Hospital Payment Policy Advisory Council
DMAS Board Room
July 21, 2009, 10 AM - 12 PM
Minutes

Council Members:
Chris Bailey, VHHA
Donna Littlepage, Carilion
Stewart Nelson, Halifax Regional Hospital
Kim Snead, JCHC
Michael Tweedy, DPB
Scott Crawford, DMAS
William Lessard, DMAS

Other DMAS Staff:
Robert Miller
Carla Russell
Nick Merciez

Other Attendees:
Joe Becht, VHHA
Ingram Haley, VHHA

1. **Introductions**

   Members of the council and other attendees introduced themselves.

2. **Council Duties and Meeting Schedule**

   William Lessard gave an overview of the duties of the council and discussed the timeline for rebasing and the meeting schedule for the council. This meeting consisted of a review of the rebasing inputs and discussion of potential issues. A draft of the rebasing results will be presented at the next meeting in early September before the DMAS budget submission due in September. Future meetings may be scheduled to consider additional issues.

3. **Review of Payment Changes Since Last HPPAC Meeting**

   Mr. Lessard presented a summary of the changes in hospital reimbursement since the last rebasing. Chris Bailey requested a summary of physician rate increases.

4. **Rebasing Effective SFY2011**
   a. **Inpatient Operating Rates**
      i. Description of Rebasing Process
      Mr. Lessard listed the statewide operating rate per case, the DRG weights, the outlier threshold, and the psychiatric and rehabilitation per diem rates as the outputs of the rebasing process. Carla Russell continued the discussion of the inputs and outputs of rebasing and noted that freestanding psychiatric facilities are no longer exempted from rebasing.

ii. Base Year – Cost reports with PFYEs in SFY2008

iii. Ratio of Cost to Charges (handout)
Mr. Bailey noted that the ratios of cost to charges (RCCs) appear lower than the past rebasing. The council discussed the potential discrepancies between managed care RCCs and fee-for-service (FFS) RCCs. DMAS and hospital representatives each agreed to try to validate that FFS RCCs are reasonable to use with managed care charges.

iv. Charges used for rebasing
1. Claims data for period comparable to cost report
Carla Russell stated that FFS and managed care claims for SFY 2008 will be used in rebasing for the DRG weighting. Managed care data would not be used to set the FFS rates.
2. Include managed care encounter data charges and cases for DRG weights

v. Labor Adjustment Factor (2007 VHI data)
DMAS presented the calculation of the labor factor that represents all labor costs for the state.

vi. FFY 2008 Wage Indices (handout)
DMAS presented the list of Medicare wage indices that corresponds with the base year. Mr. Bailey expressed a preference for an annual adjustment of the Medicare wage index using the most current wage indices for the hospital specific rates. VHHA representatives suggested that any potential cost impact of the annual adjustment could be offset by normalizing the wage index.

vii. Inflation Adjustment from Base Period (handout)
Mr. Russell introduced the draft inflation calculation for the rebasing and noted that the inflation will be updated with the first quarter 2010 report in the spring of 2010. Donna Littlepage commented that the inflation factors were not consistent for some periods. DMAS clarified that the modified projections will reflect any corrections made to previous projections.

viii. AP-DRG Grouper, Version 25
Ms. Russell stated that for the SFY 2011 rebasing, DMAS will use version 25 the most current version. In the event of insufficient cases, DMAS uses an average of the New York AP-DRG data and DMAS data to determine the weight. If DMAS uses managed care data, there may be fewer DRGs with insufficient cases.

b. DSH – Medicaid Utilization Percentages (handout)
Medicaid utilization percentages for each hospital were presented. Hospitals must have Medicaid utilization equal to or greater than 15 percent to qualify for DSH.

5. Other Issues

a. Rebasing Issues

i. APR-DRGs
Ms. Russell shared that New York Medicaid will be converting to APR-DRGs effective January 1. If DMAS does not change, it may have to develop an alternative to supplement DRGs with

insufficient cases. The council discussed the use of the managed care encounters or cases from multiple years to address the insufficient data for certain DRGs. A number of council members expressed the opinion that APR-DRGs may improve payment accuracy and documentation as hospitals have experience with MS-DRGs. DMAS could consider implementing APR-DRGs in the 2014 rebasing using 2011 as the base year.

ii. Annual DSH Determinations

The council members proposed the implementation of annual DSH determinations in lieu of the current DSH methodology citing the annual and future shifts in volume and in the Medicare policy. DMAS advised that any change in the current DSH methodology will not be budget neutral and will require a regulation change. Increases in eligibility may also increase DSH payments and produce a significant budget impact. Mr. Crawford indicated that implementing this policy would first have an impact in SFY 2012 and therefore it was not necessary to decide immediately.

b. Non-Rebasing Issues

i. Ambulatory Patient Groups

1. To be used in Ambulatory Surgery Center reimbursement effective January 1, 2010

   DMAS will be implementing Ambulatory Patient Groups (APGs) for Ambulatory Surgery Centers (ASCs) effective January 1, 2010. Medicare changed to APCs in 2007 which prompted DMAS to change its methodology.

2. Under consideration for use in Outpatient Hospital reimbursement

   DMAS is also considering applying the APG methodology to outpatient hospital reimbursement no earlier than SFY 2012. Mr. Bailey stated that VHHA is supportive of prospective payment for outpatient hospital reimbursement. Ms. Littlepage mentioned the impact of new technology on software updates and consideration of different cost structures. The methodology implemented for ASCs will be different than the outpatient hospital methodology. VHHA is supportive of moving forward in 2012 if no significant road blocks.

ii. Hospital Acquired Conditions and Never Events

In addition to the Medicare Never Event policy adopted July 1, 2009, DMAS will be implementing the Medicare Hospital Acquired Conditions (HACs) policies effective January 1, 2010. DMAS expects that the policy will result in limited cost savings and will be received as a positive quality-based policy. Ms. Littlepage encouraged consistency with Medicare for HACs and other policies. Mr. Lessard mentioned a potential differential impact based on the Medicaid grouper.

iii. Episodes of Care

Mr. Bailey led the discussion of episodes of care. An episode of care may be determined using an off-the-shelf grouper, Prometheus. A Potentially Avoidable Condition (PAC) amount is determined for management of certain conditions – aged, disabled, chronic disease and certain conditions – diabetes, heart disease for each pilot. The health care delivery system site must manage the individual's care based on the PAC amount determined for the condition. Any loss or profit will be absorbed by the health care delivery system site. Ms. Littlepage cautioned that this payment methodology would be more challenging for the Medicaid population because of patient compliance. DMAS agreed to continue discussions and develop next steps toward a potential pilot and/or evaluation of baseline claims using the grouper software.

c. Additional Discussion/Issues

DMAS requested feedback from council members regarding the communication to providers for the DSH audit.

6. Next Steps

The Council agreed on the next meeting date of the second week in September to discuss the preliminary rebasing results and any other issues related to rebasing.