HOSPITAL STAKEHOLDER ENGAGEMENT MEETING

Friday, March 1, 2024
9:00 AM - 11:00 AM

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 2024
General Hospital Stakeholder Engagement Meetings

Dates of Meetings	Meeting Time
~~January 12, 2024~~	~~1:00pm-3:00pm~~
~~March 1, 2024~~	~~9:00am-11:00am~~
May 3, 2024	9:00am-11:00am
July 12, 2024	1:00pm-3:00pm
September 6, 2024	9:00am-11:00am
November 1, 2024	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

March 2024 Hospital Stakeholder Engagement Meeting Topics - mm:ss
FY 23-24 Inpatient Hospital Base Rates Update – 3:35
Version 40 Update – Hospital Feedback Requested – 5:30
Version 40 State Plan Changes – 10:10
Proposed Timeline of Regulatory Changes - 19:00
EAPG Module Update -20:05
Multiple E&M Code Billing - 20:41
Future Outpatient Hospital Payment Projects - 23:21
Regulatory Updates - 36:34
(OPR) Provider Claim Edit - 41:10
Behavioral Health Billing questions - 42:47

FY 23-24 Inpatient Base Rates

- On Feb. 9, 2024, the Centers for Medicare & Medicaid Services (CMS) approved State Plan Amendment CO-23-0003, which authorizes HCPF to implement its revised inpatient hospital base rate methodology effective July 1, 2023.

- HCPF will be implementing the related base rates into its MMIS in February and will begin work on the retroactive claims adjustments for claims with Through Dates of Service on or after July 1, 2023. Claims adjustments related to this effort are anticipated to occur throughout March 2024.
  - Hospitals can download the CMS approval letter by searching for transmittal **CO-23-0003** on the CMS website.

- Contact Diana Lambe at Diana.Lambe@state.co.us with any questions relating to the topic of the implementation of the July 1, 2023, new inpatient hospital base rate methodology.

Version 40 Update – Hospital Feedback

- APR-DRG transition to Version 40 Proposed Weights have been available as of December 2023 on Inpatient Hospital Payment page

- January Hospital Stakeholder Engagement Meeting had call to action for feedback – no feedback received

- Hospital-specific payment differentials used in Version 40 modeling to be posted. **Intends to show difference in version 33 and version 40 payments for Calendar Year 22 used for DRG statistics calculation.** True fiscal impacts will depend on hospital-specific case-mix on implementation.

- **Feedback requested by end of day 4/1/2024**

- Impacts to implementation date

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TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

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I. Methods and Standards for Establishing Prospective Payment Rates - Inpatient Hospital Services

A. Payment Methods for Hospitals

Effective December 15, 1989 (unless otherwise specified in this plan) the following prospective. payment method shall apply to all Colorado participating hospitals except those specialty hospitals and units within general acute care hospitals designated by the State agency as exempt.

B. Definitions

1. Diagnosis Related Group (DRG): Means a cluster of similar conditions within a classification system used for hospital reimbursement. It reflects clinically cohesive groupings of inpatient hospitalizations that utilize similar amounts of Hospital resources. ~~A patient classification system that reflects clinically cohesive groupings. of inpatient hospitalizations utilizing similar hospital resources. Colorado will adopt the Medicare classification system as a base for the DRG payment system. The State Agency has the authority to make changes to the Medicare grouper methodology to address issues specific to Medicaid~~.

2. Principal Diagnosis: The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

Modified definition to match what appears in Rule.

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2. Principal Diagnosis: The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

3. Relative Weight: Refers to ~~either~~ the DRG weight ~~or the Enhanced Ambulatory Patient Grouping (EAPG) weight,~~ which represents a numerical value that reflects the relative resource consumption for the DRG ~~or EAPG~~ to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost for each DRG ~~or EAPG~~. Relative weights are intended to be cost effective, and based upon national data, as available. ~~A numerical value which reflects the relative resource consumption for the DRG to which it is assigned. A specific Colorado case mix index is calculated by adding the relative weights of all DRG cases for a specific period of time and dividing by the total number of cases.~~

~~4. Modifications to these relative weights will be made when needed. Relative weights are intended to be cost effective, and based upon Colorado data as available. The State Agency shall rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG.~~. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight.

Again, modified definition to match what appears in Rule but removed reference to EAPG since that appears in another section (4.19B).

Modified language since relative weights will be based on national data based on the HSRV file and consolidated sentences to avoid duplication.

