DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning HB23-1130 Implementation, Section 8.800.1 and 8.800.7.
Rule Number: MSB 23-04-25-B
Division / Contact / Phone: Pharmacy Office / Korri Conilogue / 303-866-6398

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: Revision to the Medical Assistance Act Rule concerning HB23-1130 Implementation, Section 8.800.1 and 8.800.7.

3. This action is an adoption of: HB23-1130 an amendment

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

   Sections(s) 8.800.1 and 8.800.7, 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 text beginning at 8.800.1.KK through the end of 8.800.1.OO. Replace the current text at 8.800.7.D with the proposed text beginning at 8.800.7.D through the end of 8.800.7.D. This rule is effective October 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning HB23-1130 Implementation, Section 8.800.1 and 8.800.7.
Rule Number: MSB 23-04-25-B
Division / Contact / Phone: Pharmacy Office / Korri Conilogue / 303-866-6398

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 purpose of this rule change is to implement HB23-1130 Therefore, 10 C.C.R. 2505-10, Section 8.800.1, is being amended to define "Serious Mental Illness".10 C.C.R. 2505-10, Section 8.800.7, is being amended to describe the preliminary determination process for the coverage of FDA approved drugs used to treat serious mental illness.

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:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, 25.5-4-103, 25.5-4-428, and 25.5-5-516 (effective August 7, 2023), C.R.S. (2023).

Initial Review **08/11/23** Final Adoption **09/08/23**
Proposed Effective Date **10/30/23** Emergency Adoption

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning HB23-1130 Implementation, Section 8.800.1 and 8.800.7.
Rule Number: MSB 23-04-25-B
Division / Contact / Phone: Pharmacy Office / Korri Conilogue / 303-866-6398

REGULATORY ANALYSIS

5. 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.

   Medicaid members and providers will benefit from an expedited review process for FDA approved drugs used to treat serious mental illness.

   The proposed rule would result in no additional costs to Medicaid members.

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

   Qualitatively, having an expedited review process for FDA approved drugs used to treat serious mental illness can help ensure members have access to new treatment options once they are available on the market. Quantitatively, there is not an impact.

7. 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 changes are budget neutral.

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

   The cost of inaction is that the Department would not be compliant with HB23-1130 . There are no benefits of inaction.

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

   N/A

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10. 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.

    N/A

8.800 PHARMACEUTICALS

8.800.1 DEFINITIONS

A. 340B Pharmacy means any pharmacy that participates in the Federal Public Health Service's 340B Drug Pricing Program as described in Title 42 of the United States Code, Section 256b (2020). Title 42 of the United States Code, Section 256b (2020) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

B. Average Acquisition Cost (AAC) means the average acquisition cost for like drugs grouped by Generic Sequence Number (GSN). For GSNs with both generic and brand drugs, the Department shall determine two separate AAC rates for the GSN. One AAC rate shall be based on the average acquisition cost for all generic drugs while the other shall be based on the average acquisition cost for all brand drugs.

C. Clotting Factor Maximum Allowable Cost (CFMAC) means the rate for a clotting factor drug for which no Average Acquisition Cost (AAC) rate is established. The CFMAC rate is determined based on available acquisition cost data and publicly available data unique to each clotting factor drug. D.Conflict of Interest means having competing professional or personal obligations or personal or financial interests that would make it difficult to fulfill duties in an objective manner.

E. Department means the Colorado Department of Health Care Policy and Financing.

F. Dispensing Fee means the reimbursement amount for costs associated with filling a prescription. Costs include salary costs, pharmacy department costs, facility costs, and other costs.

G. Dispensing Prescriber means a health care professional who, as licensed by Colorado state law, prepares, dispenses and instructs members to self-administer medication.

H. Drug Class means drugs that are grouped together due to a common mechanism of action, or to treat a particular disease, symptom or indication.

I. Emergency Situation means any condition that is life threatening or requires immediate medical intervention as determined in good faith by the pharmacist.

J. E-prescription means the transmission of a prescription through an electronic application.

K. Fiscal agent means a contractor that supports and operates the pharmacy benefit management system on behalf of the Medical Assistance Program.

L. Federal Upper Limit (FUL) means the upper limit for multiple source drugs as set by the Centers for Medicare and Medicaid Services pursuant to Title 42 of the Code of Federal Regulations, Part 447.512-447.516 (2020). Title 42 of the Code of Federal Regulations, Part 447.512-447.516 (2020) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on

how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

M. Generic Sequence Number (GSN) means a standard number to group together drugs that have the same ingredients, route of administration, drug strength, and dosage form.

N. Good Cause means failing to disclose a Conflict of Interest; participating in wrongdoing or misconduct in the case of serving as a member of a committee or other advisory body for the Department; failing to perform required duties; or missing two scheduled meetings per calendar year.

O. Government Pharmacy means any pharmacy whose primary function is to provide drugs and services to members of a facility whose operating funds are appropriated directly from the State of Colorado or the federal government excluding pharmacies funded through Indian Health Services.

