HOSPITAL STAKEHOLDER ENGAGEMENT MEETING

Friday, March 7, 2025
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 Della.Phan@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 Della Phan at Della.Phan@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 2025
General Hospital Stakeholder Engagement Meetings

Dates of Meetings	Meeting Time
~~January 10, 2025~~	~~1:00pm-3:00pm~~
~~February 7, 2025~~	~~9:00am-11:00am~~
~~March 7, 2025~~	~~9:00am-11:00am~~
May 2, 2025	9:00am-11:00am
July 11, 2025	1:00pm-3:00pm
September 5, 2025	9:00am-11:00am
November 7, 2025	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 2025 Hospital Stakeholder Engagement Meeting Topics – mm:ss
Update to EAPG Version 3.18 Transition – 3:17
EAPG Category Payment Differentials – 11:40
Observations on Payment Changes – 12:11
Correction to Hospital Acquired Conditions Version in APR-DRG Settings – 20:08
Clarification on Interpretation of Present on Admission Indicators - 22:14
Upcoming 30-day Review of Inputs to Inpatient Rates Rebasing – 24:17
Proposed Inpatient-specific Regulatory Updates – 27:51
Regulatory Updates – 36:10
Provider Services Call Center Changes - 37:50

Update to EAPG Version 3.18 Transition

- **Identify all in-state FFS EAPG-paid claims with service dates within CY23**
  - Identify Medicaid-only Claims
  - Remove instances of duplicate drugs billed in dataset
  - Remove claims where non-EAPG payment was made on any line (LARCs, specialty drugs, opioid antagonists)

- **Use 3M/Solventum Software to reprocess all claims identified under EAPG 3.18 using rates effective January 1, 2023 for entire dataset**
  - Equally weight payments across year, reduce seasonality effects

Update to EAPG Version 3.18 Transition

- **Determine Scaling Factor**
  - Determine number to uniformly multiply Solventum national weights by for EAPG Version 3.18 such that total payments across system is equal total payments calculated from prior version in Solventum software
  - Drug re-weighting (3.47% reduction, 42.93% increase) to still apply throughout transition
- **Reprocess claims in Solventum software using scaled National Weights for version 3.18**
  - Compare total claims payments between 3.18 and 3.16
  - Identify variances in payments by hospitals, services

Update to EAPG Version 3.18 Transition

- **1.9 million fee for service outpatient hospital claims analyzed**
- **~9 million billed services**

- **Total Allowed Payments using version 3.16, 65% 340B Rate Reduction**
  - $741.9 million

- **Total Allowed Payments using version 3.18, 65% 340B Rate Reduction**
  - $283.1 million

- **Scaling Factor:** 2.620542

EAPG Category Impacts

- **Top 10 Payment Changes per EAPG Category (Positive Impacts)**

EAPG Category	3.16 EAPG Payment	3.18 EAPG Payment	Difference
Infectious and parasitic diseases, systemic or unspecified sites	$ 9,795,560.01	$ 11,934,688.43	$ 2,139,128.42
Rehabilitation	$ 33,197,414.77	$ 34,805,000.50	$ 1,607,585.73
Diseases and disorders of the skin, subcutaneous tissue and breast	$ 12,521,416.02	$ 13,813,299.16	$ 1,291,883.14
Ear, nose, mouth, throat and craniofacial diseases and disorders	$ 19,323,059.63	$ 20,601,048.93	$ 1,277,989.30
Musculoskeletal system procedures	$ 76,017,303.89	$ 77,270,905.33	$ 1,253,601.44
Diseases and disorders of the digestive system	$ 20,119,514.65	$ 21,104,689.01	$ 985,174.36
Neurologic system procedures	$ 16,075,202.20	$ 16,972,303.51	$ 897,101.31
Pathology	$ 616,442.01	$ 1,447,303.81	$ 830,861.80
Diseases and disorders of the nervous system	$ 7,711,965.83	$ 8,451,341.82	$ 739,375.99
Diseases and disorders of the musculoskeletal system and connective tissue	$ 19,665,717.14	$ 20,363,817.95	$ 698,100.81

