HOSPITAL STAKEHOLDER ENGAGEMENT MEETING

Thursday, March 4, 2021
2:00 PM - 4:00 PM

Friday, March 5, 2021
9:00 AM -12:00 PM

Location: Online Only

Rural Hospital Zoom Meeting: Dial Toll-free 833 548 0276 / Meeting ID: 912 7916 2807 / Passcode: 240320

All Hospital Zoom Meeting: Dial Toll-free 1 877-853 5257 / Meeting ID: 987 2946 5513 / Passcode: 353674

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

About this Zoom 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.
- Due to transition of colorado.gov/hcpf webpage to new content publishing platform, posting tentatively scheduled for early April

Thank you for your cooperation

AGENDA

March 2021 Hospital Stakeholder Engagement Meeting Topics
FY 20-21 Inpatient Claim Reprocessing Update
FY 21-22 State Budget Action Inpatient Base Rate Update
Draft Inpatient Base Rate Methodology Discussion
Rule Updates
Emergency Medicaid Services (EMS)
Outpatient Hospital Rate Update
EAPG Drug Re-weight Update
EAPG Module Update
EAPG Version Updates
Drug Acquisition Cost Surveys

2021 Rural Hospital Engagement Meeting Schedule

Rural Community Meetings 2021 Schedule			
Date	**RHC Time**	**Break**	**Hospital Time**
1/7/2021	12:30pm-1:30pm	1:30pm-2:00pm	2:00pm-4:00pm
3/4/2021	12:30pm-1:30pm	1:30pm-2:00pm	2:00pm-4:00pm
5/6/2021	12:30pm-1:30pm	1:30pm-2:00pm	2:00pm-4:00pm
7/8/2021	12:30pm-1:30pm	1:30pm-2:00pm	2:00pm-4:00pm
9/9/2021	12:30pm-1:30pm	1:30pm-2:00pm	2:00pm-4:00pm
11/4/2021	12:30pm-1:30pm	1:30pm-2:00pm	2:00pm-4:00pm

Dates and Times for Future General 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

Staffing Update

Welcome Jonathan Rempfer our new Specialty Hospital Rates Analyst

FY 20-21 Inpatient Rate Update

- FY 20-21 Inpatient Rates were approved by CMS on 12/22/2020.

- Updated rates were added to the claims system and the reprocessing of all claims with last date of service >= 7/1/2020 was completed by end of January.

- After reviewing the results, ~1,500 claims were not reprocessed. Identified claims will be reprocessed by early March at the very latest.

- A big thanks to those hospitals who reached out indicating there might be a problem. The Department is working with Gainwell to determine how to avoid this problem in the future.

Fixed Documentation on 7/1/2020 APR-DRG Weight Table

- The Department instituted APR-DRG weight table changes to separate Mom/Baby claims as of July 1, 2020.

- The weight tables loaded to the Inpatient Hospital Payment web page had the old weight, average length of stay (ALOS) and trimpoint data elements listed for DRG 541: VAGINAL DELIVERY W STERILIZATION &/OR D&C.

- A new weight table has been uploaded to the Inpatient Hospital payment web page fixing this error (see below).

- ***The Colorado interChange has been processing claim payments for DRG 541 using the correct weight, ALOS and trimpoint since the July 1, 2020, implementation.***

- Please contact Diana.Lambe@state.co.us with any questions.

7/1/2020: The Department separated Baby from Mom's claim on 7/1/2020 after three years of stakeholder discussion and involvement. The resulting change in Weights, Average Length of Stay (ALOS) and TrimPoint to Delivery and Neonate DRGs using the National HSRV file Ver 33 from 3M and multiplied by a factor of 1.2699 to achieve a budget neutral change in payment for hospitals. Reductions for IPP-LARCs devices were instituted after the budget neutral changes. DRG's 540, 542 & 560 weights were reduced by .004 to allow for a separate payment for IPP-LARCs devices. Please see IP/OP Billing Manual for billing instructions.

2.17.2021: DRG 541 Weights, ALOS and Trimpoints updated to reflect desired changes instituted on 7.1.2020.