P. Institutional Pharmacy means any pharmacy whose primary function is to provide drugs and services to hospitalized patients and others receiving health care provided by the facility with which the pharmacy is associated.

Q. Mail Order Pharmacy means any pharmacy that delivers drugs primarily by mail.

R. Maintenance Medication means any drug, as determined by the Department, which is used to treat a chronic illness or symptoms of a chronic illness.

S. Maximum Allowable Cost (MAC) means the rate for a covered drug which does not possess Average Acquisition Cost (AAC) nor National Average Drug Acquisition Cost (NADAC) rates. This rate is calculated using an adjustment of the national pricing benchmark Wholesale Acquisition Cost (WAC).

T. Medical Assistance Program shall have the meaning defined in Section 25.5-1-103(5), C.R.S. (2020).

U. Medical Assistance Program Allowable Charge means the allowed ingredient cost plus a dispensing fee or the provider's Usual and Customary Charge, whichever is less, minus the member's copayment as determined according to Section 8.754.

V. Medical Director means the physician or physicians who advise the Department.

W. Medicare Part D means the prescription drug benefit provided to Part D eligible individuals pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

X. Medicare Part D Drugs means drugs defined at Title 42 of the United States Code, Section 1395w-102(e) (2020) and Title 42 of the Code of Federal Regulations, Section 423.100 (2020). Title 42 of the United States Code, Section 1395w-102(e) (2020) and Title 42 of the Code of Federal Regulations, Section 423.100 (2020) are hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

Y. National Average Drug Acquisition Cost (NADAC) is a Centers for Medicare and Medicaid Services published rate which represents the national average of the drug acquisition costs submitted by retail community pharmacies.

Z. Non-preferred Drug means a drug that is designated as non-preferred by the Medical Director pursuant to Section 8.800.16 and which requires prior-authorization to be payable by the Medical Assistance Program.

AA. Old Age Pension Health Care Program and Old Age Pension Health Care Supplemental Program (OAP State Only) means the program established to provide necessary medical care for clients that qualify for Old Age Pension but do not qualify for the Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes.

BB. Over-the-Counter (OTC) means a drug that is appropriate for use without the supervision of a health care professional such as a physician, and which can be purchased by a consumer without a prescription.

CC. Part D eligible individual has the same meaning as defined in Section 8.1000.1.

DD. Pharmacy and Therapeutics Committee (P&T Committee) means an advisory board that shall perform reviews and make recommendations which facilitate the development and maintenance of the Preferred Drug List as described in Section 8.800.17.

EE. Preferred Drug means a drug that is designated preferred by the Medical Director pursuant to Section 8.800.16.A, that is payable by the Medical Assistance Program without first obtaining a prior authorization unless otherwise required to protect the health and safety of specific members.

FF. Preferred Drug List (PDL) means a list, applicable only to fee-for-service and primary care physician Medical Assistance Program members, which identifies the Preferred Drugs and Non-preferred Drugs within a drug class.

GG. Prescriber means a healthcare professional who, as licensed by Colorado state law, may prescribe and authorize the use of medicine or treatment to a member. Prescribers must be enrolled in the Medical Assistance Program to receive reimbursement.

HH. Provider Bulletin means a document published and distributed by program and policy staff to communicate information to providers related to the Department.

II. Retail Pharmacy means any pharmacy that is not a 340B Pharmacy, Government Pharmacy, Institutional Pharmacy, Mail Order Pharmacy, or Rural Pharmacy.

JJ. Rural Pharmacy means any pharmacy that is the only pharmacy within a twenty-mile radius.

KK. Serious Mental Illness means the following psychiatric illnesses: bipolar disorders (hypomanic, manic, depressive, and mixed), depression in childhood and adolescence, major depressive disorders (single episode or recurrent), obsessive-compulsive disorders (single or recurrent), paranoid and other psychotic disorders, schizoaffective disorders (bipolar or depressive), and schizophrenia.

LL Submitted Ingredient Cost means a pharmacy's calculated ingredient cost. For drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program, the Submitted Ingredient Cost means the 340B purchase price.

~~LL~~MM. Total Prescription Volume means all new and refill prescriptions dispensed for all payer types. Payer types include but are not limited to Medicaid, Medicare, commercial, third-party, and uninsured.

~~MM~~NN. Usual and Customary Charge means the reimbursement amount the provider charges the general public to pay for a drug.

~~NN~~OO. Wholesale Acquisition Cost (WAC) means with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

8.800.7 PRIOR AUTHORIZATION REQUIREMENTS

8.800.7.A. Prior authorization shall be obtained before drugs that are subject to prior authorization restrictions may be provided as a benefit. Prior authorization requests may be made by the member's physician, any other health care provider who has authority under Colorado law to prescribe the medication being requested or any long-term-care pharmacy or infusion pharmacy that fills prescriptions on behalf of the member and is acting as the agent of the prescriber. The prior authorization request shall be made to the Fiscal Agent. The prescriber shall provide any information requested by the Fiscal Agent including, but not limited to, the following:

1. Member name, Medical Assistance Program state identification number, and birth date;

2. Name of the drug(s) requested;

3. Strength and quantity of drug(s) requested; and

4. Prescriber's name and medical license number, Drug Enforcement Administration number, or National Provider Identifier.

