COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Colorado Rural Health Conference Meeting

October 24th, 2019

Known Issues

The Department has collected a listing of issues relating to rural hospitals through various forums, including its hospital engagement meetings and its surveys filled out by rural hospitals. Below is a collection of the various issues the Department has heard most frequently, including descriptions of each issue and their status.

Meetings with Rural Providers

Feedback: Rural hospitals need a better forum to convey their concerns to the Department

What HCPF has done:

The Department has initiated further communication strategies and forums for assisting with gathering concerns from the rural hospital community. Most recently this has consisted of a meeting scheduled for Friday the 25th of October at the CRHC conference in Stapleton. Rural stakeholder leaders and the Department had a meeting on September 30th to prepare for this upcoming meeting. The Department has also set up a separate website to contain the meeting materials for the rural hospitals.

Next steps:

Work with representatives from the rural hospital community to ensure that new meetings and communications are beneficial for rural hospital providers. Bimonthly meetings are planned for 2020 which will coincide with the existing hospital stakeholder engagement meetings, however, a definitive schedule needs to be determined.

Timeline:

The Department's next meeting dedicated to rural hospitals will be Thursday January 9th at 2pm. Information related to the meetings will be posted to the Department's website at https://www.colorado.gov/pacific/hcpf/rural-hospital-and-rural-health-clinics

Rural Hospital Definitions

Feedback received from providers:

Currently, the Department classifies hospitals as in Urban or Rural peer groups for outpatient hospital rate setting purposes. These classifications are determined based on the hospital's presence within a Metropolitan Statistical Area. This has led to some Critical Access Hospitals being identified as Urban hospitals. Additionally, this does not fully recognize the variation in cost profiles amongst smaller hospitals, which then produces payments which are out of alignment with certain hospitals' costs.

What HCPF has done:

The Department is researching more granular means of classifying rural hospitals, specifically adding in classifications for both frontier and resort hospitals. The intention behind these more granular classifications is to guide payment policy which will better distinguish between hospital cost profiles. A draft of the classifications has been distributed through various forums and is included below.

Draft hospital classifications:

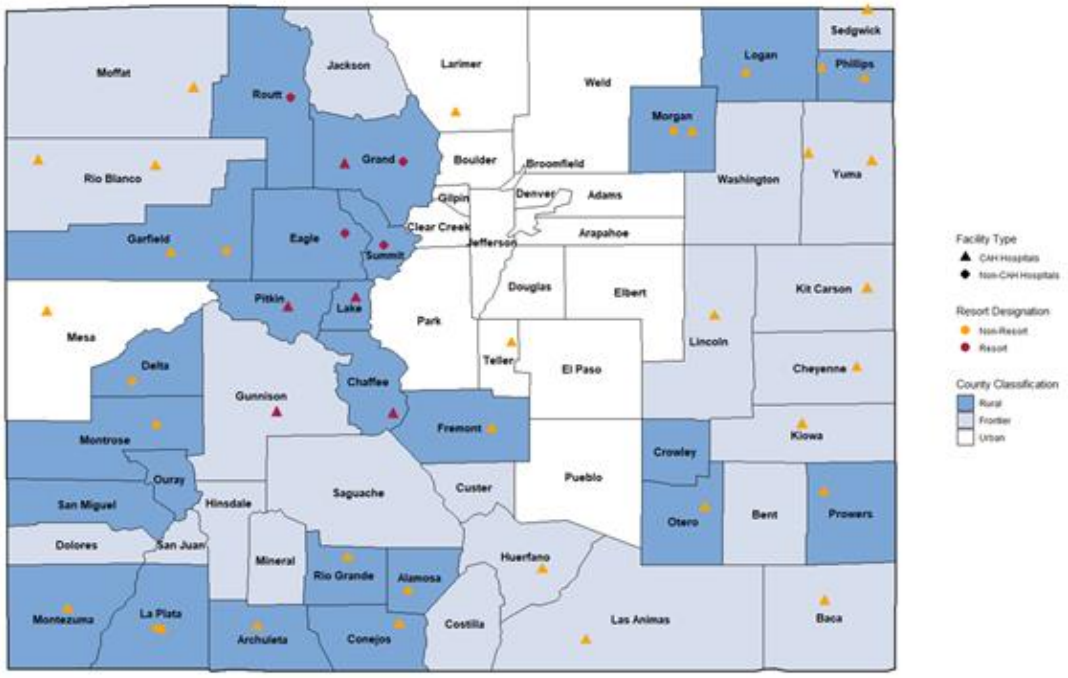
County Designations

- Frontier = any county with less than 6 people per square mile (based on land area)
- Urban = any metropolitan county with a city over 50,000 residents
- Rural = any non-frontier and non-urban county
- Resort = any county that meets both of the following criteria
    - Has 30% or more of the workforce (based on census data) in two tourist related industries:
        - Arts, entertainment, and recreation
        - Accommodation and food service
    - Contains at least one ski resort
- NOTE: a county can be designated as a resort county and one of the other three designations but the urban, rural, and frontier designations are mutually exclusive