COLORADO
Department of Health Care Policy & Financing

Updated 7/1/2020

Colorado Department of Health Care Policy and Financing

Weights and Trimpoints by All Patient Refined-Diagnosis Related Group (APR-DRG) and Severity of Illness (SOI)

APR_DRG	SOI	APR_DRG_DESC	SOI_DESC	DRG_WT	WT_SRC	ALOS	TRIMPOINT
541	1	VAGINAL DELIVERY W STERILIZATION &/OR D&C	Minor	0.7147	National HSRV adj to CO Wts	2.08	3
541	2	VAGINAL DELIVERY W STERILIZATION &/OR D&C	Moderate	0.7715	National HSRV adj to CO Wts	2.33	5
541	3	VAGINAL DELIVERY W STERILIZATION &/OR D&C	Major	1.0997	National HSRV adj to CO Wts	4.21	27
541	4	VAGINAL DELIVERY W STERILIZATION &/OR D&C	Extreme	2.9862	National HSRV adj to CO Wts	7.96	43

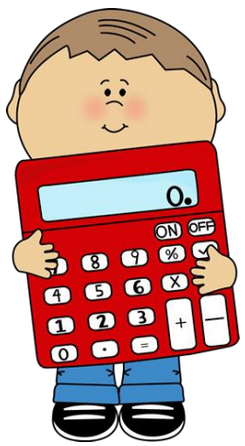
FY 21-22 State Budget Action Update

- The Department of Health Care Policy & Financing will use the upcoming State Budget Action (SBA) to update FY 20-21 base rates.

- The Department notified all hospitals that the SBA would be used to update FY 21-22 rates in an email sent January 21, 2021.

- Multiple instances of provider outreach occurred over the past few months including a survey along with discussion during the December and January Hospital Engagement Meetings.
  - Allows us to continue work on the draft base rate methodology in preparation for a 7/1/2022 implementation.
  - Removes the need to amend the rate building process due to the effects of COVID-19 on FY2020 utilization.

FY21-22 State Budget Action Update



- How does it work?

- If there is an SBA INCREASE, the new FY 21-22 rate would be Hospital's FY 20-21 Rate * (1 + x%)

OR

- If there is an SBA DECREASE, the new FY 21-22 rate would be Hospital's FY 20-21 Rate * (1 - x%)

FY 21-22 State Budget Action Update

- As the Department begins the process of making changes to the Colorado Code of Regulations, there will be time for public and stakeholder comment during the dates listed below.
  - Link to Medical Services Board
    - Public Rule Review Meeting: March 22, 2021
    - Medical Services Board Initial Presentation: April 9, 2021

- If your hospital has concerns with this approach, we urge you to contact Kevin.Martin@state.co.us, Andrew.Abalos@state.co.us or Diana.Lambe@state.co.us.

Draft Inpatient Base Rate Methodology

As a reminder, why we need to change the Inpatient Base Rate Methodology:

- Difficulty getting DRG Disclosures from Hospital Intermediaries.
- DRG Disclosures are in PDF format and require data entry.
  - DRG Cost Disclosures are incomplete and harmed hospitals who rightly deserved a Low Volume Payment.
    - Rural Hospitals participating in the Rural Hospital Community Demonstration were particularly affected by this.
    - We still need to get separate notification from Hospital Intermediaries to calculate Low Volume Payments for participating hospitals.
- Medicare does not build rates for Non-Prospective Payment System (PPS) Hospitals.

Draft Inpatient Base Rate Methodology

Where we left off…

- Letters from Colorado Hospital Association and several different hospital systems requested the following:

1. Apply Wage Index and Geographical Adjustment Factors to Federal Base Rate
2. Indirect Medical Education Add-Ons (Operating & Capital)
3. A Pediatric Hospital Add-On
4. Maintain current versions of Nursery & NICU Add-Ons

Draft Inpatient Base Rate Methodology

Just a few ground rules to establish before moving on…

- For demonstration purposes and to maintain compliance with HIPAA rules, hospital names will be masked and claim counts under 30 will be capped at 30.
- The structure of the spreadsheet will combine all Percentage Add-Ons that apply to the Adjusted Federal Base Rate vs. Other Add-Ons like GME / IME which are calculated using different numbers.
- Medicare Non-PPS hospitals = Critical Access Hospitals & Pediatric Hospitals
- The following order of decisions will be pursued:
  1. What add-ons/adjustments to include in the methodology
  2. How budget neutrality and corridor adjustments will be implemented in the methodology
  3. What percentage that will be applied to each add-on
     - Add-Ons will be color-coded to identify which groups are driving which add-ons.

