HOSPITAL STAKEHOLDER ENGAGEMENT MEETING

Friday, December 11, 2020
1:00-3:00 PM

Location: Online Only

Conference Line: 1-877-820-7831 Passcode: 294442#

Topic Suggestions, due by close of business one week prior to the meeting. Send suggestions to diana.lambe@state.co.us or Andrew.abalos@state.co.us.

Welcome & Introductions

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

GROUND RULES FOR WEBINAR

- **WE WILL BE RECORDING THIS WEBINAR.**
- **ALL LINES ARE MUTED. PRESS *6 IF YOU WISH TO UNMUTE. PARTICIPANTS CAN ALSO UTILIZE THE WEBINAR CHAT WINDOW**
- Please speak clearly when asking a question and give your name and hospital

Thank you for your cooperation

AGENDA

12/2020 Hospital Stakeholder Engagement Meeting Topics
FY 20-21 Inpatient & Outpatient SPA Update
DRAFT Inpatient Base Rate Methodology
Tentative Implementation Date 7/1/2022
FY 21-22 Rate Discussion
Medicare Base Rate – DSH calculation issues
Add-On Discussion
EAPG Version Updates
Drug Acquisition Cost Surveys

Dates and Times for Future 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

FY20-21 Inpatient/Outpatient Rates Update

- FY19-20 rates will remain in effect until CMS approval is received and claims with last service dates >= 7/1/2020 are reprocessed to apply FY 20-21 rates.

- The timeline for CMS approval is out of our hands, but we hope to get approval sometime this month.

DRAFT Inpatient Base Rate Methodology

- Estimated Implementation Date extended to **7/1/2022**.

- What should we do for FY 21-22 Rates to be implemented on 7/1/2021?

- We suggest keeping FY 20-21 Inpatient Base Rates as they are and apply the State Budget Action set by legislature directly to those rates.
  - This is the same process applied to EAPG Base Rates.

Suggested FY 21-22 Rate Update

HOW IT WORKS: In the past few years, the State Budget Action (SBA) has run anywhere between a -1% decrease and 2.0% increase.

Example: FY 20-21 rate for ABC Hospital is $6,724.90. If the State Legislature approves a **1%**:

- **INCREASE**, the new FY 21-22 rate would be $6,724.90 x 1.01 = $6,792.15.

OR

- **DECREASE**, the new FY 21-22 rate would be $6,724.90 x .99 = $6,657.66.

Reasoning for Suggested FY 21-22 Rate Update Process

- Will allow more time to work through iterations of the new base rate methodology.
  - If we used the current methodology to rebase rates, then work on the new payment methodology would effectively be shut down for 4-6 months

- We've received notice that some rural hospitals are very concerned about building hospital rates containing Covid-19 claim activity.
  - If we do build rates for FY 21-22, there would be 3-4 months of Covid-19 claim activity and more specifically nearly a month's worth of claims (March 23 to April 14) when elective surgeries/procedures were suspended.

- Not sure how Medicare Base Rates – DSH would be affected with Covid claim activity in the mix.
  - By only making the legislatively required adjustments there would be less ambiguity in next year's rates

FY 21-22 Rate Update

SURVEY

How should rates be updated for FY 21-22 rates?

- ❑ State Budget Action applied to FY 20-21 Rates
- ❑ Regular base rate calculation

Questions/Concerns from Stakeholders

- Don’t understand why we are changing the inpatient base rate formula

- Generally, want to stay using the Medicare Base Rate – Disproportionate Share (DSH) as starting point.

- Want NICU/Nursery Add-Ons maintained as is.

- Want additional Add-Ons for “specialty departments.”

Difficulty using Medicare Base Rate less DSH as starting point

Getting DRG Disclosures from Hospital Intermediaries: It takes months and repeated requests to get the DRG Disclosures from Novitas who handles 98+% of all hospitals.