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4. Hospital Peer Groups: A grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. The peer groups. are defined as follows:

   a. Pediatric Specialty Hospitals: all hospitals providing care exclusively to pediatric populations.

   b. Rehabilitation Hospitals: hospitals providing rehabilitation (excluding distinct part units and satellite locations).

   c. Specialty-Acute Hospitals: hospitals providing specialty-acute care (excluding distinct part units and satellite locations).

   d. Spine/Brain Injury Treatment Specialty Hospital: hospitals providing specialty-acute care and/or rehabilitation care specializing in treatment of a current spine and/or brain injury

   e. Rural Hospitals: Colorado Hospitals not located within a federally designated Metropolitan Statistical Area (MSA).

   f. Urban Hospitals: all Colorado hospitals in MSA's including those in the Denver MSA. Also included would be the Rural Referral Centers in Colorado, as defined by HCFA. (SSAS, 1886 (d) (5) (c) (I); Reg. 412.90 (c) and 412.96).

   Facilities which do not fall into. the peer groups described in a. through d. will default to the peer groups described in e. and f. based on geographic location.

5. Medicare Base Rate: The hospital specific Medicare base rate, which will be obtained directly from the Medicare Intermediaries represents the payment a hospital would receive from Medicare for a DRG with a weight equal to one. The Medicare base rate used for rate setting each State Fiscal Year (July 1 through June 30) will be those effective on each October 1 prior to the beginning of the State Fiscal Year..

Intention is to remove the portion that refers to Medicare Base Rate since we only use portions of the inputs to Medicare Base Rates in the Medicaid Base Rate methodology.

We also do not obtain anything from the Medicare Intermediaries anymore since we are using online CMS HCRIS reports and CMS IMPACT File for the necessary information.

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10. Outlier Days: The days in a hospital stay which occur after the trim point. The trim point is that day which would occur at 1.94. standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996,. the number of standard deviations may be adjusted when changes are made to the DRG grouper methodology. Beginning July 1, 2024, the Trim Point Day for all DRGs is equal to the Trim Point Day as calculated in the applicable 3M© Hospital Specific Relative Value (HSRV) National Weight File. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by ~~DRG per diem rate, which is the DRG base payment divided by~~ the DRG average length of stay.

11. ~~Infant Cost Outlier. To address the need for adequate payment for pediatric hospitalization involving exceptionally high costs or long lengths of stay, the State established day outlier payment at 80% of the hospital DRG per diem (rather than 60%,. the Medicare rate) rather than to establish a separate cost outlier mechanism.~~¶

C. DRG Method of Payment

1. The DRG will be assigned to an inpatient claim on the basis of the principal diagnosis for which the patient was treated, surgical procedures involved, and complication of the illness. Every DRG has been assigned a relative weight and trim point,. based primarily on Colorado-specific cost data. The State Agency shall periodically rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG.

2. The DRG relative weight will be multiplied by the base rate for the hospital to generate the payment amount.

3. When ~~approved~~ outlier days occur, 80% of the DRG per diem will be paid for each additional outlier day. The DRG per diem is the total DRG base payment divided by the average length of stay. The percentage will be determined by the State Agency.

Modify the existing definition for Outlier Days to point to the Trim Point Day as appears in the 3M Hospital Specific Relative Value (HSRV) National Weight File.

Removed duplicative language in the definition of DRG per diem rate.

Intention is to remove "Infant Cost Outlier" definition which is a left over from MS-DRGs (we think, which dates to before 1/1/2014) and establishes the outlier percentage paid to infant claims at 80% instead of 60%.

Duplicate language – we'll check with CMS whether we should leave in or remove since it appears in a different section than the definition above.

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b. In cases involving transfers, each hospital involved will be paid a DRG per diem for each ~~case~~ covered day based upon the full DRG base payment divided by the average length of stay for the DRG (up to a maximum of one full DRG payment.) These discharges may also qualify for outlier payment.

c. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's' medical needs are best met at another PPS facility. Documented emergency cases are exempt from prior authorization.

D. Adjustments To The Payment Formula

1. Adjustments to the DRG classification system, weights, and trim points will be made when appropriate.

Corrected the sentence to read: "will be paid a DRG per diem for each ~~case~~ covered day based on the full DRG base payment divided by…"

Timeline for Regulatory Changes

4.19A State Plan Changes Timeline

- The Department will need to post both public noticing and tribal consultation before submitting the State Plan Amendment (SPA).

