Hospital Payment Policy Advisory Council
DMAS Conference Room 7B, August 7, 2013, 10 am-12 pm
Minutes

Council Members:
Donna Littlepage, Carillion (via phone)
Chris Bailey, VHHA (via phone)
Stewart Nelson, Halifax
Jay Andrews, VHHA
Dennis Ryan, CHKD (via phone)
Michael Tweedy, DPB
Scott Crawford, DMAS
William Lessard, DMAS

Other DMAS Staff:
Carla Russell
Mary Hairston
Chandra Shrestha

Other Attendees:
Martin Epstein, CNMC
Aimee Perron Seibert, CNMC
Karah Gunther, VCU
John McCue, DMAS Consultant (via phone)
Jack Ijams, 3M (via phone)
Catrina Mitchell, CHKD (via phone)

1. Introduction
   Members of the council and other attendees introduced themselves. William Lessard discussed the agenda of this meeting to review the revisions that have been made to the rebasing models since the November 2012 meeting, comparisons of All Patient-Diagnosis-Related Group (AP-DRG) and All Patient Refined-Diagnosis-Related Group (APR-DRG) results. The majority of the meeting's focus will be discussing proposals for a new Disproportionate Share Hospital (DSH) formula. DMAS froze DSH in FY14 at the 2013 payment levels for providers eligible in 2013.

2. APR-DRG Implementation
   Carla Russell reviewed the efforts to evaluate the implementation of International Classification of Disease (ICD) -10 and the need to transition to APR-DRG. DMAS met with 3M to discuss impact of APR-DRG and ICD-10. CMS delivered presentation to Medicaid States on APR-DRG and ICD-10. 3M is developing budget neutral APR-DRG version to achieve a stable transition to ICD-10. 3M is revising the APR-DRG product versions to be compliant with ICD-10. DMAS will implement the most recent version that is compliant with ICD-10.

   Ms. Russell also reviewed the modeling results. The results reflect Virginia-specific weights developed from state fiscal year (SFY) 2011 base year data for fee-for-service claims. For DRGs with less than five cases, the weights were

substituted with national weights. There was a significant amount of substitution based on the distribution of the levels of severity. Compared to AP-DRG reimbursement, reimbursement is approximately budget neutral. However, the results for critical access hospitals (CAH) and rural facilities reflect significant swings in reimbursement. Overall, under APR-DRG 57 facilities experience losses and 33 facilities gain. Under the transition proposal, 53 facilities experience losses and 37 facilities gain. For facilities with impacts greater than 5 percent, overall 25 experience losses, 15 gain; under transition 15 experience losses, 13 gain. Larger facilities gain under APR-DRG. In the transition model, facilities with 400 beds and over experience gains. Most rural and sole community facilities experience losses under APR-DRG, and 50 percent gain and 50 percent lose under transition. CAHs experience gains with 100 percent APR-DRG and in the transition model.

John McCue reviewed the transition strategy and the goals of transition. The transition strategy is designed to protect hospitals when converting from one payment system to another. Typically transition involves implementing with the combination of a percentage of one payment system or grouper plus a percentage of another system or grouper over a specified period. For example, transition may occur in 25-percent increments over a four-year period: 75 percent old and 25 percent new in the first year, 50 percent old and 50 percent new in the second year, 25 percent old and 75 percent new in the third year, and 100 percent new in the fourth year.

The transition proposal reflected in the results modeled 70 percent actual severity for APR-DRG and 30 percent of the average severity for each DRG. The proposal's results did not consistently reduce outliers and in some cases did not produce the desired effect of smoothing the impact of APR-DRG. DMAS agreed to review additional proposals including recommendations from 3M and modeling the alternatives based on input from the council. DMAS also agreed that managed care results and future changes in coding may impact the expected results based on FFS data. The agency committed to additional discussions with VHHA.

3. DSH Analysis

   Bill Lessard began the discussion of developing a new DSH methodology based on reliable, comparable, and auditable data. The current methodology relies on the Medicaid days definition which produces large swings in the data by facility. The total days from the Medicaid cost report includes other days, Medicaid Health Maintenance Organization (HMO) denied days, rehabilitation, and nursery days. Validity issues exist with the total days as currently reported especially the Medicaid HMO days. DMAS is working with VHHA to review the Medicare days definition. The Medicare days include all Medicaid days and crossover days. The proposed Medicare days would be extracted from HCRIS data.

DMAS also reviewed the federal requirement of deemed DSH hospitals. These hospitals would qualify if the Medicaid utilization exceeds one standard deviation, utilization above 24.82 percent. Another DSH methodology is based on the Low Income Utilization Rate (LIUR) requirement which is 15.91 percent lower under Medicare. DMAS may float the qualifying percentage.

Historical Allocation of DSH
Mr. Lessard reviewed a historical summary of DSH on a cash versus accrued basis. The vast majority of DSH paid to Type One hospitals, Children's Hospital of the King's Daughter (CHKD), approximately 11 percent, and state mental health facilities. CHKD may be limited by federal DSH limits. The current DSH methodology is based on operating payments and spends more than the DSH allotment. DMAS and VHHA have met to discuss how to allocate the DSH reductions. The $8 million is DSH reductions will be allocated between both Type One (state) and Type Two (private) hospitals. A new private hospital method and formula will be determined.

Uncompensated Care Model
VHHA modeled Virginia Health Information (VHI) information summarizing charity care reported. The uncompensated care model is based on using uninsured losses as a proxy for uncompensated care. The proposal compares hospitals losses to the statewide average. The data contains negative losses suggesting reliability issues. In addition, VHI data is limited to Virginia hospitals. Although the DSH audit data contains limited charity care data, the audit data is old; 2010 is the most recent under review.

DSH Reductions
Mr. Lessard reviewed the DSH reduction estimate for Federal Fiscal Years (FFY) 2014 and 2015 based on the FFY 2014 proposed rule. The reductions in the proposed rule are not final; the estimate inflated the allotment by 2.5%. The reductions represent a decrease of 0.87 percent. The reductions will be impacted by changes in health insurance coverage. If Virginia Medicaid does not expand, the DSH reductions will be lower. If Virginia does expand, higher reductions will occur as result of less DSH needed. There will be no changes to SFY 2014 because the FFY allotment extends through September 2014. The reductions may only apply to one quarter. DMAS may change other aspects of reimbursement including operating rates and IME payments to implement the DSH reductions. Chris Bailey questioned the impact of the severity adjustment to DSH days. Medicaid losses are inclusive of FFS and MCO. Mr. Bailey requested more information from DMAS on the MCO analysis.

4. DSH Options
   Eligibility
   Bill Lessard summarized the options DMAS may propose to revise the DSH methodology.

a. Medicaid Inpatient Utilization Rate (MIUR) as the qualifying percentage, either a simple average or the statewide average.
    i. Modified methodology involving changes to the thresholds and an accelerator.
b. Medicaid Losses Data
    i. Allocate DSH payments based on distribution of losses.
    ii. Out-of-state hospitals will be an issue.

Meeting Adjourned 12:05pm