HOSPITAL STAKEHOLDER ENGAGEMENT MEETING

Friday, July 9, 2021
1:00 PM -4:00 PM

Location: Online Only

<u>All Hospital Zoom Meeting</u>: Dial Toll-free 1 877-853 5257 / Meeting ID: 987 2946 5513 / Passcode: 353674

Topic Suggestions, due by close of business two weeks prior to the meeting. Send suggestions to Jonathan.Rempfer@state.co.us.

Welcome & Introductions

- **Thank you for participating today!**
- We are counting on your participation to make these meetings successful

About this Zoom Meeting

- We will be recording this meeting.
- Please speak clearly when asking a question and give your name and hospital
- A recording of this meeting will be posted to the Hospital Engagement Meeting website for later viewing.
- **Hospital Generated Topics:** Please contact Jonathan Rempfer at Jonathan.Rempfer@state.co.us with requests to cover questions or topics in future hospital engagement meetings. Topics requested fewer than 2 weeks before the next meeting may need to be pushed to future meetings depending on availability of personnel with knowledge of those topics.

Thank you for your cooperation

AGENDA

July 2021 Hospital Stakeholder Engagement Meeting Topics
Kim Bimestefer– Update on Centers of Excellence – 46:50 (delayed)
Contact for RAE Questions/Issues – 7:10
Hospital Transformation Program (HTP) & Rural Support Fund – 9:41
FFY 2020-21 CHASE Reconciliation – 8:10
FY 21-22 State Budget Action Inpatient Base Rate Update – 14:05
Draft Inpatient Base Rate Methodology Discussion – Survey Feedback – 15:50
Pain Stimulators – 38:10
Outpatient SUD Service – 39:31
– Timestamp - hr : min : sec

AGENDA cont'd

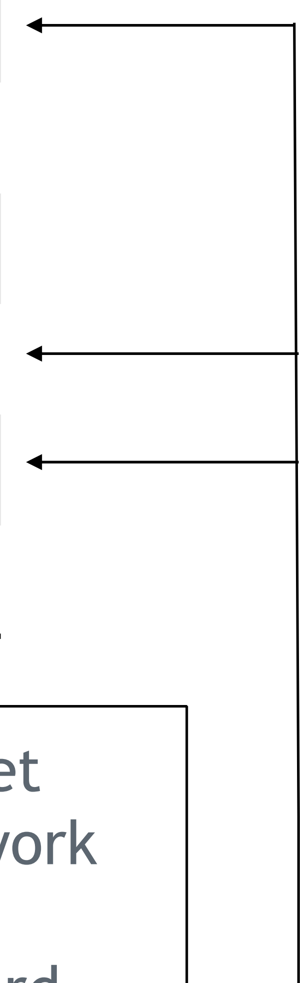
July 2021 Hospital Stakeholder Engagement Meeting Topics
EAPG Module Update – 40:40
PLA Codes – 42:05
Outpatient Drug Re-weight Discussion – 1:08:05
EAPG Rate Updates – 1:09:46
Transition to Version 3.16 of EAPGs – 1:12:20
Proposal Configuration Changes – 1:26:08
Packaged Codes – 1:30:28 – Timestamp - hr : min : sec

Combining of Rural and General Hospital Engagement Meetings

- The need for separate Rural Hospital Stakeholder Engagement meetings has been periodically assessed and it has been decided to discontinue them.
- The rationale for this decision is that topics intended for discussion during both the rural and broader hospital engagement meetings are identical, yet questions and concerns expressed amongst providers during these meetings are not always the same.
- The Department believes there are potentially harmful effects to hospital representatives only attending either meeting as responses to questions and/or concerns have impacts amongst the entire hospital community.
- There is also efficiency gained in having a single meeting for the purposes of later review.
- While further rural hospital-specific meetings are not currently scheduled, the Department remains amenable to dedicated meetings to this subgroup when sufficiently justified.

