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 24-02-06-A
Division / Contact / Phone: Special Financing Division / 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 revisions include changes to the Healthcare Affordability and Sustainability (HAS) provider fees assessed upon hospitals and the HAS supplemental payments made to hospitals for federal fiscal year (FFY) 2023-24. The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board approved the calculation of the FFY 2023-24 provider fees and supplemental payments on Monday, June 3, 2024, and recommends the approval of the proposed rule revisions by the MSB.

   The provider fees, with federal matching funds, fund the supplemental payments, healthcare coverage to 500,000+ Medicaid & CHP+ expansion members, and related administrative costs. The proposed rule revises the Inpatient per-diem fees (8.3003.B) and Outpatient percentage fees (8.3003.A) such that provider fees with federal matching funds equal the total funding obligation for FFY 2023-24. Also included are revisions to the Disproportionate Share Hospital (DSH) supplemental payment calculation for FFY 2023-24 (8.3004.D), and revisions/additions to the definitions (8.3001).

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:

   The Colorado Healthcare Affordability and Sustainability Enterprise Act [C.R.S. § 25.5-4-402.4 (2018)] instructs the state to charge provider fees to hospitals, and obtain federal matching funds, to fund supplemental payments to hospitals, healthcare coverage for Medicaid & CHP+ expansion members, and related administrative costs. The proposed emergency rule revisions are necessary to allow for sufficient provider fees to be collected from hospitals over the subsequent months to equal the funding obligation increases for FFY 2023-24. Without emergency approval there is no time to collect the necessary provider fees from hospitals by FFY year-end (September 30, 2024) to fully fund all funding obligations; meaning we will not be conpliant with state statute.

   The funding obligation for Medicaid & CHP+ expansion members and related administrative costs for FFY 2023-24 have increased $20 million compared to FFY 2022-23. Since October 2023, a HAS cash fund reserve has covered the increased funding obligations until the CHASE Board can approve the provider fee/supplemental payment calculations and the MSB

can approve the proposed rule revisions. The cash fund reserve was not intended to cover such a large funding obligation for so long. Without increased provider fees collected from hospitals, the current available funds will quickly become limited. Resulting in the inability to fully reimburse for services to our Medicaid and CHP+ expansion members funded through this program.

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. (2018);

   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.

   Hospitals will benefit through increased supplemental payments. The state will benefit through increased provider fees collected from hospitals necessary to fund the funding obligation increase for Medicaid & CHP+ expansion populations.

   Hospitals will bear the cost through increased provider fees used to fund the funding obligation increase for supplemental payments, Medicaid & CHP+ expansion populations, and administrative costs.

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 revisions will result in a $12 million net reimbursement (supplemental payments – provider fees) increase to hospitals for FFY 2023-24. The proposed rules will also result in increased provider fees collected necessary to fund the $14 million funding obligation increase for Medicaid & CHP+ expansion populations and the $5 million funding obligation increase for administrative costs.

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.

   While there are administrative costs, such costs are funded with provider fees with federal Medicaid matching funds. No state General Fund is used.

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

   If no action is taken, the Department will not be able to collect sufficient provider fees from hospitals to fully fund supplemental payments, Medicaid & CHP+ expansion populations, and administrative costs to comply with state statute. The state does not currently have the resources to fund the different funding obligation increases in absence of the provider fees.

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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. The rules are necessary to comply with the Colorado Healthcare Affordability and Sustainability Enterprise Act, under section 25.5-4-402.4, C.R.S.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017 (Act), C.R.S. § 25.5-4-402.4, authorizes the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) to assess a healthcare affordability and sustainability fee, pursuant to rules adopted by the State Medical Services Board, to provide business services to hospitals as described in C.R.S. § 25.5-4-402.4(4)(a). These business services include, but are not limited to, obtaining federal financial participation to increase reimbursement to hospitals for care provided under the state medical assistance program (Medicaid) and the Colorado Indigent Care Program (CICP); expanding health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan Plus (CHP+), and for low-income adults without dependent children; providing a Medicaid buy-in program for people with disabilities; implementing twelve month continuous eligibility for Medicaid eligible children; paying CHASE's administrative costs of implementing and administering the Act; consulting with hospitals to help them improve cost efficiency, patient safety, and clinical effectiveness; advising hospitals regarding potential changes to federal and state laws and regulations governing Medicaid; providing coordinating services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the Medicaid program; and providing funding for a health care delivery system reform incentive payments program.

8.3001: DEFINITIONS

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

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

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

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

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

"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.

"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.

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

"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.

"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.

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

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

"High Volume Medicaid and CICP Hospital" means Children's Hospital Colorado-Anshutz Medical Campus, Denver Health and Hospital Authority, University of Colorado Health Memorial Health System, or University of Colorado Hospital Authority ~~means a hospital with at least 27,500 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients~~.

"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.

"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%).

"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.

"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.

"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.

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.

"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.

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

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

"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.

"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.

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

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

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

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

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

"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).

"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.

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

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

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

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

"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.

"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.

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

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

"Rehabilitation Hospital" means an inpatient rehabilitation facility.

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

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

"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).

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

"~~State University~~ 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.

"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.

"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.

~~"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 ~~1.8705%~~1.6625% of total hospital outpatient charges with the following exception.

    a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to ~~1.8548%~~1.6485% of 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 ~~$114.10~~$106.01 per day for Managed Care Days and ~~$510.05~~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 ~~$59.57~~$55.35 per day for Managed Care Days and ~~$266.30~~$247.42 per day for all Non-Managed Care Days, and~~.~~

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to ~~$45.64~~42.40 per day for Managed Care Days and ~~$204.02~~$189.56 per day for Non-Managed Care Days.

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 ~~$244,068,958~~$257,231,668.

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

   c. Certain qualified hospitals shall receive a payment equal to a percentage of their Hospital-Specific DSH Limit.

      i. 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.

      ii. A qualified Critical Access Hospital or Rural Hospital shall receive a payment equal to a minimum of ~~96.00%~~86.00% of their Hospital Specific DSH Limit.

      iii. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than ~~2,400~~2,700 Medicaid Days shall receive a payment equal to a minimum of ~~96.00%~~80.00% of their Hospital-Specific DSH Limit.

      iv. The payment percentages for these qualified hospitals shall be published in the Colorado Medicaid Provider Bulletin.

   d. 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.

   ~~d. No remaining qualified hospital shall receive a payment exceeding 96.00% of their Hospital-Specific DSH Limit as specified in federal regulation. If a qualified hospital's payment exceeds 96.00% of their Hospital-Specific DSH Limit, the payment shall be reduced to 96.00% of the Hospital-Specific DSH Limit. The amount of the reduction shall then be redistributed to other qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH~~

~~Limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit.~~

~~e.~~e. ~~A new CICP hospital shall have their Hospital-Specific DSH Limit equal to 10.00%.~~ A Low MIUR hospital shall have their Hospital-Specific DSH Limit equal 10.00%.

i. ~~A new CICP hospital is a hospital approved as a CICP provider after October 1, 2022.~~

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