Hospital Payment Policy Advisory Council

DMAS Board Room 1301, 2 - 4 PM
June 19, 2012
Minutes

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

Other DMAS Staff:
Carla Russell
Nick Merciez
Tammy Croote

Other Attendees:
Lauren Bull, Children's National Medical Center
Ralston King, Children's National Medical Center
Jack Ijams, 3M
Dave Fee, 3M (via phone)
Rich Fuller, 3M

I. Overview of Meeting Plan

William Lessard stated the purpose of the meeting, which was to discuss transitioning to using the Enhanced Ambulatory Patient Grouper (EAPG) for reimbursement of DMAS fee-for-service (FFS) outpatient hospital claims. He also stated the overall goal was to implement the EAPG model on January 1, 2013, and that the communication strategy and more specifics on the timeline would be discussed.

One HPPAC member stated some overall questions that he would like addressed as the meeting proceeded. These were based on a discussion with the Hospital Association of New York, and it was acknowledged that these issues may not be directly applicable to Virginia's EAPG implementation due to coverage and other differences between the two states. These issues included addressing critical access hospitals, children's hospitals, and dental and drug claim reimbursement.

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. Analyses Provided to HPPAC: DMAS provided the following information to HPPAC members: (1) an overall summary of the EAPG payment impact, and claims/coding information, updated to reflect information on parent companies; (2) standardized cost indices and distribution of claims by EAPG type; and (3) estimated EAPG payment impacts on FFS and MCO providers. It was noted that the MCO impacts were calculated based on applying FFS pricing logic to the MCO encounter claims, supplemented by MCO paid claim data to identify approximately 15 percent of claims that paid the $30 Emergency Room (ER) triage rate.

There was a question regarding why the drug cost index for Halifax was so high, and DMAS stated it would look into that issue.

b. Budget Neutrality: DMAS proposed a methodology to achieve budget neutrality and requested feedback from HPPAC. DMAS noted that it expected general coding improvements under the EAPG model, and that this could have an impact on budget neutrality. DMAS noted the areas that may be subject to improved coding, including drugs, observation, and the diagnosis codes associated with medical visits. There was also discussion that the subset of claims excluded from EAPG analysis due to lack of coding could have a different pattern than the "well-coded" claims that were used in the EAPG modeling. DMAS also stated that it had made some coding assumptions for ER and therapy/rehabilitation claims, and that actual coding could be different.

One HPPAC member asked whether DMAS would make prospective coding adjustments, or whether it would wait to see if coding improvements happened first. There was discussion of how Medicare addressed this issue. DMAS stated that generally it would adjust for coding changes in between the base year and the most recent available claims after EAPG implementation. DMAS also stated that a prospective adjustment prior to EAPG implementation may not be needed, but more analysis was needed prior to making that decision.

c. **Target Reimbursement:** DMAS stated that the target reimbursement is 76 percent of costs, with the exception of ER triage claims that pay the $30 triage rate, and lab claims that pay off the Medicaid fee schedule.

d. **EAPG Rebasing of Costs:** Carla Russell stated that DMAS planned to rebase the EAPG model annually for at least three years, possibly up the six years. After that period, rebasing would occur at least every three years, but possibly annually.

William Lessard stated that rebasing annually addresses the concern about changes in cost and case-mix over time. One HPPAC member asked about the time-lag in having data available for rebasing, and DMAS stated this was three years [e.g., state fiscal year (SFY) 2011 data would be used for the SFY 2014 EAPG model update]. DMAS noted that when using claims prior to EAPG implementation, only well-coded claims would be used.

e. **Coding Adjustment to EAPG Base Rate:** DMAS stated its proposal to review the base rate for budget neutrality implications every six months. DMAS reviewed an example of updating the global EAPG base rate based on changes to the average weight per claim. There were questions about whether the weight per claim variable is stable over time, or whether there is natural volatility in this variable. It was suggested that DMAS analyze the weight per claim for other time periods, such as SFY 2011, or SFY 2009 and review whether changes in the weight per claim were associated with changes in cost. One HPPAC member proposed that DMAS not update its global EAPG base rate using SFY 2011 claims, because this was before any coding improvements associated with use of the EAPG model. Another HPPAC member stated that any base rate adjustments for coding improvement should be independent of longer-term case mix trends. DMAS stated it would continue to analyze the overall issue of what base rate adjustments may be necessary to ensure budget neutrality.

   The timing of the availability of data to support EAPG modeling was discussed. DMAS noted it would not be until SFY 2016 or SFY 2017 that the EAPG model would be based on 100 percent post-implementation data. William Lessard stated that due to the time needed to calculate rates and give notice to providers, the first "six-month" update of the global EAPG base rate may need to be delayed. There was discussion regarding whether making a potential coding adjustment to the base rate every six months was too often, and whether there were seasonal differences in the claims data. It was noted that utilization may be seasonal, but not necessarily a weight per claim variable.

   Concern was expressed that this model not result in paying providers less than 76 percent of their costs, in total. There was discussion over the prospect of increasing costs, although it was acknowledged that this was difficult to estimate prospectively.

   DMAS stated that the base rate could go up or down with the coding adjustment. DMAS asked how much notice providers needed to implement these potential base rate changes, and one HPPAC member stated that not much notice was needed.