- FY 19-20 example: initial request 10/25/2019, data received 1/10/2020. With at least 4 follow-up emails necessary.
  - Despite telling them multiple times I was part of a STATE MEDICAID Department trying to set inpatient hospital rates, Novitas suggested I get the DRG Disclosures from a hospital here in Denver. It was resolved, but this is not uncommon that I must re-explain each year.
- FY 17-18 example: initial request 11/17/2016, data received 12/20/2016. With again, at minimum 4-5 follow-up emails to get the necessary DRG Disclosures.

Difficulty using Medicare Base Rate less DSH as starting point

DRG Cost Disclosures are incomplete and have harmed hospitals who rightly deserved a Low Volume Payment:

- Low Volume Adjustments on DRG Disclosures for three rural hospitals were left at $0 because hospitals participating in The CMS Rural Community Hospital Demonstration are paid on a cost basis.
- The Department must request proof from a separate Novitas group that hospitals participating in the demonstration do indeed qualify to receive the low volume payment and ask them to provide the low volume adjustment rate we should use in our calculations.

A total of 702 claims were adjusted to reflect the new rate. The implementation of the new InterChange system delayed the adjustment of these claims for 11 months.

- This issue was discussed at length during the January 2018 Hospital Engagement Meeting.

Difficulty using Medicare Base Rate less DSH as starting point

Medicare does not build rates for Non-Prospective Payment System (PPS) Hospitals: They are paid on a cost basis.

- The State of Colorado Medicaid rates for non-PPS hospitals have been broken for many years. With the move to per diem rates, Rehabilitation and LTAC hospitals rates were fixed in 7/1/2018.

- However, that still left Critical Access Hospitals (CAH) and Children's Hospital without a working base rate methodology. This new base rate methodology is meant to correct this deficit.

Federal Base Rate - Requests to add:

- Wage Index Adjustment
- Standard Federal Rate (Capital) * Geographical Adjustment Factor (GAF)
- Operating & Capital Indirect Medical Education (IME)

Detailed look at those requests

Based on feedback, the Department is open to discussing adding the following portions to the Federal Base Rate as requested by stakeholders.

Medicare Provider ID	SAMPLE
Hospital Name	ABC Hospital
OPERATING	
Labor Related Amount (Intermediary input)	$3,959.10
Wage Index (Fill in using intermediary input above)	1.0133
Adjusted Labor Amount	**4,011.76**
Non-Labor Amount	$1,837.53
***Subtotal** (Operating Federal Portion)*	**5,849.29**
Enter Operating DSH Factor (fiscal intermediary)	0.12
O-DSH % (Disproportionate Share)	0.03
DSH AMOUNT	$175.48
O-IME % (Indirect Medical Education)	0
IME AMOUNT	**$0.00**
Hospital Specific Amount/Portion (HSP/HSA)	$0.00
OPERATING TOTAL	**6,024.76**
Hospital Value-Based Purchasing (VBP) Adjustment	1.00134490500
Hospital Readmissions Adjustment Factor (RAF)	0.9996
OPERATING TOTAL w/Adjustments	**$6,022.42**

CAPITAL	
Standard Federal Rate (entered from IPPS Table 1)	$462.33
GAF Geographic Adj Factor (Vlookup from IMPACT	1.0091
Adjusted Federal Capital Rate	**$466.54**
C-DSH Factor (Disproportionate Share)	0.0627
DSH Capital Payment	$29.25
C-IME Factor (Indirect Medical Education)	0
IME Capital Payment	**$0.00**
CAPITAL TOTAL	**$495.79**
PLUS Low Volume Payment net of DSH	$0.00
TOTAL DRG PAYMENT net of DSH	**$6,321.35**
LESS 1% HAC Reduction $ Amt net of DSH	$63.21
Federal Base Rate + Requested Additions from Stakeholders (Excludes DSH) + HAC/Readmissions & VBP Adjustments	**$6,258.14**

Non-PPS Hospitals

- Non-Prospective Payment System (Non-PPS) hospitals are paid on a cost basis through Medicare.
- Children's and CAH are non-PPS hospitals.
- This was the reason why we wanted to move to something like the Federal Base Rate so all hospitals (PPS & Non-PPS) could start from the same point.

