HOSPITAL STAKEHOLDER ENGAGEMENT MEETING

Friday, March 4, 2022
9:00 AM - 12:00 PM

Location: Online Only

<u>All Hospital Zoom Meeting</u>: 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

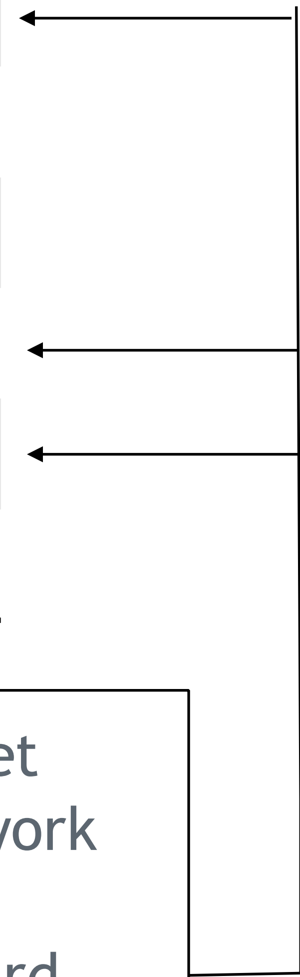
About this Zoom Meeting

- 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.
- **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 Future General Hospital Stakeholder Engagement Meetings in 2022

Dates of Meetings	Meeting Time
~~January 14, 2022~~	~~1:00pm-4:00pm~~
~~March 4, 2022~~	~~9:00am-12:00pm~~
May 6, 2022	9:00am-12:00pm
July 8, 2022	1:00pm-4:00pm
September 9, 2022	1:00pm-4:00pm
November 4, 2022	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

AGENDA

March 2022 Hospital Stakeholder Engagement Meeting Topics
Overview of Inpatient Payment Methodology Changes Timeline
FY 22-23 State Budget Action Inpatient Base Rate Update
Inpatient Base Rate Methodology discussions reboot
EAPG Module Update
EAPG 3.16 Base Rate Calculations
EAPG Billing Guidance Updated
EAPG Transition Payment Authority
Outpatient Claims Processing
OP Claims with Prior Authorization
Outpatient to Outpatient Transfer Policy
Inpatient Only List
Drug Average Acquisition Cost – Long-term Solution

INPATIENT BASE RATE METHODOLOGY & APR-DRG VERSION UPDATE TIMELINES

7/1/2020

MOM/BABY CLAIMS SEPARATED TO ALLOW FOR USE OF THE 3M™ APR-DRG HSRV WEIGHT TABLE IN FUTURE VERSION UPDATES. IP BASE RATE REBASED PER CURRENT METHODOLOGY

7/1/2021

DISCUSSIONS ON INPATIENT BASE RATE REFORM SUSPENDED DUE TO COVID CONCERNS, IP BASE RATE UPDATED WITH STATE BUDGET ACTION (SBA)

7/1/2022

DISCUSSIONS ON INPATIENT BASE RATE REFORM SUSPENDED AGAIN DUE TO REQUEST FROM CHA AND HOSPITALS RE: VARIOUS HOSPITAL CHANGES IN EAPG AND SPECIAL FINANCING LEADING TO NEED TO UPDATE IP BASE RATE WITH SBA AGAIN

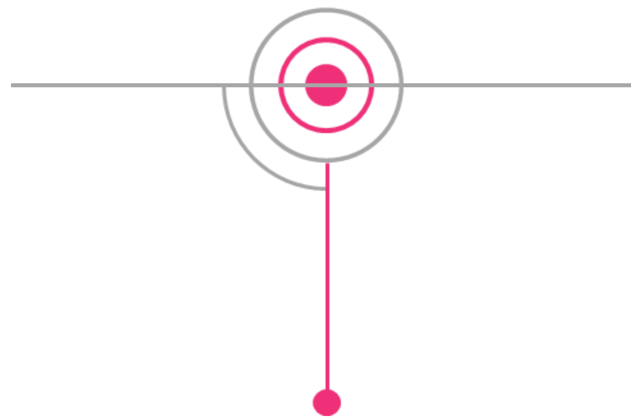
7/1/2023

MARCH 2022 WORK ON IP BASE RATE REFORM RESTARTS WITH 7/1/2023 AS PLANNED IMPLEMENTATION DATE. **RULE MAKING TIMELINE REQUIRES METHODOLOGY BE SOLIDIFIED BY JANUARY 2023**. WORK ON APR-DRG VERSION UPDATE BEGINS IMMEDIATELY AFTER BASE RATE REFORM IMPLEMENTED

7/1/2024

GOAL IMPLEMENTATION DATE FOR NEWEST APR-DRG VERSION, IP BASE RATES WILL BE UPDATED WITH SBA PER EXPECTED RULE CHANGES.

