Hospital Payment Policy Advisory Council

DMAS Conference Room 7B, 10 – 12pm November 15, 2012

Minutes

Council Members:
Donna Littlepage, Carillion
Chris Bailey, VHHA
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
Nick Merciez
Jodi Kuhn
Mary Hairston
Tammy Croote

Other Attendees:
Aimee Perron Seibert, CNMC (via phone)
Lauren Schmitt, CNMC
John McCue, DMAS Consultant (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 October 4, 2012 meeting, comparisons of AP and APR results and EAPG updates.

2. Operating Rate Rebasing Revisions
   DMAS provided an overview of the reason for revisions to the rebasing models. The main changes were corrections to the grouping and partial inflation calculation and to add hospitals that were not included in the first draft.

   Correction of the weights resulted in increased reimbursement rates; however, this was offset by the correction to the partial year inflation which led to an overall negative impact.

3. AP-DRG Weights
   Carla Russell discussed the All Patient Diagnosis Related Group (AP-DRG) weight revisions, highlighting how the distribution is similar to rebasing results from prior years. Case mix changes are similar to the averages and consistent with the weights. The outlier threshold is lower than originally calculated, reflecting the data is being grouped more effectively.

   DMAS presented the top 50 AP-DRG weights, standardized costs per case, and standardized costs for rehabilitation and psychiatric services. DMAS discussed the psychiatric decrease which was driven by both the changes in distribution and costs. DMAS clarified that these rates do not include freestanding psychiatric facilities;

however, the transition of freestanding psychiatric facilities such as Snowden to units of acute facilities may have had an effect on the rate. Freestanding psychiatric facilities typically have lower cost days; therefore, transition of the freestanding psychiatric hospital to an acute facility may lower the overall psychiatric costs for the acute facility. Donna Littlepage expressed concern that they are already operating at a loss and do not make up for these expenses with other payers. DMAS agreed to provide additional analyses to support the reductions in the psychiatric cost per day.

4. Disproportionate Share Hospital (DSH) Rebasing
   Bill Lessard reviewed the changes in Medicaid utilization and qualifications between state fiscal year (SFY) 2011 and 2014 rebasing. DMAS discussed the DSH audits that are currently being conducted. If a facility does not qualify during the three years they are receiving DSH funds, DMAS must retract the money. If DMAS increases the threshold, it moderates what their potential loss will be if they fall under the 14%.

   Chris Bailey reviewed the current DSH thresholds and inquired about the federal DSH allotment. DMAS responded that the federal allotment is $185 million, adjusted for total funds. Mr. Bailey pointed out that the current SFY 2014 DSH calculation exceeds the threshold and proposed a one year patch stating the current DSH allocation system is not sustainable.

   DMAS discussed the surprising increase in the number of Medicaid qualifying days. They plan to further research this issue and share any findings with the committee. Mr. Lessard proposed three options for collecting managed care days: MCO logs, reported days by hospital, and encounter data. He explained the limitations of using managed care days from these sources.

   Chris Bailey proposed three budget neutral choices for SFY 2014 DSH: 1. Move forward with current amounts and not rebase until the next biennium. 2. Use the SFY 2014 Rebased DSH but adjust it to be budget neutral to the SFY 2013 payments or 3. Do the rebasing but increase the calculation threshold to 14% and 25% and adjust it to be budget neutral.

   DMAS noted that Children's National Medical Center (CNMC) is not included in the DSH calculations due to a discrepancy in the number of days. Their lack of data was discussed and when CNMC inquired about what they could do to be included, Mary Hairston encouraged them to file their cost report.

5. AP-DRG Results
   William Lessard reviewed the AP-DRG rebasing results and budget impacts. Handouts were distributed with the budget impact by hospital: SFY 2013 Current Law Compared to SFY 2014 Current Law Rebasing (SFY 2011 Base Year plus 2.6% Inflation) and Budget Neutral DSH. The average change is a 5% increase. Stewart Nelson asked if those with higher Medicaid patients experienced a greater decrease. DMAS responded that was not necessarily the case.