   There were questions over the difference between "rebasing" base rates, and updating the base rate for coding improvements. DMAS explained that rebasing utilizes the latest SFY of claims and cost data to recalculate the base rate, while the six-month proposed coding adjustment only considered whether the weight per claim had changed from the base period to the most recent available claims. HPPAC members stated their preference for frequent rebasing to capture changes in cost.

f. **Facility Transition:** Carla Russell stated DMAS proposed to transition providers from cost-based reimbursement to EAPG reimbursement over the two and a half

year period from January 2013 to July 2015, by using a blended base rate. The portion of the base rate based on cost-based reimbursement would decrease each six months over the two and a half year period. DMAS reviewed two examples of how this blended rate would be calculated and updated. One example included the illustration of how full EAPG reimbursement would result in lower reimursement, and the other example showed how full EAPG results would result in higher reimbursement. Both examples demonstrated how a coding adjustment after the implementation could change the base rate.

A HPPAC member asked whether DMAS would continue cost-settlement; DMAS responded that it would collect and audit cost data, but that it would not perform cost-settlement. Another HPPAC member asked how much difference there generally was between initial cost-based rates and the cost-settled rates. DMAS did not know the answer to this, but stated it did examine cost percentages over time, and noted that these did not change much in the aggregate, though they did for some individual providers.

g. **Implementation Policies:** DMAS reviewed and summarized various implementation policies, as noted below:

   i. Base Year. DMAS stated its current plan to use FY 2010 data for initial implementation, updating to FY 2011 data at the first rebasing effective July 1, 2013.

   ii. Grouper Version. DMAS discussed updating to EAPG version 3.7, from version 3.6, which was used for DMAS modeling. There was discussion over whether there were significant changes in the 3.7 version or 3.7 weights. 3M representatives stated that the changes should not result in major changes to the EAPG reimbursement DMAS modeled. One HPPAC member requested that DMAS implement with the same version it modeled with, and DMAS stated its plan to do this. Based on the availability of new version 3.7 weights, DMAS anticipated it would have results from the 3.7 version by late August.

   HPPAC members raised questions about the availability of the VA-specific version of the 3M software. DMAS stated it would provide 3M the reimbursement scheme information needed to make the VA-specific EAPG model available in the October 2012 release.

   iii. One Statewide Base Rate. DMAS reiterated its plans to use one statewide EAPG base rate.

   iv. Adjust Statewide Base Rate for Regional Wage Differences. DMAS stated its plan to make this adjustment, using the reclassified wage index with rural adjustments.

v. Inflation Updates. Inflation would be factored into the base rate at the beginning of each SFY, if this continues to be funded in the state budget.

vi. Rebasing. Rebasing would occur annually, based on the latest SFY of costs available.

vii. Cost audits. These would be performed but cost-settlement would not occur.

viii. Lab. DMAS would make any model adjustments as needed to meet the Center for Medicare and Medicaid Services policy that it not reimburse laboratory claims at a higher rate than the Medicare fee schedule.

ix. Inpatient Services. DMAS stated it did not intend to change the policy of billing up to three days of ancillary services for non-authorized inpatient services.

x. Rehab and Other Series-Billed Claims. DMAS stated it would make any model adjustments needed to continue to pay providers for each visit for these types of claims.

xi. 340B Drugs. DMAS explained its plan to continue the existing policy of reimbursing 340B providers at a reduced rate for drugs, and would accommodate this by first increasing the overall target reimbursement for all providers by the total amount of this discount. A DMAS-specific modifier could be used to identify 340B provider claims and to reduce payment for these claims.

xii. Modifier Alternatives. Modifiers will begin being captured in DMAS's MMIS as of August 19, 2012. Because of the lack of experience with outpatient hospital claims with modifiers, DMAS stated it preferred to begin EAPG implementation without modifiers, with the exception of a modifier to identify 340B providers. HPPAC members agreed

xiii. Adjust Cost Percentage for ER Triage. Because post-EAPG implementation there would be no ER triage claims paid at the reduced triage rate, DMAS stated that it would eventually need to adjust its cost percentage for providers based on the current policy of paying a reduced rate for ER triage claims.

xiv. UVA and VCU. These providers would have a separate base rate to make their EAPG reimbursement equivalent to their current reimbursement.

xv. Medicaid Expansion. This will need to be factored into EAPG modeling.

h. **Managed Care Organizations (MCOs):** It was discussed that MCOs are not required to use the EAPG model, but that many of them had expressed interest in using it. DMAS stated its plan to create a set of "shadow" rates for MCOs based on MCO claims data and FFS pricing, including adjustments and the use of blended rates in the transition period.

Questions were raised about provider payment contracts that are based on DMAS rates. It was discussed that options for addressing this issue included other payers using the EAPG model and/or contract renegotiations. DMAS also stated it was considering continuing to update the current percent of charge report for providers.

There were questions raised about whether DMAS's MCO payments had been adjusted for EAPG. DMAS responded that any change in payment to MCOs would be lagged, and that there were no prospective changes to MCO rates. DMAS further stated that it did not believe that globally this would have an impact on MCOs, although MCOs with a smaller regional "footprint" may be more likely to be impacted. DMAS also explained that other rate changes likely had a larger impact on MCOs, for instance, DMAS's annual update of physician rates.

DMAS indicated its commitment to meeting with MCOs on the EAPG model.

III. Next Steps

a. **Timeline and Communication Strategy:** DMAS stated it would begin its meetings with the MCOs in August 2012. DMAS stated that it would draft regulations and share with VHHA for their review. It was discussed that there should be a meeting with VHHA members to communicate impacts.

DMAS noted that it may post a "Frequently Asked Questions" document regarding EAPG, and/or provide an email address/mailbox specifically for EAPG-related questions.

There was consensus that notification of the EAPG model and its payment impacts, and the rollout for MCOs, are of primary importance. DMAS noted it would work with VHHA on the timeframe for the formal notification to providers. One HPPAC member further requested that in early September 2012, meetings be held with DMAS, providers, and 3M on the EAPG model. Subsequent meetings will be held for the EAPG rollout by DMAS.

Meeting Adjourned 4:20pm