March 13, 2020

To: Members of the Medical Services Board
From: Lila Cummings, Manager, Public Policy, Colorado Hospital Association
Re: Opposition to MSB 20-01-14-A

Dear Members of the Medical Services Board,

The Colorado Hospital Association (CHA) appreciates the opportunity to provide testimony on MSB 20-01-14-A, Revision to the Medical Assistance Payments for Outpatient Hospital Services Rule Concerning Drug Payment Reweighting, Section 8.300.6. CHA represents over 100 hospitals and health systems in Colorado and writes today in opposition to the proposed rule and requests the Medical Services Board delay approval of this rule until the Department of Health Care Policy and Financing (HCPF) conducts further analyses and stakeholder engagement.

Background
In 2016, HCPF changed its payment methodology for outpatient hospital services from a cost-based payment methodology to a service grouping payment methodology – the Enhanced Ambulatory Patient Grouping (EAPG) methodology. Drugs paid through EAPGs generally include chemotherapy drugs, pharmacotherapy drugs and combined drugs. While hospitals and health systems were consulted prior to this payment methodology change, they did not anticipate that this change would result in significant underfunding of drugs delivered in the outpatient setting. Understanding that all outpatient drugs are underfunded through EAPGs, with certain drugs and certain geographies more adversely impacted, in 2018 hospitals and HCPF began exploring the process of carving drugs out of EAPGs and switching back to a cost-based payment methodology.

In July 2019, HCPF announced the potential of pursuing both a short-term and long-term solution to hospitals' concerns with EAPG payments for drugs. The long-term solution, which CHA is supportive of, involves carving drugs out of EAPGs and paying based on cost. CHA understands this change will initially be budget neutral but believes this change is the most appropriate and accurate reimbursement methodology. The Association's understanding is the earliest this long-term solution could be implemented is July 1, 2021. The proposed rule change before you today is HCPF's short-term solution, meant to provide relief for some of Colorado's rural hospitals, and was formally announced on Jan. 10, 2020.

Current Concerns
CHA acknowledges, and appreciates, the intention of this rule to provide short-term relief to critical access hospitals and a Medicare-dependent hospital but has significant concerns with the hospital groupings and the manner in which payments are proposed to be redistributed. The proposed hospital groupings and potential payments impacts are:

- Critical access hospitals (32 hospitals) – increase in payment
- Medicare dependent hospitals (1 hospital) – increase in payment
- Rural hospitals (11 hospitals) – no change in payment
- Independent hospitals (4 hospitals) – no change in payment
- System-affiliated hospitals (30 hospitals) – decrease in payment

The Association does not believe these hospital groupings are consistent with good policy development. CHA believes good policy:

- **Is developed with a full and complete understanding of the problem** – The solution in the proposed rule change only adjusts payments for some hospitals, but not for others, and does not address the issue that drug reimbursement should be based on cost.

- **Utilizes accurate data and credible, objective criteria to define the problem and assess the validity and impact of proposed solutions** – No evidence or research was provided to justify the criteria for the proposed hospital groupings. Further, the basis for HCPF's payment redistribution amounts was calculated using a figure representing hospitals' cost to charge ratio, a number derived from hospitals' drugs delivered in both the inpatient and outpatient settings to all patients.[1]
- **Applies objective criteria fairly and consistently across all hospitals** – Since the criteria for grouping hospitals was not developed objectively, the proposed change would not be applied fairly and consistently across all hospitals, leaving nearly 20% of the hospitals out of the redistribution.
- **Is developed, implemented, and evaluated in a collaborative and transparent manner with all impacted stakeholders** – At the Association's request to identify other potential hospital grouping criteria, HCPF hosted two additional stakeholder meetings to review hospital grouping criteria, potential financial impacts, and other data. While CHA appreciates these additional meetings, CHA was concerned with parts of the second meeting, when over 30 pages of data were presented for immediate reaction and HCPF used a vote at the end of the meeting (which was not announced prior and included less than 10 participants) to justify moving forward with the proposed policy.
- **Is lasting and transcends leadership and political environments** – Over the past 18 months, HCPF leadership has proposed multiple policies that separate hospitals in a manner like these proposed hospital groupings. CHA is extremely concerned about the precedence this sets for creating policies based on assumptions instead of facts, and the concern is heightened given that HCPF is currently gathering significant amounts of new data from hospitals, including hospital financial data and hospital community benefit spending data, that could be used to develop appropriate policies.

Proposed Solution

CHA requests that the Medical Services Board delay its vote on this proposed rule change and requests HCPF propose a short-term solution that more closely satisfies the policy principles outlined above. Specifically, the Association requests HCPF complete an analysis with all hospital using two hospital groupings, rural and urban hospitals, and then host another stakeholder meeting to review results. Additionally, CHA requests HCPF provide a written timeline for implementing a long-term solution. The Association will be in a better position to evaluate support of a rule change if the above requests are met.

CHA appreciates the opportunity to provide comment and thanks the Medical Services Board for their attention to this work.

Sincerely,

Lila Cummings
Manager, Public Policy
Colorado Hospital Association

[1] To estimate how relevant hospital payments varied compared to the state average, HCPF used a number from hospitals' Medicare Cost Reports – the Cost Center 73 Cost to Charge Ratio (CCR). This number represents the cost to charge ratio for all drugs in outpatient and inpatient settings for all patients, not just Medicare or Medicaid patients. Additionally, HCPF used the CCR from 2017; CHA recommends using the most recent CCR available from 2018.