EAPG Category Payment Differentials

- **Top 10 Payment Changes per EAPG Category (Negative Impacts)**

EAPG Category	3.16 EAPG Payment	3.18 EAPG Payment	Difference
Chemotherapy and other drugs	$ 63,054,356.42	$ 56,831,917.68	$ (6,222,438.74)
Radiology	$ 24,982,782.16	$ 19,537,925.26	$ (5,444,856.90)
Gastrointestinal system procedures	$ 44,071,826.82	$ 42,500,782.63	$ (1,571,044.19)
Hematologic and lymphatic procedures	$ 69,616,514.07	$ 68,847,475.34	$ (769,038.73)
Otolaryngologic system procedures	$ 30,744,539.82	$ 30,048,280.64	$ (696,259.18)
Radiologic procedures	$ 57,165,876.94	$ 56,659,840.49	$ (506,036.45)
Incidental procedures and services	$ 473,578.10	$ -	$ (473,578.10)
Radiation Therapy	$ 8,858,772.33	$ 8,506,451.81	$ (352,320.52)
Cardiovascular procedures	$ 36,420,951.15	$ 36,154,462.44	$ (266,488.71)
Laboratory	$ 27,102,928.69	$ 26,843,804.46	$ (259,124.23)

Observations on Payment Changes

- **Chemotherapy and Drug EAPGs**
  - Several of the changes in drug payments attributable to decreasing Average Sales Price

- **Radiology**
  - EAPG 288 (Level I Diagnostic Ultrasounds) is currently being separately paid when billed with more resource dominant procedures, therefore now eligible for bundling instead of always being separately payable

- **Gastrointestinal System Procedures**
  - Lower weight over versions – i.e. service is relatively cheaper to provide

Radiology Example

SCENARIO:

- Patient visits Emergency Room with Unspecified Chest Pain
- Diagnostic procedures include basic ultrasound and CT scan
- Example below when both are provided:

EAPG	Procedure	Prior EAPG Version	New EAPG Version
288 (Level I Diagnostic Ultrasound)	93971 Extremity Ultrasound	Separately Payable	**Packaged (no separate payment)**
302 (Computed Tomographic Angiography)	71275 CT Scan of Blood Vessels of Chest w Contrast	Separately Payable	Separately Payable

- Extremity ultrasound (or more broadly, services in EAPG 288) will still separately reimburse in version 3.18 when provided as a standalone service
- Costs associated with these codes built into more resource-dominant EAPG payments (Significant Procedures, Medical Visits), slightly higher payments

Further Observations on Payment Changes

Certain diagnoses have higher weights over time, i.e. increasing relative costs for outpatient hospital treatment, including:

- Viral Illnesses (including COVID-19)
- Upper respiratory tract infections
- Bacterial skin infections
- Open wounds, punctures, other open traumatic injuries

Payment Differentials

To be posted week of March 10, 2025

- Full EAPG Service Category Differentials
- Hospital-specific Payment Differentials
- Proposed EAPG 3.18 Weights

Seeking hospital feedback on proposed weights by **April 18, 2025**

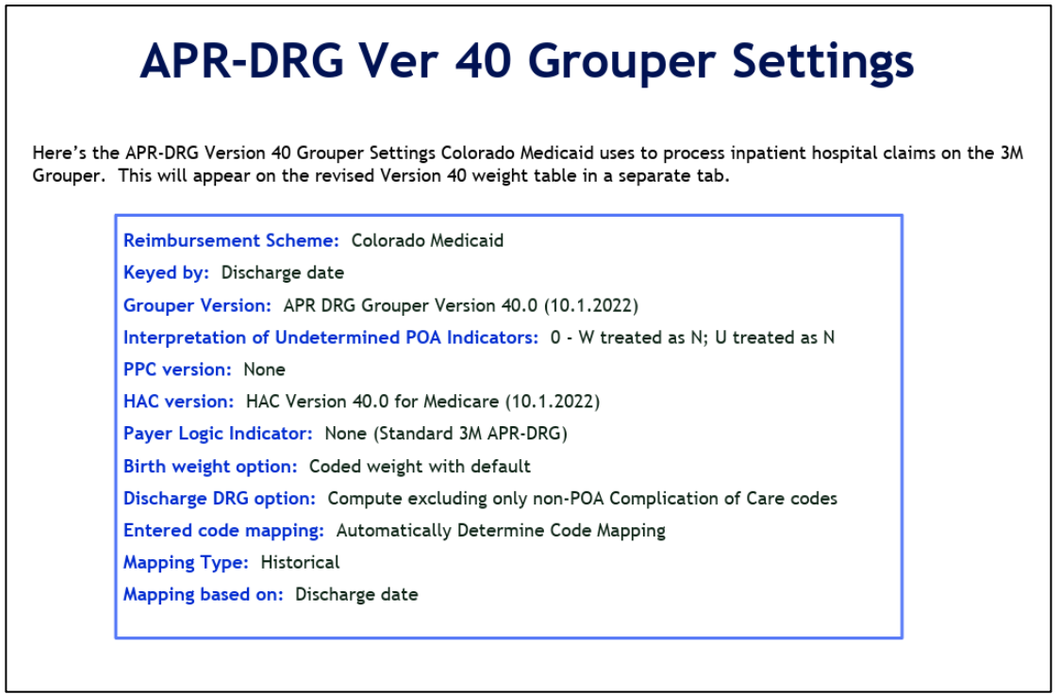
- Please email all questions and concerns to Andrew Abalos (andrew.abalos@state.co.us)

