Hospital Payment Policy Advisory Council
DMAS Conference Room 7B, October 8, 2014, 1 pm- 3 pm
Minutes

Council Members:
Donna Littlepage, Carillion (via phone)
Chris Bailey, VHHA
Jay Andrews, VHHA
Dennis Ryan, CHKD
Michael Tweedy, DPB
Kim Snead, JCHC (Not in attendance)
Scott Crawford, DMAS
William Lessard, DMAS
Kara Gunther, VCU
Lester Eljaiek, Sentara

DMAS Staff:
Carla Russell
Mary Hairston
Jonathan Walker

Other Attendees:
Martin Epstein, CNMC (via phone)
Aimee Perron Seibert, CNMC
Catrina Mitchell, CHKD (via phone)

1. Introduction
    a. Members of the council and others in attendance introduced themselves. William Lessard reviewed some of the recent transitions including: Enhanced Ambulatory Patient Groups (EAPG) going into effect January 1, 2014, Disproportionate Share Hospital (DSH) payment methodology changes effective July 1, 2014 and All Patient Refined-Diagnosis Related Groups (APR-DRG) implementation October 1, 2014 that will be discussed in detail on the meeting's agenda.

2. Old Business
    a. DSH Status
        i. Mr. Lessard began the discussion by reviewing issues with the old DSH formula including a method that covered 5 to 6 times what DMAS has allocated for DSH funding. This older methodology relied on the Medicaid day 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 and nursery days. Validity issues existed with the total days as reported, especially the Medicaid HMO days. The new formula uses Healthcare

Cost Report Information System (HCRIS) data that is more consistent and reliable.

ii. Questions:
    1. Todd Gardner and other members questioned why Medicaid cost report days were not used in the DSH calculation. Mr. Lessard explained that from research and discussions at prior meetings it was concluded that Medicaid cost report days are the least reliable source for DSH eligible day data. Mr. Lessard mentioned that there are issues with HMO days and unpaid days on the Medicaid cost report which also affect the validity of the information.

b. New DSH Formula
    i. Mr. Lessard discussed how the Medicare cost reporting data uses simple designations for counting days making it a better source for DSH calculations. This Medicare cost reporting data comes from the HCRIS which is a true and accurate representation of data on file with the Centers for Medicare and Medicaid Services (CMS).
    ii. Mr. Lessard went on to explain that the total allocation for DSH has not changed. The formula calculates a DSH per diem that is applied to each Type Two hospital. The DSH per diem is the total DSH allocation for all Type Two hospitals divided by total DSH eligible days for all Type Two hospitals. That DSH per diem is multiplied by the DSH eligible days for a facility to get their DSH allocation. DMAS started making quarterly payments with the new DSH formula September 2014. Mr. Lessard also mentioned that DSH days will be reassessed every year instead of being rebased every three years. DMAS will make state fiscal year (SFY) 2015 DSH payments based on SFY 2011 Medicare cost report data.
    iii. Questions:
        1. Lester Eljaiek questioned if it was possible to use more recent cost report data to calculate eligible days. There was a concern that payments based on older cost report data may not be accurate for the current year. Mr. Lessard and Chris Bailey explained that it would be difficult to pull data more recent than 2011 for SFY 2015 because of the timing of cost report filing. They went on to explain the time it takes to final settle a cost report and capture pending days as well.
        2. It was also requested by the council that going forward the data used to calculate the DSH allocation be shared with providers. Mr. Lessard stated that this can be done for future DSH calculations.

c. DSH Issues

i. Labor & Delivery Days
    1. DMAS missed labor and delivery (L&D) days in their DSH calculation depending on how providers reported (L&D) days on their Medicare cost report. Mary Hairston provided handouts that showed the source of the DSH days data and explained that on the Medicare 2552-96 cost report form L&D days reported on line 29 were missed but if reported on line 1 then L&D days were captured. Mr. Lessard stated that DMAS will work with the VHHA to validate calculation of DSH eligible days.

ii. Rehabilitation Days
    1. DMAS used schedule H3 of the DMAS DRG-796 data file for total days in the DSH calculation and that portion of the data file does not include rehabilitation days. Mr. Lessard stated that DMAS will work with the VHHA to correct this issue and assess the impact of the missing rehabilitation days.

d. Federal DSH Allotment Reduction
    i. Mr. Lessard reviewed the Affordable Care Act requirements for aggregate reductions to DSH allotments, which won't take effect until SFY 2017. Since Virginia Medicaid has not expanded, the DSH reductions are likely to be lower than originally anticipated since the number of uninsured is one of the criteria for reductions but it will probably not be a significant change.

e. 2011 DSH Audits
    i. Mr. Lessard discussed the 2011 DSH audit to identify any excess DSH payments if any. DMAS will assess and recover any excess DSH payments during the 4th quarter of 2014.

3. New Business
    a. Graduate Medical Education (GME) Rebasing
        i. Mr. Lessard discussed the need for GME rebasing explaining that DMAS has not rebased GME in over 10 years. Rebasing GME will allow hospitals to be reimbursed properly for their portion of cost. Mr. Lessard went on to explain that a DMAS proposal would be budget neutral and would propose rebasing every three years.
        ii. Questions:
            1. Mr. Chris Bailey questioned the budget neutrality portion of the proposal urging for more funding for the GME population. Mr. Bailey went on to explain that it is a deterrent for medical students to thrive in Virginia without more funding to GME.

2. Mr. Todd Gardner also questioned DMAS policy to pay GME to out-of-state providers stating that other states, specifically surrounding states do not have a policy of paying GME to other states and if they do it is very minimal compared to Virginia.

4. New Business
    a. Status of APR-DRG Implementation
    b. Carla Russell discussed APR-DRG implemented October 1, 2014 stating that so far the update is running correctly. DMAS will continue to assess its progress in the coming months.

5. Status of ICD-10
    a. Mr. Lessard discussed the ongoing delays with International Classification of Disease (ICD) -10 implementation. As of now ICD-10 is scheduled to be implemented October 2015 and that DMAS will start beta testing April 2015.

6. EAPG
    a. Mr. Lessard reviewed the implementation of (EAPG which went live January 1, 2014. EAPGs are a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. He went on to explain that paid claims under EAPG pay at 76 percent of cost adjusted for triage. MCOs are reviewing the EAPG implementation but only a few have implemented EAPGs. Mr. Lessard stated that some MCOs will move to EAPG in the near future.
        i. Questions
            1. A few members questioned why we can't use MCO data in the methodology. Mr. Lessard reviewed some of issues with MCO's unreliable and inconsistent data that would be difficult to incorporate into EAPG calculations.

7. Adjournment
    a. Concluding the meeting, the HPPAC agreed to schedule a follow-up meeting for November 12, 2014.

Meeting Adjourned 2:55pm