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Title of Rule: Revision to the Federally Qualified Health Center Rule Concerning Reimbursement, Section 8.700.6
Rule Number: MSB 22-01-20-A
Division / Contact / Phone: Fee-for-Service Rates / Erin Johnson / 4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-01-20-A, Revision to Federally Qualified Health Center Rule Concerning Reimbursement, 8.700.6

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections 8.700.6, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the newly proposed language at 8.700.6.D.4.e through the end of 8.700.6.D.4.e.
This rule is effective August 31, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Federally Qualified Health Center Rule Concerning Reimbursement, Section 8.700.6
Rule Number: MSB 22-01-20-A
Division / Contact / Phone: Fee-for-Service Rates / Erin Johnson / 4370

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).

Due to the COVID-19 pandemic, the Department set FQHC rates using inflationary factors for cost reports in 2020 and 2021. This helped the Department avoid skyrocketing rates due to higher costs and lower visits. Part of the FQHC encounter rates include a base rate, which is set using a three year weighted average of costs and visits. Starting with cost reports with fiscal year ends May 31, 2022 and after, we have decided to set FQHC rates using the actual cost and visit data again. However, our rules currently state that the base rates are set using the previous year's data – which we did not use to set rates at the time. This rule revision restarts the base rate calculation, so that we are not using the higher costs and lower visits from 2020 and 2021. This rule needs to be effective before the May 31, 2022 cost reports are effective, or by September 28, 2022. Therefore, this rule will become effective August 30, 2022.

☐ to comply with state or federal law or federal regulation and/or
☐ for the preservation of public health, safety and welfare.

Explain:

2. Federal authority for the Rule, if any:
   42 U.S.C.A § 1396a(bb)

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   Section § 25.5-5-408(1)(d), C.R.S. (2022)

Initial Review	**06/10/22**	Final Adoption	**07/08/22**
Proposed Effective Date	**08/31/22**	Emergency Adoption	

DOCUMENT #

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Title of Rule: Revision to the Federally Qualified Health Center Rule Concerning Reimbursement, Section 8.700.6
Rule Number: MSB 22-01-20-A
Division / Contact / Phone: Fee-for-Service Rates / Erin Johnson / 4370

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.

   Federally Qualified Health Centers will be impacted by this rule revision. This rule revision will set reasonable FQHC base rates using updated data instead of data impacted dramatically by the COVID-19 pandemic. FQHCs will benefit from this rule because their rates will neither skyrocket nor drop based on previous year's information but rates will be set using the most recent data.

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

   FQHC base rates will be set in Year 1 at the current year cost per visit. FQHC base rates in Year 2 will be set using two years' worth of cost and visit data. Then, in Year 3 base rate setting will go back to normal. This means that in Year 1, base rates will be set based on the most recent costs. Cost reports from 2020 and 2021 will not impact FQHC rate setting, which is appropriate since these cost reports were not used to set FQHC rates at the time.

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 revision will impact the Department and State revenues. Instead of having base rates set using unpredictable and potentially very high costs and low visits, we will have base rates set using more predictable data.

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

   If this rule change is not adopted, FQHC rates will be more unstable and potentially much higher. Without this rule change, costs and visits during the height of the COVID-19 pandemic will be used to set FQHC rates. Based on data the Department has received so far, this will lead to greater FQHC rates. Higher FQHC rates will cost the Department more money. Inaction will lead to a simpler rate setting model, consistent with years past.

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

   The Department could set base rates using an average of the past three years' cost reports, as is our current policy. However, this would cause FQHC rates to skyrocket and have the base rates set using cost and visit data that was never used to set FQHC rates at the time.

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.

   The Department considered using the regular base rate setting methodology and setting base rates using three years' worth of cost and visit data. However, based on data analysis it was clear that these rates would be much higher than the FQHCs current cost per visit.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.6 REIMBURSEMENT

8.700.6.A FQHCs shall be reimbursed separate per visit encounter rates based on 100% of reasonable cost for physical health services, dental services, and specialty behavioral health services. An FQHC may be reimbursed for up to three separate encounters with the same client occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: physical health encounter, dental encounter, or specialty behavioral health encounter. Distinct dental encounters are allowable only when rendered services are covered and paid by the Department's dental Administrative Service Organization (ASO). Distinct specialty behavioral health encounters are allowable only when rendered services are covered and paid by either the Regional Accountable Entity (RAE) or through the short-term behavioral health services in the primary care setting policy.

