Provider Summary of Hospital Stakeholder Engagement Meeting 1/10/2020

Welcome Message and Meeting Etiquette (Slides 1-4, Time 00:00:00-00:02:08)

- Introductions
- 2020 Meeting Schedule
- Agenda
- Next meeting **March 6, 2020 9:00 am-12:00 pm**

Hospital Base Rate Reform Development (Slide 1, 00:02:08-00:03:12) [Myers and Stauffer Costing Presentation PDF on Hospital Stakeholder Engagement Meeting Webpage]

Hospital Base Rates (Slide 2, Time 00:03:12-00:05:50)

The Department Contacted Myers and Stauffer to explore base rate reform options

Inpatient Base Rates

- Inpatient analysis begun prior to outpatient base rates
- Interest in exploring a cost-based methodology
- Modeling used to refine options

Outpatient Base Rates

- Similar cost-based methodology

Costing Claims (Slides 3-9, Time 00:05:50-00:12:16)

Revenue Code Crosswalk

Standard Revenue Code Crosswalk Medicaid Costing for FY 2018 Hospital Cost Reports

- The Revenue Code is mapped to the primary cost center. If that cost center is blank, the secondary, or tertiary options are used.
- Routine is for revenue codes less than 220.
- Ancillary is for revenue codes greater than or equal to 220.

Per Diem

- The revenue code on the detail line is linked to the corresponding cost report line. Using the cost report line, the per diem is pulled from the cost report and multiplied by the days from the current claims data.
- The Cost Center Description is from the line used from the cost report.

CCR (Cost to Charge Ratio)

- The revenue code on the detail line is linked to the corresponding cost report line. Using the cost report line, the cost to charge ratio is used and multiplied by the current charges from the claims data in order to calculate cost.
- The Cost Center Description is from the line used from the cost report.

Individual Claim

Note:

Cost factor for Revenue Code 219 and below is routine Per Diem (D-1, Part II)

Cost factor for Revenue Code 220 and below is ancillary Cost-to-Charge (CCR) – (C, Part I)

Q&A (Slide 9, Time 00:12:16-00:22:26)

- Data presented utilized fiscal year 2018 with Cost Report from 2018.
- **Provider Comment:** If the Department moves forward with this option, will want hospitals to have the option to submit their own crosswalks for the most accurate calculations.
- **Reminder:** This is an initial presentation, nothing is set in stone but one type of base rate calculations that is being considered. The Department would like to bring other options to these meetings prior to committing to additional calculations of one methodology.
- **Feedback Opportunity**: How do you feel regarding this process utilizing cost reports? Pros and Cons? If a few hospitals are unable to provide their crosswalks, will this possibly throw off calculations?

System Change Request (SCR) Updates (Slide 6, Time 00:22:26-00:24:07)

- LTAC and Rehab Per Diem (44201) – Automation by the system will be completed in Spring 2020. Currently has manual workaround.
- IPP-LARC (42654) – Completed.
- Observation (43991) – Completed. Reprocessing occurred in 12/27/2019 financial cycle.

Observation Over 48 hours Reprocessing (Slide 7, Time 00:24:07-00:25:41)

- Reprocessing occurred in the 12/27/2019 financial cycle
- Additional $6.2 million paid
- Common denial reason: Surgery date outside of FDOS/TDOS
- Common suspension reasons: Missing/invalid covered days
- For DRG claims, the entire stay must be represented on the claim for the claim to group to the correct DRG

Billing for Immediate Post-Partum Long-Acting Reversible Contraceptives (IPP--L8:13ARCs) (Slide 8-9, Time 00:25:41-00:31:03)

- Effective January 1, 2020, IPP-LARC devices inserted in a DRG Hospital may be reimbursed at the fee schedule rate or the amount billed, whichever is less.
- Prior to January 1, 2020, the cost of the IPP-LARC device was included in the All Patient Refined-Diagnosis Related Group (APR-DRG) calculation for the delivery claim.
- The IP/OP Billing Manual is currently being updated with billing information.
- Reimbursement for IPP LARCs requires submission of both:
    1. an Inpatient claim
    2. an Outpatient claim

- The Inpatient Hospital Claim form must group to APR-DRG 540, 542, or 560, and
- include:
    A. ICD-10 Diagnosis Code for LARC insertion: Z30.430 or Z30.018,
    B. ICD-10 Surgical Procedure Code for either:
        1. an IUD insertion: 0UH90HZ, 0UH97HZ or 0UH98HZ, or
        2. a Contraceptive Implant insertion: 0JHD0HZ, 0JHD3HZ, 0JHF0HZ or 0JHF3HZ.
- The Outpatient (OP) Hospital Claim form:
    A. Must include*:*
        1. the HCPCS for the LARC device: J7296, J7297, J7298, J7300, J7301 or J7307
        2. the LARC device's affiliated NDC, and
        3. Both the FP and SE modifiers
    B. No additional revenue or procedure codes can be present on the claim
    C. OP claim must be submitted at the same time or after the affiliated Inpatient claim, and
    D. OP claim's date of service must be the date of insertion and within the affiliated Inpatient claim's FDOS-TDOS.

