Hospital Payment Policy Advisory Council

DMAS Conference Room 7B, 10AM-12 PM
December 5, 2011
Minutes

Council Members:
Chris Bailey, VHHA
Donna Littlepage, Carilion (via phone)
Stewart Nelson, Halifax
Dennis Ryan, CHKD
Kim Snead, JCHC (via phone)
Michael Tweedy, DPB
Scott Crawford, DMAS
William Lessard, DMAS

Other DMAS Staff:
Carla Russell
Jodi Kuhn
Tammy Croote

Other Attendees:
Jay Andrews, VHHA
Beverly Cook, Halifax
Kendall Lee, VCU
Jack Ijams, 3M
Rich Fuller, 3M

I. Introductions

Members of the council and other attendees introduced themselves.

II. Update on Developing a Prospective Hospital Outpatient Reimbursement Methodology

a. **EAPG Overview**-Jack Ijams provided an overview of the 3M Enhanced Ambulatory Patient Group (EAPG) model for outpatient hospital services. See copy of presentation materials *(need document to reference document name).*

b. **Overview of Timeline**-William Lessard stated that DMAS would like to implement EAPG for outpatient hospital services on January 1, 2013 and that the system resources are available to meet this implementation date. This means policy decisions would need to be made by July1, 2012. DMAS would like to meet again with the Council in March 2012 and June 2012. At the March meeting, the methodology parameters would be discussed and evaluated, while the June 2012 meeting would focus on implementation, transitional issues, and final decisions on parameters as needed. 3M noted that it would create a Virginia specific version of the software and maintain and update it, so that providers could use this same model to calculate their reimbursement under EAPG. DMAS will work with 3M so that it is available October 1, 2012.

c. **National Weights**-DMAS noted that while previously it had discussed using New York (NY) weights or Virginia (VA)-specific weights, 3M had since developed national weights that DMAS and 3M agreed were preferable to use. DMAS stated its preference to use these national weights. 3M discussed the benefits of national weights, including that these weights are based on the cleanest data that is not biased based on local-level payment policy decisions and/or small data sets. The data includes about 60 million claims from Medicare. There was some discussion of using an "all-payer" or multi-state Medicaid database, but 3M noted some concerns with some all-payer databases and that the multi-state Medicaid database had not been developed. There were questions/discussions about how a Medicare claims-based database would calculate claims for pediatric procedures/visits (a potential concern because of the difference in the Medicare and Medicaid populations). 3M responded that it had evaluated this and found the relative cost difference for these services was not very significant and hence did not bias the national weights.

   DMAS noted it was using version 3.6 of the EAPG software, and that version 3.7 should be available in January 2012.

d. **Data Completeness Update for FFS and MCO claims**-Carla Russell walked the attendees through the handouts which evaluated claims to include in the EAPG model/budget neutral baseline based on a standard of (a) at least one HCPCS per claim, and (b) one HCPCS for every revenue code. It was noted that a large number of claims would be excluded under standard (b), and Carla indicated that DMAS' initial modeling runs were based on standard (a). She also noted that this issue needed to be further investigated because while many claims had at least one HCPCS, some claims did not have the "primary" procedure coded with a HCPCS, and therefore it did not get a weight for payment under the EAPG model. A question was asked regarding how the impacts of the 340(b) drug program were addressed in the EAPG modeling, and DMAS responded that it was an issue it would investigate moving forward.

   It was discussed that managed care organization (MCO) data was better coded than fee-for-service (FFS) data and therefore DMAS was considering how/if to use MCO data in its EAPG modeling. There was discussion regarding the large number of FFS line items that were "unassigned" or otherwise did not get payment under the EAPG model. DMAS noted that it believes these results are correct based on the current data, and that DMAS is investigating if further refinement of "complete claims" to include in the analysis is warranted.