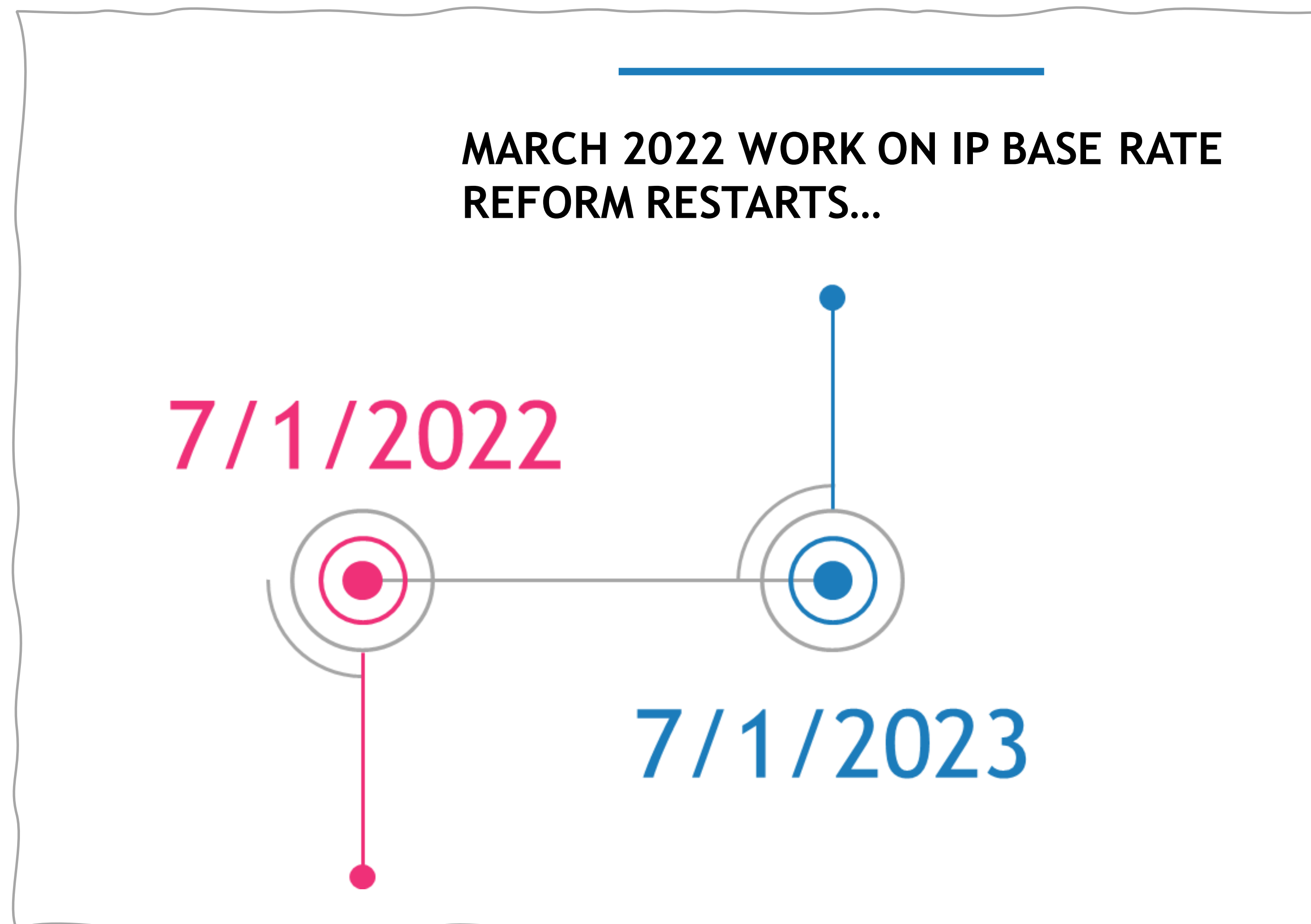
IP BASE RATE UPDATED WITH SBA



- In preparation for how rates will be updated for 7/1/2022, the Department will again be applying the State Budget Action as set by Legislature to update Hospital Base Rates for next year.
- Managed Care GME payment rates will remain the same for State Fiscal Year (SFY) 22-23 as they were for SFY 20-21 since that was last year inpatient hospital base rates were re-based.
- The Department will be presenting this rule change to the Medical Services Board (MSB) on Friday, March 11th.
  - A link to the meeting will be available on the MSB webpage the day of the meeting.
- Contact Diana Lambe at diana.lambe@state.co.us if you have any concerns.

