Title of Rule: Revision to the Medical Assistance Act Rule concerning Out-of-State Hospital and Physician Services Rate Negotiation, Section 8.013
Rule Number: MSB 24-11-12-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

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).

This rule revision aligns Department rule with current policy, and federal State Plan authority, for out-of-state services and for the negotiation of single case agreements with out-of-state hospital and out-of-state physicians. When necessary, the Department may negotiate a higher reimbursement rate with an out-of-state provider to ensure access to care for members that require services not available in Colorado. For out-of-state hospitals to be eligible for single case agreements, the required services must not be available in Colorado and they must be prior authorized. Out-of-state physician services may only be covered under a single case agreement if the services in question are not available in Colorado or if the services are provided under an out-of-state hospital's single case agreement . The authority to negotiate single case agreements in such circumstances ensures access to care for members that require hospital services or physician services not available in Colorado.

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 447.201(b) (2024)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);
Sections 25.5-5-102(1)(a-b), (d), C.R.S. (2024)

Initial Review **02/14/25** Final Adoption **03/14/25**
Proposed Effective Date **05/15/25** 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.

Members who require out-of-state hospital services or physician services not otherwise available in Colorado will be affected by the proposed rule. Out-of-state hospitals and physicians who render such services will also be affected by the proposed rule. The Department will bear the cost of the rate negotiated in a single case agreement authorized under this rule.

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 qualitative impact to members requiring out-of-state services not available in Colorado will be access to care where a single case agreement is required to negotiate a rate the out-of-state provider will accept to render such services. The quantitative impact will be the rate negotiated in the single case agreement, which will be paid by the Department.

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.

This rule is anticipated to be budget neutral because the Department already negotiates single case agreements with out-of-state providers when the required services are not available in Colorado. The proposed rule updates out-of-date rule language to align with the Department's policy for out-of-state services and for single case agreement negotiations, and with the federal authority for such negotiations in the State Plan.

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

The proposed rule has no probable costs because it aligns Department rule with current policy and federal State Plan authority, it does not add a new authority to negotiate single case agreements. The proposed rule benefit is aligning Department rule with existing policy and federal State Plan authority. The cost of inaction is continued misalignment between Department rule and the current Department policy and federal State Plan authority. There are no benefits to inaction.

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

There are no less costly or less intrusive methods to align Department rule with current policy and with federal State Plan authority.

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.

There are no alternative methods for aligning Department rule with current policy and with federal State Plan authority.

8.013 OUT-OF-STATE MEDICAL CARE

8.013.1. COLORADO RESIDENTS TEMPORARILY OUT-OF-STATE

An eligible Colorado ~~recipient~~member, temporarily out of the state but still a resident of Colorado, ~~is entitled to~~ receives the same Medicaid benefits ~~to the same extent that Medicaid is furnished to~~as members ~~-~~located in the state of Colorado ~~residents in the state~~ only under ~~any one of~~ the following conditions:

A~~1).~~ Medical services are needed because of a medical emergency.

For these services no prior authorization is needed. Whether an emergent condition exists is determined by the provider rendering service. ~~Documentation of the emergency must be submitted with the claim~~The emergency must be indicated on the claim submission.

B~~2).~~ Medical services are needed because the ~~recipient's~~ member's health would be endangered if he/she were required to ~~return~~ travel to Colorado for medical care and treatment.

~~For these services no prior authorization is required.~~ The determination as to whether the ~~recipient's~~ member's health would be endangered is made by the provider rendering service. ~~Documentation of why the recipient's health would be endangered must be submitted with the claim. However, the medical consultant of the Colorado Medicaid Program must be notified prior to the provision of services under this paragraph.~~

C~~3).~~ The ~~State Medicaid Director~~Department determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available ~~in the state~~ where the ~~recipient~~ member is temporarily located.

Prior authorization from the Medicaid Program's medical consultant must be obtained for services provided under this paragraph.

D~~4).~~ It is the general practice for ~~recipients~~ members in a particular locality to use medical resources in another state.

~~No prior authorization is necessary for services provided in accordance with this paragraph when the recipient of an area is obtaining services from a provider in a neighboring out of state locale.~~ Prior authorization from the Medicaid Program's medical consultant ~~is necessary~~may be required if the recipient is receiving services from any other out~~-~~of~~-~~state provider not in a neighboring locale.

E. The Section 8.013.1.A-D. limitations on access to out-of-state medical care, for members temporarily out-of-state, do not apply to children who reside out of the state for whom Colorado makes adoption assistance payments or foster care maintenance payments.

8.013.2. COLORADO RESIDENTS SEEKING OUT-OF-STATE CARE

~~In addition, prior authorization from the Medicaid Program's medical consultant is required for all services which are only available out of state for Colorado Medicaid recipient's located in Colorado at the time services are necessary~~ If a member requires services that are only available out-of-state at the time services are medically necessary, those services ~~must~~~~will~~may be approved by the Department.