8.700.6.B The following services are reimbursed separately from the FQHC encounter rate. These services shall be reimbursed in accordance with the following:

1. Long-Acting Reversible Contraception (LARC) devices shall be reimbursed separately from the FQHC encounter rate. In addition to payment of the encounter rate for the insertion of the device(s), the LARC device(s) must be billed in accordance with Section 8.730 and shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

2. Services provided in an inpatient hospital setting shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

3. The provision of complete dentures and partial dentures must be billed in accordance with Section 8.201. and Section 8.202. and shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

4. Dental services provided in an outpatient hospital setting shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

5. The Prenatal Plus Program shall be billed and reimbursed in accordance with Section 8.748.

6. The Nurse Home Visitor Program shall be billed and reimbursed in accordance with Section 8.749.

7. An FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number in accordance with Section 8.800.

8. Antagonist injections for substance use disorders provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

9. COVID-19 vaccine administration provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department

10. Monoclonal Antibody COVID-19 infusion administration provided at the FQHC shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

11. COVID-19 antiviral medication, remdesivir, provided at the FQHC shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

8.700.6.C A physical health encounter, a dental encounter, and a specialty behavioral health encounter on the same day and at the same location shall count as three separate visits.

1. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.700.6.D Encounter rates calculations

Effective July 1, 2018, FQHCs will be paid three separate encounter rates for three separate services: physical health services, dental services, and specialty behavioral health services. Physical health services are covered services reimbursed through the Department's MMIS, except the short-term behavioral health services in the primary care setting policy. Dental services are services provided by a dentist or dental hygienist that are reimbursed by the Department's dental ASO. Specialty behavioral health services are behavioral health services covered and reimbursed by either the RAE or by the MMIS through the short-term behavioral health services in the primary care setting policy. The Department will perform an annual reconciliation to ensure each FQHC has been paid at least their per visit Prospective Payment System (PPS) rate. If an FQHC has been paid below their per visit PPS rate, the Department shall make a one-time payment to make up for the difference.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, Dec. 21, 2000. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for a reasonable charge and for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. Each alternative payment rate shall be the lower of the service specific annual rate or the service specific base rate. The annual rate and the base rate shall be calculated as follows:

   a. The annual rate for the physical health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for physical health services and visits. The annual rate for the dental rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for dental services and visits provided by a dentist or dental hygienist. The annual rate for the specialty behavioral health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for behavioral health services and visits either covered and reimbursed by the RAE or by the short-term behavioral health services in the primary care setting policy.

   b. The new base rates shall be the audited, calculated, inflated, and weighted average encounter rate for each separate rate, for the past three years. Base rates are recalculated (rebased) annually. Initial Base rates shall be calculated when the Department has two year's data of costs and visits.

   c. Beginning July 1, 2020, a portion of the FQHCs physical health alternative payment methodology rates are at-risk based on the FQHC's quality modifier. An FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous Calendar Year.

3. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set reimbursement base rates for the first year. The base rates shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as an FQHC. These shall be the FQHCs base rates until the FQHC's final base rates are set.

   a. New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

4. The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

a. Freestanding and hospital-based FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. An extension of up to 75 days may be granted based upon circumstances. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

b. The new reimbursement encounter rates for FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement encounter rates (if less than the new audited rate) shall remain in effect for an additional day above the 120-day limit for each day the required information is late; if the old reimbursement encounter rates are more than the new rate, the new rates shall be effective the 120th day after the FQHCs fiscal year end.

c. Effective December 11, 2020, FQHC cost reports with fiscal year ends between May 31, 2020 and March 31, 2021 will be set using the previous year's rates multiplied by the Medicare Economic Index (MEI).

d. Effective September 28, 2021, FQHC cost reports with fiscal year ends between May 31, 2021 and March 31, 2022 will be set using the previous year's rates multiplied by 2.7%.

e. Starting with FQHC cost reports with fiscal year end May 31, 2022 the Department will restart the base rate setting process. For the first cost report submitted by an FQHC with fiscal year end May 31, 2022 and after, base rates will be set based on one year's worth of data. For the second cost report submitted by an FQHC with fiscal year end May 31, 2022 and after, base rates will be set as a weighted average of two years' worth of data. After this, base rates will be set as specified in 8.700.6.D.2.

