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Colorado Hospital Association

Aug. 31, 2022

Commissioner Michael Conway
Colorado Division of Insurance (DOI)
Consumer Services, Life and Health Section
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Conway:

On behalf of the Colorado Hospital Association (CHA) and our more than 100 member hospitals and health systems statewide, we are writing to provide feedback on implementation of the carrier hearing and rate-setting formula components of HB 21-1232, legislation to establish the Colorado Option (10-16-1306, C.R.S., et seq.). This follows the Association's July 27 communication and includes additional feedback surrounding the implementation process.

We would first like to thank the DOI, and in particular, Kyle Brown, Kate Harris, and Kyla Hoskins, for their partnership and willingness to work intensively with CHA through a number of challenging issues regarding implementation of the Colorado Option. As CHA continues to advocate on this issue, we value the time and effort DOI has committed to achieving our shared goals that:

- Established rates ensure payment adequacy and maintain access to quality care;
- Rate determinations follow a fair transparent process with due consideration to the full range of health care costs and key drivers; and
- Good-faith efforts to negotiate are recognized and valued.

Building on feedback and questions provided in our July 27 letter, CHA has developed the following principles and recommendations – separated into those impacting the process and those impacting the statutorily established rate formulas – to inform the DOI's forthcoming rules on Colorado Option provider rates. In addition, several crucial new recommendations worth highlighting are included here for ease of reference:

1. The process should ensure that the burden of proof rests with the payer to establish that a hospital contributed to not meeting the premium reduction target prior to determining whether a rate hearing is warranted.
2. In order to enable a fair hearing, DOI should share the estimated rates and underlying calculations with hospitals and allow hospitals to provide feedback prior to making a rate determination.
3. The rate hearing process should allow for consideration of unique hospital circumstances.
4. Efficiency metrics used in Rate Floor #1 (discussed below) should be evidence-based and reflect comparable measurement across hospitals to the extent possible.
5. Hospitals should not be expected to support more than their fair share of the total health care premiums.

CHA Principles: Rate Hearing Process

1. Public rate hearings must be held consistent with requirements in the Administrative Procedures Act, including providing adequate notice to all impacted parties; granting opportunity to comment on, question, or dispute information provided by other parties; and ensuring proceedings are open and transparent.

2. Prior to determining whether a provider rate hearing is warranted, the burden of proof that a particular hospital or health system contributed to the failure to meet premium reduction targets must rest with the payer, the allegation must be supported with clear and transparent data, and the payer must meet a "materiality threshold" determined by DOI to establish material causation.
    a. **CHA Recommendation**: The process should ensure that the burden of proof rests with the payer to establish that a hospital contributed to not meeting the premium reduction target prior to determining whether a rate hearing is warranted.
    b. **CHA Recommendation**: Information considered by the DOI at this stage should include, but not be limited to, the full scope of health care costs, trends, and assumptions; insurer initiatives and assumptions to improve on health care costs (e.g., expanded prior authorization programs, population health programs); demographics and acuity of covered population; and specific cost and utilization trends and assumptions by category.

3. Payment rate decisions should be based on the evidence presented in the public hearing and justification for decisions should be provided. In making rate determinations, the Commissioner should consider adherence to statute and legislative intent, the need to balance cost of care and access to care, and fairness and certainty for impacted parties.
    a. **CHA Recommendation**: The Commissioner should take a complete view of the health care system, including other factors or policies driving health care costs.
    b. **CHA Recommendation**: In order to enable a fair hearing, DOI should share the estimated rates and underlying calculations with hospitals and allow hospitals to provide feedback prior to making a rate determination.
    c. **CHA Recommendation:** The rate hearing process should allow for consideration of unique hospital circumstances.
    d. **CHA Recommendation:** Hospitals should not be expected to support more than their fair share of the total health care premiums. In determining the breakdown of premiums by entity, reasonable assumptions should be made when considering cost and utilization.

CHA Principles: Rate Formula

The statute establishes three "rate floors" for hospital rates should it be necessary for the DOI to mandate payments to hospitals. During the legislative debate on HB 21-1232, DOI created draft calculations by hospital based on the most recently available data. The appendix contains additional comments and questions on the methodology used for those point-in-time calculations.

Rate Floor 1: Medicare Reference Formula - Calculation of Medicare Reimbursement Rates

Statutory Definition: "The facility-specific reimbursement rate for a particular health-care service provided under the 'Health Insurance for the Aged Act,' Title XVIII of the Social Security Act, 42 U.S.C Sec 1395." 10-16-1306(4)(a)(II) defined in 10-16-1303(11)(a)

CHA Principles & Recommendations:

1. Computation of Medicare relative reimbursement rates must be reflective of the time period in consideration, hospital specific, and by hospital type (e.g., PPS, CAH, specialty).
    a. **CHA Recommendation:** Medicare reimbursement rates must be based on the applicable time period related to the rate setting period. If, for example, rate setting is to apply for 2024, then the 2024 baseline for Medicare relative reimbursement should apply.
    b. **CHA Recommendation**: Medicare reimbursement rates must be inclusive of the full scope of Medicare reimbursement and inclusive of all Medicare add-ons and adjustments. Additionally, the Medicare base should be based on hospitals most recent Medicare reimbursement information.
2. Hospitals should have the ability to negotiate with the payer to achieve the desired percent of Medicare.
    a. **CHA Recommendation**: Hospitals should have the option to negotiate with carriers to achieve the overall aggregate percentage of Medicare requirement determined by the Commissioner in the rate setting process.
3. Reimbursement for Critical Access Hospitals should follow the existing Medicare methodology for reimbursement and allow for additional considerations, avoiding retrospective settlements.
    a. **CHA Recommendation**: Utilize most current Medicare prospective cost-based payment rates (i.e., preliminary cost report) and allow for adjustments and considerations to account for inflation, unreimbursed cost items (e.g., skilled nursing, home health, other), local tax support, or other items to create a more accurate basis of Medicare costs.