Color-Coded Add-On Template	CHA/Hospital Driven
	HCPF Exec Level Driven
	HCPF Driven

1. CHA/Hospital Request: Apply Wage Index and Geographical Adjustment Factors to Federal Base Rate

Starting Point is Federal Base Rate

- The Department is open to making these changes, however we must make sure that how we institute this works for both PPS and non-PPS hospitals.

- Medicare does not provide Wage Index or Geographic Adjustment Factor (GAF) for non-PPS hospitals. The Department will be assigning Wage Index = 1 to them and non-PPS hospitals will be assigned the following figures for the Federal Base Rate. The number 1.00 will appear in the Wage Index and GAF calculations to produce a result.

FY 2020 Federal Base Rate / FY 2020 CN Tables 1A-1E			Non-PPS Medicare Hospitals
	Wage Index > 1	Wage Index < 1	Wage Index = 1
Labor-related Amount	$3,959.10	$3,593.91	$3,959.10
Nonlabor-related Amount	$1,837.53	$2,202.72	$1,837.53
Capital Std Fed Pmt Rate	$462.33	$462.33	$462.33
TOTAL:	**$6,258.96**	**$6,258.96**	**$6,258.96**

1. CHA/Hospital Request: Apply Wage Index and Geographical Adjustment Factors to Federal Base Rate

- The following change for PPS hospitals would appear as below:
  - Operating Labor-related Amount adjusted by the Wage Index (H*I)
  - Standard Federal Rate adjusted by Geographic Adjustment Factor (GAF) (L*M)
- Again, non-PPS hospitals will have a Wage Index and GAF = 1.00 entered in the calculation so the calculation produces a result.

COLUMN	H	I	J	K	L	M	N	O
X% ADD-ON = 10% for this demonstration	Medicare Labor-related amount (Source Impact File - Final Rule)	Wage Index (Source Impact File - Final Rule) Non_PPS Hospital Wage Index=1	Non-labor Related Amount (Source Impact File - Final Rule)	Operating Federal Portion w/Wage Index Adjustment ((H*I)+J)	Federal Capital Rate (Source Impact File - Final Rule)	GAF (Geographic Adjustment Factor) (Source Impact File - Final Rule) Non-PPS Hopital GAF=1	Adjusted Federal Capital Rate (Source Impact File - Final Rule) (L*M)	Medicare Federal Base Rate w/Wage Index/GAF Adj for PPS Hospitals / No Adj for Non-PPS Hospitals
RURAL HOSPITALS (hosp < 30 discharges for yr)								
Fake Hospital A: Independent Low Discharge	$3,593.91	0.9943	$2,202.72	$5,776.14	$462.33	0.9961	$460.53	$6,236.67
Fake Hospital B: CAH, Independent	$3,593.91	**1.0000**	$2,202.72	$5,796.63	$462.33	**1.0000**	$462.33	$6,258.96
Fake Hospital C: Not Independent	$3,593.91	0.9943	$2,202.72	$5,776.14	$462.33	0.9961	$460.53	$6,236.67
Fake Hospital D: Had High Medicare Base Rate	$3,593.91	0.9943	$2,202.72	$5,776.14	$462.33	0.9961	$460.53	$6,236.67
Fake Hospital E: Had High Medicare Base Rate	$3,593.91	0.9943	$2,202.72	$5,776.14	$462.33	0.9961	$460.53	$6,236.67
URBAN HOSPITALS								
Fake Hospital F: Independent	$3,959.10	1.0444	$1,837.53	$5,972.41	$462.33	1.0302	$476.29	$6,448.71
Fake Hospital G: Not Independent	$3,593.91	0.9943	$2,202.72	$5,776.14	$462.33	0.9961	$460.53	$6,236.67
Fake Hospital H: CAH, Independent	$3,593.91	**1.0000**	$2,202.72	$5,796.63	$462.33	**1.0000**	$462.33	$6,258.96
Fake Hospital I: Independent, Low Discharge	$3,593.91	0.9943	$2,202.72	$5,776.14	$462.33	0.9961	$460.53	$6,236.67
Fake Hospital J: Not Independent	$3,593.91	0.9943	$2,202.72	$5,776.14	$462.33	0.9961	$460.53	$6,236.67
Fake Hospital K: Independent	$3,593.91	0.9943	$2,202.72	$5,776.14	$462.33	0.9961	$460.53	$6,236.67
Fake Hospital L: Not Independent	$3,593.91	0.9943	$2,202.72	$5,776.14	$462.33	0.9961	$460.53	$6,236.67

2. CHA/Hospital Request: Indirect Medical Education (IME) Add-Ons (Operating & Capital)

- The following change for PPS hospitals would appear as below:
  - Operating & Capital IME Add-Ons are calculated (K * AL, N * AM, respectively)
- Non-PPS hospitals will not receive IME Add-Ons.