Dates and Times for Future General Hospital Stakeholder Engagement Meetings in 2021

Dates of Meetings	Meeting Time
~~January 8, 2021~~	~~1:00pm-4:00pm~~
~~March 5, 2021~~	~~9:00am-12:00pm~~
~~May 7, 2021~~	~~9:00am-12:00pm~~
~~July 9, 2021~~	~~1:00pm-4:00pm~~
September 10, 2021	1:00pm-4:00pm
November 5, 2021	9:00am-12:00pm



The agenda for upcoming meetings will be available on our external website on a Monday the week of the meeting.
https://www.colorado.gov/pacific/hcpf/hospital-engagement-meetings

Please note the offset dates and times to work around holidays AND Medical Services Board

STAFFING UPDATE

Kim Tolchinsky
Hospital Policy Specialist

Tyler Samora
Outpatient Hospital Rate Analyst

Requested Topics from Hospitals

Update on Centers of Excellence

Kim Bimestefer

Requested Topics from Hospitals

Contact for RAE Questions/Issues

Brooke Powers
ACC Program Specialist
Brooke.Powers@state.co.us

FFY 2020-21 CHASE Reconciliation

- Awaiting CMS approval of State Plan Amendment
  - Response due August 11th
- Reconciliation to begin in August and last two months
- August transaction date pushed to the third Friday (8/20/21) to accommodate the late federal approval
- Overview letters will be sent in mid to late July

HTP – Rural Support Program

- Awaiting CMS approval of State Plan Amendment
  - First $12 million will be paid in the months of August and September 2021 along with FFY 2020-21 CHASE fees & payment reconciliation
  - Funds for FFY 2021-22 will not be available until reconciliation next year and will remain at $12 million
- Use of funds
  - As described in hospital attestations
  - A new attestation will be required for each program year to document what the funds were used for in the prior year
- Contact Nancy.Dolson@state.co.us or HCPF_RSF@state.co.us

HTP Update

- Hospital Workgroups
  - Will meet again on Thursday, July 15th
    - ✓ Rural hospitals at 10am
    - ✓ Urban hospitals at 1pm
  - Topics: application submissions, hospital index data refresh, and implementation plan
- Application Period
  - Applications were all due by 4/30/2021
  - 100% of all eligible hospitals submitted an application
  - Currently under review with the Application Review Oversight Committee (AROC)
  - Application period will end on 7/31/2021

HTP Update

- Implementation Plan Period begins 8/1/2021
  - Due by 9/30/2021
  - Office Hours have been established to help answer questions from hospitals every Friday morning beginning 8/6/2021 from 9:30am to 11:00am
- Hospital Index Data Refresh
  - The data spans calendar year (CY) 2018 and CY 2019
  - New dashboards are available to each hospital’s attributed user

FY 21-22 Inpatient Hospital Base Rate State Budget Action Update

- All Inpatient base rates received a 2.5% increase from FY 20-21 rates as set by State Legislature.
- The 30-day review period ended June 30, 2021. The Department has sent the State Plan Adjustment (SPA) to the Centers of Medicare and Medicaid Services (CMS) for approval hospital rates for FY 21-22.
- As soon as we receive approval from CMS, we will input the new rates and reprocess all claims to apply the adjusted rates.
- Managed Care GME payment rates will remain the same for FY-21-22 as they were for FY 20-21 since rates were not re-based for this year.

Draft Inpatient Base Rate Methodology

Survey Feedback received from various hospitals – Thank you!!

Quick note: We are going to review the feedback in aggregate themes since many hospitals brought up the same/related issues. Seemed to get majority of response from system hospitals.

- Additionally, we will concentrate on the actual add-ons and reasons we are using them since that seems to still be a sticking point. We'll have to address the size of the add-ons after this

Color-Coded Add-On Template	
	CHA/Hospital Driven
	HCPF Exec Level Driven
	HCPF Driven
	Existing Add-Ons

CAH OR LOW DISCHARGE HOSPITAL ADD-ON
Independent (IF HOSPITAL SYSTEM = NULL, THEN X%)
Pediatric Add-On (If Digits 3-4 in Medicare ID=33 (Pediatric Hosp), then X% Add-On)
Medicare Readmission Reduction up to 3%
Medicare HAC Reduction = 1%
PAYER MIX ADD-ON
NET PATIENT REVENUE (NPR) ADD-ON
OPERATING EXPENSE ADD-ON
NET INCOME ADD-ON
GME COST ADD-ON (10% of Medicaid Cost Per Discharge) (FY20-21 Amounts)
Operating IME ADD-On for PPS Hospitals who Qualify
Capital IME ADD-On for PPS Hospitals who Qualify

Draft Inpatient Base Rate Methodology

WHY are we changing the base rate methodology?

