Department of Medical Assistance Services (DMAS) Hospital Payment Policy Advisory Council (HPPAC) Meeting

Minutes

Name of Meeting:	Hospital Payment Policy Advisory Council
Date of Meeting:	October 27, 2021
Length of Meeting:	1 hour and 50 minutes

Members Present:
Jay Andrews, Virginia Hospital and Healthcare Association
Sean Barden, Mary Washington Healthcare
Chris Gordon, DMAS
Jeff Lunardi, Joint Commission on Health Care
Jonathan Mattingly, DMAS
Kenneth McCabe, Department of Planning and Budget
Susan Shreeve, HCA Capital Division
Lanette Walker, Virginia Hospital and Healthcare Association

Other DMAS Attendees:
Sara Benoit
Robert Chapman
Donita Harper
Thomas Gates
Sonja Lee-Austin
Charlie Lintecum
John Snouffer
Limor Spalt
Matthew Terrill

Other Attendees:
Beth Allen
Ben Barber
Craig Connors
Cindy DiFranco
Joe Gamis
Bradley Zuzenak

Objective of Meeting:
Review coverage assessment costs and expansion forecast for FY22, the factors in any upcoming MCO risk corridor refunds, inpatient and outpatient rebasing, and future Disproportionate Share Hospital (DSH) payment issues.

Call to Order
Jonathan Mattingly called the meeting to order at 1:05 PM.

Opening Remarks
Mr. Mattingly reviewed the agenda.

Coverage Assessment Costs and Forecast

Coverage Assessment Costs

- Donita Harper, Acting Director of DMAS' Budget Division, introduced Matthew Terrill, Contract Budget Analyst, who proceeded to present the coverage assessment costs
- The FY21 administrative variance was reviewed.
- "Appropriation to Actual" comparisons were presented for management services, administration support, and the Department of Social Services (DSS).
- Expenditures for utilization-based contracts were reviewed
- Expenditures of population-based contracts were reviewed – all contracts exceeded the initial budget as population in expansion was higher than expected.
- Mr. Terrill reviewed differences between the FY21 and FY22 appropriations to be funded through the coverage assessment.

Discussion

- Lanette Walked asked during the FY21 – FY22 summary about the purpose of the $1.5 million contract for "facilitated enrollment" that had been allocated for FY22.
    - Charlie Lintecum replied that this was a new process that was currently stalled. This funding was related primarily to systems costs when Medicaid members file taxes which would allow their tax returns to be sent directly to DMAS to determine eligibility. This went through the General Assembly process this year and was expected to affect all populations, with a portion of costs allocated to expansion.
- Ms. Walker asked about the purpose of the new Health Innovation item for FY22.
    - Chris Gordon responded that this was the result of the Governor's primary care task force which would cost almost $300,000. These costs would be used to examine how to incentivize primary care providers to accept members.
    - Ms. Walker stated that this item was not appropriate to allocate to expansion costs funded by the coverage assessment.
    - Ms. Harper replied that DMAS would review this item and respond.
- Jay Andrews asked about the difference in FY21 appropriations between slides 2 and 7.
    - Mr. Terrill responded that slide 7 had appropriations for FY21 at the beginning of the year, while slide 2 had adjusted appropriations for FY21 at the end of the fiscal year.
- Ms. Walker stated that while Department of Social Services (DSS) costs were listed as on target, they submitted a decision package to increase expansion funding by $16 million. She went on to state that this was a substantial increase and explained it has been difficult in the past to receive reconciliations amounts, asking if there would be more information available for FY22.
    - Mr. Gordon responded that DMAS could not opine on another agency's package request and deferred to Mr. McCabe.
    - Mr. McCabe responded that they could not comment on the merits of the package but that it was being reviewed by DPB. He stated that DPB takes assessment dollars incredibly seriously and was asking similar questions to DSS to justify this increase.

- Mr. Gordon stated that DMAS was working to schedule a meeting with DSS for more clarity. He suggested that DMAS and the VHHA could have an additional conversation for specific questions to forward to DSS for written responses, and DMAS may have verbal meeting with DSS to follow up. Mr. McCabe stated he would be available if requested.
    - Ms. Walker asked if for future HPPAC meetings a DSS representative may be available as a non-member of HPPAC.
- Ms. Walker stated that for the past two fiscal years there has been over $50 million remaining in unspent coverage assessments. She acknowledged that DMAS was more closely examining the expenditure assumptions this year and that the 8% budget multiplier was reduced to 2%. She asked what other measures DMAS would be taking to increase accuracy for FY22.
    - Mr. Terrill replied that each quarter DMAS would be examining projections and lowering expenditure estimates if needed to accommodate.