CORRECTION: HAC Version

- November 2024 Hospital Engagement Meeting, Slide 13 contained incorrect information

- HAC Version – HCPF uses HAC version for **Medicaid**, not Medicare
  - Medicaid setting has been used since APR-DRG implementation (January 2014)

- For Medicaid HACs, HAC 10 (Deep Vein Thrombosis / Pulmonary Embolism) is excluded for pediatric (less than 18 years of age) & obstetric patients



APR-DRG Ver 40 Grouper Settings

Here's the APR-DRG Version 40 Grouper Settings Colorado Medicaid uses to process inpatient hospital claims on the 3M Grouper. This will appear on the revised Version 40 weight table in a separate tab.

Reimbursement Scheme: Colorado Medicaid
Keyed by: Discharge date
Grouper Version: APR DRG Grouper Version 40.0 (10.1.2022)
Interpretation of Undetermined POA Indicators: 0 - W treated as N; U treated as N
PPC version: None
HAC version: HAC Version 40.0 for Medicare (10.1.2022)
Payer Logic Indicator: None (Standard 3M APR-DRG)
Birth weight option: Coded weight with default
Discharge DRG option: Compute excluding only non-POA Complication of Care codes
Entered code mapping: Automatically Determine Code Mapping
Mapping Type: Historical
Mapping based on: Discharge date

APR-DRG version 40 Grouper Settings from November 2024 Hospital Engagement Meeting

- Documentation on Inpatient Hospital Payment page to be updated

Corrected APR-DRG Ver 40 Grouper Settings

Here's the APR-DRG Version 40 Grouper Settings Colorado Medicaid uses to process inpatient hospital claims on the 3M Grouper. This will appear on the revised Version 40 weight table in a separate tab.

Reimbursement Scheme: Colorado Medicaid

Keyed by: Discharge date

Grouper Version: APR DRG Grouper Version 40.0 (10.1.2022)

Interpretation of Undetermined POA Indicators: 0 - W treated as N; U treated as N

PPC version: None

HAC version: HAC Version 40.0 for Medicaid (10.1.2022)

Payer Logic Indicator: None (Standard 3M APR-DRG)

Birth weight option: Coded weight with default

Discharge DRG option: Compute excluding only non-POA Complication of Care codes

Entered code mapping: Automatically Determine Code Mapping

Mapping Type: Historical

Mapping based on: Discharge date

Interpretation of Undetermined POA Indicators

- Clarify ambiguity on Interpretation of Undetermined Present on Admission (POA) Indicators

- For APR-DRG Grouping, the Department uses:
  - W treated as N; U treated as N
  - Aligns with information on previous slide

- For HACs, the Department uses:
  - W treated as Y; U treated as N
  - Cannot be altered by HCPF, hard-coded into 3M/Solventum module

- APR-DRG Grouping relies on POA indicators in DRG and Severity of Illness Assignments, in addition to Complication of Care and High mortality rate diagnoses

Timeline for Education-related data 30-day Review Period rates effective 7/1/2025

Timeline for Education-related adjustments/add-ons	Due Date
Myers & Stauffer (M&S) pulls from HCRIS the most recently available cost reports as of the end of the first full week in January of each rebasing year	1/10/2025
M&S performs calculations and have data available for delivery to Department	3/10/2025
The Department reviews and posts Indirect Medical Education (IME) Ratios/Graduate Medical Education (GME) cost per Discharge to website for hospital review/sends Constant Contact email notifying stakeholders	3/17/2025
30 Day IME/GME Hospital Review Period ends	4/16/2025
M&S works with hospital responses to amend as necessary	4/30/2025
Department receives finalized IME/GME data to include in inpatient base rate model worksheet	5/1/2025

This is essentially the same timeline we used for our prior rebasing. Dates were adjusted to avoid due dates on weekends/holidays.