5. If an FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.

a. An FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC. The documented change in the scope of service of the FQHC must meet all of the following conditions:

i. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

ii. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5.

iii. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

iv. The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.

v. The change in scope of service must have existed for at least a full six (6) months.

b. A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.700.6.D.5.b and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.

i. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;

ii. The addition or deletion of a covered Medicaid service under the State Plan;

iii. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

iv. Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;

v. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;

vi. Changes resulting from a change in the provider mix, including, but not limited to:

a. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;

b. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the FQHC (e.g. delivery services);

c. Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and/or residents; or,

d. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

c. The following items do not prompt a scope-of-service rate adjustment:

i. An increase or decrease in the cost of supplies or existing services;

ii. An increase or decrease in the number of encounters;

iii. Changes in office hours or location not directly related to a change in scope of service;

iv. Changes in equipment or supplies not directly related to a change in scope of service;

v. Expansion or remodel not directly related to a change in scope of service;

vi. The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;

vii. The addition or removal of administrative staff;

viii. The addition or removal of staff members to or from an existing service;

ix. Changes in salaries and benefits not directly related to a change in scope of service;

x. Change in patient type and volume without changes in type, duration, or intensity of services;

xi. Capital expenditures for losses covered by insurance; or,

xii. A change in ownership.

d. An FQHC must apply to the Department by written notice within ninety (90) days of the end of the FQHCs fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.D.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may

submit a scope-of-service rate adjustment application that captures both of those changes. An FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

f. The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:

i. The Department's application form for a scope-of-service rate adjustment, which includes:

a. The provider number(s) that is/are affected by the change(s) in scope of service;

b. A date on which the change(s) in scope of service was/were implemented;

c. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;

d. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

e. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC;

ii. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

g. The reimbursement rate for a scope-of-service change applied for January 30, 2017 or afterwards will be calculated as follows:

i. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also calculate the Adjustment Factor (AF = covered health care costs/total cost of FQHC services) associated with the change in scope of service of the FQHC. If the AF is 80% or greater, the

Department will accept the total costs as filed by the FQHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the FQHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

ii. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.

iii. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The "current PPS rate" means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.

iv. The Department will check that the adjusted PPS rate meets the 3% threshold described above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.

v. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.

h. The Department will review the submitted documentation and will notify the FQHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC's fiscal year end.

i. Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified by the Department through an audit or review process.

i. If the Department identifies a change in scope of services, the Department may request the documentation as described in Section 8.700.6.D.5.g from the FQHC. The FQHC must submit the documentation within ninety (90) days from the date of the request.

ii. The rate adjustment methodology will be the same as described in Section 8.700.6.D.5.h.

iii. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

iv. The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.

j. An FQHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, an FQHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

6. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If an FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

7. Pending federal approval, the Department will offer a second Alternative Payment Methodology (APM 2) that will reimburse FQHCs a Per Member Per Month (PMPM) rate. FQHCs may opt into APM 2 annually. This reimbursement methodology will convert the FQHC's current Physical Health cost per visit rate into an equivalent PMPM rate using historical patient utilization, member designated attribution, and the Physical Health cost per visit rate for the specific FQHC. Physical health services rendered to patients not attributed to the FQHC, or attributed based on geographic location, will pay at the appropriate encounter rate. Dental and specialty behavioral health services for all patients will be paid at the appropriate encounter rate. Year 2 rates for FQHCs participating in APM 2 will be set using trended data. Year 3 rates will be set using actual data.

8. The Department will perform an annual reconciliation to ensure the PMPM reimbursement compensates APM 2 providers in an amount that is no less than their PPS per visit rate. The Department shall perform PPS reconciliations should the FQHC participating in APM 2 realize additional cost, not otherwise reimbursed under the PMPM, incurred as a result of extraordinary circumstances that cause traditional encounters to increase to a level where PMPM reimbursement is not sufficient for the operation of the FQHC.

9. PMPM and encounter rates for FQHC participating in APM 2 shall be effective on the 1st day of the month that falls at least 120 days after an FQHC's fiscal year end.

