Title of Rule: Revision to the Medical Assistance Act Rule concerning Healthcare Affordability and Sustainability Provider Fees and Supplemental Payments, Section 8.3000
Rule Number: MSB 24-10-01-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

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 achieves two purposes. These are 1) make necessary adjustments to MSB 24-02-06-A and 2) establish a one-time provider fee increase to fund supplemental payment increases for federal fiscal year (FFY) 22-23 and FFY 23-24.

   1) MSB 24-02-06-A Adjustment - The adjustments to MSB 24-02-06-A, originally presented to the Medical Services Board in July 2024, modifies the calculation of the HAS provider fees and supplemental payments. Since then, it was identified that two minor rule revisions are necessary for HAS calculations. These include:

      a. Reinclusion of the "Urban Center Safety Net Specialty Hospital" definition in Section 8.3001 DEFINITIONS. This definition was erroneously removed and needs to be a defined hospital for certain hospital reimbursement calculations.

      b. Change the hospital-specific Disproportionate Share Hospital (DSH) limit for low Medicaid inpatient utilization rate (MIUR) hospitals from "equal to 10.00%" to "greater than or equal to 10.00%" in Section 8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENTS. This is necessary to allow for increased HAS supplemental payments to low MIUR hospitals, aligning with HAS supplemental payment calculations.

   Both listed changes are minor and have negligible impacts. The Urban Center Safety Net Specialty Hospital definition makes no changes to hospital reimbursement. The low MIUR DSH limit change increases HAS supplemental payments to low MIUR hospitals by $50k.

   2) HAS Provider Fee Increase - In the subsequent months, HAS supplemental payments for FFY 22-23 and FFY 23-24 will be increased from 97.00% to 99.25% of the Inpatient/Outpatient Upper Payment Limits (UPLs), equaling a $85 million payment increase. Both years are still within the two-year federal filing requirements, allowing for federal financial participation for any supplemental payment increases. The state's funding obligation for this payment increase will come from an additional $31 million in provider fees to be collected from hospitals at the same time the supplemental payments are made. The calculation methodology for the one-time fee increase is included in Section 8.3003.A. OUTPATIENT SERVICES FEE and Section 8.3003.B. INPATIENT SERVICES FEE. No changes are required to Section 8.3000 for the payment increase for either year.

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The Department worked extensively with the Colorado Hospital Association (CHA) and the general hospital provider community over the last several months on this project. The HAS provider fee and supplemental payment increases were both presented to the Colorado Healthcare Affordability & Sustainability Enterprise (CHASE) Board at their October 2024 meeting. The CHASE Board approved the fees and payments at the board meeting and makes recommendations for the MSB to approve the proposed rule.

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 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);

25.5-4-402.4(4)(b), (g), C.R.S.

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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.

   MSB 24-02-06-A Adjustment - Low MIUR hospitals will experience a limited supplemental payment increase. Hospitals will bear the cost through increased provider fees used to fund this funding obligation increase.

   HAS Provider Fee Increase - Hospitals will bear the cost through increased provider fees. Hospitals though, will also experience greater supplemental payments with the increased provider fees.

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

   MSB 24-02-06-A Adjustment - The proposed rule will increase HAS supplemental payments to low MIUR hospitals by $50k.

   HAS Provider Fee Increase - The supplemental payment, provider fee, and net reimbursement increases for FFY 22-23 and FFY 23-24 are provided in the table below. Net reimbursement equals supplemental payments minus provider fees.

FFY	FFY 22-23	FFY 23-24	Total
Provider Fees	$21.2M	$9.9M	$31.1M
Supplemental Payments	$55.9M	$29.2M	$85.1M
Net Reimbursement	$34.7M	$19.3M	$54.0M

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.

   There are no costs to the Department with the proposed rule.

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

   MSB 24-02-06-A Adjustment - If no action is taken, low MIUR hospitals do not experience the $50k payment increase.

   HAS Provider Fee Increase – If no action is taken, the $31 million in state funding obligation cannot be collected and the $85 million supplemental payments cannot be made to hospitals.