Peer Group Classification

- Resort = any hospital that is in a resort county and is the closest hospital to a ski resort
- Frontier = any non-resort hospital that is in a frontier county
- Rural = any non-resort, non-frontier hospital that is also a CAH or located in a rural county
- Urban = any hospital in an urban county and is not a CAH

Colorado Rural Hospitals within County Designations



Next steps:

The Department is seeking feedback on this draft classification system, particularly around the resort classification. There are also a variety of other aspects that may need to be accounted for within the classification system. For example, GME, independent vs network hospitals, urban safety net, etc., which may result in the development of new peer groups. However, if only a small number of hospitals are affected by these any of these aspects then the Department will consider rate add-ons would be applied the base peer group rate.

Timeline:

The Department would like to have agreement on the classification system as soon as possible and ideally by the end of the year.

Reimbursement using the EAPG Methodology

Feedback received from providers:

The Department has heard from rural hospitals that the transition to 3M's Enhanced Ambulatory Patient Grouping (EAPG) payment methodology has been cumbersome and produced several challenges for hospitals due to lower up-front reimbursements compared to the previously used cost-based payment methodology. Additionally, some services seem to be significantly underpaid under EAPGs.

What HCPF has done:

The Department continues to evaluate the fiscal impacts from the transition from a cost reconciliation methodology to EAPGs. This analysis is still preliminary as it relies on audited Medicare cost reports but will increase in accuracy as more cost reports are completed. This preliminary analysis does confirm that there are certain claims that pay less under EAPGs than they would have under a cost reconciliation methodology. However, there are also claims that pay more than the previous methodology so that the aggregate is neutral. Unfortunately, this is not necessarily true when the entire claim set is broken down to the individual hospital level and becomes particularly volatile for hospitals with a low volume of claims.

The Department is developing a new hospital classification system so that this volatility can be addressed. Concurrently, the Department is working with its contractor (Myers & Stauffer) to develop a new base rate methodology which will be based on cost report information and the new peer groups.

Lastly, The Department has provided training regarding the 3M reimbursement methodology which is located on its Outpatient Hospital Payment* web page (see the June 1, 2018 webinar recordings and PowerPoint presentations) and will continue updating its billing manuals whenever new guidance is necessary. This training is intended to help hospitals understand the EAPG system better so that they can bill accurately and not receive unintended payment reductions.

*https://www.colorado.gov/pacific/hcpf/outpatient-hospital-payment

Next steps:

Hospitals should review the peer group classifications and provide feedback. The Department will continue to work on a new base rate model in preparation for agreed upon peer groups.

Timeline:

A draft base rate model should be ready for presentation around the middle of calendar year 2020 and will present this at the rural hospital stakeholder engagement meeting.

Outpatient Hospital Drug Payments

Feedback received from providers:

Outpatient hospital providers are not receiving adequate reimbursement for drugs.

Background:

The Department relies on the EAPG methodology for pricing drugs administered in the outpatient hospital setting. Drugs are grouped based on similar costs, meaning that drugs will be reimbursed at both greater than and less than cost. For low volume hospitals, this provides a challenge as payments that are lower than costs are not offset by payments that are higher than costs, presenting issues for hospitals that do not utilize the full range of drugs in an EAPG group.

What HCPF has done:

The Department has assessed several options for increasing payment to rural hospitals for drugs.
One option was for the removal of the 340B discounting factor, which currently pays 340B drugs at 80% of the EAPG rate. However, this only impacts a small group of rural hospitals and does not represent a holistic solution.

A second option was to transition the pricing of drugs to the Department's fee schedule. While this option has an aggregate positive payment impact to hospitals, hospitals with high base rates or hospitals that only utilize lower cost drugs would receive lower payments under this option.

The last option that the Department has assessed is for the re-weighting of the drug EAPG weights to more accurately cover costs for drugs provided in the outpatient hospital setting for its rural providers. This seems to be the most promising short-term solution but requires identifying the groups of hospitals that will have new EAPG weights. Because current weights are based on the average cost of all hospitals this means that when the weights are split one group's average cost (and weight) will be lower and the other group's will be higher.

There are other options that can be assessed as long-term solutions but those are dependent on developing new base rates and a new drug fee schedule.

Next steps:

The Department has decided to move forward with re-weighting its drug EAPGs to increase payment to rural hospitals. The exact groups of hospitals involved in the re-weighting need to be determined.

Timeline:

The new weights can be implemented 4-5 months after reaching consensus on the groups of hospitals to include.