COLUMN	K	N	AL	AM	AN	AO
X% ADD-ON = 10% for this demonstration	Operating Federal Portion w/Wage Index Adjustment ((H*I)+J)	Adjusted Federal Capital Rate (Source Impact File - Final Rule) (L*M)	Operating IME % (Source Impact File - Final Rule)	Capital IME % (Source Impact File - Final Rule)	Operating IME ADD-On for PPS Hospitals who Qualify (K*AL)	Capital IME ADD-On for PPS Hospitals who Qualify (N*AM)
RURAL HOSPITALS (hosp < 30 discharges for yr)						
Fake Hospital A: Independent Low Discharge	$5,776.14	$460.53	0.0000	0.0000	$0.00	$0.00
Fake Hospital B: CAH, Independent	$5,796.63	$462.33			$0.00	$0.00
Fake Hospital C: Not Independent	$5,776.14	$460.53	0.0000	0.0000	$0.00	$0.00
Fake Hospital D: Had High Medicare Base Rate	$5,776.14	$460.53	0.0000	0.0000	$0.00	$0.00
Fake Hospital E: Had High Medicare Base Rate	$5,776.14	$460.53	0.0000	0.0000	$0.00	$0.00
URBAN HOSPITALS						
Fake Hospital F: Independent	$5,972.41	$476.29	0.0000	0.0000	$0.00	$0.00
Fake Hospital G: Not Independent	$5,776.14	$460.53	0.0546	0.0451	$315.55	$20.77
Fake Hospital H: CAH, Independent	$5,796.63	$462.33			$0.00	$0.00
Fake Hospital I: Independent, Low Discharge	$5,776.14	$460.53	0.0000	0.5270	$0.00	$242.69
Fake Hospital J: Not Independent	$5,776.14	$460.53	0.1033	0.0993	$596.73	$45.75
Fake Hospital K: Independent	$5,776.14	$460.53	0.2023	0.1903	$1,168.34	$87.62
Fake Hospital L: Not Independent	$5,776.14	$460.53	0.2250	0.2091	$1,299.63	$96.31

3. CHA/Hospital Request: Pediatric Hospital Add-On

- The Department has agreed to add a Pediatric Add-On to the Draft Inpatient Base Rate Methodology but would like to keep open the possibility of moving this add-on to the All Patient Refined Diagnostic Related Grouping (APR-DRG) Weight Table when the capability exists to apply an add-on weight factor based on patient age.

- We do not have a "sample" Pediatric Hospital example below since we are trying to mask specific calculations for each hospital. Please remember that actual percentage of add-ons that will be applied have yet to be determined.

COLUMN	U
X% ADD-ON = 10% for this demonstration	**Pediatric Add-On** (If Digits 3-4 in Medicare ID=33 (Pediatric Hosp), then X% Add-On)
RURAL HOSPITALS (hosp < 30 discharges for yr)	
Fake Hospital A: Independent Low Discharge	0%
Fake Hospital B: CAH, Independent	0%
Fake Hospital C: Not Independent	0%
Fake Hospital D: Had High Medicare Base Rate	0%
Fake Hospital E: Had High Medicare Base Rate	0%
URBAN HOSPITALS	
Fake Hospital F: Independent	0%
Fake Hospital G: Not Independent	0%
Fake Hospital H: CAH, Independent	0%
Fake Hospital I: Independent, Low Discharge	0%
Fake Hospital J: Not Independent	0%
Fake Hospital K: Independent	0%
Fake Hospital L: Not Independent	0%

4. CHA/Hospital Request: Maintain Current Nursery & NICU Add-Ons

History:

- Before 1/1/2014, the Department employed a modified version of CMS-DRGs version 24 which lacked the granularity of DRG and Severity of Illness (SOI) assignments to accommodate payment for neonates in a Medicaid population.

- It is our understanding the Department instituted NICU & Nursery add-ons to the base rate because CMS-DRG lacked this granularity.

- On 1/1/2014, the Department instituted APR-DRGs which intended for the more expansive non-Medicare population and introduced SOI which provides for higher payment based on the resources needed to treat more severe conditions.

