Hospital Payment Policy Advisory Council

DMAS Conference Room 7B, 10AM - 12 PM
May 30, 2013
Minutes

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

Other DMAS Staff:
Carla Russell
Tammy Croote

Other Attendees:
Marty Epstein, CNMC (via phone)
Ralston King, CNMC
Aimee Perron Seibert, CNMC
Bill Lawrence, CNMC (via phone)
Peter Young, CNMC (via phone)
Linda Metro, CNMC (via phone)
Mary Daymont, CNMC (via phone)
Julie Roby, CNMC (via phone)
Veda Russ, CNMC (via phone)
Jerilyn Woelfel, CNMC (via phone)
Catrina Mitchell, CHKD (via phone)
Jack Ijams, 3M (via phone)

1. **Welcome and Meeting Plan**

   William Lessard stated the purpose of the meeting was to describe DMAS's plans for implementing the Enhanced Ambulatory Patient Grouper (EAPG) for reimbursement of DMAS fee-for-service (FFS) outpatient hospital claims beginning October 1, 2013. He also stated he planned to use this meeting to update the HPPAC members regarding what DMAS had done since the last meeting on this subject.

2. **Modifications for Drug Rebate**

   William Lessard noted that DMAS had not yet received a final answer from the Centers for Medicare and Medicaid Services (CMS) regarding whether DMAS could use the EAPG model to reimburse drugs provided with outpatient hospital services/visits, while still claiming the Medicaid drug rebate as appropriate. He stated that because DMAS does not want to jeopardize its ability to claim drug rebates, DMAS is currently excluding drugs

from the EAPG reimbursement model. Under this approach, drugs would be reimbursed 76 percent costs, that is, based on the pharmacy-specific ratio of cost-to-charges (RCC) (and adjusted to reflect 76 percent of costs). Because of this drug carve-out from the EAPG model, the budget neutral baseline for all the services reimbursed under the EAPG model was adjusted to reflect an RCC for all services except pharmacy (excluding labs and emergency room (ER) triage claims, which are not currently reimbursed based on cost).

Because DMAS still desires to be able to include drugs in its EAPG model for outpatient hospital reimbursement, DMAS provided CMS with additional information about how DMAS plans to use the EAPG model to reimburse for drugs. Specifically, DMAS clarified that all drug claim lines will receive some payment under its version of the EAPG model, which is different from what some other State Medicaid agencies have done or are planning to do under EAPG. DMAS is hopeful that CMS will rule that under this approach, DMAS could still claim drug rebates. As such, DMAS is building a system capability to include drugs in its EAPG model, if such a favorable ruling from CMS was received.

In response to questions from HPPAC members, DMAS clarified that the pharmacy cost center information used would be that from the most recently settled cost report. There was an additional question about how the drug carve-out might affect drug discounts under the 340B program, and William Lessard responded that since the EAPG drug carve-out results in a continuation of the current reimbursement policy for drugs, there should be no effects of the drug carve-out on drug discounts. William Lessard also stated that if there is a specific concern with the current drug reimbursement and/or 340B program, DMAS can look into the issue.

3. Update on Modeling and Policy Issues

a. Base Year Costs and Adjustments: To provide an overview of the budget neutral target and claims information associated with the state fiscal year (SFY) 2011 data used in the most current EAPG modeling results, Carla Russell first presented Table 1. This table provided a summary of the SFY 2011 budget neutral baseline, global base rate, well-coded claims and average weight per claim. This information was compared to similar information from the SFY 2010 EAPG modeling data.

Carla Russell provided information on changes that were reflected in the SFY 2011 results as compared to the SFY 2010 results. The following specific changes/updates were noted: (i) use of version 3.7 of the EAPG software and associated version 3.7 national weights provided by 3M, (ii) update to the federal fiscal year 2011 Medicare wage index with rural adjustments, (iii) updated labor percentage of 67.8 percent using data from Global Insight, (iv) updated inflation (the same as that used for the SFY 2011-based inpatient modeling), (v) 76 percent of costs based on global RCCs excluding pharmacy, (vi) emergency room (ER) triage adjustment for level IV and V claims (resulting in a reduction in the proportion of ER triage claims from 27 percent in SFY 2010 to 23 percent in SFY 2011), (vii) change to the Carilion RCC due to a previous error in the clinic cost

center data, and (viii) removal of Children's Hospital of Richmond (CHOR) because that hospital is now a part of VCUHS, a Type One hospital.

The next table reviewed by HPPAC members summarized the percent of claims in the SFY 2010 and SFY 2011 modeling data that, under EAPG reimbursement, were (i) not processed, (ii) fully paid, (iii) consolidated, (iv) discounted, (v) packaged, and (vi) not assigned. This table excluded drugs, and did not take into account the effect of modifiers. It was noted that the SFY 2011 results included the implementation of the National Correct Coding Initiative (NCCI), because DMAS is implementing this policy beginning June 3, 2013.