Expansion Forecast

- Coverage Assessment Costs and Expansion Forecast
    - Rob Chapman outlined the Medicaid forecast due November 1, 2021
        - Agenda –
            - Population overview
            - Preliminary population forecast
            - Preliminary forecast drivers
            - Expenditures overview
            - Policy changes and dental update
            - Base forecast changes – inpatient hospital
    - Mr. Chapman reviewed the reasons for differences between last year's forecast and actuals for FY22. Outpatient hospital utilization and physician/practitioner services have decreased. The increases include transportation and behavioral health/rehab services and supplemental rate assessment payments running higher than the FY22 forecast.
    - Mr. Chapman reviewed the FY23-24 rate changes for base and expansion populations.
    - Mr. Chapman reviewed hospital and nursing home rate changes.
    - Mr. Chapman reviewed the scope of the forecasted policy changes including the dental update.

Discussion

- Ms. Walker asked whether the change in the November maintenance of effort population would shift more than 30,000 members who aged out of base Medicaid or past their post-partum coverage but not remove those who have aged out of expansion at 65.
    - Mr. Chapman replied that the benefits of Medicaid for those 65 and older were not as generous due to asset requirements and, therefore, the agency was not planning on moving those members to base Medicaid.
    - Ms. Walker then asked why there was a November target date instead of the end of the public health emergency.

    - Mr. Chapman replied that he was unsure of the exact timing for those eligibility shifts but was working with DSS.
    - Mr. Mattingly replied that DMAS would follow up internally.
    - Ms. Walker asked the determinants in the final estimate of enrollment after the projected end of the public health emergency.
    - Mr. Chapman replied that is was difficult due to multiple unknown factors including current income of members through maintenance of effort, so the "leveling off" is based on old information.
- Ms. Walker asked if the FY23-24 managed care rate changes were amounts over the current year.
    - Mr. Chapman replied that the amounts were not cumulative, e.g. the $185 million is just 6.4% over the previous year.
- Mr. Andrews asked for the explanation on why most rate changes for FY23 and FY24 were 2.5% higher while nursing homes and outpatient rehab facilities were higher at 3.1%
    - Mr. Mattingly replied that these were based on the most recent IHS market basket and are calculated separately by class as directed by Virginia code. He stated that typically nursing homes were slightly higher, and that this has been stressed by higher wages required in nursing homes recently due to the pandemic.
    - Susan Shreeve asked what the justification was for higher cost pressure for nursing facilities and rehab facilities than hospitals if they are competing for the same labor.
    - Mr. Mattingly replied that one factor was incorporation of the Virginia nursing facility wage survey that confirmed nursing homes as a whole had lower wage staff than other providers and were more susceptible to higher costs from wage pressure.
    - Ms. Shreeve responded that the rates were surprising given current internal HCA data.
    - Mr. Mattingly replied that rates were based on quarterly updates with lookback adjustments for the previous four years.
    - Ms. Shreeve contended that the past four years did not accurately capture what was hyperinflation in the last year and stated the lookback period was illogical.
    - Ms. Walker asked why DMAS submitted a decision package to change how hospital inflation was calculated and asked Mr. Mattingly to discuss this and the rationale.
    - Mr. Mattingly replied that DMAS is statutorily required to adjust for past year inflation and currently only takes the midpoint quarter of the fiscal year. He stated that the decision package smoothes out large decreases or increases by using the average for four quarters while not changing the time frame. He stated Virginia hospitals were aware of the prior year 1.2% estimate, a decrease which was due to past year updates.
    - Ms. Shreeve asked if there was a requirement to use four years and asked if it was possible to change to a more recent time frame.
    - Mr. Mattingly stated that DMAS is not required to use four years specifically, but that DMAS is required to use current lookback adjustments from IHS during this period.
    - Ms. Shreeve stated that the four year period was detrimental to providers currently.

    - Mr. Mattingly stated that the same issue would exist if using a shorter window of time.
    - Ms. Shreeve stated that while nursing rates have increased 5-9% for base rates, all hospitals facing base rates for pay have had dramatic cost increases. She applauded the move to four quarters rather than a single midpoint for these calculations but contended that the permanent implications of the last year would require revisiting the four year lookback period.
    - Sean Barden stated that with the inflation increase this was a bad time to start smoothing over four quarters.
    - Mr. Mattingly stated that these comments were noted and that this was the appropriate forum to state and hear those concerns.

