HOSPITAL STAKEHOLDER ENGAGEMENT MEETING

Friday, May 6, 2022
9:00 AM - 12:00 PM

Location: Online Only

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

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

Welcome & Introductions

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

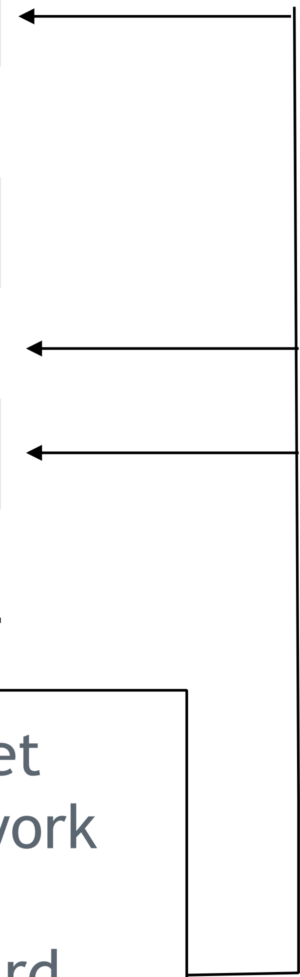
About this Meeting

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

Thank you for your cooperation

Dates and Times for 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

May 2022 Hospital Stakeholder Engagement Meeting Topics
Inpatient Subacute Care Meeting – May 20th, 9-10 a.m.
Inpatient Claims Underpayment Issue
FY 22-23 State Budget Action Inpatient Base Rate Update
Inpatient Base Rate Methodology Discussion Reboot
Rule – Peer Group Averages Eff. 9/1/22
EAPG Module Update
EAPG 3.16 Base Rate Calculations
EAPG Transition Payment Authority
Outpatient Claims Processing
Inpatient Only List
EAPG Drug Carveout Project

Inpatient Subacute Care

Only Effective During the Public Health Emergency

Emergency Rule:

Passed April 23, 2020

Emergency SPA:

SPA #20-0012 Approved May 20, 2020

Billing Guidance:

- IP Subacute Care must be billed on a separate claim
- Claim for IP Subacute Care should ONLY use revenue code 190, no other services should be billed on the claim
- IP Subacute Care is paid at $235 per diem rate
- If the member is transferred to IP Subacute Care from an IP status, use patient status code 70 on the initial IP claim.

Inpatient Subacute Care cont'd

Only Effective During the Public Health Emergency

Meeting Friday May 20, 2022
9:00am

Department will be requesting from Hospitals:

- Member Medicaid ID
- Length of stay after member should have been discharged
- Claim/ICN that preceded the extended stay
- Reason why member could not be discharged
- Any other relevant information
- Always remember to send PHI encrypted

If you can provide this information in advance of the May 20 meeting, please do so – otherwise, we will utilize this time to discuss means of obtaining this information (if available)

Please send any of the above to Andrew Abalos (andrew.abalos@state.co.us)

Inpatient Claim Underpayment Issue

An unintended change to the claims system payment methodology resulted in underpayment of many inpatient claims

What happened:

- **Affected claims:** claims that processed between 4/6/2022 – 4/28/2022 were paid a per diem rate if covered days were less than the DRG Average Length of Stay.
- System fix was put into production 4/29/2022. A mass adjustment to reprice all affected claims should be completed by early next week.
- The Department can confirm that all claims are paying correctly now. Providers should not need to take any further action.
- As always, please let us know ASAP if you find any claims paying incorrectly.
- Big thank you to Denver Health and Parallon for reaching out when they noticed payments were off.
- The Department will be instituting changes to prevent this from happening again.

Inpatient Base Rates will be updated with State Budget Action for SFY 22-23

- The Medical Services Board adopted this change on April 8, 2022.
- For State Fiscal Year (SFY) 23, The Department will again be applying the State Budget Action as set by Legislature to update Hospital Base Rates for next year.
- As mentioned before, 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.
- Contact Diana Lambe at diana.lambe@state.co.us if you have any concerns.

Draft Inpatient Base Rate Methodology

Update on ground rules…

- 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.
- 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 (Walking through tweaks today)
  2. How budget neutrality and corridor adjustments will be implemented in the methodology (No change from our last demonstration)
  3. What percentage that will be applied to each add-on with ceilings and floors for continuous variables (Will present in July)

Draft Inpatient Base Rate Methodology

Again, the Starting Point is Medicare Federal Base Rate

- Medicare does not provide Wage Index or Geographic Adjustment Factor (GAF) for non-PPS hospitals. The Department will be assigning them 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**

Draft Inpatient Base Rate Methodology

Starting Point is Federal Base Rate Adjusted by Wage Index and GAF Adjusted for all PPS Hospitals / No Adjustments for Non-PPS Hospitals (Pediatric & Critical Access Hospitals)

I	J	K	L
Medicare Labor-related amount (Source Impact File - Final Rule)	**Wage Index** (Source CMS Table 1A-1E) Assumption all hospital quality data and meaningful EHR users Non_PPS Hospital Wage Index=1	**Non-labor Related Amount** (Source Impact File - Final Rule)	**Operating Federal Portion w/Wage Index Adjustment** **((I*J)+K)**

M	N	O	P
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) **(M*N)**	**Medicare Federal Base Rate w/Wage Index/GAF Adj for PPS Hospitals / No Adj for Non-PPS Hospitals**

Draft Inpatient Base Rate Methodology

Reviewing for Accuracy

Newly Added

Calculations completed the same as Medicare					
Medicare Wage/GAF-adjusted base rate	**Medicare IME adjustment** (Operating & Capital)	**Medicaid GME adjustment** (10% of Medicaid Cost Per Discharge) (FY20-21 Amounts)	**Readmission adjustment**	**VBP Adjustment**	**HAC adjustment**

- Medicare Wage/GAF Adjusted base rate is further adjusted by Medicare IME, Medicaid GME Add-On and Medicare Readmission, VBP and HAC Adjustments

- **Please note:** The Department will be reviewing the accuracy of the calculation for the Medicare IME and Medicaid GME Add-On and will report further on this at the next hospital engagement meeting.