Timeline for CMS data 30-day Review Period rates effective 7/1/2025

CMS Data 30-day Review period will be available for review in same GME/IME workbook posted on 3/17/2025 with any requested changes due by end of day 4/16/2025 to diana.lambe@state.co.us.

Hospitals will need to provide an email containing copies of letters from their Hospital Intermediary showing the incorrect data and the correction that will be used to adjust their hospital's data points used in rate building to Diana Lambe and Andrew Abalos at diana.lambe@state.co.us and andrew.abalos@state.co.us.

Below are the specific data elements that hospitals can request a change if still incorrect after the final "correcting" files posted by CMS as of the end of the first full week in January have been posted.

Medicare Labor-related amount	Operating Indirect Medical Education (IME) %
Wage Index	Capital IME %
Medicare Non-labor Related Amount	Value Based Purchasing (VBP) Adjustment Factor
Federal Capital Rate	Readmission Factor
GAF (Geographic Adjustment Factor)	Hospital-Acquired Condition (HAC) Payment Reduction

New this year, we'll be posting Payer Mix, Low Discharge and Solvency Metric data for review

HCRIS and Hospital Transparency Data that make up the following three add-ons will be available in the same workbook as Education-related data/ CMS Data Inputs: Payer Mix, Low Discharge and Solvency Metric.

If hospitals dispute the data points that make-up the three add-ons, please provide copies of HCRIS data and/or submissions of Hospital Transparency Data showing the specific difference to Diana Lambe and Andrew Abalos at diana.lambe@state.co.us and andrew.abalos@state.co.us by the end of the 30-day review period on 4/16/2025.

Please be aware that there is an additional 30-day review of the final rates after the State Budget Action is announced and the rate workbook is approved by upper management and posted to the department website: https://hcpf.colorado.gov/inpatient-hospital-payment.

Correction on November Slide for Payer Mix Columns & Lines Pulled

The example created for the discussion on Payer Mix last fall, should have included Line 18 in both the numerator and denominator.

Please know our data mobilization has always included Line 18 in both numerator and denominator, despite having no data in Line 18 to date.

FY25-26 Payer Mix Data Pulls for Worksheet S-3, Part 1 are detailed below.

PAYER MIX NUMERATOR: COLUMN 7, LINES 2,3,4,14,16,17,18.

PAYER MIX DENOMINATOR: COLUMN 8, LINES 14,16,17,18.

Proposed Change to Graduate Medical Education (GME) Calculations for IP Base Rates & effective 7.1.2025

- **Payer Mix Calculation request:** Please consider adding in WS S-3, Part I, Col. 7, Line 3 HMO IPF Subprovider and Line 4 HMO IRF Subprovider because you are including their straight Medicaid and total days. For acute care, you are adding in line 2, so this would be consistent treatment for both acute care and the subunits.

Payer Mix data pull from Worksheet S-3, Part 1

COLUMN	LINE	NAME OF COMPONENT	
7 (Title XIX)	2	HMO AND OTHER	
7 (Title XIX)	3	HMO IPF SUBPROVIDER	request to add
7 (Title XIX)	4	HMO IRF SUBPROVIDER	request to add
7 (Title XIX)	14	TOTAL	
7 (Title XIX)	16	SUBPROVIDER - IPF	
7 (Title XIX)	17	SUBPROVIDER - IRF	
8 (Total All Patients)	14	TOTAL	
8 (Total All Patients)	16	SUBPROVIDER - IPF	
8 (Total All Patients)	17	SUBPROVIDER - IRF	

Hospital feedback is unanimously in agreement with the requested changes to the Payer Mix Add-On calculation. IP Base Rates effective 7/1/2025 will reflect these changes.

