

Hospital Payment Policy Advisory Council
DMAS Board Room
September 19, 2006, 1-3 PM
Minutes

Council Members:

Chris Bailey, VHHA
Don Lorton, Carilion
Dennis Ryan, CHKD
Richard Magenheimer, Inova
Jamie Hoyle, JCHC
Michael Tweedy, DPB
Scott Crawford, DMAS
William Lessard, DMAS

Other DMAS Staff:

Pete Epps
Carla Russell
Steve Ford

Other Attendees:

Matthew Leighty, VHHA

1. Introductions

Members of the council and other attendees introduced themselves.

2. Rebasing Issues

Bill Lessard, DMAS, initiated the discussion of issues affecting the rebasing process.

a. Wage Index

In response to VHHA's previous request to consider updating the wage index to a more recent version, the wage index used in the rebasing process is prescribed in regulations as the wage index in effect during the base year. The wage indices reflect reclassifications and will be in effect until the next rebasing year.

b. Exclusion of FAMIS, TDO and SLH claims

The exclusion of these claims reduced the total number of cases from approximately 63,000 to 59,000. With the exclusion of these claims the data more closely matches the cost report data.

c. Managed Care Claims

Two reasons for not considering inclusion of managed care claims in the rebasing process. 1) For each of the five Managed Care Organizations (MCO) there would be two datasets with different data layouts and potentially multiple data issues across the five MCOs. 2) The HMO claims data may not be coded completely, specifically the diagnosis coding. Chris Bailey, VHHA, suggested evaluating the HMO data by compiling reference statistics on the diagnosis codes and other claim variables. Mr. Bailey expressed concern regarding

setting rates on a smaller universe of claims. Scott Crawford, DMAS, indicated that the encounter data have problems and DMAS is not sure the data is viable for the rebasing. Mr. Bailey argued that HMOs see value in using claims for performance evaluation and evidence-based statistics. Steve Ford questioned whether hospitals are actually aware of the payers when coding claims. Don Lorton suggested that providers code well because of the need to measure outcomes, especially case payers. Richard Magenheimer stated that based on the population the largest sample is needed.

d. Utilization

Mr. Lessard discussed the surprising increase in HMO days and no decrease in FFS. The increase in HMO days is tied to the increase in Medicaid eligibles, probably due to the FAMIS outreach. Mr. Crawford indicated that the enrollment growth backfilled the expected move of recipients from FFS to HMO. Large IME and DSH increases are the result of increased utilization. The General Assembly may be concerned about the huge increase in DSH and IME payments.

e. Manual Inputs

Mr. Lessard presented the manual inputs to rebasing and provided an overview of the inflation adjustments for the SFY 2008 rebasing. When rebasing is finalized, the inflation factors will be based on the first quarter 2007 projections. Mr. Bailey questioned how the projections compare to cost reports and national data. Mr. Lessard indicated that the inflation changes could be the result of changes in the case mix or unit inflation. Mr. Bailey stated that in periods where cost per case declines, unit inflation is overestimated, and vice versa. Mr. Crawford suggested comparing inflation projections to the case mix neutral cost per case. Mr. Bailey recommended comparing the global insight projections to case mix neutral cost per case.

3. Draft Rebasing Impact

a. Operating Payments Summary

The operating payments include DRG and per diem payments. The rehab provider numbers are separate. For private hospitals, the overall impact is a 0.5 percent decrease in operating payments. Mr. Lessard noted that a 7 percent increase in the statewide case rates was offset by eliminating the 9 percent increase in case mix under the previous rebasing. Mr. Lorton stated that a 9 percent increase in case mix seems high and may be the result of a shift of patients to MCOs. Mr. Bailey noted that the overall effect of rebasing is essentially neutral and that rural hospitals will see a decrease. The rebasing forces the case mix to 1.0000 to assure that we do not pay more than 78 percent of cost. Mr. Bailey mentioned comparing these results to Medicare DRG redesign. The case mix growth is about 9 percent. Mr. Crawford mentioned the increase in DSH payments could be a potential issue. At some point in time

(the DSH Cliff), DMAS may not have enough DSH funding to pay all the DSH it would want to pay.

b. IME

There will be an 18 percent increase in IME payments to private hospitals. IME is subject to the Medicare Upper Payment Limit (UPL); DMAS will not pay some IME if it exceeds the UPL on operating payments.

c. DSH

There will be a 33 percent increase in DSH payments to private hospitals. DMAS and the Council may need to think about options for DSH and potentially converting some DSH to operating payments.

