobacco uncompensated care funds proportionally among the 50 percent of hospitals with the highest low-income variables.

SNAP believes that DPW should use the same low-income variable to determine eligibility for Medicaid inpatient disproportionate share payments. These hospitals have demonstrated the highest level of commitment to serving low-income Pennsylvanians and these hospitals are suffering the greatest financial strain because of this commitment, so we believe that these hospitals, and these hospitals alone, should receive Medicaid inpatient disproportionate share payments that reflect this commitment and recognize the significant role that safety-net hospitals play in delivering health care to the poor.

## **Issue: Tobacco Uncompensated Care Payments**

### ***Background***

As noted above, Pennsylvania allocates a portion of its annual proceeds from the national tobacco settlement to hospitals that provide especially large proportions of care to low-income Pennsylvanians through its “tobacco uncompensated care” program. DPW has adopted the low-income variable as its tool for identifying such hospitals, with payments made to those hospitals with a low-income variable, or uncompensated care score, above the median score of all eligible hospitals.

### ***SNAP’s Policy Recommendation***

SNAP supports the continued use of the low-income variable as a means of identifying acute-care hospitals that provide the highest proportions of care to low-income Pennsylvanians but believes that these important funds should be reserved for the 25 percent of acute-care hospitals in the state with the highest low-income variable – that is, Pennsylvania’s safety-net hospitals. These hospitals are providing the highest proportional levels of care to the poor and face unusual financial challenges because of this special role they play. Unlike other hospitals, which only benefit from receiving tobacco uncompensated care funds, the top 25 percent of acute-care hospitals on the low-income variable scale truly *need* these funds – need them to ensure continued access to care in their communities and need them for their very survival.

## **Issue: Tobacco Extraordinary Expense Payments**

### ***Background***

DPW has a “tobacco extraordinary expense” program that seeks to compensate hospitals that incur extraordinary expenses treating the uninsured on an inpatient basis. In this program, “extraordinary expenses” are defined as expenses related to hospital stays that exceed twice a hospital's average cost per stay for all patients. Hospitals must choose between participating in the tobacco uncompensated care program and the tobacco extraordinary expense program: they cannot participate in both.

SNAP disagrees with how DPW has chosen to interpret the law for this program. Currently, DPW bases payments on the *entire* extraordinary claim amount rather than only on the portion of the claim that exceeds twice the average. Our understanding of the tobacco extraordinary expense legislation was that the program was developed to compensate hospitals *only* for costs of the portion of extraordinary hospital stays that *exceed* twice a hospital’s average cost per stay – not for the entire stay. The Auditor General recently ordered an audit of these payments and the program.

### ***SNAP’s Policy Recommendation***

SNAP is not certain that the tobacco extraordinary expense program is needed. We recommend that DPW re-examine the purpose of this program and consider whether it addresses a genuine need. If it decides that the program is needed, we urge DPW to re-examine the data used for the distribution of these payments and to make those payments as provided by the enabling legislation: to compensate hospitals only for costs of the portion of extraordinary hospital stays that exceed twice a hospital’s average cost per stay, not for the entire stay. If this evaluation concludes that the program is

unnecessary, on the other hand, SNAP recommends that funds allocated to it be folded into the tobacco uncompensated care program, for which need has already been established.

## **Outpatient Fee-for-Service Payment Issues**

### **Issue: Outpatient Disproportionate Share Payments and Outpatient Fees**

#### ***Background***

Pennsylvania's Medical Assistance outpatient disproportionate share program was created in 1992 as a means of providing additional money to hospitals to help them cover their outpatient costs without raising the entire outpatient fee schedule for all providers – a move that was considered too costly at that time. At the time that the outpatient disproportionate share program was created, DPW developed and implemented a formula for determining which hospitals would be eligible for outpatient disproportionate share payments. Now, more than a decade later, DPW's approach for determining eligibility has never been reconsidered. Also, the entire program periodically comes under attack, and some public officials in Pennsylvania would like to abolish it. This has been the case in the spring of 2003, when the governor proposed, and the General Assembly adopted, a state budget that included the complete elimination of the Medical Assistance outpatient disproportionate share program.

At the same time, Pennsylvania's Medical Assistance outpatient fee schedule has not been updated since the early 1990s. A 2001 study performed for the General Assembly by the Lewin Group found that Medical Assistance outpatient fee-for-service payments to hospitals cover only about 50 percent of the cost of services provided. This disparity between costs and payments is likely to become greater in the future as advances in medical technology make it possible to treat more and more health problems in outpatient settings – as it already has in the decade since these rates were last adjusted.