An additional handout was provided with summary statistics on provider-specific claims used in the SFY 2011 EAPG modeling. It was noted that while in the aggregate, there was no change in the percent of claims considered to be well-coded (which are the claims used in the EAPG modeling) from SFY 2010 to SFY 2011, there were some provider-specific changes, with at least one provider in particular making notable coding improvements.

A question was raised about how ER triage claims would be paid under the EAPG model. DMAS responded that these claims would be priced through the EAPG model the same as any other claims. DMAS did clarify that in order to maintain budget neutrality, these claims were priced at $30 in the target baseline.

b. NCCI: Carla Russell stated that the application of NCCI edits resulted in provider-specific impacts of approximately $1.1 million. In response to a question, DMAS clarified that these costs were not removed from the overall budget neutral target.

Table 4 was presented, which showed the impacts of using modifiers on the base rate as well as provider-specific payment impacts. This analysis used data from September 2012 to March 2013 (the first period during which modifier data was collected and available), and compared EAPG payment with and without modifiers (and with NCCI edits applied). It was noted that modifiers 25 (which allows the medical visit to pay separately) and 59 (which allows two distinct procedures to be paid separately) were the most commonly used modifiers. It was also noted that due to the implementation of NCCI, in the version 3.7 EAPG settings, medical visits are no longer always paid by default. Modifier 25 is required in order for EAPG to pay for the medical visit separately, and this occurs only if the NCCI edit allows the medical visit to be paid separately (with the modifier) based on the specific procedure or service with which the medical visit is billed. Carla Russell noted this had an impact on the payment of ER claims, in particular, since the ER visit (procedure codes 99281 – 99285) would no longer be automatically separately paid, but instead would be separately paid based on the use of the 25 modifier, as appropriate and allowed based on NCCI editing logic.

Table 5 provided further information on the payment impacts associated with modifier use. This table compared the payment actions of the September 2012 to March 2013 claims, with and without modifiers. It generally showed that more claims received full payment and fewer were packaged, with modifiers.

Carla Russell explained that while the use of modifiers increased the average weight per claim somewhat, overall the average weight per claim in SFY 2011 was lower than the average weight per claim in SFY 2010 because of the following changes in the SFY 2011 data (i) the medical visit not separately payable without 25 modifier, and as allowed by NCCI, (ii) application of NCCI editing logic, (iii) lower weights for labs, as provided by 3M, (iv) the exclusion of drugs from the SFY 2011 modeling results.

c. **Laboratory:** Carla Russell informed the HPPAC members that because 3M had adjusted its laboratory weights to pay no more than the Medicare fee schedule, DMAS did not need to make any adjustments to the lab weights in the SFY 2011/version 3.7 EAPG modeling.

d. **Series-Billed Weights:** Table 6 was presented, which showed how DMAS modeled series-billed weights to be budget neutral to current cost-based reimbursement, but with increases to the weights for certain therapy EAPGs such that EAPG reimbursement was at least as much as that for outpatient rehabilitation facilities for comparable services. Carla Russell noted that upon EAPG implementation, it will be important for providers to bill one unit per visit for therapy services. Additionally, providers must include the date of service for each separate visit, in order for these visits to be paid separately and not bundled based on EAPG single-visit logic.

e. **Clinic:** Carla Russell explained that there was no adjustment made for EAPG reimbursement for clinic services, due to differences in the clinic-specific RCCs and the distribution of different types of clinics amongst providers.

f. **Children's Hospitals:** Carla Russell reviewed the issues why children's hospitals were negatively impacted under EAPG reimbursement. These issues included (i) a weight for botox that was too low based on costs for children's hospitals, (ii) difficulties in accurately modeling therapy services (which mostly affected CHOR, now excluded from the EAPG modeling), (iii) a weight for certain dental services that was too low (but which also mostly affected CHOR), and (iv) higher costs in other areas such as radiology. It was noted that HPPAC and DMAS had previously agreed there would be a five percent increase to children's hospitals' base rates to account for higher costs in areas such as radiology, and that this would be offset by a reduction to other hospitals' base rates in order to maintain budget neutrality.

4. Review of Implementation Policies

A handout was provided on EAPG implementation policies, and the following issues were highlighted: (i) ER triage claims were priced at $30 in the budget neutral target baseline, (ii) 340b providers should include a UD modifier on the applicable drug claim lines, which would apply a 25 percent reduction to EAPG reimbursement for those drugs if drugs were included in the EAPG model (and that even if drugs were not included in the EAPG model, 340B providers should use the UD modifier to support future rebasing and cost-data analysis), and (iii) if drugs were included in the EAPG model, a customization to the 3M software would be sought in order to ensure that Vaccines for Children (VFC) and non-VFC providers would all be reimbursed consistent with current policy.

There were some questions about the policy of pricing ER triage claims at $30 in the budget neutral baseline. DMAS clarified that it was required to do this in order to maintain the savings from this policy, and therefore maintain budget neutrality to current reimbursement.

