

Hospital Provider Fee Oversight and Advisory Board Update for the Medical Services Board

Friday, November 13, 2009

As a substitute for the regularly scheduled monthly presentation, the following report is presented to the Medical Services Board. Today, Chris Underwood and the Department's team implementing the Hospital Provider Fee Model (Model) is meeting with the Centers of Medicare and Medicaid Services (CMS). The meeting will cover the technical aspects of the Model to present the non-uniform, non-broad based fee waiver and to demonstrate how the Supplemental Medicaid Payments do not create a hold harmless condition.

- CMS regulations require that provider fees be broad-based (such that the fee is imposed on all providers within a class) and that the fees are imposed uniformly throughout the state (all providers within a class are assessed at the same rate). CMS may grant a waiver of the broad based and uniformity provisions if the net impact of the provider fee is generally redistributive and the amount of the fee is not positively correlated to Medicaid payments, as demonstrated via statistical tests (commonly referred to as the "B1/B2 Test"). The Department's Model requests such a waiver.
- In addition, CMS regulations specify that the Model avoid hold harmless arrangements where the reimbursement amount is positively correlated to the assessment paid by the provider, either directly or indirectly. In other words, there will be winners and losers, where some providers will receive proportionately less in reimbursement compared to their assessed amount.

At the Hospital Provider Fee Oversight and Advisory Board (the Board) meeting on October 20, 2009, minutes from the September 15, 2009 and September 29, 2009 meetings were approved. The minutes from both meetings are attached.

The Department updated the Board on two modifications to the Model. The first modification increased payments to two rural hospitals for outpatient hospital services. Now Rural Hospitals with 15 or fewer licensed beds and whose outpatient payments make up 80% or more of their total current Medicaid payments will receive an additional 60% of their current Medicaid rate. The second created a High Level Neo-Natal Intensive Care Unit Supplemental Medicaid Payment. Hospitals with level 3c or 3b neo-natal intensive care units will paid an additional \$300 per Medicaid nursery day. These changes reduced the number hospitals with a net lose from 15 to 12 and increased the aggregate net gain for all hospitals to \$82.9 million from \$81.7 million.

Two members of Department's team implementing the Model, Matt Haynes and Jeff Orford, discussed the proposal to develop a Cost-Shift Workgroup. As part of its annual report to the General Assembly the Board is required to report on how the Colorado Health Care Affordability Act reduces the need of health care providers to shift the cost of providing uncompensated care to other payers. This workgroup will be time limited and will deliver recommendations to the Board regarding collecting, aggregating, and summarizing the necessary data. The information provided to the Board is attached. The Board requested that the Department give a more detailed cost shift presentation at their November 17, 2009 meeting and provide specific direction for the workgroup.

For the remainder of the meeting, Marc Stauble, from Public Consulting Group, and Steve Scheer, from Health Management Associates, gave a presentation on their opinion of the Model. Information on both consultants is attached. Generally, both consultants believe that the Model has the following positive aspects:

- Complies with goals and objectives established by the Board
- Provides enhanced funding for Colorado Indigent Care Program (CICP)
- Meets CMS requirements of the B1/B2 test
- Payments maximize Medicaid Upper Payment Limits
- Model includes greater payment certainty (cash flow) as payments are based on past utilization and thus results are known up front

The consultants then suggested that CMS's review will focus on the following:

- Since the results B1/B2 test of the rely on self reported data, the Department may be required to audit the data in the future
- Potential to violate the hold harmless condition, since the commercial day fee is lower than Medicaid/Uninsured day fee and there is an exclusion of some providers with no Medicaid days
- Differences within the Metro-Denver Supplemental Medicaid Payment as the payment to hospitals differs based on the county where the hospital is located
- CMS may take the opportunity to perform a detailed review of the Department's UPL calculation

The next Board meeting is November 17, 2009. Please contact Chris Underwood at 303-866-4766 or Nancy Dolson at 303-866-3698 if you have any questions.