Medicare Base Rate Statistics (FFY 2020)			
	Average	**Minimum**	**Maximum**
Medicare - DSH (current formula)	$6,811.47	$6,111.62	$12,198.48
Federal Base Rate w/additions requested from stakeholders + HAC/Readmissions & VBP Adjustments	$6,406.43	$6,111.62	$7,559.47
Federal Operating Portion	$5,796.63	What can be used as starting point for non-PPS hospitals?	
Federal Capital Portion	$462.33		
Total Federal Base Rate	**$6,258.96**		

Add-On Discussion

- Stakeholders want NICU & Nursery Add-Ons to be maintained in new methodology

  - These add-ons are hold-overs from when the department used MS-DRGs (built from Medicare population and no severity of illness component to weights).

  - It still seems that these add-ons should have been removed back in 1/1/2014 when APR-DRGs were instituted.

Add-On Discussion

- Critical Access Hospital
- Low Discharge Hospital
- Independent Hospital
- Pediatric Hospital
- Payer Mix
- Net Patient Revenue / Adj Discharges*
- Hospital Only Operating Expense / Adj Discharges*
- Net Income / Adj Discharges*
- Continued Current GME Add-On

*Adjusted Discharges include both IP & OP activity

Questions & Comments?

EAPG Version Update (3.10 -> 3.16)

Background

- Department implemented EAPG Version 3.10 for EAPG implementation on October 31, 2016

- Methodology is developed and maintained by 3M Health Information Systems

- EAPG versions released January 1 of each year by 3M – distinct from quarterly module updates which are for CPT/HCPCS/ICD-10 updates, or payment policy changes

Background

- 3M does not maintain versions beyond a certain point (version 3.10, currently in use, will not be maintained beyond January 1, 2022)

- EAPG versions released January 1 of each year by 3M

- 3M will release version 3.16 for January 1, 2021

- Department intends to update to this version

EAPG Version Updates

- 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 based on changes in costs of procedures associated with EAPGs

EAPG Version Updates

- Modifications of packaging and consolidation lists
- **Lastly, 3M version update will modify inpatient-only procedure list to accommodate changes in deliveries for related services and as suggested through Centers for Medicare & Medicaid Services (CMS)**

Key Points

- Colorado is required to implement a new version of EAPGS prior to January 1, 2022

- Colorado is constrained to budget neutrality

- Aggregate (state-wide) amount spent must remain the same

- Hospital-by-hospital payments will likely change through transition (options can be explored to mitigate gains/losses)

Impact on Payments

- On implementation, HCPF worked to develop its own EAPG cost weights based on a combination of FFS claims data from its MMIS and hospital cost reports (HCRIS)

- For ease of transition, HCPF will use 3M's cost weights developed from national statistics

- **Goal**: Use national weights from 3M while maintaining hospital-specific base rates

Scaling Weights

- National weights will be scaled for budget neutrality.

- Modeled using Calendar Year 2019 data and EAPG Version 3.15, released January 1, 2020

- **Need to determine scaling factor to apply to 3M's 3.16 weights**

Scaling Weights (using 3.15)

- Calendar Year 2019 FFS claim and associated EAPG data pulled directly from MMIS, maximum allowable claim payments calculated to determine budget neutrality constraint

- Maximum allowable payment calculated as claim **adjusted** EAPG weights multiplied by hospital rates which will be effective 7/1/2020

- $603,069,112.39 maximum allowable payment (budget neutrality constraint) calculated across 1.6 million outpatient claims

Scaling Weights (using 3.15)