- Definitions: HMO = Health Maintenance Organization, IPF = Inpatient Psychiatric Facility and IRF = Inpatient Rehabilitation Facility

COLORADO Department of Health Care Policy & Financing 7

Proposed Changes CO Rule to address naming convention changes to CMS Tables/Impact data file “adjustments”

Below is a list of proposed amendments to Rule to address the change in naming conventions that we encountered this year with CMS Tables/IMPACT data file “adjustments,” and other housecleaning items:

1. The Department is amending Colorado Rule 8.300.5.A.3.a with a new paragraph that describes what files will be used this year and in the future to the best of our ability. These changes will eliminate specific file naming in subsequent portions of rule describing the base rate methodology.
2. Additionally, we amended the date of January 1 to “the end of the first full week in January” since January 1st is a holiday.
3. We also made a correction in the rate methodology portions of rule to correctly reference the “Definitions” portion of Rule for hospital types located at 8.300.1.L instead of the incorrect reference of 8.300.1.K.

New Paragraph to be added to the Colorado Rule 8.300.5.A.3.a

Here's the verbiage of the new paragraph that we will add to 8.300.5.A.3.a, "Calculation of the Starting Point for the Medicaid Inpatient Base Rate":

- "The named files used from CMS will be whatever file is the most recently deposited "adjustment" of the CMS Tables and IMPACT file data effective October 1 and available as of the end of the first full week in January of rebasing years. Similarly, the most recently available Medicare and Medicaid full year cost reports on the CMS Healthcare Provider Cost Reporting Information System (HCRIS) will be utilized by the end of the first full week in January of rebasing years."

This paragraph is intended to describe what files are used in Inpatient rebasing and remove the need for specific naming of files in subsequent portions of Rule.

Examples showing nature of Rule Changes

This screenshot shows the new paragraph deposited in 8.300.5.A.3.a: "Calculation for the Starting Point for the Medicaid Inpatient Base Rate."

The screenshot also shows the deleted portions of named files and timing since it is all now addressed in the overarching paragraph above.

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

The named files used from CMS will be whatever file is the most recently deposited "adjustment" of the CMS Tables and IMPACT file data effective October 1 and available as of the end of the first full week in January of rebasing years. Similarly, the most recently available Medicare and Medicaid full year cost reports on the CMS Healthcare Provider Cost Reporting Information System (HCRIS) will be utilized by the end of the first full week in January of rebasing years.

For in-state Colorado DRG Hospitals (both PPS and non-PPS), the starting point shall be the hospital-specific Medicare Federal base rate with the specific adjustments listed. The Operating Federal Portion and Federal Capital Rate (source: CMS Tables 1A-1B & IE) will be adjusted by the Wage Index and Geographic Adjustment Factor (GAF) from the CMS IMPACT File.

For CAH and Pediatric hospitals (non-PPS Medicare 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 because these factors are not available from CMS. Additionally, the Quality and Meaningful Electronic Health Records (EHR) User adjustments will be applied to all PPS hospitals as indicated on the CMS ~~corrected~~ IMPACT file, while all non-PPS hospitals are assumed to have submitted Quality Data and be meaningful EHR users since no data exists for them. 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.~~

b. Policy Adjustments

Indirect Medical Education (IME) / Value Based Purchasing Adjustment (VBP) Factor / Readmission Adjustment Factor and Hospital Acquired Conditions (HAC) Reduction:

1) 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 VBP Adjustment Factor and Readmission Adjustment Factor taken from CMS Final Rule ~~Correcting Amendment~~ Tables 16B and 15 respectively will be multiplied by the Adjusted Operating Federal Portion. The Hospital Acquired Conditions Reduction taken from the most recent CMS.gov Data Set ~~as of January 1~~ will be applied against the Medicare Federal Base Rate with Wage Index/GAF Adjustments.

Examples showing nature of Rule Changes cont'd

8.300.1 is the "Definitions" portion of rule and lists 12 different definitions related Hospital Services. Three of those definitions in 8.300.1.L are specific to Pediatric, Sole Community Hospitals (SCH) and Medicare Dependent Hospitals (MDH) which are detailed in the Mutually Exclusive Add-ons section of Rule.

This screenshot shows the reference for Sole Community Hospital (SCH) and Medicare Dependent Hospital (MDH) as well as the Pediatric Hospital definition being amended from K to L in the definitions portion of Rule.

Operating and Capital IME using the most recently available ~~cost report as of January 1~~HCRIS cost report data in rebasing years and will require that hospitals have a CMS approved teaching program as detailed in Section 8.300.5.A.3.e. Additionally, non-PPS Hospitals will have the opportunity to review their calculated Operating and Capital IME percent during a 30-day review period and request changes if necessary. The VBP Adjustment Factor, Readmission Adjustment Factor and HAC Reduction will not be applied to non-PPS hospitals since they are not calculated by CMS.

c. Mutually Exclusive Medicaid Add-ons:

Four Add-ons will be mutually exclusive and applied as described here and will be applied as a percentage against the Medicare Federal Base Rate w/Wage Index/GAF Adjustments as detailed below.

