EAPG Drug Re-Weight 1.31.2020 Closed Caption Transcript

*Reminder: While dominantly accurate, closed captioning cannot be 100% accurate capturing health jargon or acronyms.

Closed Captioner: Please stand by for real time captions.
Kevin Martin: Hi, everybody, we are going to give it just a little bit more time to dial in, we are going to get started about 3 to 5 minutes after.
Kevin Martin: Hello everybody and welcome to the EAPG drug re-weighting engagement meeting, this is the first of two we have scheduled, but if we have significant questions or concerns that we still need to address, we can always schedule more. For the people on the phone, we are here at 303 East 17th building on the 11th floor. So today, at the Department, you have me, Kevin Martin, the division director, and let's start with you.
Andrew Abalos: Andrew, outpatient hospital rates analyst
Elizabeth Quaife: Elizabeth, Specialty hospital analyst in hospital liaison.

[Indiscernible - low volume]

Kevin Martin: We are going to be recording the webinar and we will put it onto the website afterwards, people are muted at the moment, but please press *6 if you want to talk. You can also use the chat. If you're going to speak on the phone, make sure you're speaking from somewhere with less background noise, so we can get your recording. And also make sure to announce yourself when asking a question. The next meeting of this series will be held on Friday, February 14, in the afternoon. So not the morning, like this one. And on the seventh floor, not the 11th floor. Getting these meetings scheduled, unfortunately we couldn't get a specific time and space. Now we are going to jump into the spreadsheet, this is in the downloadable files area and we will also be presenting it but if you want to be able to scroll through it on your own, that's okay. So, this meeting is being held really because there were concerns raised about the objectivity of the division of hospitals that were either courted off to identify them as having a significantly different drug utilization profile, those are the ones that are labeled as an increase in the spreadsheet, those are the critical access and Medicare dependent hospitals. And then, the hospitals that are identified as having a decrease, these are the urban system hospitals, and the ones that are neutral are either the rural hospitals that are not critical access or Medicare dependent hospitals, or independent rural hospitals. The reason for that is, sort of twofold for the different categories, the noncritical access and Medicare dependent hospitals in the rural setting, we just recognize that they do have some more resources, they may not be contributed to the significantly different drug utilization profile like the critical access hospitals and so we just left them out of the increase bucket, and for the independent urban hospitals, we wanted to make sure that we hold them separate just because we recognize that they don't have the same kind of resources that the system hospitals do, so we didn't want to adversely affect them. So, I will go ahead and open it up to anybody that has questions or concerns, or comments.
Stakeholder/Provider: Can you help us understand how you determined the drugs that you are looking at, to make the determinations and a little more information around when you say some hospitals have greater resources, what that means.
Kevin Martin: Sure. So, the drugs, you can find those on the relevant drugs tab. And you can see this list of EAPG's there, these are all the drugs you can use, and we are including them in this exercise when they are unpackaged. There are two of the drug EAPG's, the minor -- where are they? Okay, so I have them on the list?
Andrew Abalos: Yeah, they are not on the list.
Kevin Martin: There are two more on there, the minor ones that can sometimes be packaged and sometimes cannot. When they are not packaged, we can put them in this analysis and when they are packaged, these are like really minor things that are just sort of part of a bigger bundle, but every once in a while, they are administered by themselves with nothing to bundle into and that is when they will be unpackaged. And as far as the difference between independent and system, having more or less resources, these systems have not only more hospitals to draw off of to distribute any kind of action that is happening, but also they sometimes have national networks as well. And the independent hospitals, they are very often just by themselves and they have very minimal resources to be able to support any kind of adverse action, so we are just being cognizant that they do have those limited resources when you're trying to make some changes.
So what I'm seeing is what you are including, minus the package, everything was in the analysis --
Sorry, which?

Stakeholder/Provider: Your crosswalk, so the drug psycho in the crosswalk, the EAPG's. All the indices on that?
Kevin Martin: If you are referring to appendix X, that is different, that is for the physician administered drugs, that is a different identification of drugs. The reason that those are used in a different way, to be on there, we have to have some kind of conversion factor between, so it's a comparison of those two categorizations.
Stakeholder/Provider: So how does the drug map to EAPG, how do we know which drugs go to which EAPG's?
Kevin Martin: In the system documentation for the 3M software, unfortunately that is not something that we have gotten approval yet to post all of them, but I do know that UCH licenses that software.
Stakeholder/Provider: Essentially it is all drugs.
Kevin Martin: Yes, it is all drugs that are not packaged, and the only they would package are these minor drugs, which would be considered part of a bundle and they will bundle every single time that there is something to bundle into.
Stakeholder/Provider: I'm still trying to follow the logic and what the analysis was, the 18% shift, and how do you exactly come up with that?