**HB09-1293 Oversight and Advisory Board
Hospital Provider Fee
September 15, 2009
Meeting Minutes**

PRESENT	ABSENT	GUESTS
Bruce Alexander – Chair		Matt Sorrentino – PCG – Phone
Mimi Roberson – Vice-Chair		Sean Huse – PCG – Phone
Jeremiah Bartley		Laura Scott – PCG - Phone
James Shmerling - Phone		Marc Staublely – PCG – Phone
Joan Henneberry		
Chris Underwood		
Flora Russel		
Ann King		
Anne Holton – Staff		
Randy Safady		
Robert Omer		
Janet Pogar		
Menda Warne – Phone		
Thomas Henton – Phone		
Nancy Dolson – Staff		
Jeff Orford – Staff		

AGENDA	PRESENTERS	TIME
Welcome Opening Remarks Review and Approve Minutes from 9/1/09 Meeting	Bruce Alexander	3:00 pm – 3:10 pm
9/1/09 Meeting Follow-up Model Overview	Nancy Dolson Safety Net Programs, HCPF	3:10 pm – 3:30 pm
Board Comment and Questions for staff	Board Members	3:30 pm – 4:00 pm
Public Comment	Public	4:00 pm – 4:30 pm
Additional Questions Board approval of model	Board Members	4:30 pm – 4:45 pm
Wrap up and Next Steps	Nancy Dolson	4:45 pm – 5:00 pm
Adjournment	Bruce Alexander	5:00 pm

Changes to the minutes per the Board's request are denoted in red.

Presentations:

- Welcomed **Ann King** to the board as the representative of the Colorado Hospital Association, replacing Tom Nash who resigned from the board.
- **Nancy Dolson** started a discussion on the review of the model.
 - The discussion covered what it would look like to include the Psychiatric Hospitals in the model as well.
 - Concern was expressed that general acute care hospitals would be at a double disadvantage if free-standing psychiatric facilities were not included because 1.) their free-standing competitors would not be assessed a fee and 2.) since the free-standings cannot take Medicaid they are free to cherry-pick the better paying patients.
 - The written description of the model and updated numbers were reviewed.
 - Was noted that the Colorado Orthopedic Hospital going out of business and still showing up in the model. Clarified that when they are no longer licensed in Colorado, they will be removed.
- Went over the procedure involved with presenting to CMS and the timeline involved in the process. Was clarified that you can resubmit to CMS throughout the process.
- A discussion was had regarding the payments and how it will work with the model.
 - Possible webinar to show providers that the fee is coming and so they are not surprised by the fee.
 - Hope to have fee and payments letter sent at beginning of year so the hospitals are aware of their fee payment.

Action Items:

- Need to start looking at the supplemental payments in the model for year two very soon as they are based on the previous years Medicaid days.
- Concern of cost shifting and the fact that there will be losers can be problematic in the short run. In the near future need to determine what data is needed to measure cost shifting and minimize it.
- Concern over the tier payment model for the rural hospitals – need to make sure we have back up in case it is not approved, towards the same goal.
 - Clarified that Rural Hospitals are not the only ones at risk with the tiered system; the Denver Hospitals are as well.
- Department staff will collect revised, complete data from free-standing psychiatric hospitals to model effects if they are included in this year's model. The Board may recommend that the Department amend this year's model to include those facilities in the fee.

- Department staff will look at other ways to address psychiatric days in general, acute care hospitals. Currently those days are assessed like other days and no additional payments are made for those with psychiatric units.

Public comment:

Steve Scheer – Health Management Associates

1. Feels it would be helpful to go back to beginning and look at original models and look at how there were greater gains at that time. Result of CICP general fund dollars being moved – increased tax rate, FMAP moved – increased tax rate and feels that raising the tax works against the goals in regards to cost shifting.
2. Feels that Psychiatric Hospitals are getting an advantage and can cherry pick the patients if they are not in the model.
3. Feels that the tiered system of payments is not likely to be approved by CMS and that rural hospitals would be at risk with this system.
4. Look at the areas of change.

- **Nancy Dolson** responded that they never modeled including the 13 million from the CICP general fund dollars and that the Department always did model at 50/50 and only brought the ARRA (FMAP) version of the model at the boards insistence. **Chris Underwood** also clarified that we will be modeling back up plans the minute the State Plan Amendment is sent to CMS.

Tom Nash – Colorado Hospital Association

1. Commented on the challenges of understanding the FMAP and CICP changes and as a result need to explore every option. Appreciates that the Department will continue to work on back up plans and hope that they will continue to find alternatives.

