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

Friday, March 9, 2012

The 2011-12 Hospital Provider Model (October 2011 through September 2012) was approved by the Hospital Provider Fee Oversight and Advisory Board on August 10, 2011. The model has a net gain of $122.4 million to hospital providers, which is down from $159.5 million in the 2010-11 Hospital Provider Model. The decrease in the net gain is due to the transfer from Senate Bill 11-212, increased costs related to the expansions for Medicaid Parents and CHP+, and new costs related to the Medicaid Buy-In Program for People with Disabilities and Adults without Dependent Children expansions. The gains to the hospital system that will be realized through the expansion populations are not represented in these figures.

The Department submitted the State Plan Amendment (SPA) for approval by the Centers for Medicare and Medicaid Services (CMS) on September 23, 2011. The Inpatient SPA has been approved by CMS. The Outpatient SPA has not been approved and CMS is requesting additional information regarding the calculation of the Upper Payment Limit. At this time, the Department is working with CMS on revising the calculation. Until CMS approves the Outpatient SPA, the Department will issue new interim rates to adjust the provider fees and payments.

On May 1, 2010 the population expansions for Medicaid Parents to 100% FPL and CHP+ to 250% FPL were implemented by the Department. In January 2012, 35,480 Medicaid Parents and 13,480 CHP+ (Children and Prenatal) clients were enrolled.

The Department implemented a Medicaid Buy-In Program for People with Disabilities and Adults without Dependent Children expansions on March 1, 2012. The offical implementation date for the Adults without Dependent Children expansion will be April 1, 2012 with enrollment occurring around May 15, 2012. The Medicaid Buy-In Program for Children with Disabilities will be implemented approximately 4-6 months after the Medicaid Buy-In Program for Working Adults with Disabilities implementation.

Hospital Provider Fee Oversight and Advisory Board (OAB)

a. February 28, 2012 OAB Meeting. The Department provided updates on the HB 09-1293 Performance Audit, the AwDC expansion implementation, and the revised 2011-12 interim fees and payments.

b. Minutes for the October 25, 2011 and December 13, 2011 OAB meetings are attached.

c. The next OAB meeting is scheduled for Tuesday, April 24, 2012.

Please contact Chris Underwood at 303-866-4766 or Nancy Dolson at 303-866-3698 if you have questions regarding this update.

HB09-1293 Oversight and Advisory Board
Hospital Provider Fee
October 25, 2011
Meeting Minutes

PRESENT	ABSENT	GUESTS
Ellen Robinson - Chair	Michelle Joy	Audra Burkhart- HCPF
Jeremiah Bartley	Tom Rennell	Matt Haynes - HCPF
Peg Burnette	Mimi Roberson	Martha Beavers- HCPF
Karl Gills- phone	James Shmerling	Sean Casey-King- HCPF
Bill Heller	Menda Warne	Marivel Guadarrama- HCPF
Ann King-phone		Deborah Pozarnsky- HCPF
Flora Russel		Jeremy Tipton- HCPF
Chris Underwood		
		Garrett Abrahamson – PCG - Phone
Nancy Dolson – Staff		Laura Scott – PCG- Phone
Jennifer Weaver - Counsel		

3:00 – 3:10	❑ Welcome	*Chair Ellen Robinson*
	❑ Review and Approve 8/23/11 Minutes	*Board Members*
3:10 – 3:15	❑ Department Updates	*Nancy Dolson, HCPF*
3:15 – 3:30	❑ Medicaid Buy-In for People with Disabilities Expansion Draft Rules	*Deborah Pozarnsky Marivel Guadarrama & Martha Beavers, HCPF*
3:30 – 3:45	❑ Hospital Quality Incentive Payments Update	*Jeremy Tipton, HCPF*
3:45 – 4:00	❑ Cost Shift Data Review	*Matt Haynes, HCPF*
4:00 – 4:20	❑ Draft Annual Report Review	*Nancy Dolson, HCPF*
4:20 – 4:30	❑ Public Comment	
4:30 – 5:00	❑ Additional Topics	*Board Members*
	❑ Wrap up / directions for staff / adjournment	

The minutes from the August 23, 2011 meeting was approved.

Presentations:

Ellen Robinson called the meeting to order.