Kevin Martin: So, that was the first round, and we received some feedback on the first round that was shifting too much to these large rural hospitals is not providing any kind of relief for the small rural hospitals and when we went back and into the second round which is what we are seeing here, it is now up 43% increase but it is for a much smaller utilization so the actual decrease for the opposing side is, really didn't change. Also, when we went to the second round, we did update these a little bit as well so now it is based on calendar year 18 utilization as opposed to fiscal year 18. So, we may be utilization system more correct. Sorry, but that didn't really get to the question, how. So, that is also explained here on the notes tab, so the first thing that we did which was essentially how we set the EAPG weights to begin with, was we take all of the billed amounts for the claims for drugs, for all hospitals, and then we use the cost to charge ratios from the Medicare cost reports, and we transform the billed amounts into costs. And the costs divided by the number of occurrences is the cost per drug. That is just a very blanket overall cost for drug for all of them. And then we split into the two different categories of the critical access and Medicare dependent hospitals, we did the same calculation and compared that to the overall average cost per drug. And, their overall, the critical access Medicare dependent hospital cost per drug is about 43% higher than the overall average, showing that their cost per drug is significantly different, and that is because of the utilization. Now, when we do that for the urban system hospitals, it shows a decrease, and I don't have that, I was trying not to put too many numbers in there, it shows a decrease of, I think it was 14 or 16%, but that would have been a huge savings which was not the point of this, the point was trying to just balance back out, so that we actually put the correct cost per drug with the critical access hospitals. So then, we just figured out how much it would be shifting in terms of money, and back into how much that would need to decrease the other set. So theoretically, the system, urban system hospitals should have a way to that is more like 15% lower than the current weights, but that would, we only wanted to make a budget neutral shift.
Stakeholder/Provider: So, in regard to 340 B, how did you make the count? The drug hospital will be less than the reimbursement is less, so how did you normalize the count for that?
Kevin Martin: Well, your cost to charge ratio should get to the actual cost.
Stakeholder/Provider: Right, so it's going to show the 340 B hospitals is less than the other set that are not. On the drug by drug basis, yes, however if you are utilizing primarily less expensive drugs, and you do have, you are also using 340 B so the less expensive drugs, so that means that you would also -- I guess I'm not sure. So, yes, it would show that.
Kevin Martin: I think I just needed a little bit more, but in general, the assumption is that rural hospitals, a segment of the hospitals are paying more for drugs, they don't have the contracts to be able to do that. We compare that to the hospital 340 B of course the costs are going to be, they are not even thinking about contracting.
Kevin Martin: Okay, it's not just about the cost, it's also about the drug psycho into the utilization profile, because there are different sets of drugs that are used in a rural setting than the urban settings. In urban settings, my understanding is that TPA is rarely used because you actually have the resources to treat it right there available, however on the rural side, they need to use the drug in order to stabilize the transport. So that is just one example of drugs that are used in a rural setting that aren't used as often in an urban setting. Does that make sense?
Stakeholder/Provider: I actually disagree with that comment. The academic hospitals, the urban hospitals used TPA, and the freestanding, but on-site, it is commonly used.

Kevin Martin: Okay, and I guess maybe then it's not that it's not used, but there is still a difference in the drugs that are used in an urban versus rural setting. So, not only can the price of the drugs be used, but the average cost of the drugs, so the average drug that has been used in a rural setting is just one of the more expensive drugs, versus an urban setting.
Stakeholder/Provider: Do you have that data in the spreadsheets?
Kevin Martin: I cannot share individual claim data because it contains PHI. You do have your own data, and I guess we can share some aggregated data, but I can't share individual claims.
Stakeholder/Provider: My perception is the hospitals, larger hospitals, especially are using a lot more drugs than all of the drugs in the rural hospitals, as a subset and small subset.
Kevin Martin: Okay, and my information is coming just from claims and from anecdotes from hospitals. So, I don't know, if anyone else has anything to speak to the way that they utilize drugs, that is just our perception from looking at the information and from hearing from hospitals. I can only speak to the information that I have at hand.
Stakeholder/Provider: Kevin, this is Ryan, can you hear me? Ryan W from CHA.
Kevin Martin: Yes.
Stakeholder/Provider: You mentioned you can share some aggregated information, I think that would be helpful in this conversation, and for the February 14 meeting. Just to let hospitals, like you said, they can take a look at their information and come up with using their claims, come up with their costs and what they're thinking their cost is for drugs and compared to how you are doing it with your claim numbers compare to your cost to charge ratio. I'm interested in how the cost of charge ratio that you are calculating compared to how hospitals are going to prepare it. I guess my question is, are you using the overall hospital cost to charge ratio, like total charges? Or are you using cost and 56 on the cost report, which is like drugs that are being recorded?
Andrew Abalos: Cost center 73, I need to double check on that though.
Stakeholder/Provider: So, you are using the actual cost center, okay. I think sharing that with the hospital was really necessary to have the next conversation. We can all agree on the cost figure, how the calculation is being put together, then I think we can have, that leads into the next step of how they are being separated and who is being included. Thank you.
Stakeholder/Provider: I have a question, but I wanted to give everybody else time to ask. Sorry, would it be possible, because it seems like the drug profile of each hospital would also be important. Is there a way that you could share, and I don't know if it could be like individual hospitals, but instead of absolute numbers like percentages, you know, is that a way to get around PHI? Just so I understand, I don't even know what drug it is, but the hospital drug profile, this percentage is CPA and then the urban, but I was wondering if you could tell me if there was a way.
Kevin Martin: I would have to check. I can try to figure out some way to present that that doesn't allow people to hack into it. Because obviously, the more information you put out there, you can start cross-referencing all the different things, and get down to an individual.
Stakeholder/Provider: Right.
Kevin Martin: I do want to be as transparent as possible, but I do still have to --
Stakeholder/Provider: I was just thinking, too, from CJ's perspective, I understand that rural hospitals have different concerns, so I think the objection last time was how the criteria worked, so if there is a kind of more granular, oh, this proportion of drugs, here is the cost center 76, Cost to charge, like if we are getting into that level of detail, I think that is the stuff, like okay, it's not based on who owns, like the fact that you are in a system, but then it gets to each individuals hospital. I mean, that is, if it is information that you can share, that is what we are trying to get.
Kevin Martin: Okay.
