HOSPITAL STAKEHOLDER ENGAGEMENT MEETING

Friday, January 13, 2023
1:00 PM - 3:00 PM

Location: Online Only

All Hospital Zoom Meeting: Dial Toll-free 1-877-853-5257 / Meeting ID: 870 4490 0719 / Passcode: 245046

Topic Suggestions, due by close of business two weeks prior to the meeting. Send suggestions to Tyler.Samora@state.co.us.

Welcome & Introductions

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

About this Meeting

- We will be recording this meeting.
- Please speak clearly when asking a question and give your name and hospital
- A recording of this meeting will be posted to the Hospital Engagement Meeting website for later viewing.
- **Hospital Generated Topics:** Please contact Tyler Samora at Tyler.Samora@state.co.us with requests to cover questions or topics in future hospital engagement meetings. Topics requested fewer than 2 weeks before the next meeting may need to be pushed to future meetings depending on availability of personnel with knowledge of those topics.

Thank you for your cooperation

Dates and Times for 2023
General Hospital Stakeholder Engagement Meetings

Dates of Meetings	Meeting Time
~~January 13, 2023~~	~~1:00pm-3:00pm~~
March 3, 2023	9:00am-11:00am
May 5, 2023	9:00am-11:00am
July 7, 2023	9:00am-11:00am
September 8, 2023	1:00pm-3:00pm
November 3, 2023	9:00am-11:00am

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

AGENDA

January 2023 Hospital Stakeholder Engagement Meeting Topics – mm:ss
Provider Service Announcement: Authenticating When Contacting the Provider Services Call Center - 05:00
IP Hospital Survey Review - 07:56
Inpatient Base Rate Methodology Rules Draft Review – 09:09
Updating Constant Contact Lists – 30:45
EAPG Module Update – 32:04
EAPG Billing Guidance Updated - 32:53
Error in Drug Pricing – 34:44
Regular EAPG Updates - 35:27
Cost Settlements - 38:15
Outpatient Naloxone Carveout - 42:46
Inpatient Naloxone Carveout Options - 44:11

STAFFING UPDATE

Gabriel Hottinger
Hospital Services Rate Analyst

Topics to be Included in March Meeting

- Discussion on Kepro Authorization Timelines
- Denial rates on EAPG Claims Relating to Missing or Invalid Combinations of Drug and NDC Codes

Call Center Authentication

Are you ready for the call center change?

An additional verification will soon be required when a provider contacts the Provider Services Call Center. **Gainwell will require the caller to provide an 8 to 10 digit Health First Colorado (Colorado's Medicaid program) ID** and the National Provider Identification (NPI) (if applicable) to release Health Insurance Portability and Accountability Act (HIPPA) protected information.

Call Center Authentication

- Providers that use a third-party vendor or billing agency to check claim status or to verify eligibility or provider enrollment information must ensure the vendor is given both the NPI and the Health First Colorado ID.

Inpatient Hospital Review Program (IHRP) Relaunch

- IHRP 2.0 launch scheduled for April 3, 2023, significant changes from IHRP 1.0, which has been suspended since April 1, 2020

- For more information please visit the IHRP Website: https://hcpf.colorado.gov/IHRP

Inpatient Hospital Review Program (IHRP) Relaunch

- If you would like to be included in the bi-weekly Joint Operating Committee meeting or have questions about the program please email hcpf_um@state.co.us
  - Next Meeting: Thursday, January 19, 2023 1:00 pm, Virtual

- If you believe you will be involved in IHRP 2.0 (or you are unsure) please complete the IHRP Provider Survey at: https://survey.alchemer.com/s3/7115547/Kepro-CO-Medicaid-IHRP-2-0-Provider-Survey

Draft Inpatient Base Rate Methodology

Quick Updates:

- We are building rates for 7/1/2023 right now
  - Hospital Acquired Condition (HAC) Reduction wasn't calculated for Medicare PPS Hospitals in most FFY 2023, so no hospital will receive a reduction for HAC in FY 2023-24 IP Base Rates.

- **Looking ahead:** The APR-DRG version update will be pursued immediately after rules and state plan changes are in motion.

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- This is just a high-level overview.
- Our review today is mainly focused on the characterization of the changes we have been working through for the past 1-2 years so that hospital stakeholders fully understand the adjustments being made to the Inpatient Base Rate Methodology.
- The changes we will go through here are not final and are very likely to be tweaked as to references to other sections and also wording to pass review with the Attorney General's office along with the Medical Services Board.
- For those interested, we will be posting a version of 8.300: Hospital Services on our Inpatient Hospital Payment website for stakeholders to review by mid-week next week.