8.800.7.B. When the prior authorization request is received, it shall be reviewed to determine if the request is complete. If it is complete, the requesting provider shall be notified of the approval or denial of the prior authorization request via telephone and/or facsimile at the time the request is made, if possible, but in no case later than 24 hours after the request is made. If the prior authorization request is incomplete or additional information is needed, an inquiry to the party requesting the prior authorization shall be initiated within one working day from the day the request was received. If no response is received from that party within 72 hours of the Department's inquiry, the prior authorization shall be denied.

8.800.7.C. In an emergency situation, the pharmacy may dispense up to a 72-hour supply of a covered drug that requires a prior authorization if it is not reasonably possible to request a prior authorization for the drug before it must be dispensed to the member for proper treatment. The pharmacist may call the prior authorization help desk to receive override approval. Prescriptions dispensed under the override approval are eligible for reimbursement.

8.800.7.D. PRIOR AUTHO~~I~~RIZATION FOR NEW DRUGS

1. If a new drug entity, including new generic drugs and new drug product dosage forms of existing drug entities, is approved by the FDA and is in a Drug Class already subject to prior authorization, the new drug entity may be subject to prior authorization without any comment period.

    a. If it is a new drug entity that is subject to the PDL, the prior authorization criteria for that new drug entity shall remain in effect until the applicable Drug Class is reviewed by the Drug Utilization Review (DUR) Board.

    b. If it is a new drug entity that is not subject to the PDL, the prior authorization criteria shall remain in effect until the new drug entity is reviewed by the DUR Board, which shall be within six months.

2. If a new drug entity, including new generic drugs and new drug product dosage forms of existing drug entities, is approved by the FDA and is not in a Drug Class already subject to prior authorization, the new drug entity may be subject to prior authorization and will be reviewed by the DUR board within six months.

3. The Department shall conduct preliminary coverage reviews for a new drug entity indicated for the treatment of Serious Mental Illness within 90 days of FDA approval.

8.800.7.E. Any changes to the drugs that are subject to prior authorization or any documentation required to obtain a prior authorization shall be published in the Provider Bulletin, Appendix P or PDL. Notification in the Provider Bulletin, Appendix P or PDL shall satisfy any notification requirements of any such changes. The Appendix P and PDL documents can be accessed on the Department's website at www.colorado.gov/hcpf.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospital Services Rule, Section 8.300
Rule Number: MSB 23-05-17-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

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 23-05-17-A, Revision to the Medical Assistance Act Rule concerning Hospital Services Rule, Section 8.300

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(s) 8.300.1, 8.300.2, 8.300.3.A-B, 8.300.12.A-B, 8.300.12.A-B, and 8.320.1, 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*

Replace the current text at 8.300.1 with the proposed text beginning at 8.300.1 through the end of 8.300.3.B.3. Replace the current text at 8.300.12 with the proposed text beginning at 8.300.12 through the end of 8.300.12.B.3. Replace the current text at 8.320.1.E with the proposed text beginning at 8.320.1.E through the end of 8.320.1.E. This rule is effective October 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospital Services Rule, Section 8.300
Rule Number: MSB 23-05-17-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).

   The proposed rule change clarifies covered hospital services by moving from time based standards to medical necessity standards. The changes simplify inpatient, outpatient, and observation stay definitions and move the standards from those definitions to the covered services section of the rule. Criteria for medical necessity for inpatient, outpatient, and observation stays were also added to the covered services section. Technical changes were also addressed in this rule change such as changing in-network and out-of-network to in state and out of state. Temporal standards were also removed in the inpatient psychiatric covered services section. Corrective action was defined in rule and clarifying language was added to the utilization management section. This revision provides more clarity to hospitals and providers on medical necessity criteria and determining the appropriate level of care for members. The community clinic, including freestanding emergency departments, rule is also being revised to align with the proposed changes to the hospital services rule.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   Social Security Act, Section §§ 1905(a)(1-2) [42 U.S.C. 1396d(a)(1-2)] (2022); 42 C.F.R. §§ 440.10-.20 (2023)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Sections 25.5-5-102(1)(a-b), C.R.S. (2021)

Initial Review	**08/11/23**	Final Adoption	**09/09/23**
Proposed Effective Date	**10/30/23**	Emergency Adoption	

DOCUMENT #10

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospital Services Rule, Section 8.300
Rule Number: MSB 23-05-17-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

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 that serve Health First Colorado members will benefit from clarified definitions and standards including medical necessity criteria. Members that utilize hospital services will benefit from being placed in appropriate levels of care as determined medically necessary.

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

   Removing temporal standards from rule and clarifying medical necessity criteria will improve the clarity of the rule for providers and improve billing guidance. Members will be treated in a level of care that addresses their medical needs by medical necessity standards and not primarily by time-based standards. The quantitative impact of the rule changes is that it will provide clarity regarding hospital admission standards and therefore reduce inappropriate admission and billing.