Stakeholder/Provider: Can you help us understand the vision for how this would play out? So, are you literally going to go into the EAPG rates by hospital? How are you going to do this?
Stakeholder/Provider: So, this is a percentage change to the EAPG weights, not for the base rates for each individual hospital, so they have two components to arrive at a dollar figure, you have the base rate and the weight for each EAPG, so we have the ability to create separate weight sets, the vast majority of it would be the same for the three different groups, for the neutral group, it would just remain the same. And for the critical access group, just the drug EAPG's would receive that percentage increase, and then for the urban system hospitals, it would receive the percent decrease, just for the drug EAPG's.
It would be even for all of us across all of the drug EAPG's?
Kevin Martin: Yes.
Stakeholder/Provider: And with that require adjustments to the other known drug EAPG's?
Kevin Martin: Yes, that is why we are just looking at the cost per drug right now.

Stakeholder/Provider: So, if you're hospital that uses a lot of the high chemotherapy infusions specialty service lines, because those drugs are more expensive in that case, 10,000 for administration, you have a high volume there. You actually could end up having a higher reimbursement reduction, something that you were on the lower end.
Kevin Martin: Yes, but likewise, your high utilization of those high cost drugs would have fed into the information to begin with. So, while we were looking at this in looking at the cost per drug for the overall average, versus the system hospitals, we still found that it was quite a bit lower than the overall average. So, yes, but less so than if we just went and did the full shift. It seems like we have some questions in the chat.
Provider Chat Question: So, Megan asks, can you confirm, is the direct fragile listed on the slide an annual production or monthly?
Kevin Martin: So, if we go back to the last one, the numbers presented are for calendar year 18, we are not attempting to project into the future, we are just showing that if we had implemented those percent changes for calendar year 18, what the difference would be. So, theoretically, there is some shift as we go into the future of inflation or changes in utilization patterns or those types of things, and we are just trying to account for those in any way, we are just purely looking at what happened in the calendar year 18. And those are annual. Okay, I've got a couple people typing but we can definitely go to other questions in the room while we are waiting. Okay, we will get that fixed and we will get that out to you as soon as we can.
Stakeholder/Provider: Can you said that with the proposed EAPG rates will be, so we can write it against our volumes?
Kevin Martin: Sure. Until we get there, the easiest way to do that would be to just use the EAPG's on the relevant drug EAPG tab and apply the percentage that is on the top of the impact estimate tab.
Provider Chat Question: So, Natalie is asking, how often we update these percentages.
Kevin Martin: So, that's probably a much broader question, because there are some other things that do come into that. As we go forward with EAPG's, we will have to adjust all of the rates going forward, as we go to new versions of EAPG. So, it's more likely that we are going to do a complete re-weight to the entire list before we would for these individual drugs. Also, like I mentioned, the hospital engagement meetings, we have plans for a longer-term way to address drugs in the outpatient hospital setting. We currently are working on a different methodology for doing physician administered drug, fee schedule, which is an average acquisition cost methodology come a very similar to the way we do prescription drugs. At least the way we do prescription drugs is we do a quarterly survey of the pharmacy providers, they send in their invoices for drugs, and that goes through a vendor. So that is not information that the state ever receives. The vendor does a little bit of statistical analysis there to throw out extreme outliers and they create an average acquisition cost for each drug. This has been very successful and our prescription drug, and we are looking to implement it with our physician administered drug fee schedule and as part of that, we would also do a survey of the hospitals to receive that wide spectrum of real-time, or I guess delayed by quarter cost information of drugs. And then we can use that to figure out how we could make a hospital fee schedule. That would actually be based on actual cost, we wouldn't need conversions of billed amounts with cost to charge ratios several years after the fact, and that kind of thing. And it could actually account for things as they are entering the market as opposed to being several years after the fact. But that is a longer-term project because we have a couple of considerations there, one, we need to see how pervasive of a suite of average acquisition costs we can make because if we go to a fee schedule methodology, we need a rate for every drug. That is something we have with EAPG's because there's only about 20 of them, whereas if we go to sort of like a HCPC billing level, there's thousands. We need to have a rate for each one, so that we know it needs a backup, and we need to make sure everybody has it first, and that kind of thing. That is a longer-term process, we don't even have the funding to do the survey yet, let alone performing the survey, during the analysis to get the average acquisition cost, finding out where the holes are, figuring what we need to fill the holes, and presenting that kind of proposal.
Stakeholder/Provider: Have you considered just using ASP as your reference?
Kevin Martin: We looked into that, we are using ASP for our primary source of administered physicians right now, there are several problems with that. Because it is by Medicare, it is automatically missing all pediatric drugs, or a majority of them. And then, we use wholesale acquisition costs as sort of a backup for ASP. And that is actually a pharmacy measure. So, in both cases, you're using something that is meant for a different purpose to try to create something that is specific for the Medicaid world. And, you know, we're never going to have something that is totally specific, but the average acquisition cost would get as close to that. The other problem with ASP that we found with the physician administered drugs is that as we wrote that out, there were some circumstances where the providers that use the physician administered drug fee schedule cannot actually obtain the drug at the average sales price. And that is because of the way that the average sale price is derived, that is a self-recorded number from the manufacturer to Medicare. So, because

it is a self-reported number by the manufacturer, which it does have some checks and balances to it, but it's something that we don't have a lot of insight into and there are ways for it to be manipulated so that downstream consumer, being the provider, can't actually obtain the drug at ASP. So, that's just something that we found not only has holes in it, but then also doesn't accurately represent our provider population.