Motions:

- **Ann King** gave a motion that the Department start collecting new data from free standing psychiatric hospitals not part of the model to be submitted but to have another revised model that included the free standing psychiatric hospitals. And to see the impact on the other hospitals and open up conversation with CHA consultants who might have some ideas on the calculation. Mentioned that they didn't get a copy of the calculation so did not see ahead of time and surprised by some of the changes. A motion to get some new data from psychiatric hospitals and run that side of the model not to be submitted but to be aware of.
 - **(There was not a second to the motion at this point)**
 - Bruce Alexander made a friendly amendment - Approve the model as is today with the caveat that:
 1. Staff works with CMS to keep the integrity of the rural hospital model and potential impact on non rural hospitals.
 2. Address the psychiatric issue to gather incremental data to at least engage these folks that have missed out in the dialog and
 3. Try to pursue the impact on to quantity if there truly is an impact on those who provide these services. Not only look at impact of those

who are included and is there some way to true up for those who provide those services.

- Motioned and seconded all were in favor. (Note that this motion was not a motion on the approval of the model, rather it directed staff to continue modeling revisions, to gather psychiatric hospital data, and to continue to work with CHA's consultant on revisions.)

- **Jeremiah Bartley** made a motion to approve the current model without the Psychiatric Hospitals as it was presented today. **Joan Henneberry** seconded the motion. **Mimi Roberson** voiced that there were still concerns about cost shifting and clarified that the Department would still be working on the issue after the vote was taken. A vote was taken of the board and the motion was approved by majority vote (9-yes votes and 4-no votes) as follows:
 - Bruce Alexander – Yes
 - Mimi Roberson - No
 - Jeremiah Bartley - Yes
 - James Shmerling - No
 - Joan Henneberry - Yes
 - Chris Underwood - Yes
 - Flora Russel - Yes
 - Ann King - No
 - Randy Safady - Yes
 - Robert Omer - Yes
 - Janet Pogar - Yes
 - Menda Warne - Yes
 - Thomas Henton – No

The meeting was adjourned at 5:15 pm.

The next meeting is scheduled for Tuesday, September 29, 2009, from 3:00 pm – 5:00 pm. Cassidy Smith will give an update on the Stakeholders forum. It will be held at 225 E. 16th Avenue, Denver, CO 80203.

"The mission of the Department of Health Care Policy & Financing is to improve access to cost-effective, quality health care services for Coloradans."



**HB09-1293 Oversight and Advisory Board
Hospital Provider Fee
September 29, 2009
Meeting Minutes**

PRESENT	ABSENT	GUESTS
Mimi Roberson – Vice-Chair	Bruce Alexander	Matt Sorrentino – PCG – Phone
Joan Henneberry	Thomas Henton	Sean Huse – PCG – Phone
Jeremiah Bartley		Laura Scott – PCG - Phone
James Shmerling		Marc Staublely – PCG – Phone
Chris Underwood		
Flora Russel		
Janet Pogar		
Ann King		
Menda Warne – Phone		
Randy Safady		
Robert Omer		
Anne Holton – Staff		
Nancy Dolson – Staff		
Jeff Orford – Staff		

AGENDA	PRESENTERS	TIME
Welcome Opening Remarks Review and Approve Minutes from 9/15/09 Meeting	Mimi Roberson	3:00 pm – 3:05 pm
Adults Without Dependent Children and Disabled Buy-In Stakeholder Forums Update	Cassidy Smith Special Programs, HCPF	3:05 pm – 3:15 pm
HRSA Grant Award	Joan Henneberry Executive Director, HCPF	3:15 pm – 3:25 pm
Modeling Next Steps	Nancy Dolson	3:25 pm – 3:35 pm
Public Comment	Public	3:35 pm – 4:15 pm
Discuss Updated Work Plan and Timeline, Next Steps By-Laws Example Schedule Future Meetings	Board Members	4:15 pm – 4:45 pm
Additional Comments	Board Members	4:45 pm – 5:00 pm
Adjournment	Mimi Roberson	5:00 pm

The meeting was called to order at 3:05.

The minutes from the September 15, 2009 meeting will be approved at the October 20th meeting subject to review and changes per the Board's request.