- Nursery & NICU Add-Ons are calculated as 10% of Medicaid Cost Per Discharge.

4. CHA/Hospital Request: Maintain Current Nursery & NICU Add-Ons

HCPF's Position:

- In retrospect, the Department should have reviewed the need to continue Nursery & NICU Add-Ons prior to the roll-out of APR-DRGs on 1/1/2014.

- The Department's combining of Mom/Baby Claims at birth prior to 7/1/2020 is likely a complicating factor that kept this practice in place.

- As a rule of thumb, the Department cannot defend the approach of providing an add-on designed to address payment situations for a subset of the population to all claims.

- Currently, EVERY SINGLE CLAIM for hospitals who have Nursery & NICU departments receive an add-on. Payments for NICU/Nursery should not be made on a claim to fix a broken leg.

4. CHA/Hospital Request: Maintain Current Nursery & NICU Add-Ons

- Can hospitals share with us how the Severity of Illness changes in weights do not address the increased resources necessary to treat more severe cases that would appear in the NICU vs. Nursery departments?
  - What is lacking in the APR-DRG-SOI methodology payment here? Why would a separate add-on be needed to provide for increased resource utilization when severity of illness is meant to address it?
  - What coding is available on claims that we can use to identify claims that were treated in the NICU vs. Nursery departments? Revenue Codes? ICD-10 Diagnosis Codes? If we can separate NICU vs. Nursery claims, perhaps we can take a look and see if there is something that would support the need for a supplemental add-on.

It looks like revenue codes 017X that are not 0174 can be considered Nursery, while 0174 can be considered NICU (though this may also be Nursery?)

017x Nursery

Accommodation charges for nursing care to newborns and premature infants in nurseries.

SubC	Subcategory Definition	Standard Abbreviation	Unit	HCPCS
0	General Classification	NURSERY	Days	N
1	Newborn - Level I	NURSERY/LEVEL I	Days	N
2	Newborn - Level II	NURSERY/LEVEL II	Days	N
3	Newborn - Level III	NURSERY/LEVEL III	Days	N
4	Newborn - Level IV	NURSERY/LEVEL IV	Days	N
5-8	RESERVED			
9	Other Nursery	NURSERY-OTHER	Days	N

HCPF Driven: HAC / Readmissions from Medicare OR something else?

HCPF Executive Leadership specifically wants a Readmissions Measure based on Medicaid.

- There are two options:
  1. Build one measure for Medicaid readmissions (yet to be defined measure)
  2. Deny readmission claims for X type of claims if < 15 days from LDOS of initial claim.

- Current state is to use Medicare-Based Measures until Medicaid-specific measures can be assessed.

COLUMN	V	W	X	Y
X% ADD-ON = 10% for this demonstration	Readmission Factor	Medicare Readmission Reduction up to 3%	HAC Reduction Indicator Y=YES	Medicare HAC Reduction = 1%
RURAL HOSPITALS (hosp < 30 discharges for yr)	S:\DATA\DATA\HEDIS\HEDIS MY 2020 & 2021			
Fake Hospital A: Independent Low Discharge	1.0000	0.00%	N	0%
Fake Hospital B: CAH, Independent	0.0000	0.00%	0	0%
Fake Hospital C: Not Independent	0.9985	-0.15%	N	0%
Fake Hospital D: Had High Medicare Base Rate	1.0000	0.00%	Y	-1%
Fake Hospital E: Had High Medicare Base Rate	0.9995	-0.05%	N	0%
URBAN HOSPITALS				
Fake Hospital F: Independent	0.9931	-0.69%	Y	-1%
Fake Hospital G: Not Independent	0.9982	-0.18%	Y	-1%
Fake Hospital H: CAH, Independent	0.0000	0.00%	0	0%
Fake Hospital I: Independent, Low Discharge	1.0000	0.00%	N	0%
Fake Hospital J: Not Independent	0.9983	-0.17%	N	0%
Fake Hospital K: Independent	0.9991	-0.09%	N	0%
Fake Hospital L: Not Independent	0.9991	-0.09%	Y	-1%