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

   No other methods are available to achieve the purpose of the proposed rule.

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.

   No other alternatives are available.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

8.3001: DEFINITIONS

1. "Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-402.4, C.R.S.

2. "CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability Enterprise described in C.R.S. § 25.5-4-402.4(3).

3. "CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

4. "CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.

5. "CMS" means the federal Centers for Medicare and Medicaid Services.

6. "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and licensed or certified as a critical access hospital by the Colorado Department of Public Health and Environment.

7. "Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to qualified hospitals that serve a disproportionate share of Medicaid and uninsured individuals as required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that limits federal financial participation for total statewide DSH payments made to hospitals.

8. "Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described in C.R.S. § 25.5-4-402.4(7).

9. "Essential Access Hospital" means a Critical Access Hospital or General Hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget and having 25 or fewer licensed beds.

10. "Exclusive Provider Organization" or "EPO" means a type of managed care health plan where members are not required to select a primary care provider or receive a referral to receive services from a specialist. EPOs will not cover care provided out-of-network except in an emergency.

11. "Fund" means the healthcare affordability and sustainability fee cash fund described in C.R.S. § 25.5-4-402.4(5).

12. "General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

13. "High Volume Medicaid and CICP Hospital" means a hospital with at least 30,000 Medicaid Days per year that provides over 35% of its total days to Medicaid and CICP clients.

14. "Health Maintenance Organization" or "HMO" means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency.

15. "High Medicaid Utilization Hospital" means a hospital with a Medicaid payer mix greater than or equal to twenty-five percent (25%) and a Medicaid non-managed care patient days utilization rate greater than or equal to forty percent (40%).

16. "Heart Institute Hospital" means a hospital recognized as a HeartCARE Center by the American College of Cardiology (ACC) with at least 25,000 Medicaid Non-Managed Care Days per year.

17. "Hospital-Specific Disproportionate Share Hospital Limit" or "Hospital-Specific DSH Limit" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.

18. "Hospital Transformation Program Supplemental Medicaid Payments" or "HTP Supplemental Medicaid Payments" means the:

    1. Outpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.B.,

    2. Inpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.C., and

    3. Essential Access Hospital Supplemental Medicaid Payment described in Section 8.3004.E.

19. The HTP Supplemental Medicaid Payments do not include the Hospital Quality Incentive Payment described in Section 8.3004.F. or Rural Support Program Hospital Supplemental Medicaid Payment described in Section 8.3004.G.

20. "Independent Metropolitan Hospital" means an independently owned and operated hospital located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget with at least 1,500 Medicaid Days per year.

21. "Inpatient Services Fee" means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

22. "Inpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

23. "Long Term Care Hospital" means a General Hospital that is certified as a long-term care hospital by the Colorado Department of Public Health and Environment.

24. "Managed Care Day" means an inpatient hospital day for which the primary payer is a managed care health plan, including HMO, PPO, POS, and EPO days.

25. "Medicaid Day" means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

26. "Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is Medicaid.

27. "Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.

28. "MMIS" means the Medicaid Management Information System, the Department's Medicaid claims payment system.

29. "MIUR" means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospital days.

30. "Neonatal Intensive Care Unit Hospital" or "NICU Hospital" means a hospital with a NICU classification of Level III or IV according to guidelines published by the American Academy of Pediatrics (AAP).

31. "Non-Managed Care Day" means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.

32. "Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a local government.

33. "Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges.

34. "Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

35. "Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric populations.

36. "POS" or "Point of Service" means a type of managed care health plan that charges patients less to receive services from providers in the plan's network and requires a referral from a primary care provider to receive services from a specialist.

37. "PPO" or "Preferred Provider Organization" means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost.

38. "Privately-Owned Hospital" means a hospital that is privately owned and operated.

39. "Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

40. "Rehabilitation Hospital" means an inpatient rehabilitation facility.

41. "Respiratory Hospital" means a hospital that primarily specializes in respiratory related diseases.

42. "Rural Hospital" means a hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget.