4. VHHA Reimbursement Proposals

Mr. Bailey proposed the following hospital reimbursement changes: 1) increase hospital outpatient reimbursement from 80 percent to 95 percent of costs 2) for rural hospitals, use the wage index for the nearest MSA and 3) reimburse critical access hospitals at cost. Mr. Crawford would want to clearly specify in regulation how to determine the nearest MSA to avoid disputes. He also suggested setting the adjustment factor to 1.0000 for critical access hospitals rather than reimbursing them at costs.

5. Draft Rebasing Results (compared to previous rebasing)

Mr. Lessard presented an overview of the rebasing results.

a. DRG weights and LOS

The new weights use the AP-DRG version 23 grouper.

b. DRG Case Rates by Hospital

Variations in the hospital specific rate per case are tied to the wage indices. The increase in the statewide rate per case is approximately 7 percent.

c. DRG Case Mix Index by Hospital

Rebasing eliminates the 9 percent increase in hospital specific case mix between 2002 and 2005.

d. Psychiatric Per Diem Rates by Hospital

There is an increase between 5 and 21 percent in psychiatric per diem rates.

e. Rehabilitation Per Diem Rates by Hospital

There is an increase between 12 and 15 percent in rehab per diem payments by private hospitals.

f. Freestanding Psych Per Diem Rates by Hospital

The 2005 rates were not rebased because rates would have been reduced. Rebasing in 2008 would also result in a 32 to 34 percent reduction in these rates. The rebasing data is derived from the Medicare cost reports. Mr. Bailey suggested the freestanding psych data be compared to the hospital psychiatric

units. Pete Epps suggested that the overhead is spread over more patients with the introduction of residential care. Mr. Bailey advised that the rate reduction is not conducive to keeping private providers. Steve Ford stated that a data exercise was conducted in 2005 and the reduced rate data was not disputed.

g. Outlier Threshold

The outlier threshold is going down for most providers so that more cases will qualify for outlier payment to fully spend the target of 5.1 percent of operating payments. The lower threshold is cost driven.

h. IME Calculation

The calculation is based on 2007 bed ratios, the IME percentage and operating payments. IME is subject to inflation and changes in the bed ratios. The calculation includes psych and excludes rehab. The Council mentioned the Medicare cap on IME. Mr. Lorton and Mr. Magenheimer questioned the ratios. The Council requested updated bed ratios.

i. DSH Calculation

Mr. Magenheimer questioned the DSH payments to out-of-state hospitals. A revised DSH policy could potentially refer to the federal minimum DSH policy for out-of-state hospitals.

6. Other Issues

Mr. Magenheimer expressed concern regarding the New York (NY) weights. He stated that the obstetrics procedures were geared toward teaching hospitals' experience. The possibility of using other states' data was discussed. Mr. Lessard noted that the NY weights confirmed that the use of the New York weights are only used for DRGs with less than five cases and are averaged with Virginia data.

7. Next Steps

DMAS will review and evaluate the costs of the policy changes proposed by VHHA. DMAS will investigate the impact of changes in emergency room physician services and the relationship to outpatient services.

DMAS will research the impact of the rebasing on the DSH Cliff.

DMAS will perform a high level comparison of inflation to increases in case costs.

DMAS will update the IME bed ratios with the most recent data.

VHHA will review the rebasing data and provide feedback.

The Council agreed on the next meeting date of October 10 at 2 p.m. to discuss next steps of the rebasing process.