HCPF Driven: Payer Mix Add-On & GME Cost Add-On

COLUMN	AA	AK
X% ADD-ON = 10% for this demonstration	**PAYER MIX ADD-ON**	**GME COST ADD-ON (10% of Medicaid Cost Per Discharge) (FY20-21 Amounts)**
RURAL HOSPITALS (hosp < 30 discharges for yr)		
Fake Hospital A: Independent Low Discharge	0.00%	$0.00
Fake Hospital B: CAH, Independent	10.00%	$0.00
Fake Hospital C: Not Independent	8.99%	$0.00
Fake Hospital D: Had High Medicare Base Rate	0.00%	$0.00
Fake Hospital E: Had High Medicare Base Rate	0.00%	$0.00
URBAN HOSPITALS		
Fake Hospital F: Independent	0.00%	$2.73
Fake Hospital G: Not Independent	0.00%	$62.93
Fake Hospital H: CAH, Independent	6.65%	$0.00
Fake Hospital I: Independent, Low Discharge	0.00%	$452.40
Fake Hospital J: Not Independent	0.00%	$84.88
Fake Hospital K: Independent	8.44%	$64.49
Fake Hospital L: Not Independent	0.00%	$76.74

HCPF Exec Level Driven: Critical Access Hospital (CAH) Add-On & Independent Add-On

COLUMN	R	T
X% ADD-ON = 10% for this demonstration	**CAH ADD-ON** (IF Y, HOSPITAL GETS X%)	**Independent** (IF HOSPITAL SYSTEM = NULL, THEN X%)
RURAL HOSPITALS (hosp < 30 discharges for yr)		
Fake Hospital A: Independent Low Discharge	0.0%	10.0%
Fake Hospital B: CAH, Independent	10.0%	10.0%
Fake Hospital C: Not Independent	0.0%	0.0%
Fake Hospital D: Had High Medicare Base Rate	0.0%	10.0%
Fake Hospital E: Had High Medicare Base Rate	0.0%	0.0%
URBAN HOSPITALS		
Fake Hospital F: Independent	0.0%	10.0%
Fake Hospital G: Not Independent	0.0%	0.0%
Fake Hospital H: CAH, Independent	10.0%	10.0%
Fake Hospital I: Independent, Low Discharge	0.0%	10.0%
Fake Hospital J: Not Independent	0.0%	0.0%
Fake Hospital K: Independent	0.0%	10.0%
Fake Hospital L: Not Independent	0.0%	0.0%

The Department is considering expanding the CAH add-on to include low-discharge hospitals (yet to be defined) to fulfill a Department goal without duplicating for hospitals that fit both definitions

HCPF Executive Level Driven: Net Patient Revenue, Operating Expense & Net Income Add-ons

COLUMN	AC	AE	AG
X% ADD-ON = 10% for this demonstration	NET PATIENT REVENUE (NPR) ADD-ON (X%/2 on graduating scale with X%/2=max amt)	OPERATING EXP ADD-ON (X%/2 on graduating scale with X%/2=max amt)	NET INCOME ADD-ON (X%/2 on graduating scale with X%/2=max amt)
RURAL HOSPITALS (hosp < 30 discharges for yr)			
Fake Hospital A: Independent Low Discharge	0.00%	0.00%	0.00%
Fake Hospital B: CAH, Independent	5.00%	5.00%	4.83%
Fake Hospital C: Not Independent	2.53%	5.00%	0.00%
Fake Hospital D: Had High Medicare Base Rate	0.00%	0.00%	0.00%
Fake Hospital E: Had High Medicare Base Rate	0.00%	0.91%	0.00%
URBAN HOSPITALS			
Fake Hospital F: Independent	2.13%	2.42%	4.64%
Fake Hospital G: Not Independent	0.00%	0.00%	0.00%
Fake Hospital H: CAH, Independent	0.00%	0.00%	0.00%
Fake Hospital I: Independent, Low Discharge	5.00%	5.00%	3.69%
Fake Hospital J: Not Independent	0.69%	1.88%	0.00%
Fake Hospital K: Independent	5.00%	2.88%	3.73%
Fake Hospital L: Not Independent	0.00%	0.00%	0.00%

Calculation of Estimated Budget Spend per Hospital based on Utilization

- Column AP: Total Add-Ons calculated based on percentage of Adjusted Federal Base Rate
- Column AQ: Total Add-Ons (GME, IME) that are calculated using differing numbers.
- Column AR: Final Federal Base Rate prior to any adjustments.
- Column AT: Estimated MMIS Discharges adjusted by expected caseload growth
- Column AU: Case Mix Index
- Column AV: Estimated Budget for State Fiscal Year by Hospital prior to budget neutral adjustments or corridors (AR * AT * AU)

