Provider Summary of Hospital Stakeholder Engagement Meeting 1/11/2019

Welcome Message and Meeting Etiquette (Slides 1-6, Time 00:00:00-00:06:07)

- Webinar Rules
- Introductions
- Survey
- 2019 Meeting Schedule
- Agenda Item requests

Community Clinic and Community Clinic and Emergency Center (CC/CCEC) Rule Update (Slide 7, Time 00:06:07-00:09:46)

- The CC/CCEC rule is effective November 30, 2018.
- CC/CCECs currently enrolled as a hospital provider type and/or billing through their main hospital ID will need to enroll as and bill under the CC/CCEC provider type for dates of service beginning December 1, 2018, going forward.
- Details on enrolling as in the CC/CCEC provider type can be found on the Information by Provider Type page under Community Clinic.

Pending Additional Research and/or Actions (Slide 8, Time 00:09:46-00:10:10)

- The following items have been discussed at previous meetings and are pending while additional research and/or processes are being completed.
    - Observations over 24 hours
    - Observation 24-48 hours prior to Inpatient Stay
    - 12X and Medicare Crossover Claims (update in March)

Upcoming Topics/Discussions (Slide 9, Time 00:10:10-00:36:53)

March 1, 2019 Hospital Stakeholder Engagement Meeting

- 12X Medicare Crossover Claims Update
- BHO/RAE Representatives

May 3, 2019 Hospital Stakeholder Engagement Meeting

- UB-04: IP and OP Billing Manual Update

Inpatient Hospital Review Program Email Sent (Slide 10, Time 00:36:53-00:37:50)

- Newsletter was sent to provide Updates and Resources for the Inpatient Hospital Review Program
- Used Hospital Stakeholder Engagement Meeting Email list to reach high number of Stakeholders
- For Questions/Comments please email HospitalReview@hcpf.state.co.us

Potential Change to Inpatient Readmission Policy (Slide 11, Time 00:37:50-00:46:31)

The Department is proposing changes to the inpatient readmission policy from 48 hours to 15 days and has asked stakeholders for feedback on situations or conditions that should be exempted from this policy and should not be considered one episode of care even when services are delivered within the readmission window.

The Department received feedback from two hospital systems on the proposed change to the inpatient readmission policy The information provided is currently under review.

Please contact Raine Henry at Raine.Henry@hcpf.state.co.us and Rob Edwards at Robert.Edwards@hcpf.state.co.us with any additional questions.

Hospital Rates Effective 7/1/2018 Approved by CMS (Slide 12, Time 00:46:31-00:47:34)

- Notification of **CMS approval was received** by the Payment Reform Division on 12/26/2018 and a transmittal to update rates and reprocess claims with serve to dates of July, 1, 2018 or later was immediately submitted to DXC.
- All mass adjustments for FY2018-19 rates should be completed by end of January 2019.

Separating Baby from Mother's Claim (Slides 13-16, Time 00:47:34-00:58:23)

During the November 2nd Hospital Engagement Meeting, we discussed in detail the results of the survey regarding whether to separate baby from mother's claim.

Survey: Over 70% of participating hospitals said yes or were neutral to separating Mother and baby claims. This supports what we have been hearing for years that combining them is burdensome to hospitals.

Based on these results, separating Baby from Mother's birth claim is the first in a series of steps we would like to make this year.

Chart of Survey results provided

To make the change, the Department has been working on a plan to present to hospitals which will consist of the following universe of Delivery & Neonatal DRGs:

Chart of APR-DRGs impacted provided

Steps involved in estimating change in payment:

1. Estimate payments for babies born who did not stay after Mother left – we currently have no claims for these since they are combined with Mother's delivery claim. These births will be assigned to a low severity Neonate DRG (DRG= 640 & 626) to cover normal birth with very few difficulties.

2. Estimate payments for Sick Newborns who stay after their Mother leaves the hospital. We will take Neonate DRGs and use birth date to re-calculate the full stay for these claims.

3. Use National DRG Weights, Average Length Of Stay and TrimPoint for delivery and neonate DRGs since the standard in the US is to separate Mother's delivery and Baby birth claims.

4. Apply a multiplier to National DRG Neonate & Delivery Weights to align with current Colorado DRG weights. This will allow Inpatient Hospital Base Rates to remain stable.
5. Remove claims where a solid payment cannot be reasonably estimated such as third-party liability payments.
6. Prepare a comparison of the old payments (current state) vs. new payments by DRG to be presented in March.
7. We aren't sure what other things we may encounter but this is what we've uncovered as being important so far…

Managing Change (Slide 17, Time 00:58:23-01:01:09)

We've realized that combining the change to National Weights & Separating Baby from Mom's Claim is just too much change at once. Therefore, we currently see the upcoming changes to Inpatient Reimbursement in this order:

1. Separating Baby from Mom's Claim
2. Move to National Weights (we discussed during November 2nd meeting)
3. Begin work on creating a new Hospital Base Rate methodology since the maintenance on using Medicare – Disproportionate Share as the starting point for the Medicaid Base Rate has increased substantially over the years.

We also recognize that there are other policy-driven changes that are currently being made so avoiding too much change all at once will help avoid unintended consequences.