Stakeholder/Provider: I would like to encourage you, as we go down this path, to continue to look at reimbursing off the actual dose, which Medicare went to the hit pick models, to get 21 milligrams reimbursed for 21 milligrams. It is flat, so if it takes something to cost $20,000, and we are reimbursed 1000, it is very difficult for us. So, if we can get to that somehow, the method is already out there in standardized across the country, and you do your AAC or whatever your reference price is per unit, and you just multiply it out by your dose, which is something we all know today.
Kevin Martin: It would just be based off of the survey that we do in Colorado, as opposed to self-reported numbers from the manufacturer. But, the dosing and the units and everything would be the same. Again, that is sort of the ultimate goal and something we want to examine further. I can't say that is definitively what we are going to go to because we don't even have the AAC's yet, so that is not something I can say we are using this when I don't know what it is, but it is something that seems promising. It just might be a much longer-term project.
Stakeholder/Provider: You will do that survey for 340 B and non-340 B?
Kevin Martin: Yes, and we are also looking at other ways we can obtain 340 B, it's very difficult for us to receive ceiling prices, that is something that is changing and something we can get more readily now, that is also something that we are having difficulty I guess really understand because the source that we have has about 10% of the ceiling prices are what is referred to as paid pricing, when the 340 B calculation ends up with a negative number. Obviously, the wholesalers are not the prime vendor is not going to pay you to give you a drug. So, instead of having a negative ceiling price, they put it at one penny. But our understanding is that there is still actually a number that is being purchased that is greater than a penny, but as it shows up in our file as a penny, that results in something that we just don't know what it is. So again, just trying to figure out where those holes are and how to fill them.
It is first come first served, we are placing orders, so you might have it in the morning but not in the afternoon, it's very difficult.
Yes.
Elizabeth Quaife: There are some questions in the chat, before we get to those, on the downloadable files, it has been fixed, it's no longer PDF, it is the Excel sheet, so if you re-download it, you should have access to all of the sheets we are going over.
Provider Chat Question: Okay. So we have a guest that says, you are telling us that with thousands of different drugs, with hundreds of different dosing regimens, depending on diagnosis, patient weight, illness, severity, etc., all those variables are fairly accounted for in two only 20 or so EAPG classifications, this problem method for drugs, not accounting for upper end dosing regimens has been a long-standing problem since the implementation of the EAPG's, and are you also saying a separate drugs fee schedule is no longer in effect?
Kevin Martin: So, we just went over a lot of that, so I hope I answered some of that question. Those are the concerns that we do recognize with the EAPG's and why we are looking into other options that are dosing specific. Unfortunately, that is something that is going to take some time, like I said, I needed to get some funding in order to do this. So first we had to, overtime, as we had EAPG's and we received some example information from hospitals, that gave us enough information to look into it and to come up with some kind of plan to do. Which then gave us the ability to request funding to then go forward and have the funding available to actually develop a new model. And after we develop a new model, we will bring it to the group. It's just a very long-term process, is just not something that we had the ability to switch straight over to something else.
Stakeholder/Provider: What kind of dollars do you need for that funding?
Kevin Martin: It's a couple hundred thousand. For the vendor. The contract that would then do the survey.
Stakeholder/Provider: That is nothing, so it, if that is the limiting step, maybe we can get some donations.
Kevin Martin: Fortunately, and it's not just so much the dollar amount, because honestly, that has changed us, but our funding is all segmented, it's very specific to certain things. So, I can't just take, like, say reduce all the EAPG's by 0.001% to save us $100,000 and put that into a contract, I can't do that, that's not allowed. So, I have to specifically ask, and I can't even take money from one contract and put it into another. I have to request funding for a specific purpose. We talked yesterday.
[Laughter]
In the best-case scenario, and the timeframe, for if --

Yeah, the first, I guess it's there's obviously a lot of work before this, but receiving that funding, I'm fairly confident that we will, and that would then give us the funding as of July. Then, when July hits, that gives us the ability to go out with a contract, that takes about six months to procure the contract, and we can do the survey. Hopefully we can do both the survey and fixing whatever components we can identify, that is different between the prescription model and the hospital model, to try to account for those differences while the survey is taking place. But, that process is probably another success. And at that point, so I'm looking at somewhere in the latter half of 21, to bring a model to this group and at that point, we have sort of an open forum of the providers to then ask questions, poke holes in what we have come up with. Give us suggestions for improvements and that kind of thing. That process, I usually leave at least six months for that process. Usually ends up being more like a year, if something has a lot of problems with it, then it can take significantly longer. If we have something that is very robust to begin with and can fit into this model that we already have, then it could be shorter. But, let's say on the short end, that we have six months of provider dialogue, that brings us to the end of 21 and it takes me about another six months to get an authority to pay for that person. And that would mean going through the MSP rulemaking process and the CMS estate plan approval process. So, that would mean that, best case scenario, we are looking at July 2020.
Stakeholder/Provider: My perception is, going forward, when we finally get to the analysis and do this, that's going to be significant dollars from Medicaid to the organization, on a limited budget. But, if your budget doesn't increase to give you the hospital's, where you can get in, I was wondering if you were hitting any consideration to establishing a formulary, from our perspective, we just can't get everybody all drugs, we are having those conversations about where to retreat, what to retreat, and how do we treat.
Kevin Martin: There is something called the Medicaid drug rebate program, and this is the program that really it is built off of, so from Medicaid to reimburse for any drug, the manufacturer must enter into a rebate agreement with CMS. And the flipside of that is if the manufacturer enters into that rebate agreement with CMS, then they must provide the drug. So, there's not a way for us to actually create a formulary. We can't say there are certain drugs we will pay for.