5. Review of Facility Transition Plan

Carla Russell stated that there would be a four-year transition to full EAPG reimbursement for outpatient hospitals. The transition would involve the use of a base rate that was a blend between the provider's specific cost-based rate and the EAPG regional base rate, with the EAPG regional base rate reflecting 25 percent, 50 percent, 75 percent, and 100 percent of that base rate over the four years, respectively. A handout was provided to demonstrate these calculations, with estimated provider-specific impacts shown for both full EAPG implementation and the first transitional period.

6. Revised Budget Neutrality Proposal

William Lessard discussed DMAS's revised budget neutrality proposal, and a handout was provided. First, he noted that DMAS had previously proposed potential budget neutrality adjustments based on changes in case-mix, but stated that DMAS had agreed with HPPAC concerns that this approach may not be able to determine the reasons for changes in case-mix.

William Lessard then noted that there was a risk of both over-payment and under-payment under EAPG reimbursement, for reasons such as changes in coding, implementation of NCCI, and the use of modifiers. He discussed that the new budget neutrality proposal would be useful to correct for both over- and under-payment. He stated that this new proposal was to re-price claims based on cost-based reimbursement and then compare this to EAPG reimbursement. A change to the global base rate would be made, as appropriate, to account for these results. He noted that rebasing even as frequently as every year would not address discrepancies between EAPG and cost-based reimbursement because of the three to four year lag in the base-year and rate-year costs.

He also noted that the use of this new budget neutrality methodology may mean DMAS would not need to rebase the EAPG model every year.

In response to questions from HPPAC members, William Lessard stated that the use of a budget neutrality mechanism may be necessary for up to six years, and that by then the EAPG model should be mature enough to not require these annual adjustments. He also stated DMAS planned to use the cost percentages from the most recently settled cost report, and that usually there were not large swings in these cost percentages. There was discussion regarding what the transition period was for the implementation of the Diagnosis Related Grouper for inpatient hospital reimbursement, for the purpose of comparing that transition period to the proposed EAPG transition period and policies.

HPPAC members noted this new proposal seemed to take into account real changes in costs and case-mix that may occur, and that the proposal seemed to address the risk of both under- and over-payment under EAPG. It was noted that the HPPAC members needed some time to consider this proposal, and William Lessard requested feedback soon and offered to reexamine details of the proposal based on HPPAC feedback.

7. Provider-Specific Impact Data

Carla Russell reviewed Tables 7 and 8, which provided details on provider-specific payment impacts under EAPG. Table 7 presented estimated impacts without modifier adjustments, with modifier adjustments, and with the adjustment to the children's hospitals' base rates. Table 8 provided information on claims used in the EAPG modeling, average weight per claim, base rates, and estimated payment impacts upon full implementation and the first transitional period.

One HPPAC member noted that some provider-specific impacts were estimated to be fairly significant. Another noted that impacts for hospitals in southwest Virginia could be different from those estimated due to the transition of FFS reimbursement to managed care.

8. MCO Reimbursement

William Lessard discussed the difficulties in modeling an EAPG base rate for MCOs, citing reasons such as MCOs having different payment policies for ER triage, therapy, and laboratory claims. He stated that DMAS's plan was to provide as much information as possible to MCOs about the assumptions that went into DMAS's FFS base rates, and how MCO rates may be different based their individual payment policies. He also stated DMAS may provide MCOs with a pre-ER triage base rate.

One HPPAC member asked whether the use of the EAPG model for outpatient hospital reimbursement would affect MCO capitation payments. William Lessard explained that it would not, since EAPG was intended to be budget neutral. Another HPPAC member

questioned how MCOs may be able to estimate DMAS cost-based rates, which are used as a benchmark for payment by many MCOs. DMAS stated it planned to continue to provide the cost percentages for some period of time, based on a desk audit of the cost information provided by hospitals for their outpatient services.

9. Timeline

Carla Russell reviewed the timeline for EAPG implementation. She informed the HPPAC members that the July release of the EAPG software will have all the final weights except for therapy and other series-billed services, for which DMAS did not have all the final adjustments made at the time the July release weights were due to 3M. She stated that DMAS would send a Medicaid Memo in early August, and at that time would post the final weights and rates. She further stated that DMAS planned to provide training in August and September, and hoped to have the provider manuals updated by September. Carla Russell also informed the HPPAC that the October release of the EAPG software will have the final weights and rates. DMAS stated that if it received approval from CMS to include drugs in its EAPG model (while maintaining the ability to claim rebates) before August 1, DMAS would plan to update the October release to include drugs. If CMS approval was received after August 1, DMAS would develop a schedule to implement the EAPG model to include drugs, but that this implementation would likely not occur until the next state fiscal year.

William Lessard requested feedback from HPPAC members regarding the budget neutrality proposal, by June 11, if possible.

It was noted that the next HPPAC meeting was scheduled for August 7, to discuss the All Patient Refined Diagnosis Related Groups model and Disproportionate Share Hospital payments.

Meeting Adjourned 12:10pm