Graduate Medical Education (GME) payments to hospitals for Managed Care Entities (MCE) utilization (Slides 18-20, Time 01:01:09-01:08:00)

- In the November 2018 Provider Bulletin, the Department notified hospitals that it was considering amending the rules governing reimbursement for GME. The Department's proposed rule would have incorporated GME payments into managed care capitation payments.
- However, under C.R.S. §25.5-5-402(5), "GME funding for recipients enrolled in an MCE shall be excluded from the premiums paid to the MCE and shall be paid directly to the teaching hospital." **The rule, if put into effect, would have been in direct conflict with state statute. It was therefore removed from consideration for presentation to the Medical Services Board.**
- Should the Department wish to incorporate GME funding into the premiums paid for recipients enrolled in an MCE, the statute must first be amended to eliminate the conflict.
- **Effective immediately, MCE utilization reports delivered to the department on a quarterly basis should be resumed starting with the Q3-2018 report** until C.R.S. §25.5-5-402(5) can be amended.
- Additionally, the Department will be reaching out to MCEs individually to notify them to resume normal reporting processes as detailed in their contracts.

- You can find this notification in its entirety in the January 2019 Provider Bulletin.
- Payments for GME MCE utilization Q1-2017 through Q2-2018 will be made to hospitals by end of Q1-2019.

*Stopped for a Break**

FY 2019-20 Rate Build has already begun…(Slides-21-24, Time 01:08:00-01:13:07)

- **Hospitals participating in rural community hospital demonstration:** CMS has provided the State with confirmation of whether a hospital qualifies for low volume payments based on mileage from closest hospital.
- **Low Volume Payment** – those who are looking for Table 14 "List of Hospitals with fewer than 1,600 Medicare Discharges…" on the CMS site, they no longer produce this table and the information can be found on the FY 2019 IPPS Impact File.
- If you have anything special going on this year, please contact me at diana.lambe@state.co.us or 303.866.5526.
- We used to send Fedex letters but to save money and time. We now post a notice in the February Provider Bulletin and will also be sending reminder emails 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."
- As specified by Medicaid regulations, 10 CCR 2505-10, Section 8.300.5, for the purpose of rate setting effective on July 1 of each fiscal year, the Department uses the most recently audited Medicare/Medicaid Cost Report (CMS 2552) available as of March 1 of each fiscal year.
- In order to calculate your hospital's inpatient base rate and the Medicaid specific add-ons for FY 2019-2020, 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, **2019.** The Department will be using the most recent finalized report Myers and Stauffer LC has as of March 1, 2019 close of business for rebasing inpatient hospital rates. Please note that there is no extension to this date.
- Please submit the following: Electronic Cost Report (ECR) file (if available) or hard copy, copy of Medicare adjustments and NPR letter. If a reopening was completed, send the most recent finalized report. **If your facility fails to include the NPR letter, the documents you have submitted will not be used for rate setting.**
- Electronic submissions may be sent to Kelly Swope at kswope@mslc.com or through regular mail to:

  Kelly Swope, Senior Manager

  Myers and Stauffer LC

  6312 S. Fiddlers Green Circle

  STE 510N

  Greenwood Village, CO 80111

- **In summary, we need two things by March 1, 2019:**

1. Most recently audited Medicare/Medicaid Cost Report (CMS 2552) available as of March 1, 2019.
2. Most recent finalized Medicare Notice of Program Reimbursement (NPR)

- Electronic submissions may be sent to Kelly Swope at kswope@mslc.com or through regular mail to:

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EAPG Module Updates (Slide 25, Time 01:13:07-01:19:52)

- GPS v2019.0.0 Released December 27, 2018
    - Installed into DXC system January 2, 2019
        - EAPG Grouper will recognize 2019 updates to CPT/HCPCS
        - Version 3.10 remains in use
        - No rate change effective January 1, 2019
- No planned changes for any upcoming Service Packs released during this quarter
    - In rare circumstance of an interim update, communication will be released as soon as possible

JW Modifier – Discarded Drugs (Slide 26, Time 01:19:52-01:20:53)

- Impacts claims where discarded portions of drugs were billed (JW modifier)
- DXC's system not interfacing correctly with EAPG grouper
- System Change Request submitted

Multiple Same Day Visits (Slides 27-28, Time 01:20:53-01:25:43)

Emergency Room visits should not be included on outpatient claims describing recurring visits (regularly scheduled visits for ongoing treatment, such as physical therapy or oncology treatment). Emergency Room visits should be billed separately in order for the EAPG grouper to calculate payment appropriately per claim and visit. Recurring visits which may include Observation services should have each visit billed separately to avoid unintended bundling during payment calculation.

- Services may not appropriately bundle per visit, causing issues with payment calculation
- Multiple same-day visits should be combined, unless otherwise instructed (see previous slide)
- Topic of discussion in previous EAPG meetings / survey

EAPG Survey Results (Slides 29-30, Time 01:25:43-01:54:56)

Result Chart Included

- 17 hospitals responded to the survey
    - Entries were de-duplicated
- EAPG Base Rate Reform as the highest priority
- Non-packaged Drug Carveout lowest priority
- Survey feedback
    - Usefulness of survey
    - Future surveys

Questions: Topics Covered (Slide 31, Time 01:54:56-02:15:09)

- HMS Audits concerns/questions
- Updates to NDCs not on Crosswalk
- Customer Service at DXC
- Missing parts on REMITs
- Incorrect advice being provided by DXC
- Transgender claims – status of fix to stop manual processing
- Non-Binary