- We, again, heard that hospitals were unaware of why we are updating the base rate methodology and want to keep it as is.
  - The most recent explanation of WHY we are doing this was presented during December 11, 2020, Hospital Engagement Meeting and briefly again in the March 5, 2021, Hospital Engagement Meeting. Additionally, we have mentioned that we will need to explore a new base rate methodology during past Hospital Engagement Meetings:
    - January 10, 2019, September 7, 2018, May 4, 2018, March 2, 2018 & January 12, 2018
- Receiving the DRG Cost Disclosures from hospital intermediaries (specifically Novitas) has been like pulling teeth over the years – shouldn't be this way.
- DRG Cost Disclosures are incomplete and have harmed hospitals who rightly deserved a Low Volume Payment. We must get extra information from Novitas to calculate low volume payment.
- Medicare does not build rates for Non-Prospective Payment System (PPS) Hospitals. They are paid on a cost basis.
- Medicare Base Rate Methodology is not transparent and hard for us to explain what happens from year to year when hospitals ask us why their Medicare base rate changed.

Draft Inpatient Base Rate Methodology

ADD-ONS

CAH or Low Discharge Hospital Add-on:

- We've heard that there are concerns that paying an add-on for a low-discharge hospital is basically something that should be covered by disproportionate share.
- Disproportionate share is not equal to low discharge.
- In current methodology, we allowed hospitals with under 21 discharges to receive their peer group average which increased their based rate. We do have a few small rural hospitals that do not qualify as critical access hospitals.
- We still see a need for the low discharge add-on and may narrow the number of hospitals that may qualify while applying the add-on using a graduated scale.

Draft Inpatient Base Rate Methodology

Independent vs System Hospital Add-on

- We received some feedback from hospitals that disagreed with this add-on.
- Independent hospitals do not have the same support or market advantage as system hospitals.
  - Research shows that when independent hospitals are purchased by a system, the prices of the services provided by that hospital increase, but quality doesn't necessarily increase.
  - The research further shows that system hospitals margins are also dramatically higher than independent hospitals.
  - The Department's position is to help preserve independent hospitals in the State of Colorado.
- We will be retaining this add-on. Although, the size and scope of this add-on is still yet to be determined.

- National Council on Compensation Insurance. (2018, July 11). The Impact of Hospital Consolidation on Medical Costs. www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx.
- Schmitt M. (2018, August). Multimarket Contact in the Hospital Industry. American Economic Journal: Economic Policy, Volume 10. doi.org/10.1257/pol.20170001.
- Beaulieu, N. (2020, January 2). Changes in Quality of Care after Hospital Mergers and Acquisitions. The New England Journal of Medicine. doi.org/10.1056/NEJMsa1901383.
- Department analysis of Medicare Cost Report data.
- Department analysis of dataset from White and Whaley. (2020, September 18). Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative. RAND Corporation. doi.org/10.7249/RR4394.

Draft Inpatient Base Rate Methodology

Pediatric Add-on

- We'd like to just reiterate that we wouldn't normally agree to add this on to the base rate because we feel it needs to be applied at a claim level.
- However, the Department is unable to institute this at a claim level with our current system resources. We will be working toward making that possible in the future.
- The Department understands that equipment to treat children results in higher costs, but we are unable to quantify exactly how much higher those costs are.
- We have been told the "test" 10% that was used is insufficient. What numbers can be provided to show what the size of this add-on should be?

Draft Inpatient Base Rate Methodology

Readmission and HAC measures from Medicare

- Several hospitals have declared that these measures are duplicative of The Hospital Transformation Program (HTP) and/or the Hospital Quality Incentive Payment program (HQIP) run by Special Financing.

- The Department has addressed this issue previously and maintains that all hospital payments have quality measures applied to them. They are not duplicative.

- Additionally, these measures have been present in our inpatient base rate payment methodology for many years and will continue to be present going forward.

- We are currently going to continue the Medicare-based quality measures until such time that we can focus on making the measures Colorado Medicaid specific.

Draft Inpatient Base Rate Methodology

GME, IME, Wage Index Adjustments & Geographic Adjustment Factors:

- Hospitals overwhelmingly agree with these measures being part of the draft inpatient base rate methodology.

- Feedback was somewhat incomplete and mentioned using National Statistics with no links.

Draft Inpatient Base Rate Methodology

A general statement regarding Cost Report financial measure add-ons

- Payer Mix, Net Patient Revenue, Hospital-Only Operating Expense & Net Income Add-ons are unpopular to some of the responding hospitals.

- Colorado hospitals are among the highest paid in the nation.
  - Prices did not drop when uninsured rates dropped with Medicaid expansion and prices didn't drop when Medicaid payments increased with CHASE.
  - Colorado pays hospitals with base rates and supplemental payments and these payments need to remain in equilibrium.

