COLORADO
Department of Health Care Policy & Financing

Dear Hospital Provider,

Thank you for the care you provide to Health First Colorado (Colorado's Medicaid Program) and Child Health Plans *Plus* (CHP+) members. The Department of Health Care Policy & Financing (the Department) continues to work closely with DXC Technology (DXC) to resolve issues raised by you.

This email provides an update on these issues. The previous communication and a schedule of upcoming webinar meetings can be found on our Outpatient Hospital Payment web page.

Background

- Historically, the Department reimbursed hospitals under a cost-to-charge reimbursement methodology; hospitals submitted charges, the Department paid a percentage of the charges at the time of service and the Department later reconciled to a percentage of audited costs.
- The Enhanced Ambulatory Patient Grouping (EAPG) is a policy change impacting hospitals. The policy change was expected to be revenue neutral for hospitals in aggregate on an accrual basis.
- Under the EAPG reimbursement methodology, hospitals are paid a final rate based on the type and relative resource intensity of the group of services provided.
- The transition away from the cost-to-charge reimbursement methodology eliminated the need for cost settlements that had sometimes occurred years later – depending on the length of the cost report audit.
- The Department received approval to begin applying the reimbursement methodology to outpatient hospital claims effective October 31, 2016.
- The Department began processing claims according to the EAPG methodology on March 1, 2017 to align with the transition to the Colorado interChange, the new claims processing system in Colorado. Claims will be adjusted for the period of October 31, 2016 through February 28, 2017 at a later date.

Rate Setting with EAPG Methodology

- Each hospital was assigned a unique base rate calculated using historical claims and cost reports. An estimated fiscal impact of the EAPG implementation was performed and communicated to each hospital.
- To help ensure revenue stability for hospitals, a 10 percent risk corridor was built into the rate setting methodology.
    - Hospitals with a projected fiscal impact greater than 10 percent received an adjusted base rate to mitigate gains or losses to the risk corridor.
    - Fiscal impacts were calculated by:
        1. Converting claim charges from state fiscal year (SFY) 2015 to 71.6% of costs using the Healthcare Cost Report Information System (HCRIS).
        2. Adjusting costs for increased caseload during the implementation period.
        3. Comparing the adjusted costs to the expected EAPG utilization for hospitals, multiplied by their base rate.
            - EAPG utilization was estimated by:
                1. Processing claims from SFY 2015 through the EAPG grouper
                2. Summing the resulting EAPG Adjusted Relative Weights
            - When specific EAPGs could not be assigned due to missing procedure codes, the adjusted weights were estimated based on the average weights associated with the relevant revenue code on claims that did include procedure codes.
            - The EAPG Relative Weights can be found on the Outpatient Hospital Payment web page
- With the implementation of the EAPG pricing methodology, procedure codes (CPT/HCPCs codes) are critical for accurate payments.
    - Providers were encouraged to submit as many CPT/HCPCs on a claim as possible in ensure accurate payment. In some cases, not submitting all CPT/HCPCs on a claim will result in lower reimbursement than a hospital is eligible to receive.

    - As providers continue to modify their billing practices to consistently include procedure codes on the claim, the Department is seeing more accurate payments. The average completion rate (the proportion of paid claim lines including procedure codes vs the total number of paid claim lines) has increased from 80% to 90% since October of 2016. 34 out of 86 hospitals are over 90% with 17 of those over 95%, however, this still leaves room for hospitals with lower completion rates to include more procedure codes and be paid more accurately.
- Lastly, a limited set of services that were previously reimbursed as part of the outpatient visit and billed on the CMS UB-04 are now billed separately on the CMS-1500 form. These include transportation services and durable medical equipment.

EAPG and the "Lower of" Pricing Logic

The Department has updated the "lower of" pricing logic which compares EAPG payment to line item submitted charges. This update, which was released as part of 3M's October 12, 2017 service pack, utilizes the EAPG grouper to redistribute billed amounts by visit, prior to the "lower of" pricing comparison between EAPG payment and line item submitted charges. This change and reprocessing of claims more closely aligned payments under the EAPG methodology with initial payment projections.

Future State of EAPG Methodology

- **Pharmaceuticals associated with EAPG claims.** Pharmaceuticals (including pharmaceuticals procured through the 340B program) associated with outpatient hospital claims continue to be a source of concern among hospital providers. The Department is investigating both short and long-term solutions to these concerns through the EAPG engagement meetings. In the short term, the Department has proposed changing the UD modifier discount percentage to 20 percent in order to more accurately reflect the discounts that covered 340B entities receive. This compares to the current discount factor of 50 percent. The effective data is not yet final, but the Department is working to have an effective date in mid-March to late April. In the long term, the Department is investigating the feasibility of carving out most or all pharmaceuticals from the EAPG methodology and paying for the carved-out pharmaceuticals according to the fee schedule.
- **Base Rate Setting Methodology.** The Department is committed to developing an on-going methodology of setting EAPG base rates, separate from the budget neutral base rates set during implementation. The most recent model that was presented has one standard base rate that has separate adjustments for both rural/critical access (CAH) and graduate medical education hospitals. It would also remove the separate hospital base rate categories of rural, urban, and pediatric. Instead, the per hospital base rate adjustment for rural/CAH or a per claim adjustment for pediatric clients would be applied. The standard base rate calculation and adjustments are still being discussed in the biweekly EAPG meetings, so no implementation date has been established.