   In response to a question, DMAS clarified it was excluding University of Virginia (UVA) and Medical College of Virginia (MCV) from the analysis at this point because DMAS currently reimburses these facilities at a higher level than other outpatient facilities. DMAS plans to include these facilities in its EAPG modeling once it addresses the issues particular to UVA and MCV.

e. **Special Modeling Issues**-Carla Russell discussed other special modeling issues. She noted that therapy, emergency room (ER), and laboratory claims each have some unique modeling issues and therefore more research and analysis will be required. Laboratory claims were excluded from the initial EAPG modeling runs and therapy claims were mapped to comparable procedure codes.

William Lessard noted that DMAS welcomes input on whether to keep the current ER pend policy. He noted that eliminating the policy would have no fiscal impact, but eliminating it could save some DMAS and hospital staff time. Two provider representatives indicated a desire to eliminate the ER pend policy and there were no objections from any attendee.

f. **Base Rates**-Carla Russell noted that DMAS was considering the advantages and disadvantages of different base rates for different types of services such as ER, therapy, and clinics, and solicited 3M's opinion on the topic. 3M noted its preference to not have different base rates so as to not establish a different payment for the same service based only on the site of service. One provider commented that an emergency department (ED) that is open 24 hours a day/7 days a week may have different costs than a clinic that's open only 9am-5pm on weekdays. 3M stated that it noted this in its analysis and thought an aggregate payment across different sites of service may create better incentives. One council member noted that all providers are invested in site of service issues. DMAS agreed and noted that provider-specific analysis would help in assessing this issue.

Wage Rates-Carla Russell noted that DMAS used Federal Fiscal Year (FY) 2010 Medicare Wage Index data in its EAPG modeling thus far. There was discussion about the reclassified wage index, and questions about which was the correct index to use. DMAS noted it would consider these issues moving forward and perhaps a mixed-approach in terms of the percentages used for labor and non-labor costs would be appropriate. In response to questions, 3M offered that it did not think the mix of labor/non-labor was much different under outpatient and inpatient procedures.

g. **EAPG Distribution by FFS and MCO Claims**-Carla Russell reviewed the handouts that summarized how FFS and MCO claims were mapped to EAPGs, EAPG categories, and EAPG payment actions. She stated that DMAS was comfortable that the mapping was being performed appropriately based on similar results for MCO and FFS claims where expected, and differences in areas of known differences (e.g., FFS data excluded labs). There were questions/discussions whether DMAS was going to use MCO and/or FFS data in its modeling, and DMAS noted that was yet to be determined based on more analysis of the issues identified.

h. **Procedure Modifiers**-Carla Russell reminded attendees that DMAS' current data systems did not store procedure modifiers. Starting July 31, 2012, VA's MMIS will be updated to accept modifiers. William Lessard noted that DMAS was considering whether to implement EAPGs with or without modifiers. When asked, 3M noted its opinion that DMAS move forward without modifiers because unless there are large

differences between facilities in the use of modifiers, the effects of modifiers are not significant. DMAS discussed that it would consider the effects of recognizing modifiers as it proceeded with its analysis.

i. **Adjustments for Budget Neutrality**-Carla Russell emphasized the importance of the goal of budget neutrality in making decisions moving forward, and that especially the expected increase in coding needed to be considered. A proposed method of monitoring changes in the average total weight over time would help identify needed adjustments for budget neutrality.

j. **Next Steps**-Bill Lessard wrapped up the meeting by summarizing (a) the plan for March and June meetings, (b) DMAS' plan to share information as available, and (c) the implementation date decision. It was noted that the MCOs would like one-year advance notice of reimbursement system changes, and Bill stated DMAS could have a "soft" deadline of January 1, 2013.

The option of implementing EAPG July 1, 2013 (as opposed to January 1, 2013) was discussed as an alternative. Providers expressed concern with implementing EAPG, APR-DRG, and ICD-10 all within a 90-day window (which would occur if EAPG were implemented July 2013). One provider suggested that DMAS proceed with a January 1, 2013 implementation goal, but revisit this issue at the March 2012 meeting based on the status of the EAPG project at that time. DMAS agreed this was a good idea, and there were no objections to this proposal.

Meeting Adjourned 12:10pm