- These measures are being utilized to identify the hospitals who have managed to keep costs, profits and revenues in balance.

Draft Inpatient Base Rate Methodology

Excerpt from Colorado Hospital Cost Shift Analysis – January 2020

(Executive Summary points page 4)

1. The cost of health care has gone up much more sharply in Colorado than nationally. These increases are driven primarily by high hospital prices. In fact, on average, Colorado hospitals charge some of the highest prices in the country.
2. Hospital profits have increased by more than 280% between 2009 and 2018, from $538 to $1,518 per adjusted discharge.
3. Colorado hospitals' prices went up far more sharply than the growth in patient volume. Colorado hospitals' prices grew 71.3% between 2009 and 2018 (7.8% per year) while adjusted discharges* only grew 16.6% (1.8% per year).
4. Cost shifts are driven by strategic hospital decisions, not by shortfalls from public insurance.

Draft Inpatient Base Rate Methodology

Payer Mix

- We just want to mention that hospitals have said that government payers don’t cover hospital expenses which is why we included both Medicare & Medicaid in the measure.

- One hospital suggested that the measure should be based on Medicaid only (not Medicare & Medicaid) and focus on hospitals with >40% Medicaid patient load to receive the continuous add-on.

- It has also been suggested that Payer Mix as a proportion to gross charges may be a better measure.

- The Department is open to the above two suggestions pending further review.

Draft Inpatient Base Rate Methodology

Net Patient Revenue

- After feedback, the Department will pursue Profit Margin as a better measure of hospitals in need.

Net Income

- No specific complaints about this add-on but is generally wrapped in with the three other cost report financial measures.

Hospital-Only Operating Expense

- It has been mentioned that the Provider Fee may be included in this measure and our preference would be to remove it.
- We will review this add-on more thoroughly and determine if it will be modified or replaced with a different measure.

Draft Inpatient Base Rate Methodology

Next Steps:

- The Department will work on researching alternative measures for the add-ons we discussed as well as setting the parameters around each of the add-ons.

Questions or Comments?

Pain Stimulators

- Currently identifying unbundled DME codes that are not open for enrolled DME providers including HCPCS codes L8679 - L8689
- When the analysis is complete, the claims system will be updated via transmittal
- Some codes may require prior authorization
- Updates will be announced via provider bulletin and the September Hospital Engagement meeting

Outpatient SUD Services

- Outpatient SUD services were denying billing RAE.
- The resolution to this issue is resolved and affected claims were reprocessed on 6/18/2021.
- For more information on billing SUD Benefits, refer to the Ensuring a Full Continuum of SUD Benefits web page.
- We appreciate you bringing this to our attention.

Please contact Janna Leo with any questions.

EAPG Module Update

- 3M Released v2021.2.0 on June 24, 2021
- Gainwell installed into MMIS on June 30
- Applies quarterly CPT/HCPCS Updates
- No Claim Adjustments Required
- Still using version 3.10 of EAPGs

EAPG Drug Re-weighting Update

- Balances payment for drugs provided in outpatient hospital setting to reflect cost discrepancies in hospital groups, effective June 1, 2020
  - See EAPG Drug Re-Weight Meetings for more detail
  - 42.93% Increase for Critical Access, Medicare Dependent Hospitals
  - 3.47% Decrease for non-independent urban hospitals
- All authorities required for implementation

- Collaborating with Gainwell Technologies (formerly DXC) and 3M for system implementation with mass adjustment to follow

PLA Codes in Outpatient

- Proprietary Lab (PLA) Codes are reimbursed through EAPG Methodology for OP payment
  - Cost statistics currently in use in version 3.10 do not incorporate updated codes – therefore payment is based on EAPG grouping per 3M's assignments with no extra payment
- Department is reviewing how this will function in the version update – will require coordination with 3M depending on outcome

EAPG Drug Re-weighting Update

- Internal work with GWT for continued use of 3M modules (both APR-DRG and EAPG pricing), transition to version 3.16 of EAPGs

- Work cannot be completed in parallel
  - Claims impacted by drug re-weighting payment policy tentatively scheduled for reprocessing third quarter of calendar year

EAPG Rate Updates

- July 1, 2021 Rate Update: 2.5% increase to July 1, 2020 rates
- No update required to Code of Colorado Regulations (i.e. no meeting with MSB necessary)
- Rates posted to the Outpatient Hospital Payment web page
  - No appeals received to rates posted on June 1, 2021
- State Plan Amendment required for implementation – submitted to CMS late June – seeking approval in late September at latest