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 Department anticipates that this rule change will be budget neutral. No new services are being provided just updating guidance. The updated guidance may result in paying for more observation stays in the outpatient setting; this is projected to be offset by a shift of claims billed for the inpatient setting to the outpatient setting.

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

   The benefits of the proposed rule are improved clarity in the billing guidance for providers. Inaction will result in continued unclear standards in the hospital services rule. Not updating the rule could potentially discourage providers from enrolling and not provide care to Health First Colorado members. Also, needed technical changes would not be completed.

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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 other methods to implement this policy change.

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 is no alternative method for achieving the purpose of the proposed rule.

8.300 HOSPITAL SERVICES

8.300.1 Definitions

8.300.1.A. Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.

8.300.1.B. Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.

8.300.1.C. Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.

8.300.1.D. Corrective Action is a step-by-step plan approved by the Department to achieve targeted outcomes and address patterns of inappropriate behavior, including, but not limited to, improper billing, unwarranted utilization, or questionable quality of care. Corrective action may include, but is not limited to, Concurrent Review, Continued Stay Review, Prospective Review, Retrospective Review, requirement to self-audit, or any other action as determined appropriate by the Department.

8.300.1.~~D~~E. Department means the Department of Health Care Policy and Financing.

8.300.1.~~E~~F. Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.

8.300.1.~~F~~G. DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals.

8.300.1.~~G~~H. Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury or other health condition in a client.

8.300.1.~~H~~I. Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.

8.300.1.~~I~~J. Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

8.300.1.~~J~~K. Enhanced Ambulatory Patient Group (EAPG) means a cluster of similar procedures within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of services performed during Outpatient visits that utilize similar amounts of Hospital resources.

8.300.1.~~K~~L. Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified

for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

1. A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

2. A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical services and/or obstetrical services including a delivery room and nursery.

3. A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.

4. A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.

5. A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital which primarily serves an inpatient population requiring longterm care services including but not limited to respiratory therapy, head trauma treatment, complex wound care, IV antibiotic treatment and pain management.

6. A Spine/Brain Injury Treatment Specialty Hospital licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital OR CMS-certified as a Rehabilitation Hospital is a Not-for Profit Hospital as determined by the CMS Cost Report for the most recent fiscal year. A Spine/Brain Injury Treatment Specialty Hospital primarily serves an inpatient population requiring long term acute care and extensive rehabilitation for recent spine/brain injuries. To qualify as a Spine/Brain Injury Treatment Specialty Hospital, for at least 50% of Medicaid members discharged in the preceding calendar year the hospital must have submitted Medicaid claims including spine/brain injury treatment codes (previously grouped to APR-DRG 40, 44, 55, 56, and 57). The Department shall revoke the designation if the percentage of Medicaid members discharged falls below the 50% requirement for a calendar year. Designation is removed the calendar year following the disqualifying year.

7. A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.

8. A Medicare Dependent Hospital is defined as set forth at 42 C.F.R § 412.103 (2022). 42 C.F.R. § 412.108(1) (~~2019~~2018) is hereby incorporated by reference into this rule. Such

incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S § 24-4-410(12.5)(V)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

9. A Non-independent Urban Hospital is a hospital which reports a name of the home office of the chain with which they are affiliated on the CMS-2552-10 Cost Report in Worksheet S-2 Part 1, Line 141, Column 1, with the exception of individual hospitals reporting an affiliation not reported amongst other hospitals located in Colorado.

8.300.1.~~L~~M. Inpatient is a person who has been admitted to a Hospital for purposes of receiving Inpatient Hospital Services~~means a person who is receiving professional services at a Hospital; the services include a room and are provided on a continuous 24-hour-a-day basis. Generally, a person is considered an Inpatient by a physician's order if formally admitted as an Inpatient with the expectation that the client will remain at least overnight and occupy a bed even though it later develops that the client can be discharged or transferred to another Hospital and does not actually use a bed overnight~~.

8.300.1.~~M~~N. Inpatient Hospital Services means services that are furnished by a Hospital for the care and treatment of an Inpatient and are provided in the Hospital by or under the direction of a physician~~preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by a Hospital for the care and treatment of Inpatients and are provided in the Hospital by or under the direction of a physician~~.

8.300.1.~~N~~O. Medical Necessity is defined at Section 8.076.1 and, for members ages 20 and under receiving Early and Periodic Screening, Diagnosis, and Treatment services, at Section 8.280.4.E.2.

8.300.1.~~O~~P. Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals, Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital are considered NonDRG Hospitals since their reimbursement is based on a per diem rate.

8.300.1.~~P~~Q. Observation Stay means Outpatient Hospital Services provided in a Hospital for the purposes of evaluating a person for Inpatient admission, stabilization, or extended recovery ~~a stay in the Hospital for no more than forty-eight hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed twenty-four hours in length~~.

8.300.1.~~Q~~R. Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.

8.300.1.~~R~~S. Outpatient means a person who is receiving professional services at a Hospital or an off campus location of a Hospital but is not admitted as an Inpatient~~client who is receiving professional services at a Hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-aday basis~~.