Presentations:

- **Cassidy Smith** gave a presentation on Adults without Dependent Children and Disabled Buy-in stakeholder Forums Update and a discussion with the board took place.
- **Joan Henneberry** gave an update on the HRSA Grant Award. The grant will allow the Department to do several things in relationship to 1293.
 1. To continue to work toward eligibility modernization.
 2. Interface with different databases in Department of Revenue and Department of Public Health and Environment for getting citizenship information and income verification.
 3. Allows for outreach to the new populations.
 4. Can get help from consultants
 5. Expand CHP+ at work statewide
 6. Expand some pilot programs
 - a. Health Access Program in Pueblo County – 3 Share Program
 - b. In San Luis Valley to replicate the 3 Share Program
 7. Carry on the Centennial Care Choices Bill
- **Nancy Dolson** started a discussion on what the **NEXT STEPS** are.
 - State Plan Amendment to CMS on September 30, 2009.
 - Will continue to look at the Psychiatric Hospitals.
 - The board asked to have both the Department's and CHA's consultants work together and give a combined presentation at the next meeting regarding the model and what the issues they feel the model had and their recommendations on the model.
 - The Department will bring their recommendation to the next meeting on forming a sub group that will focus on cost shifting. Along with questions that they want this group to answer.
 - At the November meeting Anne Holton will present suggested by laws for the board to adopt.

The meeting was opened for public comment and there was none.

Additional Items:

- Joan Henneberry resigned from the Board and introduced Phil Kalin, CIVHC Director as her replacement.
- Future Meeting dates were set as follow:
 - October 20, 2009 – 3:00-5:00 pm
 - November 17, 2009 – 3:00-5:00 pm
 - December 15, 2009 – 3:00-5:00 pm
 - January 26, 2010 – 3:00-5:00 pm
 - February 23, 2010 – 3:00-5:00 pm
 - March 23, 2010 – 3:00-5:00 pm

The meeting was adjourned at 4:05 pm.

The next meeting is scheduled for Tuesday, October 20, 2009, from 3:00 pm – 5:00 pm. It will be held at 225 E. 16th Avenue, Denver, CO 80203.

"The mission of the Department of Health Care Policy & Financing is to improve access to cost-effective, quality health care services for Coloradans."

HB 09-1293 Oversight and Advisory Board
Cost-Shift Workgroup

As part of its annual report to the General Assembly as required in the Act, the Hospital Provider Oversight and Advisory Board must estimate the differences between the cost of care provided and the payment received on a per-patient basis for patients covered by Medicaid, Medicare, and All Other Payers, respectively, aggregated for all hospitals. The Board formed a workgroup (or subcommittee) to advise how to collect data to measure the extent to which the Colorado Health Care Affordability Act reduces the need of health care providers to shift the cost of providing uncompensated care to other payers. This workgroup will be time limited and will deliver recommendations to the Board and the Department regarding collecting, aggregating, and summarizing the necessary data.

1) Scope

- Recommend working definition of cost-shifting.
- Deliver a report to the Board that includes a standard method for collecting data necessary to calculate the cost of care and payments by payer group for all hospitals as required in the Act, a standard method for determining hospital costs, recommended data sources, and well-defined data points.

2) Timeframe

- Convene every two weeks for 60 minutes and report back to the Board within 4 months of the first workgroup meeting.

3) Workgroup Composition

- Health insurance carrier representative
- Hospital representative (financial)
- Business representative who purchases health insurance for his or her employees
- Health care consumer advocate or advocacy organization representative
- Colorado Hospital Association (CHA) representative
- Colorado Association of Healthcare Plans (CAHP) representative
- Health care economist-type
- Department of Health Care Policy and Financing representative with knowledge of managed care or hospital rate setting

Public Consulting Group (PCG)

- Founded in 1986 and headquartered in Boston, Massachusetts
- PCG has more than 700 professionals in 28 offices around the U.S. and in Montreal, Canada
- PCG addresses the unique and often multidimensional challenges of each public sector client by assembling project teams across our four areas of expertise:
 - Education Services
 - Health, Human Services and Other Government
 - Consumer-Directed Services
 - IT Services

PCG's Provider Fee and Medicaid Hospital Experience:

- *State of Wisconsin, Department of Health Services (DHS) Provider Assessment Services*
 - Assisted the State to receive CMS approval
 - Used financial survey data model provider outcomes fee models and analyzed results
 - Performed P1/P2 statistical analyses to determine the feasibility of excluding CAH and stand alone Psychiatric Hospitals
 - Developed post assessment IP and OP hospital rates
- *Massachusetts, Executive Office of Health and Human Services*
 - Prepared Upper Payment Limit (UPL) calculation in support of Health Care Reform waiver applications
 - Conducted Uncompensated Care Pool Audits
- *Medicaid UPL, DSH, Audit, and Other Hospital Rate Setting Projects for State Medicaid Agencies*
 - UPL – AL, MA, TX, WI, WV
 - DSH – CT, MA, MO, NC, NH, and WI
 - Rate Setting – AL, AK, FL, LA, MA, MO, ND, OH, VA, and WI

PCG's Experience in Colorado:

- *Department of Health Care Policy & Financing, School Health Services Program (HCPF)*
 - Implemented revised, CMS approved cost-based/cost reconciled reimbursement process for SHS providers
 - Developed and operates Random Moment Time Study for direct service, TCM, and administrative claiming
 - Currently collecting cost reports from SHS providers for cost settlement and rate setting purposes
- *Department of Health Care Policy & Financing, Rates Section*
 - Provided a gap analysis between existing accounting and auditing guidelines in Colorado's Medicaid and indigent care mental health program and best practices nationwide
 - Assessed and submitted recommended changes and to create a revision to the Mental Health Services Accounting and Auditing Guidelines
 - Incorporated the move to a Relative Value Unit (RVU)-based pricing methodology into the updating of the guidelines
- *Department of Health Care Policy & Financing, Long Term Care Section*
 - Reviewed, evaluated, and validated applications from the nursing facilities that applied for the pay for performance (P4P) program
 - Developed and implemented an application evaluation tool, finalized nursing facility scores, and made recommendations to the Department for improving the program and process
- *Department of Health Care Policy & Financing, Consumer Directed Attendant Support Services*
 - Public Partnerships, LLC (PPL), a PCG company, was awarded a contract with the State of Colorado on August 10, 2009
 - PPL has designed a wide array of services that support consumer direction

Presenter:

Marc Stauble, a Manager with PCG, is an experienced public sector financing expert within the health and human service industry. For the past fifteen years, he has assisted more than twenty state health and human service programs to design and develop public financing mechanisms to increase accountability and improve funding. Mr. Stauble has the necessary practical experience in the all areas of public finance including State Plan development, provider fee program design and implementation, federal compliance monitoring, and provider billing and cost reporting operations. He has broad experience across a wide variety of providers, including hospitals, health centers, community mental health agencies, home health agencies, psychiatric residential treatment facilities, intermediate care facilities for the mentally retarded, and skilled nursing facilities. Mr. Stauble currently manages PCG's provider fee engagements, oversees all rate setting activities, provider cost report projects, provider billing operations, a variety of revenue enhancement initiatives as well as a variety of technical consulting projects. Examples of some of these projects include: Upper Payment Limit (UPL) projects for hospitals, nursing facilities, and physician groups; rate setting for: hospitals, waiver programs, physician services, dental providers, etc.; Medicare cost report adjustments and appeals; provider assessment engagements; and a variety of cost savings initiatives related to State facility consolidation projects.

Health Management Associates

Health Management Associates (HMA) is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.

HMA's staff is made up of experienced professionals, with backgrounds as health program administrators, managers, and analysts in public health policy and administration, health care finance and reimbursement, pharmacy benefit design and management, health economics, and program development and evaluation. HMA colleagues include over thirty principals, all of whom have held highly-visible, senior-level positions in public sector programs or large health systems, including ten former State Medicaid Directors, three former SCHIP Directors, a State Mental Health Commissioner, State budget officials, public and private hospital CEOs, and policy advisors to governors and other elected officials.

Steven B. Scheer, Principal

Mr. Scheer and the firm specialize in assisting providers, state hospital associations and other clients with concerns regarding public programs or public populations such as Medicaid and the uninsured. He works with governments, hospitals and hospital associations on coverage for the uninsured and Medicaid financing. He also assists association clients with association strategic planning and member satisfaction improvement. Among his projects Mr. Scheer has worked on assignments involving Medicaid financing in 30 states during the past eight years. Prior to joining Health Management Associates, he served as executive vice president of the Illinois Hospital Association.