Hospital Payment Policy Advisory Council

DMAS Conference Room 7B, 2 - 4 PM
May 23, 2012
Minutes

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

Other DMAS Staff:
Carla Russell
Nick Merciez
Tammy Croote

Other Attendees:
Kim Snead, Joint Commission on Health Care
Lauren Bull, Children's National Medical Center
Jack Ijams, 3M (via phone)
Dave Fee, 3M (via phone)
Rich Fuller, 3M (via phone)

I. Overview of Meeting Plan

William Lessard stated the purpose of the meeting, which was to explain reasons for the impacts resulting from using the Enhanced Ambulatory Patient Grouper (EAPG) for reimbursement of DMAS fee-for-service (FFS) outpatient hospital claims. He stated the purpose of the meeting to be held on June 19th, 2012, as discussing transition options. He also noted that prior to the next meeting, DMAS planned to provide information on impacts associated with using EAPG to reimburse Managed Care Organization (MCO) outpatient hospital claims.

There was a question regarding whether MCOs would be required to use EAPG to reimburse outpatient hospital claims. DMAS responded that MCOs are not obligated to use EAPG. DMAS also noted that it had heard that some MCO Plans planned to use EAPG as they updated contracts with providers, while others had inquired with DMAS regarding whether it still intended to issue cost-to-charge ratios for providers (indicating a desire to continue to use cost-based reimbursement for at least some period moving forward). It was noted that cost-to-charge ratios may be different for the FFS and MCO populations. One HPPAC member commented that some MCO Plan contracts are tied the DMAS payment rates, and therefore DMAS's use of EAPG would lead to MCOs discussing with their hospitals how and whether to revise outpatient hospital reimbursement rates.

II. DMAS Presentation of Information on EAGP Model Impacts for Outpatient Hospitals

Carla Russell reviewed information and led the discussion on the following EAPG topics:

a. **Coding:** DMAS's analysis of claim coding was presented, which included information on the providers' claims included in the EAPG model, as well as claim line items used in the EAPG model that had missing procedure codes.

It was noted that while many providers had a high percentage of well-coded claims, some providers had fewer well-coded claims and therefore may want to consider this in moving forward with coding claims under EAPG. There were some questions regarding whether DMAS could use more recent provider data in its modeling. DMAS explained its choice of data was based on the most recent cost-settlement information available. There was discussion that DMAS would consider whether it could use more recent data as part of its transitional strategy.

b. **Impacts of Model Change Based on March 2012 HPPAC Meeting:** Information was presented on payment changes resulting from model changes decided at the March 2012 HPPCA meeting. These changes included adjustments to the wage index; revised weights for laboratory, vaccine administration, therapy and other series-billed claims; and improvements made to the emergency room (ER) claim coding. It was noted that these changes did not have much of an impact for most providers, although a small number of providers would experience more significant impacts from these changes.

One HPPAC member noted that the payment impacts resulting from EAPG are similar to those resulting from some of Medicare's payment methodology changes. It was discussed that these impacts resulted from providers being paid an average amount for services provided, versus a cost-based payment that may vary more by provider.

One HPPAC member noted that Twin County Regional Hospital was not a Carilion provider and DMAS responded that it would adjust its information accordingly.

Another member noted that the impacts to Richmond Community Hospital were of concern.

c. **Labor Cost Policy:** William Lessard discussed the results of using a different percentage of labor in the EAPG calculations. He noted that DMAS considered options such as using the labor percentage used by Medicare in its outpatient hospital service reimbursement, using data from the Virginia Hospital Information (VHI) data collection, using data from Global Insight, or using a higher percentage. He noted that while VHI data was used for DMAS's inpatient reimbursement modeling, this VHI data was a composite of hospital inpatient and

outpatient data. William Lessard noted that the choice of a labor percentage could have a small impact on whether providers are "winners" or "losers" under EAPG.

There was discussion about the goal of the choice of a labor percentage, and that choosing an option that reduces impacts could be preferable if it did not create other problems. DMAS noted that it wanted to choose the most appropriate number, but that perhaps using a higher percentage could be part of a transition strategy.

HPPAC members agreed to revisit this issue later in the meeting after other information on options was presented.

d. **Base Rate Policy:** Carla Russell described the impacts associated with the policy choice to use different base rates in EAGP modeling, with base rates being developed based on factors such as whether the claim was for an ER service or not, and/or whether the claim was for ER "triage" service or not. It was noted that there was not much of a difference in the results of these options, although a more complicated three-base rate option did somewhat reduce impacts for some providers.

   There was discussion that some options were more difficult to implement for both DMAS and providers than others, and that it was easier to administer the single-base rate option. It was also noted that the EAPG model already adjusts payment based on diagnosis codes for medical visits, in which case a separate base rate for ER claims based on diagnosis codes would not necessarily result in more appropriate payment.

   A concern was raised regarding whether higher payment for ER-triage claims under EAPG would encourage higher ER utilization. HPPAC members discussed that ER use was driven primarily by patient behavior and access, and that the current ER triage payment policy had not been effective in discouraging ER utilization.

