Hospital Payment Policy Advisory Council

DMAS Conference Room 7B, 2 - 4 PM
March 27, 2012
Minutes

Council Members:
Donna Littlepage, Carilion
Jay Andrews, VHHA
Stewart Nelson, Halifax
Dennis Ryan, CHKD
Michael Tweedy, DPB
Scott Crawford, DMAS
William Lessard, DMAS

Other DMAS Staff:
Carla Russell
Nick Merciez
Jodi Kuhn
Tammy Croote

Other Attendees:
Beverly Cook, Halifax
Ralston King, Children's National Medical Center
Jack Ijams, 3M
Dave Fee, 3M
Rich Fuller, 3M

I. Overview of Meeting Plan

William Lessard stated the purpose of the meeting, which was to describe policy issues and initial modeling results associated with using the Enhanced Ambulatory Patient Grouper (EAPG) for reimbursement of outpatient hospital services. He stated the purpose of the meeting to be held on June 19, 2012, as finalizing the model and planning for implementation, including transition options and the frequency of rebasing.

II. DMAS Presentation on the EAPG Model for Outpatient Hospitals

Carla Russell provided a presentation of the latest EAPG modeling results and issues. The topics listed below were presented and discussed.

a. **Overall Methodology:** An overview of the EAPG methodology was presented, which included information on EAPG weights, base rates, the budget neutral target reimbursement, and an analysis of the claims to included in the EAPG model.

   A question was asked regarding what happens to claim line items with no procedure codes, when put through the EAPG Grouper. DMAS responded that these claim lines would not be paid, and further explained that it was possible that even if these lines did have procedure codes, they may not be separately payable if their payment was "bundled" with another procedure. There was a request that DMAS provide provider-specific information on blank procedure codes.

There were questions about whether the "bundling" logic that EAPG uses is similar to the APC (Ambulatory Patient Classification) that Medicare uses. 3M stated that there are dissimilarities, including (i) emergency room visits are not paid based on the level identified, but instead based on diagnosis code, (ii) APG bundling is sometimes more aggressive, and (iii) there is no site-of-service differential under EAPG payment. 3M explained that the EAPG model is similar to the DRG (Diagnosis Related Group) model (for inpatient hospital services) in that it utilizes diagnosis codes, and also pays based on the "average" patient. It was noted that this "averaging" approach means that a hospital may get paid more or less under this model than they would based on a purely volume-based payment, for a given claim.

3M also explained that there is a list of services which are always "bundled" under EAPG, and stated this list could be provided to the hospital representatives.

b. **Distribution of Services:** Information on the distribution of claim by type (i.e., Emergency Room – Non Triage, Emergency Room – Triage, Therapy, Clinic, and Other) was provided, and it was explained that this claims distribution could affect a provider's payment differential under EAPG.

c. **Emergency Room:** Carla Russell described the importance of emergency room claims in EAPG modeling, because they make up a significant portion of total provider claims. DMAS indicated that, in its EAPG modeling, it assumed the elimination of the current DMAS policy that pays emergency room triage claims at a reduced rate. Two examples of emergency room claims were presented to show the impact of payment under EAPG versus the current cost-based reimbursement method. One claim was an emergency room non-triage claim, and one was an emergency room triage claim.

There was discussion regarding the significant reduction in payment for some Level V emergency room claims. It was discussed that the payment for all medical visits (including emergency room medical visits) is tied to the diagnosis code identified. It was noted that payment for other claim line items (i.e., non-medical visits) is not associated with the diagnosis code, but based on the procedures provided and any payment "bundling" that occurs under the EAPG model.

There were concerns expressed regarding the payment differential for medical visits based on diagnosis codes, and providers questioned the basis for this differential. 3M stated that the weights were developed based on reported costs from providers. Providers also questioned whether more than one diagnosis code was used in the modeling results. 3M explained that one diagnosis code is currently being used for these results.

Concern was expressed over the DMAS policy proposal to eliminate the emergency room triage rate reduction policy. It was stated that some providers have put significant effort into addressing the requirements associated with the DMAS policy regarding a reduced rate for emergency room triage claims.

When DMAS stated that the managed care organization (MCO) payment data suggested that MCOs did not generally pay a reduced amount for emergency room triage claims, a hospital representative stated that some MCOs pay these emergency room triage rates. DMAS noted its appreciation for this information, and stated that its conclusions were based on the MCO data currently available to DMAS. DMAS noted while there were some provider-specific differences, the data available to DMAS showed that in aggregate the MCO paid amount was equivalent to the amount that would be paid for claims with no emergency room triage rate reduction.

d. **Therapy:** It was explained that DMAS had recalculated the weights for therapy claim line items because the weights from 3M reflected monthly billing. DMAS noted that it had more work to do in this area, to ensure that modeling results were not distorted based on the unique billing policies associated with therapy claims.

e. **Laboratory:** The packaging of laboratory claims was explained, and an example laboratory claim was presented to illustrate how this packaging was performed under EAPG.

