

**Final Recommendations for Revisions to the HSCRC's
Charge per Visit Methodology**

July 1, 2009

Health Services Cost Review Commission
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This document is ready for Commission action.

Background:

Outpatient revenue at Maryland hospitals has been increasing much faster than approved outpatient rate increases. At its June 4, 2008 meeting, the Commission approved the Charge per Visit (CPV) methodology as a means to limit the rate of increase in the revenue per case-mix adjusted outpatient visit at each hospital. Using a base year of data, the CPV methodology establishes a hospital specific CPV target which is the allowable average charge per outpatient visit for the subsequent year. The target is adjusted for rate increases, for an intensity factor to allow for changes in technology, and for changes in case-mix.

The CPV system includes ambulatory surgery, emergency department, and clinic visits. The outpatient visits are segregated into 3 groups: 1) Those that include a significant procedure Ambulatory Patient Group (APG); 2) visits with a medical APG and no significant procedure APG; and 3) visits with no significant procedure or medical APG. Only groups 1 and 2 are included in the CPV, and the visits in the third group, along with excluded visits, are treated as a pass-through and subject to unit rate compliance. Under the current exclusion logic, 55% of total outpatient revenue is included under the CPV.

Since adoption of the CPV methodology, the Commission staff, with guidance from the Outpatient Technical Workgroup, has been working to address issues that, due to time constraints, could not be incorporated into the original CPV recommendation. The following are recommended revisions to the CPV exclusion logic as well as recommended refinements to the case-mix methodology. Under these recommended revisions to the exclusion logic, approximately 78% of outpatient revenue will be included under the CPV.

Revisions to the CPV Exclusion Logic:

When the CPV methodology was originally being proposed, it was expected that FY 2007 outpatient data would be used as the base to set the CPV target for FY 2008. The FY 2007 data did not include the variable "number of visits," a field included in the data submission regulations beginning FY 2008. The majority of the records in the outpatient data represent one outpatient visit. The "number of visits" field is used to identify records/claims that include more than one outpatient visit due to "cycle-billing." A cycle-billed claim is a claim that remains open because the patient is expected to return at regular intervals for treatment. Because the FY 2007 data did not include information regarding the number of visits represented by each record, Commission staff identified the kinds of outpatient visits that were "likely" to be cycle-billed (chemotherapy, pharmacotherapy, radiation therapy, psycho-therapy, and dialysis) and excluded these types of visits from the CPV. This method excludes revenue beyond that represented by cycle-billed visits. Commission staff recommends that the exclusion of cycle-billed records be based on the "number of visits" field (record would be excluded if number of visits > 1) for FY2010. This will be a temporary measure while staff investigates the best way to include multiple visit records under the CPV in FY 2011. Radiation therapy visits (APGs 340-348) will continue to be excluded as these visit types are cycle-billed at all hospitals except one (Johns Hopkins Oncology Center). The radiation therapy visits will be included under the CPV in FY 2011 with the other cycle-billed visits.

Outpatient records with APGs that represent the following radiology procedures are also currently excluded from the CPV: MRI, CAT scan, myelography, mammography, ultrasound (except obstetric), PET scan, angiography, and diagnostic nuclear medicine. Analysis indicated that visits through the emergency department that included these APGs had significantly higher charges compared to referred ambulatory visits with the same APG. Because there was insufficient time to develop a refinement to the case-mix methodology that would address this issue, staff recommended that visits with the above radiology APGs be excluded from the CPV. In the last several months, staff has developed a refinement to the case-mix methodology that provides a separate case-mix weight for the radiology APGs when the visit occurs in the emergency department or clinic. Staff recommends that this refinement to the case-mix methodology be implemented in FY 2010. Because the added resource use associated with visits to the emergency department or clinic will be reflected in the case-mix, staff also recommends that visits with radiology APGs no longer be excluded from the CPV in FY 2010.