#### ***SNAP's Policy Recommendation***

SNAP believes that the commonwealth should make a full commitment to financing the delivery of Medical Assistance services in outpatient settings so that recipients can continue to have access to these cost-efficient services. This commitment should take three parts.

First, the outpatient disproportionate share program should be restored, preserved, and updated. Eligibility should be re-evaluated, and SNAP believes that DPW should employ the same criteria for outpatient disproportionate share eligibility – the low-income variable – that it currently employs for tobacco uncompensated care payments and that SNAP believes also should be used to determine eligibility for inpatient disproportionate share payments. We also believe that eligibility should be limited to the 25 percent of acute-care hospitals that have the highest low-income variables – that is, to the state's safety-net hospitals.

Second, SNAP urges DPW to increase Medical Assistance outpatient payments to bring them up to the cost of services provided. For years, government has been urging providers to deliver as much care as possible in outpatient settings because such care is almost always less expensive – yet at the same time, government has failed to ensure that outpatient rates keep pace with growth in the cost of delivering care in this manner. Consequently, the more that hospitals do to provide care in outpatient

settings, as requested, the more money they lose. This is especially difficult for Pennsylvania's safety-net hospitals, which treat such high proportions of Medical Assistance recipients.

Third, SNAP recognizes that state officials may believe that Pennsylvania cannot afford an across-the-board increase in outpatient fees for all providers. If this is the case, we urge policy-makers to ensure that fees are increased at least for all safety-net hospitals. The most appropriate vehicle for increasing outpatient reimbursement to safety-net hospitals is probably to increase their Medical Assistance outpatient disproportionate share payments after implementing SNAP's proposed criteria for determining eligibility for these payments.

## **Managed Care Program Issues**

DPW implemented HealthChoices, a mandatory managed care program for Medical Assistance recipients, in 1997. DPW generally maintains a laissez-faire approach to operating HealthChoices, frequently giving participating Medicaid managed care organizations the flexibility to design and implement the program as they see fit – a reflection of DPW's apparent belief that these organizations are best suited to contain Medical Assistance program costs.

This approach has given rise to a lack of accountability for the participating managed care organizations. With limited program oversight, they have not been held appropriately accountable for their efforts, performance, and outcomes, and as will be described below, the lack of adequate financial oversight has led to disastrous results for the commonwealth's health care providers. Under DPW's current approach, little attention is given to provider concerns and there is no effective mechanism for providers to offer input into the program's design, implementation, and operation. DPW has been inconsistent in its willingness to involve itself in matters or disputes between providers and managed care organizations: while ostensibly fostering a hands-off approach, it periodically intervenes in the provider/insurer relationship in a manner that is both unpredictable and, occasionally, counterproductive.

Currently, more than 65 percent of the state's Medical Assistance recipients are enrolled in HealthChoices, and DPW expects that figure to rise past 90 percent by 2007. Any program of this size will inevitably result in a number of policy challenges and concerns; below are brief discussions of just a few of those concerns.

### **Issue: Default Rates**

#### ***Background***

The HealthChoices appropriation in the commonwealth's fiscal year 2002-2003 budget includes a provision for a "default rate" to be used in selected circumstances when paying for care for Medical Assistance recipients. Specifically, when a hospital provides emergency care to a HealthChoices member who belongs to a managed care plan with which that hospital does not have a contractual relationship governing rates, that hospital is now required, by law, to accept a default rate, which has been defined as the current Medical Assistance fee-for-service rate, as payment in full for any and all emergency services rendered.

During several previous rate agreement negotiations between the state and the hospital industry, DPW sought to include a similar provision in the hospital inpatient rate agreement, but the hospital industry

fought vigorously, and successfully, to keep it out. Now, such a provision has become law without benefit of negotiation.

### ***SNAP's Policy Recommendation***

SNAP believes that the imposition of this default rate provision keeps the health care market from functioning properly by unduly favoring the HealthChoices managed care plans and giving them no incentive to negotiate in good faith with hospitals. In the past, when hospitals brought HealthChoices-related problems to DPW's attention, DPW continually responded that its policy was to refrain from interfering with the contractual relationship between the managed care plans and providers; on the other hand, DPW supported the inclusion of this provision in the state budget, knowing that it dramatically affects such relationships – and that it does so to the detriment of hospitals. Consequently, SNAP recommends that the question of default rates be left to negotiation between hospitals and the managed care plans and not legislated or regulated in any way in the future.

