

Title of Rule: Revision to the Medical Assistance Rates Section Rule Concerning the Adding Definitions of Hospital Services, Section 8.300.1; and Payments For Outpatient Hospital Services, Section 8.300.6

Rule Number: MSB 16-06-20-A

Division / Contact / Phone: Payment Reform / Andrew Abalos / 2130

## STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The proposed rule will allow the Department to pay hospitals for outpatient services provided to Medicaid clients under a prospective payment methodology. Currently, the rule describes a methodology which relies on the Medicare cost reports that are made available years after services are provided. As such, interim payments are made and are later reconciled based on the Department's contracted cost report auditor's findings. This methodology presents difficulties in budget planning and payment consistency for both the Department and its hospital providers. The proposed rule allows a methodology to be used which is based on fixed payments calculated using state-wide average costs and payment will no longer require reconciliation. Additionally, the proposed rule allows payment under a methodology which provides incentives for efficiency and minimization of upcoding to generate higher payments. In order to accommodate the implementation of this methodology, updates will also be required to the rule's definitions.

2. An emergency rule-making is imperatively necessary

- to comply with state or federal law or federal regulation and/or  
 for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

42 U.S.C. 1396a(a)(30)(A);

42 C.F.R. 447.321

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2015);

25.5-4-402.3(4)(B)(I) C.R.S (2014); 10 CCR 2505-10 8.300.6;

Initial Review

**08/12/2016**

Final Adoption

**09/09/2016**

Proposed Effective Date

**10/30/2016**

Emergency Adoption

**DOCUMENT #07**

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## REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

The proposed rule will allow Hospitals will receive payment for outpatient services provided to Medicaid clients under a prospective payment methodology. The implementation of the methodology is budget neutral and is accounted for in the state budget. While the proposed rule is budget neutral long-term, the proposed rule would result in temporary savings for the first several fiscal years as the Department would continue to reconcile hospital cost reports from fiscal years prior to FY 2016-17.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

The proposed rule fixes the payment amount for outpatient services provided to Medicaid clients based on state-wide average costs. As such, the economic impact for each hospital provider is dependent on the expended resources for classification of services provided. In anticipation of these variances, the proposed rule applies a risk corridor to each hospital during the rate-setting process. Hospital base rates are set such that projected gains or losses will be mitigated to 10% of what the hospitals would have received without implementation of the proposed rule.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The proposed rule is budget neutral long-term and therefore accounted for in the state budget. There are no additional costs to the Department or any other agency due to the implementation and enforcement of the proposed rule.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

The proposed rule will allow both the Department and its Hospital providers to more accurately plan budgets based on providing outpatient services to Medicaid clients. The proposed rule will also provide a transition away from the current reimbursement methodology based on interim payments which generally results in overpayments to hospitals which later have to be reconciled.

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5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

The proposed rule is budget neutral long-term and therefore accounted for in the state budget. There are no methods for achieving the purpose of the proposed rule that are less costly or less intrusive.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

A payment methodology for outpatient hospitals based on Medicare's Ambulatory Payment Classifications (APCs) was considered. The Department and its contractor solicited feedback from Colorado Hospital Association (CHA) and Hospital representatives, but determined that the proposed prospective payment system was better designed to address the needs of the Colorado Medicaid population.

1 **8.300 HOSPITAL SERVICES**

2 **8.300.1 Definitions**

3 Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves  
4 against medical advice.

5 Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care  
6 procedure, treatment or service during the course of treatment.

7 Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient  
8 health care procedure, treatment or service.

9 Department means the Department of Health Care Policy and Financing.

10 Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used  
11 for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize  
12 similar amounts of Hospital resources.

13 DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system  
14 of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access  
15 Hospitals, Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals.

16 Diagnostic Services means any medical procedures or supplies recommended by a licensed professional  
17 within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or  
18 extent of illness, injury or other health condition in a client.

19 Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals  
20 receive for serving a disproportionate share of low-income clients.

21 Emergency Care Services, for the purposes of this rule, means services for a medical condition, including  
22 active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, for  
23 which the absence of immediate medical attention could reasonably be expected to result in: (1) placing  
24 the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction  
25 of any bodily organ or part.

26 Enhanced Ambulatory Patient Group (EAPG) means a cluster of similar procedures within a classification  
27 system used for Hospital reimbursement. It reflects clinically cohesive groupings of services performed  
28 during Outpatient visits that utilize similar amounts of Hospital resources.