8.300.1.~~S~~T. Outpatient Hospital Services means services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist~~preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist~~.

8.300.1.~~T~~U. Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service prior to treatment.

8.300.1.~~U~~V. Rehabilitative Services means any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his/her best possible functional level.

8.300.1.~~V~~W. Relative Weight (DRG weight or EAPG weight) means a numerical value which reflects the relative resource consumption for the DRG or EAPG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost for each DRG or EAPG. Relative Weights are intended to be cost effective, and based upon Colorado data as available.

8.300.1.~~W~~X. Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.

8.300.1.~~X~~Y. Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by the United States Office of Management & Budget.

8.300.1.~~Y~~Z. State University Teaching Hospital means a 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.

8.300.1.~~Z~~AA. Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called “swing beds.”

8.300.1.~~AA~~BB. Trim Point Day (Outlier Threshold Day) means the day during an inpatient stay after which Outlier Days are counted. The Trim Point Day occurs 2.58 standard deviations above the average length of stay for each DRG. Beginning July 1, 2020, the Trim Point Day for delivery and neonate DRGs is equal to the Trim Point Day as calculated in the applicable Hospital-Specific Relative Value National File for Delivery and Neonate DRGs.

8.300.1.~~BB~~CC. Urban Hospital means a Hospital located within a MSA as designated by the United States Office of Management & Budget.

8.300.1.~~CC~~DD. Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

8.300.2 Requirements for Participation

8.300.2.A ~~In-Network~~ In-~~-~~State Hospitals

1. In order to qualify as an in-~~-~~state ~~-network~~ Hospital, a Hospital must:

a. be located in Colorado

b. be certified for participation as a Hospital in the Medicare Program;

c. have an approved Application for Participation with the Department; and

d. have a fully executed contract with the Department.

2. A border-state Hospital (located outside of Colorado) which is more accessible to clients who require Hospital services than a Hospital located within the state may be an in-~~-~~state~~-network~~ Hospital by meeting the requirements of 10 CCR 2505-10 Section 8.300.2.A.1.b – c. The Department shall make the proximity determination for Hospitals to enroll as a border-state Hospital.

3. In-~~-~~state Hospitals located in Colorado ~~hospitals network and out-of-network Hospitals located in Colorado~~ shall be surveyed by the CDPHE. Failure to satisfy the requirements of CDPHE may cause the Department to institute corrective action as it deems necessary.

8.300.2.B Out-~~-~~of-~~-~~State~~-of-Network~~ Hospitals

An out-~~-~~of-~~-~~state~~-of-network~~ Hospital~~, including out-of-state Hospitals,~~ may receive payment for emergency Hospital services if:

1. the services meet the definition of Emergency Care;

2. the services are covered benefits;

3. the Hospital agrees on an individual case basis not to charge the client, or the client's relatives, for items and services which are covered Medicaid benefits, and to return any monies improperly collected for such covered items and services; and

4. the Hospital has an approved Application for Participation with the Department.

~~**8.300.2.C Out-of-State Hospitals**~~

Out-of-s~~S~~tate Hospitals may receive reimbursement for Outpatient Hospital Services if they meet the conditions specified in 10 CCR 2505-10 Section 8.300.2.B.2 – 4.

Out-of-state Hospitals may receive reimbursement for non-emergent Inpatient Hospital Services ~~Hospital services~~ if they meet the conditions specified in 10 CCR 2505-10 Section 8.300.2.B.2 – 4, and the Department has issued a ~~written~~ prior authorization.

8.300.2.C~~D~~ Hospitals with Swing-Bed Designation

1. Hospitals which intend to designate beds as swing beds shall apply to CDPHE for certification of swing beds and to the Department for participation as a Medicaid provider of nursing facility services. The criteria in 10 CCR 2505-10 Section 8.430 must be met in order to become a Medicaid provider.

2. Hospitals providing nursing facility services in swing beds shall furnish within the per diem rate the same services, supplies and equipment which nursing facilities are required to provide.

3. Clients and/or their responsible parties shall not be charged for any of these required items or services as specified in 10 CCR 2505-10 Sections 8.440 and 8.482.

4. Hospitals providing nursing facility services to swing-bed clients shall be in compliance with the following nursing facility requirements.

   a. Client rights: 42 C.F.R. Section 483.10(b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (l), and (m).

   b. Client Admission, transfer and discharge rights: 42 C.F.R. Section 483.12 (a)(1) through (a)(7).

   c. Client behavior and facility practices: 42 C.F.R. Section 483.13.

   d. Client activities: 42 C.F.R. Section 483.15(f).

   e. Social Services: 42. C.F.R. Section 483.15(g).

   f. Discharge planning: 42 C.F.R. Section 483.20(e)

   g. Specialized rehabilitative services: 42 C.F.R. Section 483.45.

   h. Dental services: 42 C.F.R. Section 483.55.

5. Personal Needs Funds and Patient Payments

   Swing-bed Hospitals shall maintain personal needs accounts, submit AP-5615 forms, and be responsible for collecting patient payment amounts in accordance with the requirements established for nursing facilities in 10 CCR 2505-10 Section 8.482.