Nancy Dolson went over the Department and model updates

- State Plan Amendments were been submitted to Center for Medicare and Medicaid Services (CMS) on September 23rd, 2011 as planned to implement changes to payments under the provider fee model. CMS will approve or request additional information within 90 days of submission. Upon approval, likely by December 23rd, the Department plan to reconcile payments to the new model in January.
- Rules went before the Medical Services Board (MSB) on October 14th, 2011 and were approved. They will be back at the MSB in November for final adoption. Payment and fee letters were sent to hospitals in September to inform them of the new fees and payments once there is Federal approval.
- Approximately 40,000 individuals are covered by expansions funded by hospital provider fees as of the end of September.

Martha Beavers, Marivel Guadarrama, and Deborah Pozarnsky presented Medicaid Buy-In for People with Disabilities expansion draft rules.

- The Department will take the rules to the MSB on December 8th, 2011 for initial reading, and the implantation date is scheduled for March 1, 2011
- There has been work with stakeholder groups and other states as well as Federal guidance to determine premiums for the expansion. The proposed monthly premiums include 4 tiers:
    - Tier One: Up to 133% Federal Poverty Level (FPL) is $25 premium
    - Tier Two: Up to 200% FPL is $100 premium
    - Tier Three: Up to 300% FPL is $225 premium
    - Tier Four: Up to 450% FPL is $400 premium
    - Premiums for those over 450% FPL are still being determined; Hospital Provider Fee Funds will not be used at this level.
- It is expected many clients will have Medicare or insurance through their employer that will be billed first; as always, Medicaid will be the payer of last resort.
- The Department is on target for CBMS and MMIS to be ready by the implementation date of March 1, 2011.

Sean Casey-King and Jeremy Tipton presented a Hospital Quality Incentive Payments (HQIP) update.

- In the past months, the Department has been working on obtaining sources for data on the four measures:
    - Elective deliveries prior to 39 weeks
    - Postoperative Pulmonary Embolism and Deep Vein Thrombosis
    - Central line associative blood stream infection
    - Care transitions measure

- The HQIP work group will be coming together to discuss a scoring methodology for the hospitals to present to the board for feedback and approval. This will hopefully be ready in May 2012.
- The Department has worked on the State Plan Amendment for the rules of this program and they have been submitted to CMS. No response has been received from CMS at this time.

Matt Haynes presented Cost Shift Data review.

- Working with the Colorado Hospital Association and their data, it was determined that reporting on a calendar year basis would be more relevant than reporting on a fiscal year basis. Data is now presented on a calendar year basis.
- With the implementation of the Colorado Health Care Affordability Act the payment to cost ratio of Medicaid and CICP (public payers), that pay below cost, increased while insurance, that pay above cost, decreased.
- Previously, the board had mentioned concerns about case mix and, after research, it was determined that an additional adjustment for case mix was not necessary.
- When looking at payment to cost ratio, both Medicaid and CICP showed an increase from CY09-CY10 with the implementation of the Hospital Provider Fee program. Insurance showed a 1.97% decrease from CY09-CY10, but is still at an increase from CY06-08.
- The actual dollar amount of payment less cost from Medicaid improved by 28.87% while Insurance showed a 1.62% decline from CY09 to CY10. There was also a dollar payment decline from Medicare during this time of 13.43%.
- Payment less cost per patient calculated based on adjusted discharge showed a slight increase in insurance from CY09-CY10, but a large increase from CY06-CY10.
- CICP data, which is still calculated on a fiscal year basis, has improved on all levels from FY09-FY10.
- Overall, bad debt and charity care increased CY06-CY09 and declined from CY09-CY10.
- The cost shift data report is still being reviewed internally so it can be included in the annual report. A final copy will be sent to the Board.

Nancy Dolson presented the Draft Annual Report review.

- As required by statute, the board's Annual Report is due to the Health and Human Services Committees of the General Assembly, Joint Budget Committee and Governor's office on January 15, 2012. The report contains:
    - Recommendations made by the Board to the MSB
    - Description of the Provider Fee formula and how it is assessed and collected
    - Fee, payments, and projected revenue for each hospital
    - Increased eligibility
    - Itemization of the cost to the Department
    - Estimates of the Cost Shift on a per patient basis

- The annual report gives information on the Colorado Health Care Affordability Act; it is the same as previous years in giving an overview of the Act and the implementation of the Hospital Provider Fee.
- The benefits of the Hospital Provider Fee are described in detail including expansion programs, HQIP, and Cost Shift. The data included is reported on the model year of October 10-September 11.
- The Board is asked to send any suggestions or revisions by November 23rd, 2011. A final report should be available at the next meeting on December 13th for the Board's approval.
- Members of the board suggested including feedback from stakeholders on the expansion, cost shift, or incentive payment.