8.700.6.E The Department shall notify the FQHC of its rates.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Outpatient Payment Rates for Newly Enrolled and Out of State Hospitals, Sections 8.013 & 8.300.6.
Rule Number: MSB 22-03-22-A
Division / Contact / Phone: Fee for Service Rates / Tyler Samora / 4416

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-03-22-A, Revision to the Medical Assistance Act Rule concerning Outpatient Payment Rates for Newly Enrolled and Out of State Hospitals, Sections 8.013 & 8.300.6.

3. This action is an adoption of:

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.013 & 8.300.6, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing).

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.013 with the proposed text beginning at 8.013 through the end of 8.013.2. Replace the current text at 8.300.6.A with the proposed text beginning at 8.300.6.A.1 through the end of 8.300.6.A.1. This rule is effective August 31, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Outpatient Payment Rates for Newly Enrolled and Out of State Hospitals, Sections 8.013 & 8.300.6.
Rule Number: MSB 22-03-22-A
Division / Contact / Phone: Fee for Service Rates / Tyler Samora / 4416

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).

   Rule MSB 22-03-22-A updates the references found within the current rule and adds clarifying language regarding payment for Outpatient services provided by hospitals, effecting newly enrolled and out of state hospitals. Currently, to assign an outpatient base rate to a newly enrolled hospital, the hospital is placed into either an 'Urban' or 'Rural' category. Then they are assigned the base rate which is the average of the other hospitals that currently fall into the assigned category. In addition, any out of state hospital requiring an outpatient base rate would be assigned 90 percent of the assigned peer group weight. Effective 09/01/2022, rule MSB 22-03-22-A will exclude any provider that is considered as Pediatric, Rehabilitation, or Long-Term Acute Care from these grouped averages, as relative to other hospitals, their costs for outpatient services are atypical. If a hospital is not deemed as a Pediatric, Rehabilitation, or Long-Term Acute Care, it is then grouped into either the Urban or Rural category. For the hospitals that are not within these three groups, this adjustment will align payment more accurately with the type of services they provide. Pediatric, Rehabilitation, and Long-Term Acute Care hospitals will each have their own peer groups from which average base rates will be calculated. Those average rates will be used for assigning outpatient base rates for new and out-of-state hospitals.

   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:

2. Federal authority for the Rule, if any:

   42 C.F.R. § 447.321

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

Initial Review **06/10/22** Final Adoption **07/08/22**

Proposed Effective Date **08/31/22** Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Section 25.5-4-402, C.R.S. (2022)

Initial Review **06/10/22** Final Adoption **07/08/22**

Proposed Effective Date **08/31/22** Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Outpatient Payment Rates for Newly Enrolled and Out of State Hospitals, Sections 8.013 & 8.300.6.
Rule Number: MSB 22-03-22-A
Division / Contact / Phone: Fee for Service Rates / Tyler Samora / 4416

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.

   New and out-of-state outpatient hospitals will be impacted by this rule revision. This rule revision will alter how new hospitals base rates will be assigned and clarify how out of state hospital base rates are assigned.

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 will establish a rate setting process to align outpatient payments to the hospitals that typically provide these services. This new process will more accurately account for the variation in hospital cost profiles.

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.

   The proposed rule will align payment rates with costs to the type of hospitals that provide these services. Any costs that would happen would come from any out of state hospital or newly in state. However, it would generate savings as opposed leaving the rule as is.

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

   If this rule change is not adopted, outpatient rates for out of state and new in state hospitals will not reflect the cost for providing outpatient services.

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

   There are no other ways to achieve the intent of this rule that are less costly or intrusive. By simply aggregating peer groups by Urban or Rural, which currently include rehabilitation, long-term acute care and pediatric hospitals, the Department risks overpayment for outpatient hospital services.

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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.

   An alternative to this rule is to utilize out-of-state hospital cost reports for the development of out-of-state rates. However, the outpatient services provided to Colorado Medicaid patients are infrequent and across a significantly varied group of hospitals. The administrative costs of setting base rates in this way would exceed the value gained. Similarly, cost reports for new hospitals do not exist, and the effort to estimate their costs would produce little value. Using the average outpatient base rates of similar hospitals will produce consistent and predictable payment rates.

8.013 OUT-OF-STATE MEDICAL CARE

An eligible Colorado recipient, temporarily out of the state but still a resident of Colorado, is entitled to receive benefits to the same extent that Medicaid is furnished to residents in the state under any one of the following conditions:

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.