Rebasing results for freestanding psychiatric hospitals were discussed. Carla Russell reviewed 2009 changes in psychiatric reimbursement when it was rebased and increased to 100% of costs. Virginia has a decreasing number of Medicare cost reports which are used to rebase the rates.

6. APR-DRG Operating Rate Rebasing Results

   Carla Russell reviewed the rebasing results using the All Patient Refined Diagnosis Related Group (APR-DRG) software. The updated severity distribution is generally comparable to national distributions. Chris Bailey asked what the national weights were based on and DMAS responded that is an all-payer dataset. DMAS noted they are trying to acquire New York data as a method of comparison. Ms. Littlepage suggested using a state with more comparable Medicaid population. Mr. Bailey asked about the normalization of the weights. DMAS explained these are modeled with normalized national weights but are discussing ways to develop Virginia specific weights (including managed care data) with national weights for low volume DRGs.

   Carla Russell reviewed the current vs. last handout for APR-DRG. The impacts vary considerably between individual providers; however, the overall impact is similar to AP with an overall trend of increases going to the higher severity facilities. The number of total cases varies slightly because of how the cases are grouped. DMAS will monitor changes in coding as we move closer to APR implementation.

   Based on the large number of facilities with decreases, DMAS recommended future discussion of a transition option. Mr. Lessard proposed an implementation of January 1, 2014 to begin the transition period. Chris Bailey responded with a July 1, 2014 begin date. Mr. Nelson and Ms. Littlepage stated their facilities already have APR and use it internally so they did not have a preference regarding implementation.

7. Enhanced Ambulatory Patient Grouper (EAPG) for Outpatient Hospital Services

   <u>Children's Freestanding Hospital Concerns and Related EAPG Model Changes</u>

   DMAS reiterated its decision to delay implementation of EAPG for reimbursement of outpatient hospital services, from January 1, 2013, to July 1, 2013.

   DMAS agreed to the following changes to address concerns raised regarding EAPG-related impacts on freestanding children's hospitals:

   Increase of five percent to the base rates for children's hospitals; and,

   Changes to the weights for therapy, botox, and dental surgery.

   It was noted these changes must be made in a budget-neutral manner, and that increases in payment to children's hospitals would be offset by decreases in payment to other hospitals.

   DMAS stated that the technical changes to the botox and dental weights were subject to be revisited based on the results of Version 3.7 of the EAPG model, and use of State Fiscal Year (SFY) 2011 rebasing data.

   DMAS also stated it would provide for a four-year transition to the EAPG reimbursement model; the previous DMAS proposal was a 2.5 year transition. It was

noted that this longer time period would give hospitals time to adjust, and DMAS time to evaluate data and make changes as needed.

The revised reimbursement impacts to children's hospitals--based on changes to the EAPG model to therapy, botox, dental surgery, and base rates, and using SFY 2010 data--were presented. It was noted these impacts were based on the data currently available to DMAS.

Other EAPG Model Changes/Information

DMAS further noted that it had made changes to some of the drug weights, in order to maintain its ability to claim rebates under the Medicaid Drug Rebate Program. The changes involved ensuring all drugs were reimbursed at least a small amount under EAPG.

It was discussed that during the transition period, the base rate used would be a blend between the cost-based base rate and the EAPG regional base rate.

Next Steps for EAPG

DMAS will model provider-specific impacts using Version 3.7 of the EAPG model and SFY 2011 data, including the adjustments for children's hospitals. These model results will also include additional payment, in the baseline, for all hospitals affected by recent corrections (payment increases) for certain emergency room claims that were incorrectly paid at the triage rate.

Budget neutrality will be assessed by examining the most recent DMAS claims with more complete coding.

DMAS discussed that it was still analyzing whether or not to implement with modifiers.

The following deadlines were noted: (a) December 1, 2012, for DMAS systems changes, (b) mid-January 2013 for changes to the EAPG reimbursement scheme, and (c) February/March 2013 for getting HPPAC input on draft regulations. DMAS noted that the timeline is on its website, and is updated monthly if there are significant changes.

The DMAS Training Unit will provide training beginning in the May for providers, including webinars through July.