Restart work on the Draft Inpatient Base Rate Methodology

In order to restart the process, we will be covering some old ground to remind everyone where we left off during this meeting so we can start covering new ground during the May 2022 Hospital Engagement Meeting.



Draft Inpatient Base Rate Methodology

Where we left off in March 2021…

➢ 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 data points.
- 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 Hospital 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 it stands now, 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.

2022 Update: Based on our research of information contained on claims, we cannot distinguish between children who have been cared for in a Nursery vs. a NICU department.

In order to further pursue this, the Department needs to understand from hospitals why the differences in the APR-DRG Weights by Severity of Illness (SOI) is not covering the cost of resources provided by NICU & Nursery departments.

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.

2022 Update: Based on prior feedback from Hospital Engagement stakeholders, we understand that instituting a new measure will require significant lead time and coordination with hospitals. This measure will likely not be explored until after the new base rate methodology is deployed and the new APR-DRG version has been updated.

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 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%

2022 Update: In May 2021, the Department combined the Critical Access Hospital (CAH) and Low discharge hospital add-ons on a sliding scale to eliminate duplicating add-ons for hospitals who fit both definitions.

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%
F			0.00%
U			
F			4.64%
F			0.00%
F			0.00%
F			3.69%
F			0.00%
F			3.73%
Fake Hospital L: Not Independent	0.00%	0.00%	0.00%

2022 Update: We have since found out that the Operating Expense Add-On may contain Provider Fees and the Net Income Add-On may not be the correct measure the Executive Director wants incorporated into the base rate. We will meet with Special Financing Team and come back to the group with other suggestions.

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

May 2021 Updates to Base Rate Methodology Workbook:

1. Updated claim counts & case mix index to calculate budget.

2. Updated Cost Report Data used in add-on calculations to data available as of December/January 2021.

   - Uses maximum of 3 year's worth of full-year reports. For new hospitals, one to two year's worth of reports will be used. New hospitals with no cost reports on file will not receive add-ons until they do have cost reports.

3. Added low discharge hospital component working on a sliding scale (ceiling/floor) to the Critical Access Hospital add-on.

4. Updated Color-Coded Add-On Template

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

CAH OR LOW DISCHARGE HOSPITAL ADD-ON
Independent (IF HOSPITAL SYSTEM = NULL, THEN X%)
Pediatric Add-On (If Digits 3-4 in Medicare ID=33 (Pediatric Hosp), then X% Add-On)
Medicare Readmission Reduction up to 3%
Medicare HAC Reduction = 1%
PAYER MIX ADD-ON
NET PATIENT REVENUE (NPR) ADD-ON
OPERATING EXPENSE ADD-ON
NET INCOME ADD-ON
GME COST ADD-ON (10% of Medicaid Cost Per Discharge) (FY20-21 Amounts)
Operating IME ADD-On for PPS Hospitals who Qualify
Capital IME ADD-On for PPS Hospitals who Qualify

Draft Inpatient Base Rate Methodology

May 2021 Updates to Base Rate Methodology Workbook cont'd:

5. **Computing Budget Neutrality:** Originally tried to used the "Solver" add-in from Excel which allows constraints like the +/-10% corridor to be entered into the "Goal Seek" type solution. However, we found that solution (regardless of different methods offered) tended to automatically input the outer edges of the corridors to arrive at a result.

- ➢ The Colorado Hospital Association agrees that a solution that doesn't automatically inflict maximum corridor adjustments to hospital base rates in the form of the -/+10% base rate change from prior year is a better method to pursue.
- ➢ The resulting calculation reflects an attempt to minimize the number of hospital base rates at the edges of the corridor.

Draft Inpatient Base Rate Methodology

May 2021 Updates to Base Rate Methodology Workbook cont'd:

6. Sample spreadsheet demonstrating the method will be available on the Inpatient Hospital Payment web page to download and view how all calculations work. **Excel document name:** Draft Inpatient Hospital Base Rate Methodology May 2021 Stakeholder Review

During last year's May Hospital Engagement Meeting, Kevin went into detail in explaining how the budget neutrality calculations work and that discussion can be found here: May 7, 2021 Webinar Recording. Forward to timestamp: 20:14 to watch.

Questions?