DMAS stated it was looking further into the weights for laboratory services, given that the total EAPG payment for these services was approximately twice as much as the DMAS payment. 3M offered to help DMAS compare these payments to Medicare payments. It was also clarified that DMAS would continue to pay physician-ordered laboratory services based on the DMAS fee schedule.

f. Clinic: DMAS described that its current EAPG modeling reimbursed for revenue code 510 line items, while noting that MCOs generally do not reimburse for these particular line items. It was noted that the EAPG payment for clinic visits was high relative to current payments. DMAS agreed, and also noted these claims represent a small percentage of services. A question was raised regarding whether these claims would be paid at the lower of the EAPG modeled payment or provider charges. DMAS responded that, as with DRG, DMAS does not currently intend to reimburse the lesser of payment or charges.

g. **Radiology:** DMAS described how radiology payments were often lower under the EAPG model because the ratio of cost-to-charges was lower for these services than average, and these services are frequently packaged/consolidated under the EAPG model. Hospital providers expressed concern regarding the "0%" payment noted for CAT scans after the first CAT scan is paid at "100%" under EAPG, and questioned whether this payment policy disincentivizes the provision of services to Medicaid patients. DMAS noted that the "0%" payment phrase was actually

misleading, because all services are paid; it is more accurate to state that all services are not "separately payable" under EAPG. William Lessard reiterated that payment under EAPG is budget neutral to the current cost-based DMAS reimbursement policy. 3M noted that certain services are not separately payable because there is very little marginal cost associated with the additional services (on average), after the initial service is provided. 3M also noted that the cost of these additional services are factored into the weight (payment) associated with the initial service.

Hospital representatives expressed concern with DMAS's proposal to limit payments to one day of ancillary billing associated with inpatient stays without service authorization. The current DMAS policy is three days, and hospital representatives stated that Medicare has a three-day policy. There was a concern expressed that this was an issue separate from those associated with implementing the EAPG model.

h. **Drugs:** DMAS explained that for certain drugs (i.e., Class I Chemotherapy and Class I Pharmacotherapy), there was a value of 0 assigned for the weight, because the provision of these drugs is incidental to other procedures and services.

   There was a request for clarification regarding why vaccines should have a weight of zero. DMAS explained the weight should be zero in those instances for which the provider receives the vaccine for free under the Vaccines for Children Program.

   There was a concern stated that hospitals utilizing the 340B drug program should not get a reduced payment for drugs, because hospitals receive drugs for a discount under the 340B program because they serve a high percentage of Medicaid patients. DMAS noted that paying hospitals less under the 340B program is consistent with the current cost-based reimbursement policy. There was discussion among the hospital providers regarding the applicability of this program.

i. **Procedure Modifiers:** It was explained that modifiers on outpatient hospital claims were not yet available, but that the DMAS claims system would start collecting these modifiers in July 2012. DMAS also indicated it had not yet decided whether to implement EAPG for outpatient hospitals with modifiers.

j. **Managed Care Considerations:** DMAS discussed the areas in which FFS and MCO claims reimbursement appeared to be different, and also stated managed care plans were not required to use EAPG for reimbursement.

k. **EAPG Weights:** DMAS stated that it was using national weights developed by 3M in its EAPG modeling, and presented the differences in FFS and MCO average weights per claim.

l. **Payment Action Summary:** DMAS reviewed the payment actions produced by the EAPG modeling for both FFS and MCO claims. The distribution of payment actions is similar for FFS and MCO. MCO claims had a higher percentage of claims with full payment and lower percentage of claims with no payment. The no payment lines reflect primarily the zero weights for drugs.

m. **FFS and MCO Base Rates:** DMAS explained that it was using one global base rate for FFS claims, and that it separately calculated an MCO base rate to price MCO claims in the same way as it did FFS claims. DMAS presented information that showed that the FFS and MCO base rates were very similar when claims were paid using the same policies. When pricing FFS claims using a reduction for emergency room triage claims, and recognizing/reimbursing clinic claims, the FFS base rate was reduced.

n. **Provider-Specific Impacts**: DMAS presented two sets of provider-specific results, namely, (i) those resulting from paying FFS claims using a FFS global base rate, and (ii) the combined results from paying FFS claims using a FFS global base rate and paying MCO claims using an MCO global base rate.

   There were a number of questions, comments, and concerns on the provider-specific impacts associated with the EAPG model.

   i. There was a concern expressed that some hospitals already serving challenged communities would face a payment reduction under EAPG.

   ii. There was a question raised about how to reconcile which DMAS cost-based rate was used in the analysis of payment differentials under EAPG. DMAS clarified that it used the final cost-settled rate for each provider for State Fiscal Year (SFY) 2010.

   iii. There were questions and concerns raised about what policy choices are being made by using the EAPG model, and the political implications of these choices. William Lessard explained that this reimbursement model rewards low-cost providers, and penalizes high-cost providers, which DMAS believes is fair and a worthy policy goal. DMAS reiterated that a significant contributing factor to provider-specific impacts is the current cost-based payment differential to providers for the same service.

   iv. There were questions and concerns raised about how the EAPG payment model would affect children's hospitals, noting that the initial modeling results showed payment reductions for these providers. William Lessard stated that DMAS would look further into this issue, including whether adjusting a higher percentage of the payment with the wage index would reduce payment differentials.

v. There was a question regarding whether more recent provider data was better coded than the SFY 2010 data. DMAS stated that it analyzed the most recent data, and while some specific providers had notable improvements in coding, in aggregate the coding was very similar.

vi. There were concerns expressed that providers can not verify that DMAS payment is correct without the 3M EAPG software.

vii. There was general recognition that transitioning to a new payment model raised many challenges.

o. **Additional Meeting/Information Needed:** The hospital representatives requested additional information and an additional HPPAC meeting to discuss this information, prior to the June 19, 2012, meeting (already scheduled). DMAS stated it would make some EAPG model adjustments already discussed (e.g., changes to the wage index used), and would develop reports for providers to assess (i) coding (i.e., blank procedure codes), (ii) distribution of claims by type of service/procedure, and (iii) cost-based payment differentials.

p. **Policy Issues for Implementation:** DMAS noted that key policy issues still needed to be addressed, including budget neutrality adjustments, transition options, and frequency of rebasing.

III. Next Steps: The meeting ended with DMAS committing to develop and share information with providers as noted above, and make plans for an additional HPPAC meeting to review this information with providers, prior to the June meeting on finalization of the model and implementation.

Meeting Adjourned 4:10pm