Stakeholder/Provider: I mean, can you do restrictions on it though?
Kevin Martin: Yes, we can have restrictions, that is something that is sort of kicked around a little bit, that is something that we do anti-prescription drug role, the preferred drug list. It's but that is probably something we can look into in the hospital realm as well. So far, that has been something, when it is brought up, it hasn't been received very well, much like the other prior authorization requirements that were recently instituted to the hospital segment however, if that is something that would actually make life easier, that is something we can definitely look into. And sorry, there was a question a little while ago, backing way up to as far as getting additional funds out the door. Yes, whenever we do something initially, it has to be budget neutral. So, whatever average acquisition cost we come up with, we would have to do some factor on it to make it so that it is neutral to a we were paying before. However, then once we just have sort of a factor that is applied to something that is identified as the cost, that gives us a clear ability to make additional requests to reduce that, in order to get up to the actual cost. Because right now, if you look at the old methodology prior to October 2016, we were doing a cost settlement for outpatient hospitals, but it was 72% of cost. And that was due to the budget process. We had one number that just said, we are going to pay cost except for reducing it by 20%. When we instituted EAPG's, we added the neutral, so it was really intended to be 72% of the cost. We do have some more questions. Have we looked at the impact of 340 B on hospital costs, or hospitals that serve the higher portion of the Medicaid population are getting lower cost. Is this factored into the model? So, yes, because we are actually using cost information that is factored into the model... So, I guess you might be asking if it is factored in in a specific way? Sorry, we may have covered that already. If we haven't, or if I'm not getting good explanation right now, please just help me out and give me a little bit more and I will be happy to address it. Okay. I guess that is up to current, great. Okay.
Stakeholder/Provider: I have a question. And I guess this is for hospitals, so the long-term plan, the best-case scenario is July of 2022. Is there a way to get a validated way to get the cost in a point of time survey, like for now? Is that something that would be possible?
Kevin Martin: So, we did do that. Let's see, December 2018. And, that is how we were vetting this process of doing the average acquisition cost, we got a grant from the national Association of State health programs. But, in what we were doing with that grant was to try to develop this process of using a cost methodology, because like I said, we not only in Colorado use the average acquisition cost methodology for our pharmacy, prescription pharmacy benefit but that is actually a pretty widely used methodology, but nobody is using that for drugs and other settings. So, we wanted to examine whether it would work in other settings. And, going through that effort, we did find that with the grant and how long it takes us to pick her of an end everything, we had to do that survey in one month in December, which is not a great month, but it gave us enough response in order to be able to develop some good averages. And we did find that yes, overall, it is fairly

comparable to the payment we are currently doing. But there are some extreme variations on both the high and the low end. So really, with the average acquisition cost methodology, it would sort of smooth it out. So, we are not overpaying on some things that are cheaper versus our current methodology. And not underpaying for some things that are more expensive. Those two reports, they consider it to be public.
Stakeholder/Provider: Okay, I guess my question was, is there a way that a survey like that could be either redone, and I don't know because it sounds like I'm guessing the level of validation needs to be done is pretty significant, but could that be redone within the next five months? And, that could be more of the basis.
Kevin Martin: Yeah. At least on our end, it's sort of what I have been trained to work on, to see if there is somewhere I could get that funding to start that process a little bit earlier. Yes, in the moment we are in a holding pattern until we have additional funding, and if we have something to get us through July or something like that, the other issue, if we were doing that, it would be a very short-term contract where's the other one would be a long-term contract, but again, there are other logistical problems on our end. But I'm trying to get just a small amount of funding in order to just do a survey.
Stakeholder/Provider: And who is it that is the survey?
Kevin Martin: That is something we have to put out to contracting, so it does have to go through the RFP process, unless it's for a longer-term project, that is in the hundreds of thousands of dollars realm, that is something we have to put out for contract, I'm sort of hoping that if we are just going to do a survey for a very limited amount of money, that is something that would fall low enough we have to go through that 4 to 6 month time of RFPs and contracting. So, hopefully that is something that we can get done quicker but even that, I can't really say who that would be at the moment. The company that did the original one are the ones that do our current pharmacy agency, some other companies that do something similar, the prior vendor that was doing the pharmacy AAC was Mercer and I know that there are a small number of other companies that do it as well. Okay we have one more here, I realize 340 B reduced cost is factored into the model with the CCR's, but isn't that an additional discount to the medical Medicaid program with an additional 20% is taken due to the UD modifier? When you are looking at the cost of charge ratios and you are figuring out who is 340 B and then you are trying to account for what the weight would be, then you add 20% of the weight to account for the -20% for the 340 B calculation within the weight. Sorry, within the EAPG weight piece when you are doing the calculation. Sorry, maybe I didn't say that very well. So, when you look at the average cost per drug, and then compare that to another segment that has 340 B utilization, the cost per drug is going to tell you how much above or below it is. But then, to then make the comparison to what awake would be, you need to instate that cost by 20% in order to account for the 20% reduction when it is eventually used. Did that make a little more sense?
Stakeholder/Provider: Would you explain briefly for us, 340 B 20% reduction policy?