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 in section 8.300.1.~~K~~L,

3) Low Discharge Add-on based on the average of up to three years of Total Discharges ~~of most recently available~~from cost reports on HCRIS ~~as of January 1 of~~ in rebasing years and excludes hospitals that are classified as Pediatric, SCH/MDH or CAH. For hospitals with subunits of Psychiatric, Rehabilitation and other subunits discharges in those subunits with be added to total discharges. The percentage add-on is set at 10% and distributed on a sliding scale with a ceiling of 2,500 and floor of 500 discharges,

4) The Pediatric Add-on is open only to hospitals defined as Pediatric in Section 8.300.1.~~K~~L.3 and the percentage add-on is set at 25%.

The exact same nature of changes are being made to Colorado State Plan

When the Department changed Colorado State Plan to accommodate the new inpatient base rate methodology effective 7/1/2023, we made sure to add the exact same language to Rule where possible since there is no reason why it should be different. The nature of the changes to Colorado State Plan 4.19A and 4.19B will consist of the exact same nature of changes shown here today.

For brevity, I won't be showing those changes since it is very duplicative. However, if any stakeholder would like to get a copy of the proposed Colorado Rule and/or State Plan changes, please email Diana Lambe and Andrew Abalos at diana.lambe@state.co.us and andrew.abalos@state.co.us.

Please get back to us by end of day on Friday, March 16, 2025, with any concerns regarding Rule or State Plan changes discussed here today.

These rule changes will be presented to the Medical Services Board (MSB) on April 11, 2025, with the final adoption scheduled for May 9, 2025. Here's the link to the MSB website if you'd like to attend: https://hcpf.colorado.gov/medical-services-board. State Plan changes occur later in the year after we know the budget neutrality factor for FY 2025-26.

Regulatory Cleanup

- Repealing the following section of rule through the Medical Services Board process:
  - 10 CCR 2505-10 8.220 Competitive Procurement and Selective Contracting, Including Global Fee Payment Programs
  - 10 CCR 2505-10 8.221 General Provisions

- These sections of rule describe an obsolete procurement process for organ and other transplants services

- Reviewed in 2017 and 2022's Regulatory Efficiency Reviews
  - The Department does not have SPA authority for process as described
  - Cross referenced citations no longer exist in CCR

- Medical Services Board webpage
- Contact Raine Henry with any questions

Regulatory updates

- Inpatient Hospital Housekeeping Update
  - State Plan Amendment
    - Public Noticing required
  - Code of Colorado Regulations Update
    - To be presented to Medical Services Board April 11, 2025
    - Effective July 1, 2025

- **340B Rate Reduction (80% -> 65%)**
  - State Plan Amendment
    - Public Noticing required
  - Code of Colorado Regulations Update
    - To be presented to Medical Services Board April 11, 2025
    - Effective July 1, 2025, regardless of EAPG version update timeline

Did You Know...

Optum will be the new
Provider Services Call Center
vendor beginning May 1, 2025.

What is not changing

- Optum is **only** taking over management of the Provider Services Call Center. Gainwell will continue as the vendor for the Colorado interChange and the Provider Web Portal.
- Many provider-facing processes and functionality will stay the same, including:
  - Provider Web Portal General Functionality and password resets (excluding Secure Correspondence)
  - Provider payment and Remittance Advice
  - Provider enrollment and revalidation
  - Other call centers (Member, Pharmacy, CCM, RAE, Dental)

What is changing

When Optum takes over management of the Provider Services Call Center, there will be some changes.

There will be a new phone number for the Provider Services Call Center.

The Provider Services Call Center will operate separately from the larger MMIS contract.

Providers can answer an after-call survey to give feedback.

Optum and Gainwell will partner to ensure providers receive accurate and helpful customer service for questions that relate to Gainwell's MMIS.

…more enhancements to come!

Stay Informed

- HCPF website
  - Provider Contacts page
  - Provider News page

- HCPF news
  - Provider Bulletin (sign up here)
  - At a Glance (sign up here)


Questions?
Comments?
Solutions?

Thank You!

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