- The effective date of the new SPA must be after the public noticing, and the SPA can only be submitted 30 days after the tribal consultation. We will keep you up to date on the timing of the SPA submission.

- Suggestions from hospital stakeholders on the proposed SPA changes are due by end of day **4/1/2024** to Diana.Lambe@state.co.us.

EAPG Module Update

- 3M released General Availability Version 2024.1.0 on March 28, 2024
- Installed within interChange the week of 4/1/2024
- Applies quarterly CPT/HCPCS updates

Multiple E&M Code Billing

- EAPG 449 – Additional Undifferentiated Medical Visits/Services
- October 31,2016: removed from EAPG packaging list. Nonzero weight
  - With modifier 27 and no significant procedures, this allowed payment for multiple E&M codes
- January 1, 2022: 449 still removed from packaging list. Zero weight
- Please continue using modifier 27 as this will allow accurate assessment of any future payment policy related to this modifier or E&M codes.

Future Outpatient Hospital Payment

- Analysis on long-term reimbursement for Outpatient Hospital drugs
  - Currently modeling EAPG versus alternatives
    - EAPG payment bundles are based on median doses, previous ASP
    - Updates in drug payments tied to EAPG version changes
    - Wide variation in drug payments through Drug Re-weight (June 2020)
    - Average Sales Price ± %, 340B Considerations
      - Aligns with basis for Medicare payments
      - ASP does not capture Colorado hospital-specific costs, based upon manufacturer provided data
      - ASP not available for all lines considered “drugs” in EAPGs
    - Average Acquisition Cost ± %, 340B
      - Requires periodic surveying of hospitals – requiring updated survey
      - Previous effort in late-2021
- Long-term Base Rate Setting
  - Still using modified implementation rates, adjusted for annual changes in appropriations and budget neutral figures from 3.16

Future Outpatient Hospital Payment (cont’d)

- Need for greater frequency of updates to continue aligning payments with modernized cost experiences, advancements in medicine

- Adds/removes EAPGs, up to date drug pricing

- Opportunity for review of payment mechanisms employed through EAPG methodology (e.g. modifier 27, amongst others)

Regulatory updates

- Inpatient Specialty Drug Carveout 23-0042
  - Submitted to CMS January 2, 2024
    - 90-day clock for CMS response set to expire April 1, 2024
    - Payments to continue within APR-DRG methodology until SPA approval – retroactive claims adjustments to follow
  - Related Emergency Rule approved by Medical Services Board, made permanent to ensure no gaps in effective rule
  - Collaborating with Gainwell Technologies on System Change Request with intent to simplify billing payment process

Regulatory updates

- Outpatient Specialty Drug Carveout 23-0043
  - Submitted to CMS January 2, 2024
    - 90-day clock for CMS response set to expire April 1, 2024
    - Payments to continue at 90% of Invoiced Cost Until Approval
  - Related Emergency Rule approved by Medical Services Board, made permanent to ensure no gaps in effective rule

- IP Naloxone Carveout – Emergency Rule
  - Original language not in alignment with HB22-1326
  - Emergency rule to be presented in March or April

Ordering, Prescribing, and Referring (OPR) Provider Claim Edit

- Some outpatient hospital claims are currently posting the informational Explanation of Benefits (EOB) 1390 – “The attending physician number is missing or invalid. Enter or verify the attending physician's 10-digit NPI number”
- Starting April 1, 2024, claims for outpatient hospital-based audiology, physical therapy, occupational therapy, speech therapy, lab and radiology services will deny for EOB 1390 if:
  - ➢ The NPI of the OPR provider must be entered in the Attending Provider or the Other ID field on the hospital claim.
  - ➢ The OPR provider's NPI must be enrolled with Health First Colorado.
- For more information: IP/OP billing manual and OPR webpage.

Behavioral Health Billing questions

- The primary diagnosis determines when hospital claims are submitted FFS or to the RAEs.
  - If the claim's primary dx code is a RAE covered diagnosis, the claim is submitted to the RAE.
  - If the claim's primary dx code is not a RAE covered diagnosis code, the claim is submitted FFS.
  - If the member is not attributed to a RAE, the claim is submitted FFS.
- Split billing is not allowed.
- Refer to the State Behavioral Health Services Billing Manual for more resources.
- Reach out to hcpf_bhcoding@state.co.us for behavioral health billing questions.

Questions, Comments, & Solutions

Thank You!

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