### **Issue: HealthChoices Managed Care Plan Solvency**

#### ***Background***

The solvency standards established by DPW for managed care plans that participate in HealthChoices must be called into question in light of the recent bankruptcy of HRM, a now-defunct managed care plan that operated under contract with DPW in the HealthChoices southeastern Pennsylvania region. This is the second Medical Assistance managed care plan to go bankrupt, and others plans are suffering from financial difficulties as well. When HealthChoices managed care plans become insolvent, they leave the hospitals with which they have contractual relationships with millions of dollars in unpaid claims.

This situation raises three important questions: first, are the state's solvency standards adequate or do they require reconsideration; second, does the state do an adequate job of monitoring the financial condition of HealthChoices managed care plans; and third, because the state is responsible for selecting and regulating those managed care plans, should it assume a greater level of financial responsibility when a HealthChoices managed care plan folds despite its own oversight efforts.

### ***SNAP's Policy Recommendation***

When a HealthChoices managed care plan goes bankrupt, provider claims are not paid and those providers are forced to absorb sometimes significant losses of money; they become, in effect, reinsurers for the managed care plans and the insurers of last resort for low-income Pennsylvanians.

This is not how the Medical Assistance program is supposed to work. The bankrupt managed care plan received its money; DPW received its money – funds from state tax revenue and federal Medicaid funds; and hospitals provided services to Medical Assistance recipients. But only hospitals, in this situation, are left with nothing. Hospitals in general, and safety-net hospitals, in particular, are the least able, among all these parties, to absorb these losses, so SNAP believes that the state must adopt more rigorous solvency standards for HealthChoices managed care plans; it must do a better job of monitoring the financial condition of those plans; and it must guarantee payments to hospitals for Medical Assistance services that have been provided in good faith by hospitals and other health care

providers. Paying for Medical Assistance services is the commonwealth's responsibility, not the responsibility of private hospitals, and the commonwealth should live up to this responsibility.

## **Issue: The Impact on Providers of DPW Risk-Adjusting Capitation Rates to HealthChoices Managed Care Plans**

### ***Background***

DPW intends to begin risk-adjusting capitation rates for HealthChoices managed care plans in selected parts of the state beginning in 2003. This means that some HealthChoices managed care plans that serve members who require more health care than the typical Medical Assistance recipient will receive higher monthly capitation payments (payments per member per month) and that those with members who need less care will receive lower monthly capitation payments. This approach reflects DPW's understanding that not all Medical Assistance recipients need similar amounts of health care services. While some need only average amounts of care, some need much more than average amounts of care and some need much less. Risk-adjusted capitation rates will help ensure that the HealthChoices managed care plans are not punished financially for enrolling individuals who are much sicker than average.

### ***SNAP's Policy Recommendation***

SNAP believes that the same recognition of the differences in resources required to care for some Medical Assistance recipients should be extended to the manner in which hospitals are paid to care for those same Medical Assistance recipients who are much sicker than average. If managed care plans will be paid through a more sophisticated approach to determining capitation payments, those same managed care plans should be required to reimburse providers through a comparable system that reflects a basic understanding that hospitals that treat patients who are sicker than average should receive higher-than-average payments for those services. A severity-based DRG system, such as the APR-DRG system described above, would be an appropriate mechanism for ensuring that this is accomplished. The purpose of severity-adjusting capitation payments should be to ensure that both insurers *and* providers are made whole and treated fairly when caring for especially sick Medical Assistance recipients. Unless some effort is made to ensure that providers share in these supplemental payments, the only value of risk-adjusting capitation payments to managed care plans is to help those plans increase their profitability at taxpayer expense.

## **Conclusion**

Many of the policy issues described in this paper have not been addressed in a meaningful way in Pennsylvania in 10 or 15 years or more. Pennsylvania's Medical Assistance program has rather systematically and purposefully eschewed its policy development responsibilities and instead chosen for itself a simpler, narrower role that focuses almost exclusively on negotiating payment rate levels. The result has been a decade of neglect, a decade in which no substantive effort has been undertaken to take stock of how well the Medical Assistance program functions, how the delivery of health care has changed, and how the program might be improved to reflect the changing times. Such a process is currently beginning on the national level, and the Safety-Net Association of Pennsylvania hopes that our state, too, will now initiate a systematic, policy-oriented examination of its Medical Assistance program and the changes that program will need to ensure its effectiveness in the future.

We hope that the information we have provided in this paper, and the policy changes we have recommended, will provide an important foundation from which to build, but equally important, we hope they will stimulate the kind of serious, analytic discussion and debate that these issues so greatly need at this time in history.