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

Inpatient Hospital Services are a covered Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. ~~1.~~ To support the Medical Necessity of an Inpatient admission, the provider must adequately document in the member's medical record that a provider with applicable expertise expressly determined that, based on the client's severity of illness, the client required services involving the intensity of services that cannot be provided safely and effectively in an ~~n~~ Outpatient setting. Such determination may take into account the amount of time the client is expected to require Inpatient Hospital Services. However, the decision to admit a client to Inpatient may not be based solely on the expected length of stay. The decision to admit a client to Inpatient is a medical determination that is based on a multitude of clinical factors, including, but not limited to the:

   a. Client's current medical needs;

   b. Client's medical history;

   c. Severity of the signs and symptoms exhibited by the client at the time of presentation to the hospital, and at the point of admission decision;

   d. Medical predictability of an adverse clinical event occurring with the client;

e. Results of diagnostic studies, laboratory tests, and other clinical tests and examinations; and

f. Types of services available to Inpatients and Outpatients at the specific hospital of admission

~~1.~~2. Inpatient Hospital services include:

a. bed and board, including special dietary service, in a semi-private room to the extent available;

b. professional services of H~~h~~ospital staff;

c. laboratory services provided within the Hospital, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;

d. related outpatient services, including but not limited to emergency department services, provided prior to Inpatient admission;~~emergency room services;~~

e. drugs, blood products; and

f. medical supplies, equipment and appliances as related to care and treatment~~; and~~

~~g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.~~

3~~2~~. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.

4~~3~~. Prior to July 1, 2020, Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

Beginning July 1, 2020, reimbursement for a mother's hospitalization for delivery does not include reimbursement for the newborn's hospitalization. Services shall be reimbursed under the identification number of each client.

5~~4.~~ Psychiatric Hospital Services

Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-~~-~~state ~~network~~ Hospital.

a. Inpatient care in a Psychiatric Hospital may require ~~is limited to forty-five (45) days per state fiscal year, unless additional services are~~ prior-authorization~~ed as medically necessary~~ by the Department's utilization review vendor or other Department representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.

b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:

i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and

ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.

c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

65. Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-~~-~~state ~~network~~ DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

a. an acute medical condition for which dialysis treatments are required; or

b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or

c. placement or repair of the dialysis route ~~("shunt", "cannula")~~.

76. Inpatient Subacute Care

Administration of subacute care by an enrolled hospital in its inpatient hospital or alternate care facilities is covered for the duration of the Coronavirus Disease 2019 (COVID-19) public health emergency. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Members may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital.

8.300.3.B Covered Hospital Services – Outpatient

Outpatient Hospital Services are a Medicaid benefit when determined Medically Necessary and provided by or under the direction of a physician. Outpatient Hospital Services are limited to the scope of Outpatient Hospital Services as defined in 42 C.F.R. Section 440.20. Outpatient Hospital Services include:

1. Observation Stays

Observation Stays are a covered Medicaid benefit when provided by or under the direction of a physician, for as many days as determined Medically Necessary. The physician must adequately document in the client's medical records that Observation Stay is Medically Necessary for the purposes of evaluating a client for possible Inpatient

admission, treating a client expected to be stabilized and released without the need for Inpatient admission, or allowing extended recovery following a complication of an Outpatient procedure. In a majority of cases, the decision whether to admit a client to Inpatient admission or discharge from the hospital can be made in less than twenty-four hours. Only rarely shall Observation Stay exceed forty-eight hours in length.

Observation Stays end when a physician orders either Inpatient admission or discharge from the hospital. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged unless for purposes of rebilling after an audit finding as specified in 10 CCR 2505-10 8.043.

The decision to admit a client to Observation Stay is a medical determination that is based on a multitude of factors, including, but not limited to the:

a. Client's current medical needs;

b. Client's medical history;

c. Severity of the signs and symptoms exhibited by the client at the time of presentation to the hospital, and at the point of the admission to observation status;

d. Medical predictability of an adverse clinical event occurring with the client;

e. Results of diagnostic studies, laboratory tests, and other clinical tests and examinations; and

f. Types of services available to Inpatient and Outpatients at the specific hospital of admission

~~Observation stays are a covered benefit as follows:~~

~~a. Clients may be admitted as Outpatients to Observation Stay status.~~

~~b. With appropriate documentation, clients may stay in observation more than 24 hours, but an Observation Stay shall not exceed forty-eight hours in length.~~

~~c. A physician's order must be written prior to initiation of the Observation Stay.~~

~~d. Observation Stays end when the physician orders either Inpatient admission or discharge from observation.~~

~~e. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged.~~

2. Outpatient Hospital Psychiatric Services

Outpatient psychiatric services, including prevention, diagnosis and treatment of emotional or mental disorders, are Medicaid benefits at non-~~-~~Psychiatric Hospitals.~~DRG Hospitals.~~

a. Psychiatric outpatient services are not a Medicaid benefit in ~~freestanding~~ P~~p~~sychiatric H~~h~~ospitals.