The third and final recommended revision to the exclusion logic involves the infusion APGs (APG 110 = pharmacotherapy by extended infusion, APG 111 = pharmacotherapy except by extended infusion). These two APGs were excluded from the CPV because analysis showed that there was a large dispersion in the total charges within these APGs due to large differences in the associated drug charge. Staff recommends a refinement to the case-mix grouping methodology for these APGs based on the 10 classes of associated drug APGs (APGs 430-439) in the record. This refinement, in addition to a trim methodology for outlier drug charges, significantly reduces the dispersion in total charges within the infusion APGs. At the Outpatient Technical Workgroup meeting on 6/23/09, industry representatives requested that staff explore further refinements to the infusion APGs based on primary diagnosis and/or multiple drug infusions. Staff recommends that the infusion APGs be included under the CPV in FY 2010. Staff will implement additional data edits and explore other potential refinements to the infusion APGs during July and August and, if the case-mix methodology can be improved, will incorporate these refinements in the case-mix methodology prior to calculating the base-year weights for FY 2010.

Case-mix Refinement for Multiple Significant Procedures and Observation:

Of the included significant procedure visits, 88% have a single significant procedure performed during the visit (referred to as "singletons") and therefore have one significant procedure APG in the record. The remaining significant procedure visits have 1-2 additional APGs in the record. The current significant procedure case-mix methodology for visits with multiple procedures is based on the highest weighted APG in the record. Therefore, the case-mix weight assigned to a visit with multiple procedures is equal to a visit where a single procedure is performed. Comments from the industry have suggested that the current methodology may be unfair to hospitals that perform multiple procedures within a single visit. Based on these comments, staff is recommending for FY 2010 that visits with multiple significant procedures be given a separate weight if the secondary significant procedure APG has a singleton weight greater than 1.0.

Outpatient visits that include observation have higher average charges when compared to visits within the same APG that do not include an observation component. To appropriately reflect the added resource use associated with observation, staff recommends that a separate observation APG weight be developed and that coding for observation be based on Medicare guidelines.

Summary of Recommendations:

Staff recommends the following revisions to the current CPV methodology for FY 2010:

1. Exclude cycle-billed visits based on the "number of visits" field (record excluded if number of visits >1) instead of visit types thought to be cycle-billed. Continue to exclude radiation therapy visits until FY 2011.
2. Implement the recommended refinement to the case-mix methodology that would give appropriate case-mix weight for radiology procedures performed in the emergency department or clinic and no longer exclude these APGs from the CPV system.
3. Implement the recommended refinement to the case-mix grouping methodology for infusion APGs (110, 111) based on the associated drug APGs (430-439), and no longer exclude the infusion APGs from the CPV system.
4. Implement the recommended refinements to the case-mix methodology to reflect the added resource use for visits where multiple significant procedures are performed and where observation services are provided.

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June 24, 2009

Char Thompson

Via e-mail

Dear Char:

This letter, written on behalf of CareFirst BlueCross BlueShield and Kaiser Permanente, offers our comments on the proposal entitled "Draft Recommendations for Revisions to the HSCRC's Charge per Visit Methodology" as distributed at the June 3, 2009 Commission meeting.

CareFirst and Kaiser Permanente support the staff proposal. The extension of the CPV's incentives to an additional \$1,000,000,000 in outpatient charges is crucial for incorporating incentives and constraining outpatient costs. *Monitoring Maryland Performance* continues to show outpatient revenue growth far greater than inpatient and some improved incentives are clearly needed. This change will also allow the Commission to come closer to achieving the revenue increase it approved for rate year 2010 with less slippage due to outpatient charge increases.

The MHA argued for further delay because of the risk associated with some elements that would be brought under the CPV system per the staff recommendation. The MHA also argued that some details were not known and so the hospitals would not be able to respond to the incentives. Neither of these arguments should be persuasive. The risk is of very manageable proportions and, indeed, is much less than the risk associated with DRGs when the Commission adopted that constraint system. The risk is less both because the percent of cost variance explained (the R-squared) is higher than for many DRGs and in total and because the average cell is associated with a much lower percent of hospital overall revenues. The broad incentives are also clear. While hospitals may not know which outpatient services they are most efficient in providing, they know what to do to improve their overall outpatient efficiency. Just having incentives to purchase outpatient supplies and drugs more efficiently should be sufficient for the Commission to adopt the staff recommendation.

The MHA has raises some specific issues. One of those issues relates to observation rates. CareFirst and Kaiser agree that observation cases cost more than cases in which observation is not present. We agree with staff that the Medicare guidelines for coding be used to identify observation cases. This is a payment issue and we believe observation revenue should be associated with APG 450 and a high level ED/E&M code. Both payers have had trouble with some Maryland hospitals refusing to provide observation services. It is important that there be no delay in adopting incentives to provide clinically

appropriate observation services – especially given Maryland hospitals' poor performance on one-day stays.