MCO Risk Corridor Refunds

- Mr. Mattingly presented the items for the MCO risk corridor refunds.
    - January 1, 2019 – June 30, 2020
    - Claims runout through March 31, 2021
    - All plans received draft results on Aug 20, 2021 and commented
    - Comments reviewed and some revisions incorporated (some rejected)
- The best current estimate is $31.7 million in the non-federal share of the remittance with $398 million in total remittance using both enhanced federal match (EFMAP) timeframes and non-EFMAP timeframes.
    - Next steps
        - Additional calculation updates
            - VA Premier – Kaiser payments
            - Anthem NEMT exclusions
            - TPL mix
            - Clinical risk bearing entities
            - VA Premier Medical Home spend and claims duplications

Discussion

- Ms. Walker asked if the draft number would be finalized and applied to the Q3 coverage assessment.
    - Mr. Mattingly said that he believed it would.
    - John Snouffer stated that the current coverage assessment schedule tentatively had a notification of change in assessment amount for December 2, 2021 with the associated assessment invoices delivered December 17, 2021.
- Ms. Walker asked what the result was of the administrative appeal of clinical risk bearing entities.
    - Mr. Mattingly replied that the agency determined that sub-capitation does not qualify to have administrative costs included in medical expenditures. He state that they would clarify the third party liability (TPL) mix and that it has been a major agency priority over the past several months.

Inpatient & Outpatient Rebasing

- Mr. Mattingly introduced the current inpatient and outpatient rebasing and Bradley Zuzenak of MSLC presented.
- Mr. Zuzenak reviewed the timeframe for inpatient hospital DRG rebasing
    - Kickoff November 2020
    - November – February 2021 data gathering
    - February – August 2021 analysis and provider costing
- Mr. Zuzenak reviewed that the DRG version 35 was updated to version 38 this year with lowered DRG weights and newly introduced mapping procedures for claims.
    - The estimated fiscal impact would be a 4.69% reduction to total inpatient hospital payments.
    - Rehab and Psych
        - Base Year Claim Set –
            - Hospital discharges and days breakout from most recent cost report (12/15/20)
        - Per Diem Calculations
            - Cost adjusted for labor portion and wage index
            - Inflated to common point SFY2020 GIVHMB
        - Percentage of Cost included in Per Diem
            - Type 2 hospitals
            - Type 1 hospitals
        - Rehab and Psych per diem chart presented.
        - Rehab and Psych Fiscal Impact
    - Key Takeaways reviewed
        - Rehab and psych rates increase for type 2, decreasing for type 1
        - Outpatient rebasing numbers coming 2021

Discussion

- Ms. Shreeve raised that the 4.64% didn't seem to be explained by the version change.
    - Mr. Zuzenak replied that the base weights decreased for several reasons and that MSLC was instructed to remain at 78% of cost
    - Ms. Shreeve asked if this implied hospital costs decreased.
        - Mr. Zuzenak replied that:
            - Costs did not keep up with CMI in prior rebase. Overall CMI as a system was 1.11, per MSLC's methodology they have to normalize those weights back to 1 to reset the system each time.
            - The version 35 was pre-ICD-10 and 3M did a significant rebase to this system. Over the past few rebases these have increased but not to the scope they were in version 35.
            - The majority of discharges hit state specific weights that are truly based on cost of each claim. So there was 3 year lag for CMI creep.
    - Ms. Shreeve contended that if CMI was increasing it must mean the resource consumption is increasing.

- Mr. Zuzenak replied that these are all the same steps taken 3 years ago when $2.5 million was added to the system. They used the same methodology for the FY2023 rebasing with hospital specific crosswalks.
- The cost to charge ratio was based on most recent cost report from middle of December 2020 and CMS gave extension to file the 2020 cost report. There are no CMS cost reports that encompass the pandemic period. MSLC's discharge period was based on majority in CY2019.