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.I.K-CC Definitions Section**

9. A Non-independent Urban Hospital is a hospital which reports a name of the home office of the chain with which they are affiliated on the CMS-2552-10 Cost Report in Worksheet S-2 Part 1, Line 141, Column 1, with the exception of individual hospitals reporting an affiliation not reported amongst other hospitals located in Colorado.

10 A Sole Community Hospital (SCH) should we use same language used to describe Medicare Dependent Hospital above? and CMS-certified as a Sole Community Hospital.

11 For the purposes of 8.300: Hospital Services, Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as hospitals which Medicare pays on a prospective basis and provides data in the Medicare IPPS IMPACT file from which to create their PPS rate. Conversely, non-Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as Pediatric and Critical Access Hospitals for which Medicare does not pay on a prospective basis and therefore do not have data available on the Medicare IPPS IMPACT file.

8.300.1.CC. ~~Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.~~

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.I.K-CC Definitions Section**

  - The non-independent urban hospital definition is not new and will be used to identify system hospitals for the purpose of assigning the Operating Cash Flow Margin Percent (aka Solvency Metric).

  - Medicare Dependent Hospital (MDH) definition already exists so that leave us needing the Sole Community hospital definition to be added as well as a definition for PPS hospitals (Prospective Payment System hospitals).

  - We will also be checking to see if we can remove the definition for Urban Safety Net Hospital since that term no longer applies in our new base rate methodology.

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.5.A.1 Peer Groups**

8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services

1. Peer Groups

For the purposes of Inpatient reimbursement, DRG Hospitals are assigned to one of the following peer groups. Hospitals which do not fall into the peer groups described in a and b shall default to the peer groups described in c and d based on geographic location.:

a. Pediatric Hospitals

~~b. Urban Safety Net Hospitals~~ – need to ensure no other groups are using this designation before removing

~~c.~~ Rural Hospitals

d. Urban Hospitals

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.5.A.3.a.i Calculation of Starting Point for the Medicaid Inpatient Base Rate,**

3. Medicaid Inpatient Base Rate for In-network Colorado DRG Hospitals

a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate

i For in-state Colorado DRG Hospitals~~, excluding Rehabilitation Hospitals, Long-Term Care Hospitals,~~ CAHs, Pediatric Hospitals~~, and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year~~, the starting point shall be the hospital-specific Medicare Federal base rate with the specific adjustments listed. ~~minus any DSH factors~~. The Operating Federal Portion will be added to the Federal Capital Rate adjusted with Wage Index and Geographic Adjustment Factor as appears in the CMS corrected IPPS IMPACT File for each listed hospital. For CAH and Pediatric hospitals, both adjustment factors as listed above will be set to 1.0 and the corresponding labor and non-labor related amounts will be applied since these factors are not available from CMS. Additionally, all non-PPS hospitals are assumed to have submitted Quality Data and be meaningful EHR users. This is because there is no data available for non-PPS hospitals. The corrected Medicare base rate IMPACT File shall be used to set the Federal Base Rate and other adjustments detailed above effective on October 1 of the previous fiscal year.

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.5.A.3.a.ii Calculation of Starting Point for the Medicaid Inpatient Base Rate: Indirect Medical Education/Proxy Value Based Purchasing Adjustment Factor/Proxy Readmission Adjustment Factor & Hospital Acquired Conditions**

ii **Indirect Medical Education / Proxy Value Based Purchasing Adjustment Factor / Proxy Readmission Adjustment Factor & Hospital Acquired Conditions Reduction:**

- **For PPS hospitals**, Operating IME% will be multiplied by Adjusted Operating Federal Portion and the Capital IME% will be multiplied by the Adjusted Federal Capital Rate. The Proxy Value Based Purchasing Adjustment Factor and Proxy Readmission Adjustment Factor will be multiped by the Adjusted Operating Federal Portion. The Hospital Acquired Conditions Reduction will be applied against the Medicare Federal Base Rate w/Wage Index/GAF Adjustments.