EAPG Module Update

- No updates to the module in interChange as of January's stakeholder engagement meeting

- Still using version 3.10 of EAPGs
  - Depending on when we receive SPA approval, we will update GPCS with most recent version
    - Likely v 2022.1.0 which will be released on March 24th

- Applies off-quarter CPT/HCPCS Updates
  - As a reminder, version 3.10 does not recognize codes effective 1/1/22 and beyond
  - Claims currently in suspense if code effective on or after 1/1/2022 is billed

EAPG Base Rate Calculations

- Process for 3.16 Hospital-specific Base Rates detailed in November 2021 Hospital Stakeholder Engagement Meeting

- Base rates and EAPG weights posted to the Outpatient Hospital Payment web page
  - Not in effect until 3.16 implementation

- For questions regarding base rate calculations, please contact Andrew Abalos and Tyler Samora

EAPG Billing Guidance Updated

- Version 3.16 updates inpatient-only list
  - 3M to eventually transition out of 3M developed list
  - Appendix O applies to claims with FDOS on or after 1/1/22
    - Claims still processed using 3.10 logic
  - CMS list still in effect, enforced through NCCI/MUE editing

- Unbundled DME List Updated
  - See points above
  - DME that is not bundled can be billed separately from institutional claim from DME supplier ID
  - Appendix G updated to accommodate 3.16 list of codes

EAPG Transition Payment Authority

- Base-rate setting methodology, scaled 3M weight list presented to Medical Services Board (MSB)
  - Approved for transition to take effect January 1, 2022

- State Plan Amendment submitted to Centers for Medicare and Medicaid Services in December
  - Approved for transition to take effect January 1, 2022
  - The 90-day deadline will be toward end of March
  - Rate load to occur first, then interChange to switch to 3.16 processing January 1, 2022 DOS claims and beyond

Outpatient Claims Processing

- As of today, still processing Outpatient Hospital claims with FDOS under version 3.10 of EAPG methodology
  - Base rates in effect immediately prior to 1/1/22 still in use

- Claims using any new CPT/HCPCS codes (effective 1/1/22 and beyond) in state of suspense
  - As of earlier this week, interChange reported 400 total suspended claims
  - Weekly reports delivered to HCPF

- Payment comparisons between 3.10 and 3.16 claims periodically performed – significant budgetary impacts monitored

- As of this week, ~250k claims will be targeted for reprocessing

OP Claims with Prior Authorization

- January meeting – question regarding Kepro for how claims with prior authorization would be handled
- HCPF objective – if claim with PA was paid prior to 3.16 reprocessing, then claim will pay after 3.16 reprocessing
- Claim denials resulting will be closely monitored – if any trends in denials occur, billing guidance to be updated accordingly and brought to engagement meeting

Outpatient to Outpatient Transfer Policy

- At present, no policies impacting payment in place for outpatient-to-outpatient transfers
- Example – patient stabilized at hospital A, transferred to hospital B for necessary services
- Both hospitals A and B will receive EAPG payment in accordance with services provided

Inpatient Only List

- As discussed, EAPG version 3.16 will use updated Inpatient Only List
- Current functionality – EAPG 993 (IP-Only), when assigned, will result in "Paid" status for line item
- All paid claims targeted for reprocessing upon SPA approval
- Version 3.10 IP-Only line items billed for FDOS on or after January 1, 2022 that are not on 3.16 list may generate non-zero payment
- Providers should re-bill denied claims with IP Only procedures if they feel payment is appropriate

Drug Average Acquisition Cost – Long-term Solution

- Problem – EAPG methodology does not adequately account for disparities in cost within EAPG Drug Bundles

- Short-term solution – drug re-weight implemented June 1, 2020 to help accommodate differences in cost profiles

- Hospitals have been surveyed for Average Acquisition Costs through Myers and Stauffer

- **GOAL:** Carveout drug payments for Outpatient Hospital from EAPG

Drug Average Acquisition Cost – Long-term Solution

- Method relies heavily on information obtained from hospitals
  - Maintaining this methodology will require regular surveying
  - Benefit of frequent surveys is up-to-date information, but cost is administrative burden to hospitals
  - HCPF open for discussing frequency of surveys / updates
- **Budget Neutrality constraint – cannot implement without payment reduction to EAPG payment bundles**
  - **Reminder –** EAPG intends to pay for outpatient visits as unit of service
  - **Costs of bundled drugs included in payment for Significant Procedures and Medical Visits – therefore, these services will have EAPGs weights reduced to accommodate payment differential**
- **Date of proposed change –** No firm date
  - As early as January 2023
  - No later than July 1, 2023

Questions, Comments, & Solutions

Thank You!

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