- Ms. Shreeve reiterated her contention that the data was incredibly aged and that MSLC was proposing a decrease based on data that is no longer relevant.
  - Mr. Mattingly replied that due to extension DMAS is required by the state to use the cost report data most recently filed.
- Mr. Andrews asked if the Medicare market basket increases were factored into all costs and asked if there was a version change in the prior rebasing.
  - Mr. Zuzenak replied that prior they had updated from version 33 to version 35. They did not see the same issues last time that were present this year, including a 17% decrease for psychiatric. The decision was made among hospitals not to use version 36 previously because it was still ICD-10.
  - Sonja Lee-Austin stated that the current software is over three years old due to ICD-10 codes and at some point 3M will stop mapping new codes to the old version. She stated that one of the major changes is the impact of birth weight. DMAS uses one uncommonly low DRG that they have asked 3M about. In the prior rebase it had a Virginia specific adjustment.
- Mr. Zuzenak stated that they did inflate using the second SFY2021-2034 Global Insight Virginia hospital market basket and that those figures were mandated specifically by the legislature.
  - Mr. Andrews replied that the SFY22 UPL calculations used costs by Medicare market basket and that currently inflation was based just on reimbursement and not costs.
    - Mr. Zuzenak stated that the GA mandate instructions on how to inflate for rebasing, while the UPL calculations have more flexibility as they are determined by CMS.
    - Mr. Gordon stated that DMAS is following regulations as they exist in the Appropriations Act and that the Administration and GA have been explicit.
  - Ms. Shreeve asked if it was possible to go back to the previous grouper version 35 given the ramifications given that 35 was previously used beyond its intended life.
    - Mr. Gordon responded that the agency cannot replicate the prior delay of version 36 as it was not in the spirit or intent of the regulations. He stated that the appropriate vehicle for addressing the reduction is outside of this specific administrative process.
  - Ms. Shreeve contended that there was an agency decision to use version 38 and that to say DMAS is limited seemed defeatist.

      - Mr. Zuzenak raised that continuing to use version 35 would cause much more difficulty for the future.
      - Mr. Mattingly raised that delaying the version change would also not pick up any new mappings, higher or lower, in the future.
    - Mr. Mattingly stated for reference that there is a protected field for MCO paid amounts so the figures presented were estimates.
      - Ms. Shreeve asked whether the 4.69% estimate represented purely rate changes or if was compounded by volume.
      - Mr. Zuzenak responded that their rate had gone up from the prior system but that weights dropped 11% compared to the current CMI.
      - Ms. Shreeve acknowledged that this treatment was consistent with prior periods but contended that their costs did not decrease by 11%.
      - Ms. Lee-Austin replied that this was still only an analytic estimate of impact and that managed care organizations (MCOs) were not required to use this grouper, and may instead be using the CMS grouper which was not factored into the analysis.
      - Mr. Mattingly affirmed that DMAS does not mandate MCOs use this version and that DMAS does not have transparency into which groupers they use.
      - Ms. Shreeve stated that she appreciated this but would like to see the impact of the rate changes vs. the volume change.
      - Mr. Mattingly stated that CMI is not completely reflective of the new fiscal year and this was a calculation based on existing claims.
      - Mr. Andrews contended that MSLC appeared to neutralize the weights in group changes when case mixes were disproportionately higher.
      - Mr. Zuzenak stated that they did an exercise not involving normalization and the result was still 4.6%.
      - Mr. Mattingly stated this was addressed briefly in the last workgroup, which Mr. Andrews acknowledged.
    - Ms. Walker asked if there should be another HPPAC meeting scheduled for outpatient rebasing when it became available.
      - Mr. Mattingly responded that he would confirm what the regulations required.
      - Mr. Gordon highlighted that the budget neutrality piece expired for outpatient.

<u>Disproportionate Share Hospital (DSH) Payment Issues</u>

- Mr. Andrews initiated discussion that last year for DSH payment calculations there was limited data for facilities that contained the expansion population.
  - He raised the concern that for the next calculation period many more hospitals would meet the current DSH eligibility threshold of 14% due to Medicaid expansion.
  - He stated that he believed it was counter to the intention of DSH to allow most hospitals to participate for smaller shares of payment.

    - He asked if it was possible going forward to use the Type 1 hospital allowable DSH amounts that are no longer being utilized. The federal cap is about $200 million. He also raised the issue of OBRA limits regarding DSH, rate assessment payments and uncompensated care.
    - He asked if the data could be abstracted and initial calculations made to determine if policy changes needed to be made during this year's General Assembly session.
- Mr. Mattingly replied that they had not examined this issue specifically yet but agreed it should be under review.
    - He said that they would discuss the scope of analysis needed in the future.
    - He stated that DMAS tracks some uncompensated care expenditures and they have decreased with expansion but they have not discussed internally to date.
    - He asked staff in attendance to see if prior analysis had been done.
- Ms. Lee-Austin replied that the former Provider Reimbursement director Bill Lessard had raised this as an issue for future analysis but no analysis had been started yet.

Other Items

Mr. Mattingly confirmed with each member whether they had additional questions or items. There were none.

Meeting Adjourned

The meeting was adjourned by Mr. Mattingly at 2:55 PM.