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30

31 Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of  
32 physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and  
33 rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a  
34 Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located  
35 in Colorado, by the state in which it is located; and (3) certified for participation in the Centers for  
36 Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations  
37 as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program,  
38 distinct part units and satellite locations are considered part of the Hospital under which they are licensed.  
39 Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado  
40 Medicaid program. Types of Hospitals are:

- 1 A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized  
2 medical staff, provides Inpatient services, emergency medical and surgical care, continuous  
3 nursing services, and necessary ancillary services. A General Hospital may also offer and provide  
4 Outpatient services, or any other supportive services for periods of less than twenty-four hours  
5 per day.
- 6 A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital.  
7 CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical  
8 services and/or obstetrical services including a delivery room and nursery.
- 9 A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital  
10 providing care primarily to populations aged seventeen years and under.
- 11 A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which  
12 primarily serves an Inpatient population requiring intensive rehabilitative services including but not  
13 limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma,  
14 fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.
- 15 A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term  
16 Care Hospital. In general, Long-Term Care Hospitals have an average length of stay of greater  
17 than twenty-five (25) days.
- 18 A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize,  
19 operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and  
20 rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals  
21 requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental  
22 rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is  
23 operated by the Colorado Department of Human Services.
- 24 Inpatient means a person who is receiving professional services at a Hospital; the services include a  
25 room and are provided on a continuous 24-hour-a-day basis. Generally, a person is considered an  
26 Inpatient by a physician's order if formally admitted as an Inpatient with the expectation that the client will  
27 remain at least overnight and occupy a bed even though it later develops that the client can be  
28 discharged or transferred to another Hospital and does not actually use a bed overnight.
- 29 Inpatient Hospital Services means preventive, therapeutic, surgical, diagnostic, medical and rehabilitative  
30 services that are furnished by a Hospital for the care and treatment of Inpatients and are provided in the  
31 Hospital by or under the direction of a physician.
- 32 Medically Necessary, or Medical Necessity, means a Medicaid service that will, or is reasonably expected  
33 to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental,  
34 cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally  
35 effective or substantially less costly course of treatment suitable for the client's needs.
- 36 Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on  
37 a system of DRGs. Psychiatric Hospitals are considered Non-DRG Hospitals since their reimbursement is  
38 based on a per diem rate.
- 39 Observation Stay means a stay in the Hospital for no more than forty-eight hours for the purpose of (a)  
40 evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and  
41 released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient  
42 procedure. Only rarely will an Observation Stay exceed twenty-four hours in length.
- 43 Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.

- 1 Outpatient means a client who is receiving professional services at a Hospital, which is not providing  
2 him/her with room and board and professional services on a continuous 24-hour-a-day basis.
- 3 Outpatient Hospital Services means preventive, diagnostic, therapeutic, rehabilitative, or palliative  
4 services that are furnished to Outpatients; and are furnished by or under the direction of a physician or  
5 dentist.
- 6 Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care  
7 procedure, treatment or service prior to treatment.
- 8 Rehabilitative Services means any medical or remedial services recommended by a physician within the  
9 scope of his/her practice under state law, for maximum reduction of physical or mental disability and  
10 restoration of a client to his/her best possible functional level.
- 11 Relative Weight (DRG weight or EAPG weight) means a numerical value which reflects the relative  
12 resource consumption for the DRG or EAPG to which it is assigned. Modifications to these Relative  
13 Weights are made when needed to ensure payments reasonably reflect the average cost ~~of claims~~ for  
14 each DRG or EAPG. Relative Weights are intended to be cost effective, and based upon Colorado data  
15 as available.
- 16 Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health  
17 care procedure, treatment or service following treatment. A Retrospective Review can occur before or  
18 after reimbursement has been made.
- 19 Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by  
20 the United States Office of Management & Budget.
- 21 State University Teaching Hospital means a Hospital which provides supervised teaching experiences to  
22 graduate medical school interns and residents enrolled in a state institution of higher education; and in  
23 which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state  
24 institution of higher education.
- 25 Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds  
26 for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare  
27 beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called  
28 "swing beds."
- 29 Trim Point Day (Outlier Threshold Day) means the day which would occur 2.58 standard deviations above  
30 the mean (average) length of stay (ALOS) for each DRG.
- 31 Urban Hospital means a Hospital located within a MSA as designated by the United States Office of  
32 Management & Budget.
- 33
- 34 Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible  
35 days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded  
36 to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net  
37 Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year  
38 for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data  
39 sources for the calculation if there are discrepancies between the data submitted by the Hospital and  
40 alternative data sources such as claims or cost report data.