- Same set of claims processed through version 3.15 for testing, using 7/1/2020 hospital-specific rates and 3M's national weights to create 3.15 maximum allowable payment

- $203,972,000.57 maximum allowable payment across the same 1.6 million claims using existing 3.15 weights

Scaling Factor Calculation

[3.15 maximum payment] x [Scaling Factor]
= [3.10 maximum payment]

OR

[Scaling Factor] = [3.10 mp] / [3.15 mp]

[Scaling Factor] = $603,069,112.39 / $203,972,000.57

[Scaling Factor] = 2.956627

Scaling Factor Application

EAPG v3.15	EAPG Description	Weights v3.15	Scaling Factor	CO Weight
2	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION	1.0008		2.9589
3	LEVEL I SKIN INCISION AND DRAINAGE, DEBRIDEMENT,	0.4149		1.2268
4	LEVEL II SKIN INCISION AND DRAINAGE, DEBRIDEMENT	1.8089		5.3483
5	NAIL PROCEDURES	0.1771		0.5237
9	LEVEL I SKIN EXCISIONS, BIOPSIES, AND REPAIRS	0.8958		2.6487
10	LEVEL II SKIN EXCISIONS, BIOPSIES, AND REPAIRS	1.8817	2.956627	5.5636
11	LEVEL III SKIN EXCISIONS, BIOPSIES, AND REPAIRS	2.8859		8.5325
16	SIMPLE WOUND REPAIR AND TREATMENT	0.4682		1.3843
17	INTERMEDIATE WOUND REPAIR AND TREATMENT	0.5974		1.7662
18	COMPLEX WOUND REPAIR AND TREATMENT	1.6044		4.7435
19	MOHS MICROGRAPHIC SURGERY	1.6121		4.7665

Hospital-by-hospital Analysis (EXAMPLE)

Medicare ID	Maximum 310 EAPG Payment	Maximum 315 EAPG Payment	Modified Weights Payment	Difference	Percent Change
06XXXX	$11,169,203.90	$3,812,415.59	$11,271,890.66	$ 102,686.76	0.92%
06XXXX	$10,276,523.14	$3,454,137.41	$10,212,595.73	$ (63,927.41)	-0.62%
06XXXX	$11,703,115.42	$4,213,824.75	$12,458,707.78	$ 755,592.36	6.46%
06XXXX	$ 6,134,192.38	$2,032,125.62	$ 6,008,237.36	$ (125,955.02)	-2.05%
06XXXX	$10,315,840.73	$3,511,959.25	$10,383,553.33	$ 67,712.60	0.66%
06XXXX	$ 7,727,503.32	$2,611,282.76	$ 7,720,588.96	$ (6,914.36)	-0.09%
06XXXX	$ 8,512,600.51	$2,923,609.87	$ 8,644,023.71	$ 131,423.20	1.54%
06XXXX	$ 8,660,254.47	$3,152,757.74	$ 9,321,528.48	$ 661,274.01	7.64%
06XXXX	$11,516,363.67	$4,056,502.14	$11,993,563.51	$ 477,199.84	4.14%
06XXXX	$ 9,979,632.97	$3,712,089.46	$10,975,263.71	$ 995,630.74	9.98%
06XXXX	$ 5,263,382.19	$1,698,433.90	$ 5,021,635.43	$ (241,746.76)	-4.59%

Payment Modeling for 3.16

- Though 3M has released changes for 3.16, currently unavailable for claims processing

- Similar model to be used once this becomes available, with analysis on more granular data

- Changes in payment for transition to 3.16 cannot be accurately estimated until 3M provides this release

- January 2021 Hospital Engagement Meeting

Drug Surveys

- Assessment of long-term payment solution for drugs in outpatient

- Myers and Stauffer – collecting information from drug

- Webinar Link

- Myers and Stauffer email: copharmacy@mslc.com

Questions, Comments, & Solutions

Thank You!

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