Opened for **Public Comment**

- **Elisabeth Arenales** of Colorado Center on Law and Policy agreed that including stakeholder feedback in the Annual Report would be favorable.

Board Recommendations

- No recommendations were made by the Board at this meeting.

The meeting was adjourned at 4:30 pm.

The next meeting is scheduled for Tuesday, December 13, 2011 from 3:00 pm – 5:00 pm. It will be held at 225 E 16th Ave, Conference Room 6a/b, Denver, CO 80203.

HB09-1293 Oversight and Advisory Board
Hospital Provider Fee
December 13, 2011
Meeting Minutes

PRESENT	ABSENT	GUESTS
Ellen Robinson - Chair	Menda Warne	Audra Burkhart- HCPF
Jeremiah Bartley		Matt Haynes - HCPF
Peg Burnette		
Karl Gills		
Bill Heller		Garrett Abrahamson – PCG - Phone
Michelle Joy		Laura Scott – PCG- Phone
Ann King		
Tom Rennell		
Mimi Roberson- Phone		
Flora Russel		
James Shmerling- Phone		
Chris Underwood		
Nancy Dolson – Staff		
Jennifer Weaver - Counsel		

3:00 – 3:10	❑ Welcome	*Chair Ellen Robinson*
	❑ Review and Approve 10/25/11 Minutes	*Board Members*
3:10 – 3:25	❑ Department Updates ❑ Status of CMS Approval of 2011-12 Model	*Nancy Dolson, HCPF*
3:25 – 3:40	❑ Annual Report Review	*Nancy Dolson, HCPF*
3:40 – 3:45	❑ Public Comment	
3:45 – 3:50	❑ Board Recommendations o Approval of Annual Report	*Board Members*

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The minutes from the October 25, 2011 meeting were approved.

Presentations:

Ellen Robinson called the meeting to order.

Nancy Dolson went over Department and Model updates.

- Expansions funded by hospital provider fees continue to grow. As of October 2011 our caseloads are approximately:
  - Medicaid Parents: 33,838
  - CHP Kids: 8,000
  - CHP Prenatal: 375
- Adults without Dependent Children (AwDC) is still on track for March 1, 2012 implementation of 10,000 enrollees for individuals up to 10% of the Federal Poverty Level. Also on track for a March 1, 2012 implementation for Adult's Medicaid Buy-in program for Persons with Disabilities.
- The Department received notification from Center for Medicare and Medicaid Services (CMS) at the beginning of December that our Disproportionate Share Hospital (DSH) allotment for Federal Fiscal Year (FFY) 10-11 has been lowered. The adjustment is approximately $90,000 and these funds must be paid back. The Department will notify each of the hospitals, hopefully in January, of the adjustments in their payments. The Department also received revised numbers for the preliminary DSH allotment for FFY 11-12 which increased approximately $2 million to $94 million.
- State Plan Amendments (SPA) were been submitted to CMS in September 2011. Some informal questions were received regarding the inpatient SPA; these questions were answered by the Department and the SPA should have approval on December 23, 2011. CMS also had questions around the outpatient SPA which resulted in CMS submitting some formal questions the Department must respond to. These questions concerned the Upper Payment Limit Methodology, specifically the Department's calculation of the inflation rate. Given this change, approval of the Model has been delayed, but hopefully will be approved by March 2012. Interim reconciliations are being considered and the Department is working with the Colorado Hospital Association to determine the best plan of action.

Nancy Dolson presented the Draft Annual Report review.

- As suggested by Members of the Board at the October meeting, the Department included comments received from the Hospitals.
- Based on comments by Members of the Board, the Department will also include that the cap for AwDC is to be 10,000 enrollees, and a footnote to specify some of the data in the report is collected on a FFY basis while other data is collected on a State Fiscal Year basis and therefore may not match.

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Opened for **Public Comment**

- **No Comments**

Board Recommendations

- Upon unanimous decision the Board approved the Annual Report , with the two inclusions suggested today.

The meeting was adjourned at 3:50 pm.

The next meeting is scheduled for Tuesday, February 28, 2012 from 3:00 pm – 5:00 pm. It will be held at 225 E 16th Ave, Conference Room 6a/b, Denver, CO 80203.

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