COLUMN	AP	AQ	AR		AT	AU	AV
X% ADD-ON = 10% for this demonstration	Medicare Federal Base Rate w/Adjustments * % of All X% Add-Ons/Reductions (Column (O*(1+AI))	$ Amount Add-Ons (Column AK+AN+AO)	FINAL Federal Base Rate after X% Add-On Adjustments/Reductions + $ Amount Add-Ons		MMIS Discharges FY19-20 Inflated by (HCPF Budget Caseload Expected Growth) HARD CODED FOR PHI REASONS	Case Mix Index FY19-20	Estimated Payments New Base Rate Methodology
RURAL HOSPITALS (hosp < 30 discharges for yr)					1.15		
Fake Hospital A: Independent Low Discharge	$6,860.34	$0.00	$6,860.34		30	1.49	$306,622.16
Fake Hospital B: CAH, Independent	$9,064.88	$0.00	$9,064.88		393	0.89	$3,166,470.18
Fake Hospital C: Not Independent	$7,257.65	$0.00	$7,257.65		350	0.77	$1,948,791.06
Fake Hospital D: Had High Medicare Base Rate	$6,797.97	$0.00	$6,797.97		256	0.92	$1,609,615.88
Fake Hospital E: Had High Medicare Base Rate	$6,290.44	$0.00	$6,290.44		233	0.89	$1,309,676.20
URBAN HOSPITALS							
Fake Hospital F: Independent	$7,577.67	$2.73	$7,580.40		1,060	1.34	$10,742,889.97
Fake Hospital G: Not Independent	$6,163.08	$399.25	$6,562.32		3,265	2.09	$44,786,171.08
Fake Hospital H: CAH, Independent	$7,926.88	$0.00	$7,926.88		72	0.66	$373,754.88
Fake Hospital I: Independent, Low Discharge	$7,713.89	$695.09	$8,408.98		30	0.81	$203,478.05
Fake Hospital J: Not Independent	$6,386.32	$727.37	$7,113.69		3,680	1.50	$39,327,460.08
Fake Hospital K: Independent	$8,104.85	$1,320.45	$9,425.30		8,447	1.71	$136,223,313.42
Fake Hospital L: Not Independent	$6,168.69	$1,472.67	$7,641.37		9,623	2.00	$146,724,090.91

Draft Inpatient Base Rate Methodology

Next Steps

- Finalize Add-Ons / Adjustments
  - The Department needs to understand why APR-DRG Weights and Severity of Illness (SOI) is not covering the cost of resources provided by NICU & Nursery departments.
- Determine Corridor & Budget Neutral applications in new methodology
- Determine individual Add-On percentages

Questions or Comments?

Rule Updates

- Hospital and CC/CCEC rules will be updated to include the prudent layperson standard in the Emergency Care Services definition.
- CC/CCEC rule will be updated to include the new FSED license type and remove/replace references to CCECs. This update will align the Department with CDPHE's rule regarding these license types.

Contact Janna Leo and Justen Adams with questions

Emergency Medicaid Services (EMS)

The EMS benefit plan has two types of coverage:

1) **EMS COVID-19 Only Emergency Benefits for Uninsured Individuals for COVID-19 Laboratory Testing**

This benefit is limited to COVID-19 laboratory testing procedure codes. Only procedure codes covered under this policy should be submitted on a member's claims. Inpatient stays, and other services not listed on the COVID-19 webpage are not a payable benefit with this coverage.

Emergency Medicaid Services cont'd

2) **EMS**

This benefit is for individuals who meet eligibility criteria for Medicaid but who are not citizens, and are not eligible non-citizens. Coverage is limited to care and services that are necessary to treat the immediate emergency medical condition through which they became eligible for EMS.

Refer to the Verifying Member Eligibility and Co-Pay Quick Guide for more information on verifying member eligibility through the Provider Web Portal.

This information can also be found in the February 26, 2021 Provider News & Resources.