APR-DRG weight changes due to removal of IPP-LARCs (Slide 10, Time 00:31:03-00:34:10)

A new DRG weight table dated 1/1/2020 will be loaded to the Inpatient Hospital Payment Webpage by the end of the week.

Inpatient Topics/Questions Submitted (Slide 11-12, Time 00:34:10-00:41:24)

Answered Topics:

- Sterilization Claim Issue
- Prior Authorization Request (PAR)
- Intensive Outpatient Program (IOP)

Pending Topics for Response or Additional Research:

- 340B Enrollments Issue
- Prior Authorization Request (PAR)

Hospital Rates Update (Slide 13, Time 00:41:24-00:44:34)

Rates Effective 7/1/2019

- We did have to reprocess about 1,000 claims in December since DXC accidentally used first service date of 7/1/2019 instead of last service date.
- All reprocessing has been completed for the FY2019-20 rate loads.
- If you find claims that have not been priced correctly, please send ICNs to Diana Lambe at diana.lambe@state.co.us.

FY2020-2021

- Rate build for FY2020-21 has already begun.

Rebasing Medicaid Inpatient Hospital Rates for Fiscal Year (FY) 2020-2021 (Slides 14-15, Time 00:44:34-00:46:49)

- Please keep an eye out for a notice in the February Provider Bulletin. We will also be sending reminder emails in February to all emails listed on our Hospital Engagement Meeting mailing list.
    - If you are not on this mailing list – please sign up here and choose "Hospital Engagement Meeting."
- In order to calculate your hospital's inpatient base rate and the Medicaid specific add-ons for FY 2020-2021, it is imperative that the Department's hospital contractor, Myers and Stauffer LC, receives your agency's most recent finalized Medicare Notice of Program Reimbursement (NPR) by March 1, 2020. Please note that there is no extension to this date.
- If we don't receive new information, the Department will be using the same information used for last year's inpatient hospital rates.
- **In summary, we need two things by March 1, 2020:**
    - Most recently audited Medicare/Medicaid Cost Report (CMS 2552) available as of March 1, 2020.
    - Most recent finalized Medicare Notice of Program Reimbursement (NPR)

Please send to:

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Hospital Peer Groups and Definitions (Slide 16, Time 00:46:49-00:48:09)

- We have heard your concerns about resort hospital definitions and have incorporated that into the proposed peer groups which are currently being reviewed by HCPF leadership.
- More information to come later...

Outpatient Topics/Questions Received (Slide 17, Time 00:48:09-00:48:50)

Inquiries were not received and none are currently pending

EAPG Module Update (Slide 18, Time 00:48:50-00:50:41)

- 3M Released new module 12/30/2019
    - Delayed release

    - Yearly CPT/HCPCS updates
    - January 8, 2020 implementation date
    - No changes in Colorado payment policies
- EAPG Version 3.10 will remain in effect

DME & Transportation Clarification (Slide 19, Time 00:50:41-00:53:58)

- Hospitals must enroll as a DME Supply / Transportation providers in order to receive reimbursement for these services.
- Unbundled DME and transportation services should not be billed on outpatient hospital claim, and instead on the CMS-1500
- Transportation: August 2017 Provider Bulletin
- Unbundled DME EAPG codes will be posted to Billing Manuals

Drug EAPG Re-weighting (Slides 20-21, Time 00:53:58-00:56:31)

- Feedback from several Critical Access and Medicare Dependent Hospitals (CAHs and MDHs) regarding the discrepancy in EAPG payment in relation to drug costs in outpatient setting
    - Analysis has shown that providing outpatient hospital drugs is more costly for these hospitals than their counterparts
- **CONCEPT:** Rebalance EAPG drug weights such that Critical Access and Medicare Dependent Hospitals see payment in greater alignment with drug costs
- In order to provide relief to such hospitals providing outpatient drugs, drug EAPG weights are proposed to be increased
- Since EAPG weights are based on averages an increase to one group of hospitals will necessarily cause a decrease for another group.
- Non-CAH non-MDH rural hospitals and urban independent hospitals will not have a change in drug EAPG weights.

Listing of Drug v3.10 EAPGs (Slide 22, Time 00:56:31-00:56:52)

- Chart shared

Hospitals with Drug Payment Increase (Slide 23, Time 00:56:52-00:57:17)

- List of Hospitals provided

Hospitals with Neutral Drug Payment (Slide 24, Time 00:57:17-00:57:26)

- List of Hospitals provided

Hospitals with Drug Payment Decrease (Slide 25, Time 00:57:26-01:10:43)

- List of Hospitals provided
- Discussion over concerns with how hospitals were separated
- The Department will be announcing a separate meeting dedicated to the EAPG Drug Re-Weighting to occur within the next month.

Questions, Comments, and Solutions (Slide 27, Time 01:10:43-01:38:44)

- Ways to promote different type of meetings or ways to combine them into one occurrence to cut down on the number of meetings? For Stakeholders, is there a way CHA can assist in keeping you informed of the different meetings?

Staffing Update (Slide 26, Time 01:13:27-01:13:52)

- Congratulations to Kevin Martin who is our new Division Director of Fee for Service Rates Division!