3. Emergency Care

a. Emergency Care Services are a Medicaid benefit, and are exempt from primary care provider referral.

b. An appropriate medical screening examination and ancillary services such as laboratory and radiology shall be available to any individual who comes to the emergency treatment facility for examination or treatment of an emergent or apparently emergent medical condition and on whose behalf the examination or treatment is requested.

8.300.12 Utilization Management and Reviews ~~Activities~~

All participating ~~in-network~~ Hospitals are required to comply with utilization management and review, prior authorization requirements, audit and/or program integrity, and quality improvement activities administered by the Department's utilization review vendor, external quality review organization or other representative.

8.300.12.A Conduct of Reviews

1. All reviews will be conducted in compliance with 10 CCR 2505-10, Sections 8.058 Request for Prior Authorization, 8.076, Program Integrity, and 8.079, Quality Improvement.

2. Reviews will be conducted relying on the professional expertise of health professionals, prior experience and professional literature; and nationally accepted evidence-based utilization review screening criteria whenever possible. These criteria shall be used to determine the quality, Medical Necessity and appropriateness of a health care procedure, treatment or service under review.

3. The types of reviews conducted may include, but are not limited to the following:

   a. Prospective Reviews;

   b. Concurrent Reviews;

   c. Reviews for continued stays and transfers;

   d. Retrospective Reviews.

4. These reviews, for selected Inpatient or Outpatient procedures and/or services, shall include but are not limited to:

   a. Medical Necessity;

   b. Appropriateness of care;

   c. Service authorizations;

   d. Payment reviews;

   e. DRG validations;

f. Outlier reviews;

g. Second opinion reviews; and

h. Quality of care reviews.

5. If criteria for Inpatient hospitalization or outpatient Hospital services are not met at any point in a hospitalization (i.e., at the point-of-admission review, Continued Stay Review or Retrospective Review) the provider will be notified of the finding.

a. When appropriate, payment may be adjusted, denied or recouped.

6. When the justification for services is not found, a written notice of denial shall be issued to the client, attending physician and Hospital. Clients and providers may follow the Department's procedures for appeal. See 10 CCR 2505-10 Sections 8.050, Provider Appeals, and 8.057, Recipient Appeals.

8.300.12.B Corrective Action

1. The Department may require or recommend Corrective Action when documentation indicates a pattern of inappropriate behavior, including, but not limited to, improper billing, unwarranted utilization, or questionable quality of care. ~~Corrective action may be recommended when documentation indicates a pattern of inappropriate utilization, or questionable quality of care.~~

2. The Department may initiate sanctions, as set forth in 10 CCR 2505-10, Section 8.076 and Section 8.130 if the required Corrective Action is not implemented or the implemented Corrective Action fails to resolve the pattern of inappropriate behavior. ~~If corrective action does not resolve the problem, T~~the Department shall initiate sanctions, ~~as set forth in 10 CCR 2505-10, Section 8.076 and Section 8.130 if corrective action fails to resolve the problem.~~

3. ~~Retrospective Review may be performed as a type of corrective action for an identified Hospital or client.~~Requirement to self-audit, Retrospective Reviews, and other actions as determined appropriate by the Department may be required or performed as a type of Corrective Action for an identified Hospital or client.

8.320 COMMUNITY CLINIC, INCLUDING FREESTANDING EMERGENCY DEPARTMENTS

8.320.1 Definitions

A. Community Clinic (CC) means a hospital-owned health care facility, licensed as a Community Clinic under 6 CCR 1011-1, Chapter IX or as a Freestanding Emergency Department (FSED) under 6 CCR 1011-1, Chapter XIII and enrolled as a CC provider type, that provides health care services on an ambulatory basis.

B. CMS means the Centers for Medicare and Medicaid Services.

C. Department means the Department of Health Care Policy and Financing.

D. Emergency Care Services, for the purposes of this rule, has the same meaning as Section 8.300.1.I.

E. Observation Stay, for the purposes of this rule, has the same meaning as Section 8.300.1.Q. ~~means a stay in the CC for no more than 48 hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed 24 hours.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Oxygen Certificate of Medical Necessity
Rule Number: MSB 23-05-31-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

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 23-05-31-A, Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Oxygen Certificate of Medical Necessity

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(s) 8.580.1, 8.580.5.C, and 8.580.8.A, 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*

Replace the current text at 8.580 with the proposed text beginning at 8.580.1 through the end of 8.580.1.I. Replace the current text at 8.580.5.C with the proposed text beginning at 8.580.5.C through the end of 8.580.5.C.2. Replace the current text at 8.580.8.A wit the proposed text beginning at 8.580.8.A through the end of 8.580.8.A.1.a.i. This rule is effective October 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Oxygen Certificate of Medical Necessity
Rule Number: MSB 23-05-31-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).