Contact Raine Henry with questions

Outpatient Hospital Rate Update

- CMS approved 1% decrease in EAPG rates effective July 1, 2020 on December 22, 2020

- All updated EAPG rates and effective mid-January 2021

- Claims reprocessed during 1/29, 2/5, 2/12, 2/19 financial cycles

- Drug re-weight claims were excluded – still being implemented in GWT

EAPG Drug Re-weighting Update

- Balances payment for drugs provided in outpatient hospital setting to reflect cost discrepancies in hospital groups, effective June 1, 2020
  - See EAPG Drug Re-Weight Meetings for more detail

- All authorities required for implementation

- Collaborating with Gainwell Technologies (formerly DXC) and 3M for system implementation with mass adjustment to follow

EAPG Drug Re-weighting Update

- Internal work with GWT for continued use of 3M modules (both APR-DRG and EAPG pricing), transition to version 3.16 of EAPGs
- Work cannot be completed in parallel
  - Claims impacted by drug re-weighting payment policy tentatively scheduled for reprocessing third quarter of calendar year
- ~44k claims currently impacted, will be adjusted following implementation (estimated ~56k claims total)

EAPG Module Update

- 3M to v2021.1.1 on March 25, 2021
- Scheduled installation date March 31, 2021
- Accommodates CPT/HCPCS quarterly updates with no other scheduled changes
- Version 3.10 remains in effect

EAPG Version Updates

- 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 released 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 by 3M based on changes in costs of procedures associated with EAPGs (National Weights)

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)**

EAPG Version Updates

- Please see December 11, 2020 Hospital Stakeholder Engagement Meeting for proposed methodology for transition

- National Weights developed by 3M were made available mid-January for payment modeling

EAPG Version Updates

- Updating will require changes to rule and SPA

- Rule updates can only be made prospectively, as opposed to SPA (with some limitations)

- Due to interest in collaboration with stakeholders and thorough fiscal impact analysis, reconsideration of July 1, 2021 implementation date – likely implementation fourth quarter CY2021

EAPG Transitions

- Updating from version 3.10 to 3.16 creates 84 new EAPGs (564 to 648)
  - Includes 10 additional drug EAPGs
- Will update consolidation and packaging lists (Appendix D for Packaging, Appendix E for Consolidation in 3M Definitions Manuals)

Update to EAPG Packaging List

- Packaged EAPGs MAY have payment bundled into Medical Visit / Significant Procedures
- Common codes ADDED to list:

Procedure Code	Description	Count
80053	COMPREHEN METABOLIC PANEL	218,631
80048	METABOLIC PANEL TOTAL CA	116,450
84484	ASSAY OF TROPONIN QUANT	62,749
87591	N.GONORRHOEAE DNA AMP PROB	46,148
80320	DRUG SCREEN QUANTALCOHOLS	33,321
80076	HEPATIC FUNCTION PANEL	32,952
83605	ASSAY OF LACTIC ACID	32,376
80061	LIPID PANEL	32,063
94640	AIRWAY INHALATION TREATMENT	23,387
80047	METABOLIC PANEL IONIZED CA	20,796

Update to EAPG Packaging List

- Codes were also removed – still subject to EAPG payment actions (consolidation, discounting)
- Common codes REMOVED from list:

Procedure Code	Description	Count
97597	RMVL DEVITAL TIS 20 CM/<	994
88172	CYTP DX EVAL FNA 1ST EA SITE	795
69209	REMOVE IMPACTED EAR WAX UNI	739
16020	DRESS/DEBRID P-THICK BURN S	688
69200	CLEAR OUTER EAR CANAL	458
69210	REMOVE IMPACTED EAR WAX UNI	441
30901	CONTROL OF NOSEBLEED	385
30300	REMOVE NASAL FOREIGN BODY	358
36593	DECLOT VASCULAR DEVICE	297
88177	CYTP FNA EVAL EA ADDL	187

Updates to IP-Only List

- Version 3.10 did not pay for EAPG 993 (IP-only) procedure codes

- 3.16 removes codes from EAPG 993 list (see below for examples)
  - Still subject to payment actions (consolidation, discounting)

Procedure Code	Description
50780	REIMPLANT URETER IN BLADDER
22552	ADDL NECK SPINE FUSION
38724	REMOVAL OF LYMPH NODES NECK
27514	TREATMENT OF THIGH FRACTURE
27280	FUSION OF SACROILIAC JOINT
27506	TREATMENT OF THIGH FRACTURE
27130	TOTAL HIP ARTHROPLASTY
27485	SURGERY TO STOP LEG GROWTH
27486	REVISE/REPLACE KNEE JOINT
50545	LAPARO RADICAL NEPHRECTOMY

Drug Surveys

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

- Myers and Stauffer – obtained information from several hospitals
  - Variety of formats were allowed for this
  - Cleansing data for draft analysis

Questions, Comments, & Solutions

Thank You!

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