Transition to Version 3.16

- Intended to account for changes in outpatient hospital care delivery based on national data / statistics compiled by 3M

- Addition, Removal, Modification of EAPGs
  - CPT/HCPCS/ICD-10 codes can be moved to different EAPGS

- New set of cost weight statistics are developed by 3M based on changes in costs of procedures associated with EAPGs (National Weights)

Transition to Version 3.16

- Please see previous Hospital Stakeholder Engagement Meetings (beginning December 11, 2020)
  - Proposition of Methodology Used for Scaling 3M National Weights
  - Relevant counts of services impacted by updates to packaging and IP only lists based on historical utilization in CO, new EAPGs

Transition to Version 3.16

- Updating will require changes to rule and SPA
- Rule updates can only be made prospectively, as opposed to SPA (with some limitations)
- Due to interest in collaboration with stakeholders and thorough fiscal impact analysis, reconsideration of July 1, 2021 implementation date – likely implementation January 1, 2022

PROPOSED Configuration Changes

- Non-payable EAPGs
  - EAPGs 168 & 169 in Version 3.10 are not reimbursed in accordance with OP Hospital Dialysis payment policy
    - Hemodialysis, Peritoneal Dialysis
  - 3.16 has removed EAPG 169, aggregated into EAPG 168 (DIALYSIS PROCEDURES)
  - EAPG 168 will not be covered

PROPOSED Configuration Changes

- **Medical Visits with Significant Procedures**
  - Medical Visits and Observation will continue to not reimburse when General SP (EAPG Type 2) is present during visit
  - Other SP subtypes can have Medical Visits and Observation pay

PROPOSED Configuration Changes

- Medical Visits will also pay
- Observation can pay if billed with >8 hours
- Consistent with 3M National Weights
- Increases in non-packaged Medical Visits and Observation Payments
- Subtypes:
  - **21 - Physical Therapy & Rehab**
  - **22 - Behavioral Health & Counseling**
  - **23 - Dental Procedure**
  - **24 - Radiologic Procedure**
  - **25 - Diagnostic or Therapeutic Proc**

Packaged Codes

- 94640 – Respiratory Therapy - $5,370,470
  - Version 3.16 eliminates the significant procedure associated with this code – all codes moved to an ancillary EAPG

- 80053 – Organ or Disease Oriented Panels - $4,399,640
  - After looking at chemistry tests I&II, there were new EAPG codes created to better represent the services.

Packaged Codes

- 80320 – Therapeutic Drug Monitoring - $3,341,336
  - Several tests in therapeutic drug monitoring and toxicology groups were moved, based on additional research into the clinical definition of the procedures.

- 80048 – Organ or Disease Oriented Panels - $2,589,259
  - After looking at chemistry tests I&II, there were new EAPG codes created to better represent the services.

Packaged Codes

- 84484 – Level II Chemistry Tests - $2,495,861
  - The largest shift of procedures moved from Level II to level I. Several procedures had to move into newer EAPGs.

- 96360 – Pharmacotherapy Except by Extended Infusion - $1,847,274
  - Separating extended administration from non-extended infusion administration and considering injection drug administration as incidental. Several procedure codes moved between EAPG 110 and EAPG 111 based on these standards.

Fiscal Impact - September

- Fiscal Impacts to be introduced to hospital provider community during **September 2021 Hospital Stakeholder Engagement Meeting**

- 1,615,965 Claims Analyzed
- 7,895,265 Claim Details Analyzed

- Based on Calendar year 2019 Data – may not be reflective of actual gains or losses due to changes in service delivery

Questions, Comments, & Solutions

Thank You!

Kevin Martin
Fee for Service Rates Division Director
Kevin.Martin@state.co.us

Andrew Abalos
Manager of Facility Rates
Andrew.Abalos@state.co.us

Diana Lambe
Inpatient Hospital Rates Analyst
Diana.Lambe@state.co.us

Jonathan Rempfer
Specialty Hospital Rates Analyst
Jonathan.Rempfer@state.co.us

Tyler Samora
Outpatient Hospital Rates Analyst
Tyler.Samora@state.co.us

Raine Henry
Hospital and Specialty Care Unit Manager
Raine.Henry@state.co.us

Janna Leo
Hospital Policy Specialist
Janna.Leo@state.co.us

Justen Adams
Hospital Policy Specialist
Justen.Adams@state.co.us

Kim Tolchinsky
Hospital Policy Specialist
Kimberly.Tolchinsky@state.co.us