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

   For these services no prior authorization is required. The determination as to whether the recipient'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.

3) The State Medicaid Director 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 is temporarily located.

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

4) It is the general practice for recipients 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 if the recipient is receiving services from any other out of state provider not in a neighboring locale.

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.

The 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.

8.013.1 ENROLLMENT PROCEDURES

To receive reimbursement, all out of state providers shall be required to 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..

8.013.2 REIMBURSEMENT PRINCIPLES

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 be paid in accordance with the Payment For Out Of State Nursing Home Care section of the Volume 8 staff manual.) All claims submitted to the fiscal agent must include:

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

2) Its Colorado provider number; and

3) Complete address, including zip code.

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:

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).

Reimbursement for physician services shall be the lower of the following:

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

B. Provider's Actual Charge.

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.

The Department may negotiate a higher reimbursement rate for out-of-state hospital services that are prior authorized.

A. These are cases which require procedures not available in Colorado and which must be prior authorized.

B. The patient's physician may suggest where the patient 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.

8.300 HOSPITAL SERVICES

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective

adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4 percent (28.4%) or billed charges less 28.4 percent (28.4%).

Effective July 1, 2015, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28 percent (28%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Effective October 31, 2016, DRG Hospitals will be reimbursed for Outpatient Hospital Services based on a system of Enhanced Ambulatory Patient Grouping and a Hospital-specific Medicaid Outpatient base rate. The reimbursement for Outpatient Hospital Services shall be referred to as the EAPG Payment.

a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR 2505-10, Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific Medicaid Outpatient base rate. If the billed amount is less than the EAPG Payment, reimbursement will be the billed amount.

b. The EAPG Payment is calculated for each detail on the claim. Claim details with the same dates of service are grouped into a visit. Claims containing details describing charges for emergency room, treatment room services or patients placed under observation will have all its details grouped into a single visit.

c. Each detail on a claim is assigned an EAPG. EAPGs can have the following types:

    (1) Per Diem

    (2) Significant Procedure. Subtypes of Significant Procedures Are:

        (a) General Significant Procedures

        (b) Physical Therapy and Rehabilitation

        (c) Behavioral Health and Counseling

        (d) Dental Procedure

        (e) Radiologic Procedure

(f) Diagnostic or Therapeutic Significant Procedure

(3) Medical Visit

(4) Ancillary

(5) Incidental

(6) Drug

(7) Durable Medical Equipment

(8) Unassigned

d. A detail will be subject to EAPG Consolidation when it is assigned the same Significant Procedure EAPG as a detail not already subjected to EAPG Consolidation for that visit. EAPG Consolidation will also occur for details assigned EAPGs considered to be clinically similar to another EAPG during the visit. Details subject to EAPG Consolidation will have an EAPG Payment calculated using an EAPG Weight of 0.

e. A detail will be subject to EAPG Packaging when its assigned EAPG is considered an ancillary service to a Significant Procedure EAPG or Medical Visit EAPG present on the claim for that visit. Details describing additional undifferentiated medical visits and services will be exempt from EAPG Packaging. A detail is also subject to EAPG Packaging when it is assigned a Medical Visit EAPG while a Significant Procedure EAPG is present on the claim for that visit. Details assigned Significant Procedure EAPGs that are not General Significant Procedures do not cause details with Medical Visit EAPGs to be subject to EAPG Packaging. Details subject to EAPG Packaging will be calculated using an EAPG Weight of 0.

f. A detail will qualify for Multiple Significant Procedure Discounting when a Significant Procedure of the same subtype is present on the claim for that visit. Details qualifying for Multiple Significant Procedure Discounting are ordered by their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG Weight will have its EAPG Payment calculated at 100 percent (100%) of its EAPG Weight. The qualifying detail for that visit with the next greatest EAPG Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG Weight. All other qualifying details for that visit will have its EAPG Payment calculated at 25 percent (25%) of its EAPG Weight.

g. Details assigned the same Ancillary EAPG on the same visit will qualify for Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment for all other details qualifying for Repeat Ancillary Discounting for that visit and EAPG will be calculated using 25 percent (25%) of their EAPG Weights.

h. Details describing terminated procedures will be subject to Terminated Procedure Discounting. EAPG Payment for a detail subject to Terminated Procedure Discounting is calculated using 50 percent (50%) of the EAPG Weight. Terminated procedures are not subject to other types of discounting.

i. Details describing bilateral services will have EAPG Payment calculated using 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

j. Details describing 340B Drugs will have an EAPG Payment calculated using 80 percent (80%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

k. The Hospital-specific Medicaid Outpatient base rate for January 1, 2022 for each hospital is calculated using the following method.