Okay, the 340 B reduction policy, if we backup to when we implemented EAPG's, this was actually something that we didn't really recognize as a big deal when we were looking at EAPG's because as far as we could tell, it was only three claims that were identified as 340 B in the old data set. So, in that point of time, we sort of thought that all we needed to really do was go into the rebates and check to see how much we received with rebates on average for drugs, and that was about 50%. That is where we came up with the original 340 B 50% discount. We came to recognize after we implemented the EAPG's that 340 B is much more widely used within the hospital community, and that 50% was way too much. So, the way that we came to 20% instead was again, with the Medicaid drug rebate program, there are two main percentages that are used for a rebate, that is 17.1% for the pediatrics and there was one other drug cutting or that I can't remember off the top of my head. And for all other drugs, except for very rare like orphan drugs, it is 23.1%. So, taking it straight average of those two would be 21.1%, but to round it off, making it a nice clean 20% discount. And that is what we changed to. I believe that was the end of 17, early 18.
Andrew Abalos: March 2018.
Stakeholder/Provider: Thank you. And that is when we got to the 20%. Is that what you were asking for?
Kevin Martin: Yes. Okay, more questions either in or out of the room?
Provider Chat Question: So, Stephanie asks, drug waste, modifier JW, I can't find any other state that has implemented EAPG's that do not pay drug waste or reduce payment when waste exists. Why doesn't Colorado pay waste associated with single-dose vials, it's a real cost of care for hospitals. This problem is extensive in the chemotherapy area.
Kevin Martin: That is a little bit outside the realm of what we are talking about here with sort of a re-weighting exercise but that is something we are happy to address with sort of a longer-term project of talking about drugs in general. I honestly do not know where that came from, that has just been something that has been on our books for a very long time. And yes, we can definitely look into that.

Stakeholder/Provider: It's interesting that you are requiring us to submit the water fire for the waste, but it appears that nothing is done with that information. How are you using that at all? Why is there that requirement?
Kevin Martin: So, my understanding of this, and this is a little bit outside, I just know that it is sort of a billing requirement type thing, so yes it is our policy that we don't pay for the unused portion of drugs, and it is billed because that is our requirement of billing, and we don't Inc., and yes, I understand it is a burden. However, I will say that having that information is still relevant because this is something that we are going to examine to then pay for the unused portion. We do need that information. Because if we don't have that information now, if we look into trying to remove that stipulation and we don't have the information, then it is an undetermined increase to the effect of our payments and that is not something that we can submit as we need who knows how many more dollars in order to change this policy. Still --
Stakeholder/Provider: I'm just curious that we are submitting the data within a black hole.
Kevin Martin: Yes, and I know that we do that sometimes for a lot of things, but I guess a great example of this is the implementation of the EA PJs -- EAPG's, and because we didn't have that information to begin with, that led to us making an improper assumption because it was not identified within our historical data. So, without having that information to start out with, we can't possibly do something accurate in the future. Any other questions? Either in the room or online?
Stakeholder/Provider: I'm wondering, so a couple things, I don't know if this is the right place to do this, but I think I heard a couple things today, questions out of, is it possible to do a point in time survey that has something that I would love to talk more about before the next meeting. And then, is there a way to share hospital specific information and I know I just said, can you share with every hospital on the information which is a lot of work but I don't know if that really gets to the cost to charge ratio, the panel of drugs that each hospital has, and I don't even know exactly where that's going but can you share that level of specific information that would allow hospitals to look at things. And it's still in my mind to the idea of how hospitals potentially split into peer groups. From what I understood so far, that does get more at kind of how we could potentially, how you all could potentially split. If that is the right direction.
Kevin Martin: So, I guess we can't, or, sharing hospital specific level information --
Stakeholder/Provider: I'm sorry, I meant just with hospitals, to their own, and I'm not there yet, but if we do kind of develop some different criteria, and being able to share with it, with each individual hospital, like across the different criteria, hearing your impact, that is. Like with each hospital, getting their own data.
Kevin Martin: Each hospital should get their own data already, but if there are things they are having trouble getting out of their system, that would be helpful for us to then do it. We can attempt to do that. Granted, having 100 and hospitals and pretty much we have Andrew to do that in the next two weeks while all of a sudden trying to develop something that we can share in that broader spectrum is a really big ask. But, if there is something that you have a question about, feel free to send it to both Andrew and I, and we will try to figure out something that we can do while we are responding to that as much as we can. We can share more information in a broader sense, because that is something hospital should have on their own, but I understand there are resource constraints and sometimes you don't know how we are looking at it versus how you can look at it and that kind of thing. We will do what we can.
Stakeholder/Provider: And that is actually the point, I appreciate that, looking to share more broad data, and if there's any template that is created that we can help distribute or something for hospitals, that makes it easier for hospitals to look at their own data. But you can put your own data in, and this is one model in this is another, and this is the impact, we are happy to share that.
Kevin Martin: I realize there might still be questions, so why don't we go ahead and take a 10-minute break, and we can give people a chance to think about information that we presented in the first hour, maybe formulate some other questions, I don't want to just cut it off after a 30 second pause for questions. So, we are going to take 10 minutes, coming back at, I will say eight minutes, and come back at a quarter after.
Closed Captioner: [The event is on an 8-minute recess. Captioner on standby an 8-minute recess. Captioner on standby]
Kevin Martin: Okay everybody, we are back sorry that we are just a minute late here. We were trying to get the screen back up and running, but I would like to go ahead and open it up to questions, either in the room or in the chat. Okay. If you do have something that comes up after the fact, oh, yes, thank you.
Stakeholder/Provider: So, we've got cost to charge ratio based on cost 73, pharmacy cost, 340 B, whether or not incorporates 340 B, I think that is whether or not it is the handle of the drugs, whether it is rural tPA or a large percentage. We've got something, I guess, what are the ways that you could potentially put it into peer groups? So, so say you got all that information, that is something I don't know yet, so I just wanted to see.

