Hospital Payment Policy Advisory Council

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

Council Members:
Donna Littlepage, Carilion (via phone)
Jay Andrews, VHHA (via phone)
Stewart Nelson, Halifax (via phone)
Dennis Ryan, CHKD
Chris Bailey (via phone)
Michael Tweedy, DPB (via phone)
Kim Snead, Joint Commission on Health Care (via phone)
William Lessard, DMAS

Other DMAS Staff:
Carla Russell
Tammy Croote

Other Attendees:
Marty Epstein, Children's National Medical Center
Carl Whitehead, Children's National Medical Center
Aimee Perron Seibert, Children's National Medical Center
Jim Deyarmin, Children's Hospital of Richmond
Kendall Lee, Virginia Commonwealth University
Jack Ijams, 3M (via phone)
Rich Fuller, 3M

I. Overview of Meeting Plan

William Lessard stated the purpose of the meeting, which was to review implementation plans regarding using the Enhanced Ambulatory Patient Grouper (EAPG) for reimbursement of DMAS fee-for-service (FFS) outpatient hospital claims beginning January 1, 2013. He noted one issue in particular was outstanding from the last HPPAC meeting and would be discussed, namely, the proposal for maintaining budget neutrality. He also stated a new issue would be discussed, which was the Medicaid drug rebate program, and how the EAPG reimbursement scheme would need to be reassessed in order to allow DMAS to continue claiming drug rebates.

II. Update on Developing a Prospective Hospital Outpatient Reimbursement Methodology

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

a. FAQs: Carla Russell explained that DMAS, VHHA, and 3M had developed a list of Frequently Asked Questions (FAQs) on DMAS's EAPG model for outpatient hospital reimbursement. She reviewed the various sections of the draft FAQs, and

stated this document would be updated as needed. She solicited input regarding other typical questions that would be useful to add to the document.

b. **Implementation Policies:** DMAS reviewed the FFS implementation policies for EAPG, which were provided in advance of the meeting to HPPAC members. During this review, the following specific questions and comments were discussed:

   i. Emergency Room (ER) Triage Policy: One HPPAC member noted it may be confusing to state that ER triage claims were priced at $30, since under the EAPG model, the policy of reimbursing ER triage claims at $30 would be discontinued. DMAS explained that ER triage claims were priced at $30 for the purpose of establishing the budget neutral target reimbursement only, and that under the new reimbursement methodology they would be priced using the EAPG model, the same as other claims.

   ii. "Right Coding": One attendee questioned how DMAS considered that claims would reflect improved procedure-coding under EAPG reimbursement, since the EAPG model uses procedure codes in payment determination, while the current methodology does not. DMAS explained how this had been factored into its analysis both by using only well-coded claims, and by making some assumptions about procedure-coding as practicable.

   iii. Vaccines: A question was raised regarding whether vaccines should continue to be billed as they currently are. DMAS confirmed that vaccines should continue to be billed as they currently are, and that there was no change in the billing policy for vaccines.

   iv. 340B Payment Adjustment: One attendee requested clarification regarding how the 340B drug program was factored into EAPG reimbursement calculations. DMAS explained that it first increased overall reimbursement by the total amount of the 340B discount, and then applied a 25- percent payment reduction for drugs to providers in the 340B program.

   v. Special Considerations for Children's Hospitals: There was discussion amongst meeting attendees regarding the impacts on children's hospitals of using the EAPG model for outpatient hospital claims reimbursement. It was noted that children's hospitals were projected to have unfavorable payment results under EAPG, as compared to the current model of cost-based reimbursement. William Lessard explained that DMAS does not currently plan on having a different payment policy for children's hospitals under EAPG, and noted HPPAC did not recommend this at previous meetings when this issue had been discussed.

Questions were raised about whether EAPG had been noted to have unfavorable payment impacts on children's hospitals in other states. 3M noted that under EAPG implementation in New York, there was no evidence that children were disproportionately impacted. There was discussion that because other states using EAPG did not have freestanding children's hospitals, the situation in Virginia may be somewhat unique.

Discussion continued regarding whether children's hospitals have higher costs relative to other hospitals because of the population they serve, including children with long-term, chronic needs. William Lessard acknowledged the reasons that costs might be different at children's hospitals, but stated that DMAS did not have data to support this. A VHHA representative stated it would get back to DMAS with recommendations on this issue.

c. **Drug Rebates:** William Lessard explained that recently DMAS became aware that drugs reimbursed under a bundled payment methodology were not eligible for Medicaid rebates. Therefore, DMAS was investigating how it needed to modify its reimbursement methodology to potentially make all drug line items separately payable so that it could continue to claim drug rebates. He noted a change to address this issue would probably affect the base rate and some EAPG weights, and stated DMAS would provide additional information to providers as soon as possible.

d. **Facility Transition Plan:** William Lessard reviewed DMAS's plan for transitioning to EAPG reimbursement. He explained that it involved using, over a two and a half year transition period, a provider-specific base rate that was a blend of a provider-specific cost-based rate and an EAPG regional rate. This blended rate would be weighted more heavily to the EAPG regional rate for each of the five six-month transition periods.