(1) Assign each hospital to one of the following groups based on hospital type and location:

(a) Pediatric Hospitals

(b) Critical Access Hospitals

(c) Non-Critical Access, System Hospitals

(d) Independent Hospitals

(e) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals

(2) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals are assigned their same hospital-specific base rate as effective immediately prior to January 1, 2022.

(3) Process Medicaid outpatient hospital claims from calendar year 2019 through the methodology described in 8.300.6.A.1.a-j using 3M's EAPG Relative Weights, scaled for budget neutrality purposes, and version 3.16 of the Enhanced Ambulatory Patient Grouping methodology. Hospital payment rates from version 3.10 of the methodology are then compared to the version 3.16 payment rates using the hospital-specific base rates immediately prior to January 1, 2022.

(4) For Critical Access Hospitals, a weighted average base rate by outpatient hospital visit is calculated EAPG payments for Critical Access Hospitals under version 3.10 and 3.16 are calculated using this weighted average base rate, then an inflation factor is applied to determine a revenue neutral rate for the Critical Access Hospital group. This inflation factor is then applied to all Critical Access Hospital rates effective immediately prior to January 1, 2022. For all other hospitals, with the exception of Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, a revenue neutral rate is calculated which aligns payment under version 3.16 of EAPGs to payments calculated under version 3.10.

(5) For Critical Access Hospitals, the average and standard deviation of their rates with the inflation factor applied is calculated. All Critical Access Hospitals with a rate falling below 1 standard deviation of the average is given a rate at 1 standard deviation below the average. For Critical Access Hospitals with a rate above 2 standard deviations of the average is given a rate at 2 standard deviations above the average. For each

other hospital group, except Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, the average and standard deviation of their rates are calculated. For hospitals that have a rate below 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations below the group's average rate. For hospitals that have a rate above 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations above the group's average rate.

(6) For new, in-state hospitals, such hospitals will be assigned to a Pediatric, Long Term Acute Care, or Rehabilitation peer group depending on hospital type. If a provider does not meet the criteria for any of the above peer groups, it will be assigned to a Rural or Urban peer group based on location. The hospital will receive a base rate of the average peer-group rate as calculated from Colorado hospitals base rate statistics.

(7) For all hospitals, the Medicaid Outpatient base rate, as determined in 8.300.6.A.k.(1)-(6), shall be adjusted by an equal percentage, when required due to changes in the available funds appropriated by the General Assembly. The application of this change to the Medicaid Outpatient base rate shall be determined by the Department.

l. Effective June 1, 2020, by the modification of the EAPG Weights, the allowed reimbursement of outpatient hospital drugs shall be increased by 42.93% for drugs provided at Critical Access Hospitals and Medicare Dependent Hospitals, and decreased by 3.47% for drugs provided at non-independent urban hospitals.

2. Payments to Out-of-Network DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

Out-of-Network DRG Hospitals will be reimbursed for Outpatient Hospital Services based on the system of Enhanced Ambulatory Patient Grouping described in Section 8.300.6.A.1. Such hospitals will be assigned to a Pediatric, Long Term Acute Care, or Rehabilitation peer group depending on hospital type. If a provider does not meet the criteria for any of the above peer groups, it will be assigned to a Rural or Urban peer group based on location. The hospital will receive a base rate of 90% of the average peer group rate as calculated from Colorado hospitals base rate statistics. Out-of-Network DRG Hospitals will periodically have their Medicaid Outpatient base rates adjusted as determined in Section 8.300.6.A.k.7.

3. Payments for Outpatient Hospital Specialty Drugs

Effective August 11, 2018, for services meeting the criteria of an Outpatient Hospital Specialty Drug that would have otherwise been compensated through the EAPG methodology, a hospital must submit a request for authorization to the Department prior to administration of the drug. If the request is approved, then the payment will be negotiated between the Department and the hospital on a case-by-case basis.