MHA also raised issues regarding the infusion APGs. We understand that issue has been resolved through a methodology for trimming certain drug costs. We are willing to support that compromise.

MHA has argued that radiation therapy should not be included under the CPV at this time because most hospitals cycle bill for this service. We disagree and urge the Commission to both move forward and to require non-cycle billing in the shortest feasible time frame.

MHA argued that private ambulatory services should not be included because they are just, in effect, fulfilling a physician's order. Not only does the staff recommendation only refer to quite expensive services, such as CT, MRI, PET, but those services have been among the fastest rising hospital costs. Further, many hospital admissions are, in effect, fulfilling a physician's order and they are still appropriately subject to the incentives of the inpatient revenue constraint system once the patient is admitted to the hospital.

In sum, CareFirst and Kaiser Permanente commend staff and its consultant, Dr. Atkinson, for developing and proposing this significant improvement to the Commission's CPV methodology and urge that the Commission adopt the recommendation as amended by staff.

Thank you for your consideration.

Yours truly,



Hal Cohen
Consultant

Cc: J. Graham Atkinson
Robert Murray
Greg Vasas
Debra Collins
Jessica Boutin



Maryland
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June 24, 2009

Sent via e-mail. Hard copy to follow.

Charlotte Thompson
Associate Director, Policy Analysis & Research
Health Services Cost Review Commission
4160 Patterson Avenue
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Dear Ms. Thompson:

On behalf of the 67 members of The Maryland Hospital Association (MHA), I appreciate the opportunity to comment on the proposed revisions to the HSCRC's charge-per-visit (CPV) methodology.

We support the staff's recommendations to exclude cycle bills based on the "number of visits field" and the recommendation to include additional weights for certain multiple procedures and observation cases. However, we do not support the recommendations to include chemotherapy, pharmacotherapy, and radiation therapy under the CPV system effective July 1, 2009. Patients receive these services to treat cancer and other serious illnesses over a series of multiple encounters (visits and treatments). To support their cancer treatment, patients receive laboratory and rehabilitation services, in addition to radiation or chemotherapy, to treat their cancer. To bill payors for these services, all hospitals, except one, use cycle bills to group a series of encounters onto a single bill. Because the HSCRC does not yet have a mechanism to consider an entire episode of care, they propose to include under CPV only those services billed as a single date of service. As a result, approximately 90 percent¹ of radiation therapy services regulated under the CPV are provided at the one hospital that does not cycle bill. We believe a similarly high skewed percentage of chemotherapy- and pharmacotherapy-regulated under CPV will be provided at the same hospital.

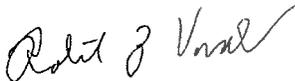
Including drug and radiation therapies billed as a single visit is problematic for several reasons. First, weights for these services will be set based primarily on one hospital. Second and most important, the variety of services provided over an episode of care is a better unit of measure than a single date of service. With technical assistance, the HSCRC could consider a single patient's entire episode of care and then parse that episode to compare utilization of like services, such as rehabilitation therapies and laboratory services within that episode. As health delivery systems and payors around the country move toward evaluating an episode of care, we believe the HSCRC is headed in the wrong direction by planning to separate cycle billing into single dates of service. Comparing single dates of service penalizes hospitals for providing services on a single date and advantages hospitals when a patient makes more frequent trips to the hospital, for the same service while doing nothing to evaluate the overall use of services for an episode of care.

Finally, we believe the 3M and HSCRC logic used to group radiation therapy and drug therapies into APGs results in groupings that are too broad. For example, 3M groups radiation therapy into four APGs, and further 91.4 percent of radiation therapy cases fall into a single APG (343). By contrast, the *HSCRC Accounting and Budget Manual* includes six pages of RVUs for radiation therapy. It is not yet clear whether the same will be true of the APG drug categories, which do not appear to be logically distributed (*see Exhibit C*).

Instead of moving ahead with a one-hospital approach this year, MHA recommends that the HSCRC outpatient groups continue to meet to develop a more refined methodology where the majority of these services, at all hospitals, can be included in the CPV system, if only a valid approach is developed within the next 60 days. Since it is unlikely that a suitable methodology will be developed in the next 60 days, we recommend that these services are excluded from the CPV for FY 2010.