There was a question about how DMAS calculated the rate percentages used in the blended rate, and DMAS explained that this was based on dividing 100 percent implementation evenly over five periods. There was a concern expressed that providers would not know what their base rate was based on this formula; DMAS explained it would publish these rates on the DMAS website.

There was discussion of different transition options, such as transitioning over a longer time period or not making any rate changes mid-year. There was a concern expressed that is was generally difficult to make mid-year changes. On the other hand, it was noted that not all providers have the same fiscal year as DMAS, and are used to making rate adjustments during the year. In response to questions about other rate-transition periods, DMAS noted that the transition to an inpatient hospital bundled payment methodology was three years. There was a suggestion that DMAS begin annual updates (vs. six-month updates) beginning July 1, 2013.

One attendee raised a question about what DMAS would do if the legislature changed the cost-reimbursement percentage. DMAS stated that it would change the model to reflect any statutory changes to outpatient hospital reimbursement, including changes to the cost-reimbursement percentage, consistent with the current process.

e. **Budget Neutrality:** DMAS stated that because "right coding" changes were not reflected in the base-year modeling, there was a need to consider the impacts of EAPG reimbursement on budget neutrality. DMAS explained that it had reconsidered its initial proposal for maintaining budget neutrality, based on concerns raised by HPPAC members at the June 2012 HPPAC meeting, and subsequent DMAS analysis. William Lessard explained that the new proposal was to include a default coding adjustment of -1.0 percent beginning July 1, 2014, through June 30, 2019, and that DMAS would continue to monitor and evaluate the coding adjustment and annually propose modifications to the coding adjustment consistent with the evaluation. He stated any coding adjustments evident in the data would have to be significant in order for DMAS to request a budget neutrality adjustment.

   There was a concern expressed about the default coding adjustment, and a question was raised regarding why DMAS would need this default adjustment since the outpatient hospital budget was a small portion of the overall DMAS budget. There was general support for the new proposed methodology, but there were comments that the default coding adjustment should be 0 percent. William Lessard noted he would take this feedback into consideration as DMAS proceeded to assess the budget neutrality issue.

f. **Communication Plan:** Carla Russell reviewed the communication plan for EAPG for outpatient hospitals. Training and documentation activities and dates were discussed. DMAS noted that the DMAS e-mailbox date may be later than indicated on the schedule due to technical requirements.

   DMAS stated it would ensure training information was communicated to all providers, and that it was still assessing whether a provider-forum was necessary. DMAS explained that the purpose of the training was how to operationalize implementation, while the provider-forum would focus on provider-specific results and related reimbursement methodology questions.

   There was a question about whether any of the training sessions would be webcast. A VHHA representative stated that the option of recording a session was being assessed.

   In response to questions about the price of the 3M EAPG software, it was noted providers should contact 3M directly, and that the phone number for 3M was included in the FAQs.

In discussing the EAPG software, DMAS stated that it did not expect significant changes between the October 2012 and January 2013 releases, although there might be some changes to reflect DMAS's decision on how to address the drug rebate issue. It was noted that 3M updates its software each quarter; 3M representatives clarified that the model logic did not change mid-year, and that only coding changes and other small updates were included in the quarterly software updates throughout the year. 3M further explained that the October 2012 EAPG release would be ICD-10 compliant.

g. **Distribution of Data to Hospitals:** Carla Russell reviewed the handouts on provider-specific EAPG payment results and related analyses. A question was raised about whether claims were analyzed by the categories of children's and non-children's claims. DMAS stated that it had not done this.

   DMAS noted that a summary of results for all providers would be provided via email to hospital Chief Financial Officers.

h. **Managed Care Organization (MCO) Reaction:** William Lessard stated DMAS had recently briefed the DMAS MCO workgroup on its plans to implement EAPG for reimbursement of FFS outpatient hospital claims. He stated the these representatives expressed interest in DMAS' plans in this area, although they were not yet certain of whether and when the MCO plans might implement EAPG. DMAS noted that when it implemented a bundled payment methodology for inpatient hospital reimbursement, while the MCO plans may not have immediately switched to this new methodology, almost all eventually made this switch. It was also explained that the MCO contracts could be negotiated for any reimbursement method and amounts, because they were not required to be tied to DMAS reimbursement in any way.

   It was discussed that the MCO plans would likely have to re-contract with providers even if continuing cost-based reimbursement, since many contracts are tied to DMAS reimbursement methods and amounts. DMAS stated it plans to continue to publish cost-based percent of charge for an extended period of time. William Lessard explained that DMAS was working on developing some benchmark rates that MCO plans could use or reference, such as pricing MCO claims based on FFS criteria. DMAS stated it was difficult to price MCO claims based on the MCO plans' pricing logic, in particular because DMAS did not have detailed information on the ER triage policies being used.

   Questions were raised about whether the EAPG model would affect capitation rates. DMAS explained that because EAPG reimbursement was designed to be budget neutral, no increases or decreases were planned for MCO capitation rates. DMAS stated that if, over time, it was found that reimbursement under EAPG was increasing or decreasing, the capitation rates would be adjusted. William Lessard noted the earliest this might happen would be fiscal year 2015.

III. Next Steps

a. DMAS noted its plans to continue to move forward with using the EAPG model.
b. A VHHA representative reiterated that he would provide feedback on any recommended policy changes within the next couple of weeks.

Meeting Adjourned 4:10pm