1 **8.300.6 Payments For Outpatient Hospital Services**

2 8.300.6.A Payments to DRG Hospitals for Outpatient Services

3 1. Payments to In-Network Colorado DRG Hospitals

4 Excluding items that are reimbursed according to the Department's fee schedule,  
5 Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges  
6 multiplied by the Medicare cost-to-charge ratio less 28%. When the Department  
7 determines that the Medicare cost-to-charge ratio is not representative of a Hospital's  
8 Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A  
9 periodic cost audit is done and any necessary retrospective adjustment is made to bring  
10 reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges  
11 less 28%.

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14 Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim  
15 basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent  
16 (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not  
17 representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated  
18 using historical data. A periodic cost audit is done and any necessary retrospective  
19 adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1  
20 percent (29.1%) or billed charges less 29.1 percent (29.1%).

21 Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim  
22 basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent  
23 (30%). When the Department determines that the Medicare cost-to-charge ratio is not  
24 representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated  
25 using historical data. A periodic cost audit is done and any necessary retrospective  
26 adjustment is made to bring reimbursement to the lower of actual audited cost less 30  
27 percent (30%) or billed charges less 30 percent (30%).

28 Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at  
29 actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%).  
30 When the Department determines that the Medicare cost-to-charge ratio is not  
31 representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated  
32 using historical data. A periodic cost audit is done and any necessary retrospective  
33 adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7  
34 percent (30.7%) or billed charges less 30.7 percent (30.7%).

35 Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at  
36 actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%).  
37 When the Department determines that the Medicare cost-to-charge ratio is not  
38 representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated  
39 using historical data. A periodic cost audit is done and any necessary retrospective  
40 adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2  
41 percent (31.2%) or billed charges less 31.2 percent (31.2%).

42 Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at  
43 actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%).  
44 When the Department determines that the Medicare cost-to-charge ratio is not

1 representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated  
2 using historical data. A periodic cost audit is done and any necessary retrospective  
3 adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8  
4 percent (29.8%) or billed charges less 29.8 percent (29.8%).

5 Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at  
6 actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%).  
7 When the Department determines that the Medicare cost-to-charge ratio is not  
8 representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated  
9 using historical data. A periodic cost audit is done and any necessary retrospective  
10 adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4  
11 percent (28.4%) or billed charges less 28.4 percent (28.4%).

12 Effective July 1, 2015, Outpatient Hospital Services are reimbursed on an interim basis at  
13 actual billed charges times the Medicare cost-to-charge ratio less 28 percent (28%).  
14 When the Department determines that the Medicare cost-to-charge ratio is not  
15 representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated  
16 using historical data. A periodic cost audit is done and any necessary retrospective  
17 adjustment is made to bring reimbursement to the lower of actual audited cost less 28  
18 percent (28%) or billed charges less 28 percent (28%).  
19

20 Effective October 31, 2016, DRG Hospitals will be reimbursed for Outpatient Hospital  
21 Services based on a system of Enhanced Ambulatory Patient Grouping and a Hospital-  
22 specific Medicaid Outpatient base rate. The reimbursement for Outpatient Hospital  
23 Services shall be referred to as the EAPG Payment.

24 a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-  
25 specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR  
26 2505-10 Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action  
27 impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG  
28 Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will  
29 then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific  
30 Medicaid Outpatient base rate. If the billed amount is less than the EAPG  
31 Payment, reimbursement will be the billed amount.

32 b. The EAPG Payment is calculated for each detail on the claim. Claim details with  
33 the same dates of service are grouped into a visit. Claims containing details  
34 describing charges for emergency room, treatment room services or patients  
35 placed under observation will have all its details grouped into a single visit.

36 c. Each detail on a claim is assigned an EAPG. EAPGs can have the following  
37 types:

38 (1) Per Diem

39 (2) Significant Procedure. Subtypes of Significant Procedures Are:

40 (a) General Significant Procedures

41 (b) Physical Therapy and Rehabilitation

42 (c) Mental Health and Counseling

43 (d) Dental Procedure

1 (e) Radiologic Procedure

2 (f) Diagnostic Significant Procedure

3 (3) Medical Visit

4 (4) Ancillary

5 (5) Incidental

6 (6) Drug

7 (7) Durable Medical Equipment

8 (8) Unassigned

9 d. A detail will be subject to EAPG Consolidation when it is assigned the same  
10 Significant Procedure EAPG as a detail not already subjected to EAPG  
11 Consolidation for that visit. EAPG Consolidation will also occur for details  
12 assigned EAPGs considered to be clinically similar to another EAPG during the  
13 visit. Details subject to EAPG Consolidation will have an EAPG Payment  
14 calculated using an EAPG Weight of 0.