~~CThe above restrictions on out of state medical care shall not apply to children who reside out of the state for whom Colorado makes adoption assistance payments or foster care maintenance payments.~~

~~The county departments of social services shall advise all applicants and recipients of this policy.~~

8.013.3 PRIOR AUTHORIZATION

All services that require prior authorization in-state also require prior authorization out-of-state. Some services may require additional prior authorization to have the services rendered out-of-state, even if the underlying service does not require prior authorization.

8.013.~~1~~ 4. PROVIDER ENROLLMENT ~~PROCEDURES~~

To receive reimbursement, all out-of-state providers ~~shall be required to~~must enroll in the Colorado Medicaid Program. Out-of-state providers are subject to the same enrollment and screening rules, policies and procedures as in state providers, as specified in Section 8.125 Provider Screening~~.~~. Some out-of-state providers are not eligible to enroll in Colorado Medicaid and cannot receive reimbursement.

8.013.~~2~~5. REIMBURSEMENT PRINCIPLES

~~A. All claims except out of state nursing home claims must be submitted to the fiscal agent for the state with documentation showing that the above requirements have been met.~~ ~~(~~Out-of-state nursing home claims ~~shall~~ must be paid in accordance with ~~the~~ Section 8.443.19. ~~Payment For Out Of State Nursing Home Care section of the Volume 8 staff manual.) All claims submitted to the fiscal agent must include:~~

~~B. 1) A copy of the provider's current Medicaid provider agreement with its state (if applicable);~~

~~C. 2) Its Colorado provider number; and~~

~~D. 3) Complete address, including zip code.~~

~~E. In addition, providers must sign a provider agreement in order to receive reimbursement. The claim form and the information contained in it shall constitute provider agreement. Except as provided elsewhere in the Volume 8 staff manual, reimbursement for out of state care shall be as follows:~~

~~F. Reimbursement for inpatient hospital services shall be 90% of the Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services (DHHS).~~

~~G. Reimbursement for physician services shall be the lower of the following:~~

~~H. A. HCFA Common Procedure Coding System (HCPCs) fee;~~

~~I. B. Provider's Actual Charge.~~

~~J. Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare.The foregoing procedures shall be in~~

~~effect for all out-of-state providers, except as provided for elsewhere in the staff manual Volume 8 regulations. Individual cases which are adversely affected by these procedures shall be presented to the Bureau of Medical Services, Director, Program Operations Division, Colorado Department of Social Services. Individual consideration shall be given to such cases.~~

A. The Department may utilize single case agreements to negotiate a higher reimbursement rate for the following types of services:

1. Hospital services

a. The Department may negotiate a single case agreement with an ~~for~~ out-of-state hospital ~~services that are prior authorized~~under the following circumstances:~~.~~

i. ~~A. These are cases which require procedures~~ The hospital services are not available in Colorado;

~~i.~~ii. ~~and which~~ The hospital services must be prior authorized; and,~~.~~

iii. ~~B.~~ The ~~patient~~member's physician may suggest where the ~~patient~~ member should be sent, but the medical consultant for the Department is responsible for making the final determination based on the most cost effective institution consistent with quality of care.

b. The reimbursement rate for out-of-state hospital services in accordance with single case agreements will be negotiated between the Department and the out-of-state facility providing the services. When negotiating the rate, the Department will take into consideration the following:

i. The actual costs of the facility;

ii. The Medicare rate for the same or similar services, if any; and,

iii. The Medicaid rate for the same or similar services in the state where the facility is located, when available.

c. The reimbursement rate for out-of-state hospital services in accordance with single case agreements may not exceed the usual and customary charges of the facility for such services.

2. Physician services

a. The Department may negotiate a higher reimbursement rate for out-of-state physician services in accordance with single case agreements under the following circumstances:

i. The physician services are either:

1) Included in an approved single case agreement with a hospital in accordance with Section 8.013.2.D.1.; or

2) Not available in Colorado and provided by an out-of-state physician.

ii. The member's physician may suggest where the member should be sent, but the medical consultant for the Department is responsible for making the final determinations based on the most cost-effective physician consistent with quality of care.

b. The reimbursement rate for out-of-state physician services in accordance with single case agreements will be negotiated between the Department and the out-of-state physician providing the services. When negotiating the rate, the Department will take into consideration the following:

i. The actual costs of the facility or the physician;

ii. The Medicare rate for the same or similar services, if any; and,

iii. The Medicaid rate for the same or similar services in the state where the facility or physician is located, when available.

~~b.~~c. The reimbursement rate for out-of-state physician services in accordance with single case agreements may not exceed the usual and customary charges for the facility or physician for such services.