Rate Floor 1: Calculation of the Combined Percentage of Medicare/ Medicaid Patients that Exceeds the Statewide Average for "Up to 30 Percentage Point Increase"

Statutory Definition: "A hospital with a combined percentage of patients who receive services through programs established through the Colorado Medical Assistance Act or Medicare that exceeds the statewide average must receive up to a 30-percentage point increase in its base reimbursement rate, with the actual increase to be determined based on the hospital's percentage share of such patients." 10-16-1306(4)(a)(VI)

CHA Principles & Recommendations:

1. The payer mix calculation should include the full scope of government programs and should allow for consideration of unique hospital circumstances.
    a. **CHA Recommendation**: Calculation of governmental payer mix percentage increase should allow for hospitals to achieve the maximum point increase as allowed by legislation.
    b. **CHA Recommendation**: The payer mix calculation should include all government payers including Medicaid managed care. Hospitals should have the opportunity to demonstrate unique circumstances prior to making the final rate determination.

Rate Floor 1: Calculation of the Efficiency Metrics as Determined by Hospitals Total Margins, Operating Costs, and Net Patient Revenue to Receive up to 40 Percentage Point Increase.

Statutory Definition: "A hospital that is efficient in managing the underlying cost of care as determined by the hospital's total margins, operating costs, and net patient revenue must receive up to a forty-percentage-point increase in its base reimbursement rate." 10-16-1306(4)(a)(VII)

CHA Principles & Recommendations:

1. Efficiency metrics should be evidence-based and reflect comparable measurement across hospitals to the extent possible.
    a. **CHA Recommendation:** In each efficiency measure, the calculation should allow for hospitals to achieve the maximum percentage point increase allowed by the legislation.
2. Realizing the limitations in developing appropriate comparable measures, the Commissioner should consider hospital-specific information prior to making the final rate determination.
    a. **CHA Recommendation:** In determining a hospital's performance in the efficiency metrics, hospitals should have the opportunity to demonstrate their unique circumstances, including comparison to more appropriate peer groups, case mix/acuity, specific cost factors, service offerings/mix, and other efficiency measures.

Rate Floor 2: Negotiated Rate – Calculation of the Inability of the Commissioner to Set Rates to Any Hospital for Any Year at an Amount that is more than 20 Percent Lower than the Rate Negotiated Between Carriers and the Hospital for the Previous Plan Year

Statutory Definition: "Any hospital for any plan year at an amount that is more than 20 percent lower than the rate negotiated between the carrier and the hospital for the previous plan year." 10-16-1306(5)(b)

CHA Principles & Recommendations:

1. Formulas for "percent" are reflective of and relative to Medicare and represent percentage points.
    a. **CHA Recommendation: "**Percent" should be 20 percentage points from the prior year relative to Medicare.
2. Negotiated rates should be set from a base year.
    a. **CHA Recommendation:** The 20 percentage point reduction should be from a base period, not each prior year. Allowing 20 percentage points to occur from each prior year would be irrational, as it allows for a "ratcheting effect" that would eliminate this safeguard over time.

Rate Floor 3: Low-Cost Hospitals – Calculation of Reimbursement from Hospitals Lower than 10 Percent of the Statewide Median. Maximum Decrease of 1/3 of the Difference Between the Rate Formula and Negotiated Rates.

Statutory Definition: "For a hospital with a negotiated reimbursement rate that is lower than ten percent of the statewide hospital median reimbursement rate measured as a percentage of Medicare for the 2021 plan year using data from the CO all-payer claims database, the Commissioner shall set the reimbursement rate as a percentage of Medicare minus one-third of the difference between the hospital's 2021 commercial reimbursement rate as a percentage of Medicare and the rate established under subsection 4 (the rate efficiency section), 165% of the hospital's Medicare reimbursement rate or equivalent rate, or the rate established by subsection 4." 10-16-1306(7)

CHA Principles & Recommendations:

1. Formulas for "percent" are reflective of and relative to Medicare and represent percentage points.
    a. **CHA Recommendation**: Percent should be 10 percentage points away from the median. For example, if the median rate for the state is 220%, then in determining

which hospitals would qualify, the calculation should be 220% - 10%= 210% and not 220% – 220%*.10= 198%

In general, we request consideration of these principles and recommendations to ensure operational success for implementation of the Colorado Option, and we welcome further dialogue with the DOI on these issues.

Regards,

/S/ Adeline Ewing
Adeline Ewing
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