In conclusion, we appreciate the opportunity to provide input on these proposed changes. Should you have any questions, please contact either of us at 410-379-6200.

Sincerely,



Robert Z. Vovak
Senior Vice President and CFO



Traci La Valle
Assistant Vice President, Financial Policy

cc: Council on Financial Policy
MHA Outpatient Work Group

Attachments

Notes

1. *See Exhibit A*, Radiation therapy includes four APGs, 93.1 percent of utilization occurs in APG 343 and Johns Hopkins Oncology Center (*see Exhibit B*) provides 95.4 percent of the visits in APG 343. 95.4 percent of 93.1 percent equals 88.9 percent.

Exhibit A

MD Outpatient Visit Data
 Radiation Therapy Visits (excl. BWMC Q2)
 FY 09, Q1 and Q2
 Encounters = 1 or 1000 OR Duration < 7

Counts of Cases Based on Total Charges - All "Non-Reoccurring" Visits													
Charge < \$500	500-1000	1000-1500	1500-2000	2000-3000	3000-5000	5000-7000	7000-10000	10000-15000	15000-20000	>15000-20000	>20000	Total	% Utiliz
High RAT APG													
342	0	0	2	5	12	7	24	39	22	46	157	1.4%	
343	2,589	4,976	639	173	254	227	218	264	140	144	9,949	91.4%	
344	0	20	14	24	43	98	72	94	49	46	538	4.9%	
346	0	2	6	44	3	2	5	13	96	49	16	236	2.2%
Total	2,589	4,998	243	305	437	311	333	493	260	252	10,880	100.0%	
	23.8%	45.9%	6.1%	2.2%	4.0%	2.9%	3.1%	4.5%	2.4%	2.3%			

Counts of Cases Based on Total Charges - All "Non-Reoccurring" Visits After Removal of Obvious Data Errors													
Charge < \$500	500-1000	1000-1500	1500-2000	2000-3000	3000-5000	5000-7000	7000-10000	10000-15000	15000-20000	>15000-20000	>20000	Total	% Utiliz
High RAT APG													
342	0	0	2	5	9	5	21	35	18	40	135	1.5%	
343	2,577	4,943	576	135	63	49	22	12	8	16	8,515	93.1%	
344	0	20	13	24	41	13	25	42	34	32	306	3.3%	
346	0	2	6	44	3	4	8	87	30	4	190	2.1%	
Total	2,577	4,965	184	184	136	71	76	176	90	92	9,146	100.0%	
	28.2%	54.3%	6.5%	2.0%	1.5%	0.8%	0.8%	1.9%	1.0%	1.0%			

Exhibit B

MD Outpatient Visit Data
 Radiation Therapy Visits (excl. BWMC Q2)
 FY 09, Q1 and Q2
 Encounters = 1 or 1000 OR Duration < 7 & Removal of Cases with Encounter Reporting Problems