   There was general consensus that a simpler, single-base rate option was preferable given that the more complicated policy options did not significantly reduce provider impacts.

e. **Payment Impacts for Certain Types of Claims:** DMAS presented information that showed the payment impacts associated with ER triage claims, ER non-triage claims, and non-ER claims. It was noted that high ER non-triage or high ER triage utilization was one factor that affected providers' payment impacts under EAPG. DMAS explained that overall ER non-triage claims tended to receive reduced payment under EAPG, while ER triage claims tended to receive higher payment under EAPG.

f. **Differences in Cost-Based Reimbursement, By EAPG Type:** Carla Russell presented information to show the average DMAS cost-based reimbursement by EAPG type, by provider and wage region. DMAS explained that this information could be used along with the information on claims distribution to help explain provider payment impacts under EAPG. It was noted that, for example, a provider with high costs for medical visits and a high percentage of ER non-triage claims would likely be a payment "loser" under EAPG.

HPPAC members noted that information on the distribution of claims by EAPG type would be useful. DMAS responded that it could provide this information.

At this point questions were raised regarding why children's hospitals generally received reduced payment under EAPG. DMAS responded that there were a few reasons, including that children's hospitals tended to have higher costs for therapy-type services, tended to have high radiology usage (which generally received lower payment under EAPG due to "bundling"), and higher-than-average payment for claim line items with blank procedure codes.

g. **Differences in Cost-Based Reimbursement/Cost-Based Indices:** DMAS presented and discussed information on cost-based indices that it developed to show provider cost-based payment differentials, and how these standardized/normalized cost comparisons were highly predictive of whether a provider would be a payment "winner" or "loser" under EAPG.

HPPAC members noted the cost-based indices were useful, and it was discussed that DMAS would produce cost-indices (and claims distribution data) by provider by EAPG type.

h. **Summary of Results and Factors Affecting Impacts:** DMAS provided information summarizing the data presented throughout the meeting on provider impacts, and factors affecting impacts, for one base rate/labor percentage option under EAPG.

DMAS discussed moving forward with a similar analysis for MCOs. There was consensus that this should be done using the one base rate/labor percentage option used in the FFS data analysis.

There was discussion that the summary information emphasized the importance of providers' costs in determining whether they were payment "winners" or "losers" under EAPG. Some HPPAC members noted that providers may be high-cost because they are small relative to other hospitals, and/or not part of a larger hospital system, although it was noted that some larger facilities/systems were high-cost. It was discussed that smaller hospitals may have some of the same fixed-costs as larger hospitals, but fewer claims to use to recover these costs.

The possibility of measuring and comparing payment impacts based on hospital bed-count was discussed, as one option for taking into consideration hospital size. It was also noted that some hospitals not noted as being part of a Virginia-based hospital system were likely part of another state's hospital system. For example, it was noted that a number of hospitals not affiliated with a Virginia-based hospital system were part of the Lifepoint hospital system.

A concern was raised regarding whether certain "critical access" hospitals would be adversely affected by use of the EAPG model. DMAS responded that it had considered this, but found that these hospitals had only a small percentage of Medicaid patients, and therefore would have limited payment impacts under EAPG. DMAS also made the general observation that Medicaid outpatient hospital reimbursement is a small percentage of total hospital reimbursement.

There was additional discussion that moving away from cost-based reimbursement to a prospective, bundled-payment approach to reimbursement, was expected.

i. **Additional Discussion of Children's Hospital Issues:** Questions were raised regarding whether the EAPG model weights were appropriate for pediatric services. It was discussed that the cost-structure for children's hospitals may be different. DMAS noted that it had performed outreach to another state's EAPG program to get information on this matter, and indicated that that state's EAPG contact had stated they had no specific knowledge of this issue. One HPPAC member noted that he was looking into this matter already, and another noted he would perform outreach to NY to determine if there were issues specific to children's hospitals to consider in an EAPG reimbursement methodology.

III. Next Steps

a. **Next Meeting**: DMAS noted that the next meeting would be June 19, 2012, which would focus on transition options.

b. **MCO Analysis:** DMAS stated it would perform an impact analysis based on MCO data prior to the next meeting. DMAS noted that since the last HPPAC meeting, additional MCO data suggested that approximately fifteen percent of their claims paid the ER triage rate, which would be factored into the MCO EAPG modeling. In response to a question from a HPPAC member, DMAS stated that the MCO data did not contain procedure modifiers. Subsequent discussion with a 3M representative indicated that most modifiers had limited impact on payment under the EAPG model, especially given the EAPG reimbursement scheme options being used by DMAS.

c. **340B Drug Program:** Carla Russell indicated that next steps also involved how to incorporate requirements under the 340B drug program into the EAPG modeling.

d. **Phase-In:** In response to a HPPAC question, William Lessard stated that DMAS was considering phasing in the EAPG model over three years, perhaps using transitional base rates.

e. **Future Model Adjustments:** A HPPAC member questioned how the model could be adjusted to account for an improving economy, or other factors as needed, moving forward. DMAS responded that the model could be adjusted for inflation or other factors affecting the budget-neutral reimbursement target, as needed. DMAS noted this approach was used in other DMAS reimbursement models.

Meeting Adjourned 3:55pm