- **For non-PPS hospitals**, Operating & Capital IME % are not calculated in the IMPACT File so the Department's Contractor will compute their Operating and Capital IME using the most recently available cost report as of Jan 1 in rebasing years and will require that hospitals have a CMS approved teaching program as detailed in 8.300.5.A.3.b.i-ii. Hospitals will have the opportunity to review these calculations for a 30-day review period and request changes if necessary. The Proxy Value Based Purchasing Adjustment Factor, Proxy Readmission Adjustment Factor & Hospital Acquired Conditions Reduction will not be applied to non-PPS hospitals since they are not calculated on the IMPACT File.

Non-PPS IME calculations will be using the most recently available cost report as of Jan 1 in rebasing years and will require GME program is certified by CMS.

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.5.A.3.a.iii Calculation of Starting Point for the Medicaid Inpatient Base Rate: Mutually Exclusive Medicaid Add-ons**

iii Medicaid Add-ons are as follows and will be applied as a percentage against the Medicare Federal Base Rate w/Wage Index/GAF Adjustments as detailed below.

- **Mutually Exclusive Medicaid Add-ons**: Four Add-ons will be mutually exclusive and applied as described above in iii
  - 1) Critical Access Hospital (CAH) Add-on will be set at 25% and is only open to those hospitals categorized as CAH by Medicare,
  - 2) Sole Community Hospital (SCH)/Medicare Dependent Hospital (MDH) will be set at 20% and is only open those hospitals categorized as SCH/MDH by Medicare,
  - 3) Low Discharge Add-on based on Total Discharge average of up to three years of most recently available cost reports on HCRIS as of Jan 1 of rebasing years and excludes hospitals that are classified as Pediatric, SCH/MDH or CAH. The percentage add-on is set at 10% and distributed on a sliding scale with a ceiling of 2,500 and floor of 500, and
  - 4) Pediatric Add-on is open only to hospitals defined as Pediatric in 8.300.1.K.3 and the percentage add-on is set at 25%.

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.5.A.3.a.iii cont'd Calculation of Starting Point for the Medicaid Inpatient Base Rate: Remaining Medicaid Add-ons**

- **Remaining Medicaid Add-ons:** The remaining add-ons are open to all hospitals who qualify and are applied as a percentage of the Medicare Federal Base Rate w/Wage Index/GAF Adjustments and distributed on a sliding scale between the respective ceiling and floor:

  - 1) Payer Mix Add-on is based on the percentage of Medicaid patients treated at the hospital using up to three years of the most recently available cost reports. The add-on is set at up to 10% with a ceiling and floor of 50% and 35% respectively. For hospitals with subunits of Psychiatric and Rehabilitation, Payer Mix in those subunits with be added to the total.

  - 2) Operating Cash Flow Margin Percent Add-on (also known as solvency metric) is set at 20% with a ceiling of 8% and floor of 0%. The source for this data comes from up to an average of 3 years of Hospital Transparency Data (source) and is based on the max of the hospital or the hospital system's (identified as Non-Independent Urban Hospital in 8.300.1.K.9) operating cash flow margin percent (whichever is higher).

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.5.A.3.b Application of GME Cost Add-On to Determine Medicaid Inpatient Base Rate**
- Now uses the most recently available cost report as of Jan 1 of rebasing years instead of audited cost reports.

b. Application of GME Cost Add-on to Determine Medicaid Inpatient Base Rate

i. The Medicaid Inpatient base rate shall be equal to the rate as calculated in 10 CCR 2505-10 Sections 8.300.5.A.3.a plus the GME Medicaid hospital-specific cost add-on. The GME Medicaid hospital-specific cost add-on are calculated from the most recently available Medicare/Medicaid cost report (CMS 2552) available as of January 1 of rebasing years. Partial year cost reports shall not be used to calculate the GME cost add-on.

The GME Medicaid hospital-specific cost add-on shall be an estimate of the cost per discharge for Graduate Medical Education (GME) based on:

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.5.A.3.b GME Cost Add-on**
- Now requires that GME programs be CMS qualified by appearing on list of CMS qualified teaching hospitals OR hospital to provide documentation proving Medicare approval of GME program.

1. Medicare approved GME program where legitimate GME expenses have been reported in accordance with Medicare's rules detailed in Title 42 Chapter IV Subchapter B Part 413 Subpart F. GME will be calculated when the following two criteria are met:

a. hospitals that appear on the most recent list as of Jan 1 of CMS qualified teaching hospitals on the CMS Open Payments website or the hospital will need to provide documentation to the State by proving Medicare approval of the GME program.

b. Have countable GME costs in the most recent cost report available as of Jan 1 of rebasing years in worksheet B, part 1 and discharges from worksheet S-3, part I.

ii Ten percent of the GME Medicaid hospital-specific cost add-on shall be applied.