Kevin Martin: So, that is a much more robust way to do what we are talking about here. That also magnifies the potential issues that you have with transforming the cost, using billed charges and cost to charge ratios and the different ways that hospitals will map revenue codes to the cost centers. I realize there is variation there, but we are using the best information that we have available at the moment. Now, hopefully, because there is a cost center that is pharmaceuticals, that is making it as much as possible, but when we start breaking it down smaller and smaller, those problems, or those issues that begin to average out more at the grand scale can lead to variations that are more apparent, at a more granular scale. So that is why we are trying to stay away from that with just this interim fix because this is just an interim fix, I recognize that there is a difference there and we are trying to do something that is just, to put a Band-Aid on the system that we have while we work on a longer-term solution. Now, breaking it down into more granular, yes, could be a more accurate way of actually developing a different, not just a straight across-the-board percentage change for all the drug EAPG's, but maybe create this EAPG needs to shift by 20%, and another one needs to shift by 2%, and another one 100%, or something like that.
Stakeholder/Provider: I was actually looking, I'm not an expert on this, I might be miss speaking but, is there a way to cost charge ratio, TBG something about the panel of drugs, panel is not the right word, the makeup of the drugs that that hospital is currently, or historically using, and come up with one and maybe it is weighted, I'm not sure, but come up with one number, and for every hospital, you result in this one number. Then we have a conversation of okay, within this hospital, then you know how you divide it.
Kevin Martin: The biggest problem with that, again, when we are talking about the critical access, they have a utilization amount that is so small, that a hospital by hospital basis, breaking it down that far is inaccurate because we know that on a hospital by hospital basis, the history is not a good reflection. We talk about somewhere like Lincoln or something like that, they have a tiny utilization, so this might be, one year they have three heart attacks, the next year, they might have two broken legs, it's so different from year-to-year that you can't necessarily use individual hospital history to predict the future, that is why we aggregate the critical access hospitals into one, sort of hoping that in aggregate, the small utilization at each individual rural hospital, or critical access hospital represents sort of an aggregate, the future of what will happen at critical access hospitals. Because we do see, at least the larger utilized costs in the urban area, that history still isn't a predicted future, but they have wild swings of various utilization when you're and very inexpensive utilization next year.
Stakeholder/Provider: I know this is more of a holistic picture but how do you see this interim fix impacting the long-term project that we are talking about?
Kevin Martin: So, I would hope that it has very low impact at all. Because really, the long-term, I guess goal here is to use the cost based off of surveys and that kind of thing. Now, the only way that I can really see it impacting that is if it affects utilization patterns significantly across the board. From what I understand anecdotally is that currently hospitals aren't necessarily changing or tried impact the utilization patterns that much from EAPG's. They are just taking the hit when there is an underpayment. So, theoretically, there's not going to be again, a utilization changes by us trying to correct the course of all of that. So hopefully that just means that we are fixing some of the disparities that are occurring at the moment. Anybody else online or in the room with questions?
Elizabeth Quaife: We did get a request via email to share the closed caption as a downloadable document on the webpage, so we will have to discuss that and make sure it is proper format, but we will look into that because a lot of people do like the questions and the answers.
Kevin Martin: Yes, we can definitely look into that. It is pretty good, however, every once in a while, there's a couple of keywords, especially jargon and acronyms that can end up jumbled within the closed captioning, but overall, they do a really good job. Just, if there something that seems off, please just assume that you need to go ahead and check the recording to figure out what was actually said. Okay. So, one thing that I have received a request for is to just take a verbal poll of the hospitals on this aspect. If I could get everybody online to just go ahead and unmute yourselves with *6. I will give people just a little bit of time to do that. And I don't need anyone to identify themselves or anything. And I'm sorry for the participants in the room. But if you could please just raise your hand. I'm going to ask two different questions, as of right now, if you support us going forward with the, exactly what we have, or if that is going to change your mind, if you receive additional formation in the second one. So, what I'm trying to get at, an understanding if this is something that is generally supported or not, and how sensitive it is to the new information that will be provided at the next meeting. So, first one is, in general, do you support this proposal as it is? Can I get the "yays" on the phone? Okay. And, in general, the proposal as it is, who does not support it? So, can I get the "nays?"
Stakeholder/Provider: Nay.
Stakeholder/Provider: Nay.

Stakeholder/Provider: Nay.
Kevin Martin: Okay, and I have one comment in the chat for support. And then for the future, the changing of your position with additional information supplied at the next meeting. So, potentially changing your position at the next meeting with additional information, can I get the "yays?"
Stakeholder/Provider: Yay.
Stakeholder/Provider: Yay.
Kevin Martin: And for the potential changing of position with potential information at the next meeting, so this would be like you already said no, and you are going to continue to say no regardless of additional information. Can I get the "nays?"
Stakeholder/Provider: Nay.
Kevin Martin: Okay. So, I do have one other yay for support on a previous one.
Provider Chat Question: And, let's see, I have one comment here about family health West, it would be more ideal if the waste was paid for in the implementation was quickened to 2020.
Kevin Martin: I want to say, we are talking about right now is just about the EAPG re-weighting and that is something that is done into the 20. The longer project is definitely something that just cannot happen in 2020. There's too many aspects to get through it this year. But we are looking into things to try to speed it up.
Stakeholder/Provider: Is it feasible to add additional EAPG categories, will be considered to be the higher weight?