Department and Ongoing Hospital Collaboration

As a reminder, the Department hosts biweekly meetings to address EAPG processes and issues on a biweekly basis. Hospitals can attend in person at 303 E 17th Avenue, Denver CO 80203 or by logging into the webinar link listed below. Prior meeting recordings can be found under the date of the meeting on the website.
Webinar Link https://cohcpf.adobeconnect.com/eapg/

Colorado interChange

The Department and DXC Technology (DXC) are diligently working to resolve outstanding issues related to the Colorado interChange claims processing and (EAPG) pricing. The Department is committed to keeping providers updated as progress continues to be made. Below are summarized issues that have been addressed over the last few months as well as the financial impact regarding the reprocessing and/or adjustments of claims.

EOB 2580: The Services must be Billed to the HMO/PHP/BHO Listed on the Eligibility Inquiry

- Claims for all Evaluation and Management (E/M) procedure codes were denying because the Colorado interChange was not using diagnosis to determine BHO coverage (*Resolved September 2017*)
- Claims were incorrectly denying for members with Kaiser Access plans (*Resolved*

September 2017)
- Claims for laboratory codes 80047 - 89398 and specific ICD-10 diagnoses were incorrectly denying for EOB 2580 (*Resolved September 2017*)
- Claims were incorrectly denying when the provider is a RHC or FQHC (*Resolved June 2017*)
- Claims were incorrectly denying for specific procedure codes (*Resolved December 2017)*
- Summary of claims impact:
    - Claims Adjusted: More than 50,000
    - Adjustment Amount Paid: $5.5 million
    - Original Amount Paid: $ 1.9 million
    - Net New Payment: $3.7 million

EAPG Related Issues

- The "lesser of" pricing logic in the EAPG grouper is resulted in significant underpayments that weren't aligned with the Department's initial EAPG payment projections. The fix implemented in October 2017 and December 2017. The Department has resolved an impactful technical issue with how the EAPG methodology applied "lesser of pricing" logic at the line level. In cases where line level charges are lower than the EAPG calculated amount for the line, the billed charges were used to determine the reimbursement amount rather than EAPG calculated amount. This resulted in lower than intended reimbursement when the charges associated with lines that bundled with other lines did not have their associated charges included in the lesser of pricing logic comparison. Another way to describe this issue is that the system was comparing bundled rates against individual lines charges instead of comparing bundled rates against bundled groups of lines' aggregated charges. This has now been resolved and billed charges are being bundled and compared to the bundled EAPG calculated amounts. Because billing practices and charge amounts dictate whether the lesser of logic will result in lower than intended reimbursement, the impact of this issue varies significantly from hospital to hospital; in fact, many hospitals are minimally impacted by this issue. In aggregate, the Department estimates that state-wide aggregate outpatient reimbursement will be 8-10% higher when this issue was mass adjusted. Again, because billing practices vary from hospital to hospital, this result cannot be interpreted as what to expect for any given hospital's change in reimbursement once claims are adjusted. (*Resolved December 2017*)
- Mass reprocessing for 7/1 Rate Updates (*Resolved December 2017*)
- Duplicate payment reprocessing (*Resolved January 2018*)
- Some laboratory services were denying for incorrect matches to revenue codes or procedure codes. This was interfering with the grouping logic for EAPGs and creating inappropriate payments. These edits have been corrected and laboratory services are now being passed through the grouper to create correct payments.
- Summary of claims impact:
    - Claims Adjusted: More than 800,000
    - Adjustment Amount Paid: $306 million
    - Original Amount Paid: $299 million
    - Net New Payment: $7 million

Hospital "Admit" Date Falls After the "From" Date

- Claims are denying when the hospital "Admit" date falls after the "From" date for any of the following EOBs: 1730, 1731, 1393, 1395, 1920, 1930 and 1702. Health First Colorado reimbursement for inpatient hospital care includes associated outpatient, laboratory, and supply services provided in a 24-hour period immediately prior to the hospital admission, during the hospital stay and 24 hours immediately after discharge. This policy affected a significant amount of claims denied because the date of their procedures done was before admission or they came in through emergency room the day before (from date was before). Without this fix, providers wouldn't have been able to bundle these services because the dates were outside the admit-through dates and claims were denying. (*Resolved January 2018*)
- Summary of claims impact
    - Claims Adjusted: 10,000
    - Adjustment Amount Paid: $25 million
    - Original Amount Paid: $0
    - Net New Payment: $25 million

Medicare Crossover Claims

Incorrect denial of Medicare Crossover Claims: The system was denying crossover claims for

services that are covered by Medicare but not Medicaid. The Colorado interChange should reimburse these claims based on the Medicare assigned coinsurance and deductible. Providers had been advised to continue to submit these claims, and resubmit them now that the issue is resolved. (*Resolved November 2017)*

- Summary of claims impact
    - Claims adjusted: 184,000
    - Adjustment Amount Paid: $11 million
    - Original Amount Paid: $8 million
    - Net New Payment: $3 million

Provider questions should be directed to the Provider Services Call Center at 1-844-235-2387.

Thank you,

Health First Colorado (Colorado's Medicaid Program)

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