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.5.A.3.c General Assembly Funding and 10% Corridor (new)**

c. Application of Adjustment Based on General Assembly Funding

- In rebasing years, for all in-state, Colorado DRG Hospitals, ~~excluding Urban Safety Net Hospitals,~~ the ~~starting point for the~~ Medicaid Inpatient base rate, as determined in 10 CCR 2505-10 Section 8.300.5.A.3.a - b, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. ~~Urban Safety Net Hospitals' starting point shall be adjusted by the percentage applied to all other Hospitals plus 10 percent. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent.~~

- In rebasing years, a 10% corridor has been implemented to prevent any hospital's inpatient base rate from increasing or decreasing more than 10% each rebasing year.

Draft Inpatient Base Rate Methodology

Proposed Changes to 10 CCR 2505-10 8.300: Hospital Services

- **8.300.5.A.3.e Annual Adjustments**
- We are now distinguishing between the rebasing every other year and the non-rebasing years when the State Budget Action is applied equally to all hospitals.

e. Annual Adjustments

The Medicaid Inpatient base rates are rebased every other year as described in 10 CCR 2505-10 Section 8.300.5.A.3.a - b and are effective ~~each~~ July 1. In non-rebasing years, the Medicaid Inpatient base rates will be adjusted by the State Budget Action as set by Legislature and are effective ~~each~~ July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department and/or adjustments necessary to balance the DRG payment equation. ~~For fiscal year 21-22, the Medicaid Inpatient Base Rates from fiscal year 20-21 will be adjusted by the percentage change in the budget as appropriated by the General Assembly. For fiscal year 22-23, the~~

Draft Inpatient Base Rate Methodology

- **8.300.5.A.4-6 Medicaid Inpatient Base Rate for New-Instate Colorado DRG Hospitals / Border-state Hospitals & Out-of-state Hospitals**

- Applying rates to New in-state, border state, and out of state hospitals will be applied same as always.

4. Medicaid Inpatient Base Rate for New In-State Colorado DRG Hospitals

The Medicaid Inpatient base rate for new in-state Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered "new" until the next Inpatient rate rebasing period after the Hospital's contract effective date. For the next Inpatient rate rebasing period, the Hospital's Medicaid Inpatient base rate shall be equal to the rate as determined in 10 CCR 2505-10 Section 8.300.5.A.3. If the Hospital does not have a Medicare Inpatient base rate or a full-year ~~audited~~ Medicare/Medicaid cost report to compute a starting point as described in 10 CCR 2505-10 Section 8.300.5.A.3, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals

The Medicaid Inpatient base rate for border-state Hospitals shall be equal to the average Medicaid Inpatient base rate for the corresponding peer group.

6. Medicaid Inpatient Base Rate for Out-of-state Hospitals

a. The Medicaid Inpatient base rate for out-of- state Hospitals~~, including out-of- state Hospitals,~~ shall be equal to 90% of the average Medicaid Inpatient base rate for the corresponding peer group.

Draft Inpatient Base Rate Methodology

- **8.300.7.A-B GME for Medicaid Managed Care Inpatient Services/Outpatient Services**

- General GME Managed Care Payments point to the new GME section which now uses unaudited cost reports available as of Jan 1 of each rebasing year and will continue to not be updated in non-rebasing years.

8.300.7.A GME for Medicaid Managed Care – Inpatient Services

1. The Hospital cost report used for the most recent rebasing shall be used to determine the Medicaid Inpatient GME cost per day for each Hospital that has GME costs in its fee-for-service base rate, excluding State University Teaching Hospitals. Each Hospital's GME cost per day shall be computed when Hospital rates are rebased according to the schedule outlined in **8.300.5.A.3.e**. Years when rates are updated with the State Budget Action as set by Legislature, GME cost per day will remain unchanged from the cost report rebasing.