15 e. A detail will be subject to EAPG Packaging when its assigned EAPG is  
16 considered an ancillary service to a Significant Procedure EAPG or Medical Visit  
17 EAPG present on the claim for that visit. Details describing additional  
18 undifferentiated medical visits and services will be exempt from EAPG  
19 Packaging. A detail is also subject to EAPG Packaging when it is assigned a  
20 Medical Visit EAPG while a Significant Procedure EAPG is present on the claim  
21 for that visit. Details assigned Significant Procedure EAPGs that are of subtypes  
22 Physical Therapy and Rehabilitation and Radiologic Significant Procedure do not  
23 cause details with Medical Visit EAPGs to be subject to EAPG Packaging.  
24 Details subject to EAPG Packaging will be calculated using an EAPG Weight of  
25 0.

26 f. A detail will qualify for Multiple Significant Procedure Discounting when a  
27 Significant Procedure of the same subtype is present on the claim for that visit.  
28 Details qualifying for Multiple Significant Procedure Discounting are ordered by  
29 their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG  
30 Weight will have its EAPG Payment calculated at 100 percent (100%) of its  
31 EAPG Weight. The qualifying detail for that visit with the next greatest EAPG  
32 Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG  
33 Weight. All other qualifying details for that visit will have its EAPG Payment  
34 calculated at 25 percent (25%) of its EAPG Weight.

35 g. Details assigned the same Ancillary EAPG on the same visit will qualify for  
36 Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail  
37 qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated  
38 using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second  
39 occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and  
40 EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment  
41 for all other details qualifying for Repeat Ancillary Discounting for that visit and  
42 EAPG will be calculated using 25 percent (25%) of their EAPG Weights.

1 h. Details describing terminated procedures will be subject to Terminated  
2 Procedure Discounting. EAPG Payment for a detail subject to Terminated  
3 Procedure Discounting is calculated using 50 percent (50%) of the EAPG  
4 Weight. Terminated procedures are not subject to other types of discounting.

5 i. Details describing bilateral services will have EAPG Payment calculated using  
6 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting  
7 from Terminated Procedure Discounting.

8 j. Details describing 340B Drugs will have an EAPG Payment calculated using 50  
9 percent (50%) of the EAPG Weight or the EAPG Payment not resulting from  
10 Terminated Procedure Discounting.

11 k. The Hospital-specific Medicaid Outpatient base rate for the year of the  
12 methodology implementation for each hospital is calculated using the following  
13 method.

14 (1) Process Medicaid outpatient hospital claims from state fiscal year 2015,  
15 known as the Base Year, through the methodology described in  
16 8.300.6.A.1.a-k using the Colorado's EAPG Weights

17 (a) For the calculation of the Hospital-specific Medicaid Outpatient  
18 base rate for out-of-state hospital providers, all out-of-state  
19 hospital providers are treated as a single hospital. The  
20 resulting Hospital-specific Medicaid Outpatient base rate  
21 calculated through the remainder of this process shall be used  
22 for all out-of-state hospital providers.

23 (2) Develop utilization trend factor for projecting from the Base Year to the  
24 fiscal year of EAPG implementation. The annual utilization trend factor is  
25 developed based on the claims data ranging from state fiscal years 2011  
26 to 2013.

27 (3) Aggregate the line item EAPG Adjusted Weights for the Base Year of  
28 claims that were processed through the EAPG grouper by hospital. The  
29 annual utilization trend factor is then applied to the aggregated weights  
30 of each hospital. For lines with incomplete data, estimations of EAPG  
31 Adjusted Weights will be used.

32 (4) Calculate a standard base rate by dividing outpatient hospital budget by  
33 the sum of the aggregated weights per hospital. This quotient is then  
34 adjusted to meet budget constraints.

35 (5) Calculate a unique base rate for hospitals with projected payments that  
36 exceed a +/-10% threshold based on the projected payments that would  
37 have been made under the prior outpatient hospital reimbursement  
38 methodology. If necessary, the standard base rate is adjusted to meet  
39 budget constraints. If the projected payments for a hospital are within the  
40 +/-10% threshold, the hospital receives the standard base rate.

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42 2. Payments to Out-of-Network DRG Hospitals

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Excluding items that are reimbursed according to the Department’s fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

Effective October 31, 2016, Out-of-Network PPS Hospitals will be reimbursed for Outpatient Hospital Services based the system of Enhanced Ambulatory Patient Grouping described in 10 CCR 2505-10 Section 8.300.6.A.1.