43. "Safety Net Metropolitan Hospital" means a hospital that provides services within the Pueblo, Colorado Metropolitan Statistical Area designated by the United States Office of Management and Budget (Pueblo MSA) with no less than 15,000 Days per year reported on its Medicare Cost Report, Worksheet S-3, Part 1, Column 7 (Title XIX), lines 1-18, and 28 (adult, pediatrics, intensive care, and subunits).

44. "State-Owned Government Hospital" means a hospital that is either owned or operated by the State.

45. "Teaching Hospital" means a High-Volume Medicaid and CICP Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a

state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

46. "Supplemental Medicaid Payments" means the:

1. Outpatient Hospital Supplemental Medicaid Payment described in 8.3004.B.,

2. Inpatient Hospital Supplemental Medicaid Payment described in 8.3004.C.,

3. Essential Access Hospital Supplemental Medicaid Payment described in 8.3004.E.,

4. Hospital Quality Incentive Payment described in 8.3004.F., and

5. Rural Support Program Hospital Supplemental Medicaid Payment described in 8.3004.G.

47. "Uninsured Cost" means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.

48. "Urban Center Safety Net Specialty Hospital" means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total inpatient hospital days per year, rounded to the nearest percent, equals, or exceeds 65%.

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.6625% of total hospital outpatient charges, with the following exception: ~~.~~

    a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to 1.6485% of total hospital outpatient charges.

4. A one-time Outpatient Services Fee shall be collected from hospitals to increase Inpatient Hospital Supplemental Medicaid Payments and Outpatient Hospital Supplemental Medicaid Payments to 99.25% of the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit for federal fiscal year 2022-23 and federal fiscal year 2023-24.

    a. The Outpatient Services Fee is calculated as .0359% of a hospital's cost report year-end (CRYE) 2022 total hospital outpatient charges, with the following exception:

        i. High Volume Medicaid and CICP Hospital's Outpatient Services Fee is discounted to .0356% of CRYE 2022 total hospital outpatient charges.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $106.01 per day for Managed Care Days and 473.90 per day for ~~all~~ Non-Managed Care Days, with the following exceptions:

    a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $55.35 per day for Managed Care Days and $247.42 per day for ~~all~~ Non-Managed Care Days, and

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to 42.40 per day for Managed Care Days and $189.56 per day for Non-Managed Care Days.

4. A one-time Inpatient Services Fee shall be collected from hospitals to increase Inpatient Hospital Supplemental Medicaid Payments and Outpatient Supplemental Medicaid Payments to 99.25%

of the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit for federal fiscal year 2022-23 and federal fiscal year 2023-24.

a. The Inpatient Services Fee is calculated as $2.68 per CRYE 2022 Managed Care Day and $11.96 per CRYE 2022 Non-Managed Care Day, with the following exceptions:

i. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $1.40 per CRYE 2022 Managed Care Day and $6.24 per CRYE 2022 Non-Managed Cared Day, and

ii. Essential Access Hospitals' Inpatient Services Fee is discounted to $1.07 per CRYE 2022 Managed Care Day and $4.78 per CRYE 2022 Non-Managed Care Day.

8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

   a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

   b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

   c. Critical Access Hospitals with at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment.

   a. Total funds for the payment shall equal $257,231,668.

   b. No qualified hospital shall receive a payment greater than 100% of their Hospital-Specific DSH Limit.

   c. A qualified hospital with CICP write-off costs greater than 700% of the state-wide average shall receive a payment equal to a minimum of 96.00% of their Hospital-Specific DSH Limit.

   d. A qualified Critical Access Hospital or Rural Hospital shall receive a payment equal to a minimum of 86.00% of their Hospital Specific DSH Limit.

   e. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than 2,700 Medicaid Days shall receive a payment equal to a minimum of 80.00% of their Hospital-Specific DSH Limit.

   f. All remaining qualified hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining funds.

   g. A Low MIUR hospital shall ~~have their~~ receive a payment greater than or equal to 10.00% of their Hospital-Specific DSH Limit ~~equal 10.00%~~.

      i. A low MIUR hospital is a hospital with a MIUR less than or equal to 22.50%.

   h. The payment percentage of the hospital specific DSH limit shall be published in provider bulletin