Breakout of APG 343 - Radiation Treatment Delivery by Type of Treatment

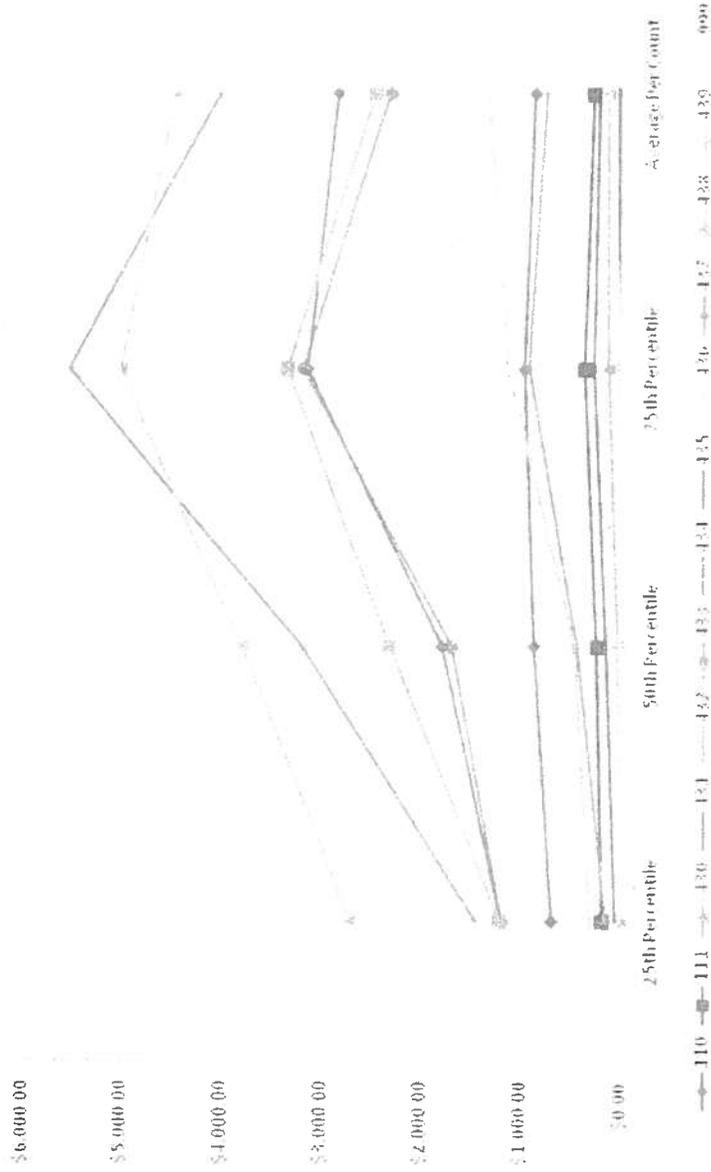
	Procedure Description	Visits	% of Visits	Chgs	Avg CPV	% of Avg
	IMRT Delivery Total	5,284	62.1%	\$4,254,330	\$805	98%
	Radiation Trmt Delivery Total	2,994	35.2%	\$1,435,457	\$479	59%
	Stereotactic Trmt Delivery Total	23	0.3%	\$575,656	\$25,029	3054%
	RAT Delivery with Chemo Total	200	2.3%	\$514,910	\$2,575	314%
	RAT Delivery with Brachytherapy Total	14	0.2%	\$197,653	\$14,118	1723%
	Grand Total	8,515	100.0%	\$6,978,007	\$819	100%

Breakout by of APG 343 by Hospital:

PROVNO	Hosp	Visits	% of Visits	Chgs	Avg CPV
210904	JH Oncology	8,125	95.4%	\$5,584,121	\$687
210044	GBMC	83	1.0%	\$121,014	\$1,458
210002	UMMC	51	0.6%	\$129,945	\$2,548
210009	JHH	48	0.6%	\$76,229	\$1,588
210012	Sinai	48	0.6%	\$608,173	\$12,670
210023	Anne Arundel	33	0.4%	\$67,337	\$2,041
210037	Easton	27	0.3%	\$61,619	\$2,282
210005	Frederick	21	0.2%	\$16,170	\$770
210043	BWMC	18	0.2%	\$29,151	\$1,620
210016	Wash Adv	11	0.1%	\$20,551	\$1,868
210011	St Agnes	9	0.1%	\$9,447	\$1,050
210056	Good Sam	8	0.1%	\$7,167	\$896
210024	Union Memorial	7	0.1%	\$19,021	\$2,717
210027	Braddock	6	0.1%	\$15,368	\$2,561
210008	Mercy	6	0.1%	\$74,544	\$12,424
210004	Holy Cross	5	0.1%	\$112,956	\$22,591
210019	Peninsula	5	0.1%	\$8,225	\$1,645
210007	St Joe's	2	0.0%	\$6,059	\$3,029
210022	Suburban	1	0.0%	\$1,180	\$1,180
210018	Montgomery	1	0.0%	\$9,729	\$9,729
	Total	8,515	100.0%	\$6,978,007	\$819

29.88158

» The distribution of line charge per percentile category by APG assigned does not appear to be logically distributed, i.e., Level V Drugs (434 or 439) line charges are lower than the levels IV or III drug line charges. See next slide for detailed percentile distribution per APG.



* Maryland IP Cancer Therapy Discharge Data - Include Cases with J or Q HCPCS Codes FY 09, Q1 and Q2; Exclude Upper BWMC (210043), Chesapeake (210049) and Hartford Memorial (210006) and line charge per record equals to \$0.