- **Value Based Purchasing (VBP) Adjustment** is new to the model. It was inadvertently left off prior versions. As with the other adjustments of this kind, all measures and calculations will mirror Medicare.

- As mentioned before, Readmission, VBP and HAC will remain the same as Medicare until such time as the Department can work on possible Medicaid-based measures. This is not likely to even be reviewed until after 7/1/2024.

Draft Inpatient Base Rate Methodology

CAH add-on (Add-On 1 of 4)	Pediatric Hospital add-on (Add-On 2 of 4)	Low Discharge add-on (Add-On 3 of 4)	Independent Hospital add-on (Add-On 4 of 4)

The Department would like to group the above set of add-ons into a mutually exclusive order of operations. Where a Critical Access Hospital would qualify for Add-On 1, but not qualify for Add-Ons 2, 3 or 4.

Similarly, a Pediatric Hospital add-on will be applied to any hospital that fits the criteria but is not a CAH (Add-On 1) and will not be allowed to qualify for Add-Ons 3 and 4 and so on for Low Discharge and Independent hospital add-ons.

The Department will present recommendations during the July Hospital Engagement Meeting for the size of each of these add-ons and the ceilings and floors that will apply for those add-ons that are continuous variables.

Draft Inpatient Base Rate Methodology

Payer Mix Add-on	Profit Margin Add-on	Operating Expense Add-on	Net Income Add-on	Quality Add-on
	Operating Margin Add-On			

The Department is recommending we remove the Profit Margin, Operating Expense and Net Income Add-ons and replace them with one measure: Operating Margin Add-on. After considering arguments from all sides, we feel this will be a more appropriate proposal for measuring Hospital health.

As mentioned before, the Department may want to add a quality measure into the methodology in the future but is currently leaving that blank.

And again, during the July Hospital Engagement Meeting, we will discuss our recommendations for the size of each of these add-ons and the ceilings and floors that will apply for those add-ons are a continuous variable.

Draft Inpatient Base Rate Methodology

The Department wants to deposit a fully-functional model on its website so hospitals can see how everything works…

- The model we've adopted includes a budget neutrality factor and +/-10% corridors, so a hospital's final rate is based on the factors included but also adjusted in relation to other hospital's potential reimbursement.

- Masking specific hospital data undermines the understanding of how the model works.

- Please note that Medicaid discharges* from the prior year along your hospital's overall CMI will be displayed.

- All other data is public knowledge through CMS Impact File and/or HCRIS cost report database that is fully downloadable to anyone.

- We will be sending out a poll next week through Constant Contact and would like to have all our hospital stakeholders weigh in on our preferred way to present the working inpatient base rate model.

*Within the posted model, hospitals with discharges of 30 or under in the previous year will be all capped at 30 to adhere to HIPAA rules.

Questions?

Outpatient Peer Group Averages Rule

- Currently, in-state hospitals are divided into 'Urban' or 'Rural' peer groups depending on if they fall within a metropolitan statistical area.
  - The averages of these two groups are used to calculate EAPG base rates for new in-state hospitals and out of state hospitals.

- The Department is proposing a rule to MSB that will add more granular peer groups
  - LTAC, Rehab, Pediatric along with the Urban and Rural categories

- Averages for these groups will be used for rate calculations for new in-state hospitals and out of state hospitals

Outpatient Peer Group Averages Rule

- This will be presented to MSB on June 10th
- The Public Rule Review meeting will be on May 23rd
- For any questions or concerns regarding this rule change, please contact Andrew Abalos and Tyler Samora

EAPG Module Update

- No updates to the module in interChange as of March'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

- Applies off-quarter CPT/HCPCS Updates
  - As a reminder, version 3.10 does not recognize codes effective 1/1/22 and beyond

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. As a result, the base rates effective immediately prior are still in use along with v3.10's EAPG weights

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

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
  - Submitted RAI response to CMS on Friday April 22nd, 2022. This reset the 90-day timeframe for an additional RAI or SPA approval.
    - 90-day timeframe ends on July 21, 2022
  - 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 01/01/22 and after 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) may have line level denials

- Payment comparisons between 3.10 and 3.16 claims periodically performed – significant budgetary impacts monitored
  - Hospitals will be contacted if any action is necessary.

- As of this week, ~513k claims will be targeted for reprocessing

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

EAPG Drug Carveout Project

- Currently paying drugs through EAPGs, previously discussed a carveout
- Hospitals have been surveyed for Average Acquisition Costs through Myers and Stauffer in 2021
- Since implementation of EAPGs in 10/31/2016:
  - 340B Discount Modifier Adjusted
  - EAPG Drug Re-weight implemented
  - Specialty Drug Carveout
  - EAPG Version 3.16 to be implemented

EAPG Drug Carveout Project

- Survey was component of a potential carveout of drug payments from EAPG – pay based on percent of Average Acquisition Cost

- Suspending project indefinitely, given:
  - Feedback from hospitals – administratively burdensome for periodic surveying of drug costs
  - Would be budget neutral – added payment for drugs would need to be subtracted from EAPG payments
  - Budget neutrality constraint would also be applied to all hospitals, therefore would create more "winners" and "losers"

Questions, Comments, & Solutions

Thank You!

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