2. MCOs shall provide to the Department Inpatient days by Hospital for discharges (net of adjustments) during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

3. The Medicaid managed care Inpatient days for each Hospital shall be the total of the Inpatient days for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the GME cost per day to determine the Inpatient GME reimbursement for each Hospital per quarter. The GME reimbursement will be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

8.300.7.B GME for Medicaid Managed Care – Outpatient Services

1. The Hospital cost report used for the most recent rebasing shall be used to determine the Outpatient GME cost-to-charge ratio for each Hospital that has a graduate medical education program. Each Hospital's GME cost-to-charge ratio shall be computed when Hospital rates are rebased according to the schedule outlined in **8.300.5.A.3.e**. Years when rates are updated with the State Budget Action as set by Legislature, GME cost-to- charge ratio will remain unchanged from the cost report rebasing.

2. MCOs shall provide to the Department Outpatient charges for Medicaid clients by Hospital for Outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

3. The Medicaid managed care Outpatient charges for each Hospital shall be the total of the Outpatient charges for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the cost-to-charge ratio and reduced by 28 percent to determine the Outpatient GME reimbursement for each Hospital per quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

Draft Inpatient Base Rate Methodology

- Please go to https://hcpf.colorado.gov/inpatient-hospital-payment to download the document showing the draft changes we reviewed today. The document will be deposited there by end of day Wednesday, 1/17/2023.

- If you have concerns or suggestions, please contact Diana Lambe at diana.lambe@state.co.us

Questions?

Updating Constant Contact List's

- To update/sign up for Constant Contact communications please visit the Hospital Stakeholder Engagement Meeting website

Home › For Our Providers › Provider Services › Billing Manuals › Hospital Stakeholder Engagement Meetings

Hospital Stakeholder Engagement Meetings

Important Update to Rural Health Clinic Reconciliations and Outpatient Hospital Cost Settlements

Next Hospital Stakeholder Engagement meeting is January 13, 2023 1.00pm-3.00pm

Please sign up to receive the Hospital Engagement Meeting newsletters. A week prior to the webinar, a reminder email with this inf posted closer to the date.

- Join Zoom Meeting

EAPG Module Update

- 3M released General Availability Version 2023.0.0 on 12/28/22
- Installed within interChange the week of 01/02/2023
- Applies quarterly CPT/HCPCS Updates
- Still working with 3M for Naloxone carveout for implementation in Licensed Software
  - InterChange processing Naloxone codes on OP claims correctly

EAPG Billing Guidance Updates

- EAPG 993 (Inpatient Only) List Updated
  - Appendix O updated to accommodate new codes
    - 14 HCPCS codes added
  - New add-on codes. See extra tab within Appendix O
- Unbundled DME List Updated
  - DME that is not bundled can be billed separately from institutional claim from DME supplier ID
  - Appendix G updated to accommodate 3.16 codes

Error in Pricing Claims

- Parallon notified the Department a pricing issue now identified as an open defect that impacted the drug direction for EAPG

- All impacted claims have been reprocessed with the correct pricing
  - Should be reflected in the Remittance Advices

- Please reach out to Tyler Samora and Andrew Abalos for assistance on identifying any claims.

Regular EAPG Version Updates

- The Department would like to start a discussion on how to do regular updates
  - Hospital Base Rates
  - EAPG Versions

- Motivation for each

- Ideally, alternate updates to base rates and EAPG versions on a yearly basis

- Our current proposition is to align with the State FY
  - Updates effective in July of each year

- Feedback? Please email Tyler Samora and Andrew Abalos

Outpatient Cost Settlements

- Payment methodology prior to EAPGs
  - Hospitals reimbursed around -70% of cost, depending on payment policies
  - Variance in timing due to complexity of cost reports

- Backlog of cost settlements remain unprocessed
  - More than half of Colorado Hospitals caught up with OP Cost Settlements

- Hospitals may have received Myers and Stauffer letters, but no official demand letters from HCPF
  - Demand letters for many outstanding settlements to be sent out in the coming weeks

- No Claims Reprocessing Required

Outpatient Naloxone Carveout

- Attach link to IP/OP billing manual for guidance
- HB22-1326 (Fentanyl Accountability And Prevention) Bill Signed into law May 25, 2022
- Within InterChange, any line billing procedure codes G1028, G2215, and G2216 will be 'carved out' of the EAPG payment
  - G1028
  - G2215
  - G2216
- 3M's Core Grouping Software is not updated but should be in forthcoming release from 3M

Inpatient Naloxone Carveout

- State:
  - Emergency Rule passed December 9, 2022

- Federal:
  - Pursuing a State Plan Amendment (SPA)

- Implementation:
  - Billing guidance will be updated in the provider bulletin and billing manuals when changes are complete

Questions, Comments, & Solutions

Thank You!

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