Kevin Martin: That is something that we have suggested to 3M. This is their software at the end of the day, we don't have the ability to make those types of adjustments on it. And also to take advantage of something like that, we would need to move to an entirely new version of EAPG's and do it over, we relay, and we also have a going forward base rate methodology which is something we touched on in the past, but just for people that haven't been participating before, and need a reminder, the base rate methodology right now was set to have a revenue neutral corridor around 10%, or not revenue corridor, a cost neutral corridor from 10% to the cost to charge methodology to the EAPG methodology, so we have sort of peer group average base rates, so if you fell outside of that 10%, we adjusted it up or down just base of the neutrality for individual hospital so it's not really sort of set on a base rate methodology that we can have, we need to develop a new base rate methodology before we can move to a new EAPG version and do a re-weighting, so that is again, a very long-term project. Assuming that it was there, because that is something that has been kicked around by 3M, but I haven't heard that they have actually committed to doing that yet. Okay. So, let me just summarize what I heard from the voting, I heard overall, that people do not support the proposal as it is, but they could change their minds with additional information. Yes, I know that there are some people that already support it and some people that don't support it, but that is what I heard overall from a series of questions. So, we will work diligently in over the next two weeks to bring you additional information, if anyone has suggestions, please feel free to reach out to me or to Andrew, or you can even go through your Association. Anyway, that makes you feel most comfortable. And we will help you, I will ask that if you have additional information that you would like to see at the next meeting to try to get a hold of us sooner rather than later because it is going to take us time to develop that. So, if we start receiving stuff on the 12th, that's probably not going to be incorporated into the meeting on the 14th.
Stakeholder/Provider: Kevin, I don't know if you're able to do this but, and to have it all in my notes, but can you summarize with that additional information is that we will be looking at?
Kevin Martin: I'm trying to figure that out, just in my head, because it was added with additional information yesterday and today, so I don't have everything figured out.
Stakeholder/Provider: That's fine.
Kevin Martin: However, I know one thing that we sort of looked at in the past is, I'm tempted to draw, but we have so many participants on the phone, I'm going to try to explain this verbally. If you look at each individual EAPG for the two categories, like critical access at a system hospital, you can create a histogram or distribution of the cost of the drugs that are used, and I'm using my hands, which is not going to help the people on the phone. The distribution of the cost of the drugs that are utilized within EAPG, and so looking at that distribution by EAPG for the two different groups and comparing that distribution to the overall average can give you a visual of how the different groups have different utilization patterns by EAPG. And that is something that wouldn't have numbers or anything like that. So, I'm contemplating that it wouldn't have PHI either, I would have to scan it a little bit because obviously if I just use raw numerical numbers, you are going to have a big distribution for the urban hospitals and a little tiny distribution for the rural. So, they'll have to be scaled to the same size when you look at them in sort of a distributional visual. But I think that is something that could help people understand.
Stakeholder/Provider: Could you provide that for the other two categories that are held neutral as well?

Kevin Martin: I can. The problem with the other two categories is that we start getting into low-volume, and just different types of hospitals, like with the noncritical access rural hospitals, they are still fairly different, like you have some sort of moderate sized hospitals and some large role hospitals, so they don't necessarily mesh together, and I can't put the independent, urban and all the rural hospitals.
Right.
Even separating it into those two, and even thinking about what we have for the independent urban hospitals, you have very different types of hospitals there. So, when you talk about, and I apologize but I'm going to call out the individual hospitals here, Boulder, Parkview down in Pueblo, you got Denver health, and community and Grand Junction. So vastly different areas in sort of a vastly different clientele, so when you try to mesh those together into one category, it just creates a distribution that is really meaningless because it is a conglomeration of so many different types of things.
Stakeholder/Provider: Okay. Because I think, well, got it.
Kevin Martin: Yeah. But, I am open to trying to figure out a way to do that. Again, so looking at it, once we look at that shift from overall average cost per drug to comparing it to the people that we have pulled out. That just created a really wonky number. So again, all of them put together, so understand why it's wonky. We pulled them out and said this is either relevant or whatever, it just wasn't putting the resources, like, I don't know, really investigating that group as much. We have a couple things online. So, let me try to go into that. A request for the transcript. Late suggestions potentially for further information at the next meeting, several other EAPG states have high-cost add-ons to account for dosing, etc. Check with states like Ohio, Virginia, etc., just a thought, thanks. And I will say that is another thing we have looked into with those other states, and another one I know of is in New York and really, those add-ons tend to be something like a fee schedule. So, that's one of the paths that we have examined as we talk about drugs in general. None of those, the solutions that were used in other states, none of those were something that was easy to implement in the year term. And, when we are choosing a long-term approach, we have to choose one of them to commit our resources to. At the moment, that is this average acquisition cost methodology. I guess we can bring more information about that as we continue to talk about drugs, to see if maybe one of those other solutions does make more sense. However, that is a slightly different conversation because for this point, it's not something we can do right now. Okay, I've got another support, but also wanting additional information, so we have a couple of those. And another support but would like additional information. So, a couple votes there, but it sounds like in general, everybody wants more information. Great, we will do that. But now it sounds like it's maybe a little bit more split between the support and the nonsupport. And there's another comment, that was you, Elizabeth, sorry. Okay. Opening it back up to the group for another second here, seeing if there is other comments or questions before we break out. Again, please feel free to reach out for us via email and we have all of our contact information up there on the screen, and again, the one thing that I would really stress is that we need that very soon so we can incorporate it into the next meeting. I would say by mid next week, that is going to be something that we can address in some form or fashion, late next week, we will do our best and after that, it's highly questionable whether or not we are going to be able to incorporate it.
Stakeholder/Provider: I just want to say thank you. I originated from CHA so thank you.
Kevin Martin: Welcome. Okay. I will give everybody about 20 minutes back. Thank you.
[Event Concluded]