

**Hospital Payment Policy Advisory Council**  
**DMAS 7A Conference Room**  
**October 10, 2006, 2 PM**  
*Minutes*

**Council Members:**

**Chris Bailey, VHHA**  
**Don Lorton, Carilion**  
**Dennis Ryan, CHKD**  
**Richard Magenheimer, Inova**  
**(Conference Call)**  
**Michael Tweedy, DPB**  
**Scott Crawford, DMAS**  
**William Lessard, DMAS**

**Other DMAS Staff:**

**Pete Epps**  
**Carla Russell**  
**Steve Ford**

**1. Introductions**

Members of the council and other attendees introduced themselves.

**2. Rebasing Issues**

**a. Updates**

Bill Lessard gave an overview of the rebasing results and indicated that DMAS was notified of an error on the DRG, psych, and rehab impact sheets. The error is the result of the wrong cell reference and does not affect the overall rebasing impact, only the percentages on those sheets. Mr. Lessard distributed updated sheets.

**b. Comparison of Increase in Cost per Case and Inflation**

Mr. Lessard presented a comparison of the increase in cost per case to Global Insight's inflation calculations. The comparison inflated the 2002 base year costs and compared the costs to the 2005 cost per case and cost per day. The data showed a 7 percent cost per case change; an 8 percent cost per day change for psych, and a 16 percent cost per day change for rehab. Mr. Lessard stated that inflation may not be perfect in that it's not measuring all aspects of costs. Chris Bailey indicated that the trend is an argument in favor of doing rebasing at least every 3years.

**c. IME Resident to Bed Updates**

The IME resident to bed ratios include data from cost reports through September 30, 2005. The rebasing uses the most current ratios available as specified in the

regulations. IME is settled to cost in the end whether no rebasing or rebasing occurs. The IME payments are prospective in terms of the quarterly payments, but are settled in the end. Approximately 17 providers would have updated bed ratio figures. Mr. Bailey requested the updated bed ratios. Mr. Lessard will distribute by email both current and updated bed ratios.

**d. Overall Comments**

Mr. Bailey had no comments regarding the overall rebasing results except that the essentially neutral percentage change is consistent with the intent of the regulations. Mr. Bailey understands that the HMO data is not available for this rebasing, but possibly will be used for future rebasings. Mr. Bailey suggested that the recalibration of the weights to 1.0000 assumes no shift in the population. The 7 percent change in the cost per case should account for the 9 percent increase in case mix. Mr. Bailey questioned if the shift to MCOs should explain the increase. Scott Crawford mentioned that the pre-assignment phase of Medicaid enrollment is also a factor in the case mix of the population.

**3. VHHA Proposals**

**a. Reimburse Critical Access Hospitals at Cost**

Mr. Lessard stated that DMAS evaluated two methods of implementing reimbursement at cost for Critical Access Hospitals: 1) reimbursement at cost, and 2) reimbursement using an adjustment factor of 1.0000. The adjustment factor methodology is closest to the VHHA estimate.

**b. For Rural Hospitals use the Wage Index for the Nearest MSA**

Mr. Lessard presented the rural wage index reassignment analysis. The DMAS methodology differed from the VHHA methodology as a result of excluding hospitals that were reclassified or otherwise adjusted beyond the rural wage index by CMS.

**c. Increase Outpatient Reimbursement from 80% of Cost to 95% of Cost**

Mr. Lessard discussed the outpatient cost reimbursement increase estimate. Mr. Bailey questioned the managed care impact indicating that previously a doubling effect of FFS expenditures was appropriate. Steve Ford stated that the managed care impact was based on a comparison of operating payments and excluded IME and DSH.

Mr. Bailey stated that VHHA plans to work with a coalition of representatives of nursing homes, pediatricians, emergency room physicians, AARP, and the Medical Society to make proposals for the 2007 General Assembly (GA) Session. Mr. Bailey mentioned that VHHA will push hard on rural items and will request that items be sent forward to the Executive Branch. Mr. Crawford mentioned that DMAS shares information with the Secretary and the Department of Planning and Budget (DPB).

**4. DSH**

Mr. Lessard mentioned that the DSH Cliff looks fine through this biennium and through 2009. Mr. Bailey expressed concern regarding the out-of-state hospitals receiving DSH payment. Out-of-state hospitals use the same population to determine the utilization percentage for each state. Mr. Crawford stated that since 1982 the federal methodology does not distinguish DSH payments based on geography. For example, Johnson City Hospital in Tennessee is pretty much considered a Virginia hospital. Mr. Crawford further explained that Virginia DSH payments are calculated based only on Virginia operating payments. Mr. Bailey wanted to know the total DSH paid by other states to hospitals claiming DSH payments in Virginia. Mr. Crawford recalled that if DMAS paid the federal minimum DSH the amount would be less than \$5 million.

Mr. Bailey agreed that there was no urgent need to change the out-of-state DSH policy, but DMAS should keep the issue on the front burner based on the federal changes in DSH payment methodology. Mr. Lessard explained that DSH payments unlike IME are prospective payments and are not settled.

**5. Other Issues**

No other issues were discussed.