   The proposed rule removes the requirement that oxygen providers obtain a Certificate of Medical Necessity (CMN) for members receiving long term oxygen therapy (oxygen therapy lasting greater than ninety days). Oxygen providers must still obtain a prescription from an eligible prescribing provider, and have the prescription reviewed and renewed annually in accordance with 42 C.F.R. 440.70(b)(3)(iii), for members receiving long term oxygen therapy. The Department is now capable of receiving the information needed for long term oxygen therapy claims through the electronic claims system, making CMN duplicative and unnecessary. Oxygen providers are also required to maintain records of the oxygen therapy services and equipment in accordance with Section 8.580.8.A.1 if additional clinical information is required to document medical necessity.

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 C.F.R. 440.70(b)(3)(iii) (2023)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Section 25.5-5-102(1)(f), C.R.S. (2023)

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Oxygen Certificate of Medical Necessity
Rule Number: MSB 23-05-31-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

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.

   Oxygen providers will be affected by the proposed 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.

   Oxygen providers will no longer be required to obtain a Certificate of Medical Necessity (CMN) for long term home health members or have it reviewed annually. They will still be required to obtain a prescription and have it reviewed and renewed annually.

   Because oxygen providers will no longer be required to engage in a duplicative certification process, they will have lower administrative burden in providing the benefit.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are not costs to the Department or to any other agency to implement or enforce the proposed rule. The proposed rule has no anticipated effect on state revenues.

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

   There are no probable costs of the proposed rule. The benefit of the proposed rule is removing the duplicative CMN requirement for long term oxygen therapy. The cost of inaction is continuing to require the duplicative CMN requirement. There are no benefits to inaction.

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 methods for removing the CMN requirement for long term oxygen therapy from Department 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.

   There are no alternative methods for removing the CMN requirement for long term oxygen therapy from Department rule.

8.580 DURABLE MEDICAL EQUIPMENT – OXYGEN AND OXYGEN EQUIPMENT

8.580.1 DEFINITIONS

~~8.580.1.A. Certificate of Medical Necessity means the Medicare CMN-484 Oxygen form or the Colorado Medicaid Certificate of Medical Necessity for Oxygen Benefits form.~~

8.580.1.~~B~~A. Concentrator means an oxygen delivery system that operates electrically to concentrate oxygen from room air.

8.580.1.~~C~~B. Hypoxemia means deficient oxygenation of blood.

8.580.1.~~E~~C Nursing Facility means nursing facilities, intermediate nursing facilities, and skilled nursing facilities that receive facility payment reimbursement for care.

8.580.1.~~F~~D. Oxygen Concentrator is the same as a concentrator.

8.580.1.~~G~~E. Oxygen Delivery System means the method by which oxygen is delivered to the client.

8.580.1.~~H~~F. Portable Oxygen System means an oxygen delivery system, utilizing either concentrators or tanks, that can be easily moved with the client on a frequent basis.

8.580.1.~~I~~G. Post-Acute Oxygen Therapy means providing short term oxygen lasting three months or less to address a client's acute condition that is expected to resolve.

8.580.1.~~J~~H. Stationary Oxygen Delivery System means an oxygen delivery system that cannot be easily moved with the client on a frequent basis and does not concentrate oxygen from room air.

8.580.1.~~K~~I. Ventilator means a device to assist or control ventilation for a client who is unable to maintain spontaneous ventilation unassisted.

8.580.5 COVERED SERVICES AND EQUIPMENT

8.580.5.C. Long Term Oxygen Therapy ~~Certificate of Medical Necessity~~Prescription

1. Long Term Oxygen Therapy may be provided to clients for greater than ninety days with a prescription from an OPR provider identified in Section 8.580.3.A ~~and a Certificate of Medical Necessity~~.

~~a. The Certificate of Medical Necessity must:~~

~~i. Be obtained by the rendering provider within one hundred twenty days of the client beginning oxygen therapy;~~

ii. Be signed by a physician or licensed professional responsible for care of the client, which includes the medical director of a Nursing Facility;

iii. Include the most recent blood gas study or oxygenation assessment, obtained within thirty days of the initial oxygen provision date on the Certificate of Medical Necessity.

ba. Recertification Review and renewal of the CMN prescription required under Section 8.580.5.C.1 is required every twelve months or when the client's condition changes, whichever comes first. Pursuant to Public Law 116-127, the Families First Coronavirus Response Act, § 6008, continued coverage of oxygen is was required during the Coronavirus Disease 2019 (COVID-19) public health emergency as it was covered prior the emergency. For the duration of the COVID-19 public health emergency, the CMN recertificationreview required every twelve months under this section, and the requirement for annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii), is was suspended. Clients must obtain recertification as soon as practicable after the COVID-19 public health emergency ends, as declared by the President of the United States on March 13, 2020, and every twelve months thereafter.

i. Clients certified for twenty-four consecutive months no longer require a Certificate of Medical Necessity for oxygen, but still require a documented annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii). Documented annual reviews include a renewed prescription for oxygen or other medical record documentation.

2. Suppliers must have a completed and current Certificate of Medical Necessityprescription on file to support claims for oxygen therapy and oxygen equipment for non-ventilator dependent clients aged twenty and older requiring long term oxygen therapy lasting ninety days or more. For clients certified for twenty-four consecutive months, the most recent certified Certificate of Medical Necessity and the most recent annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii) must be on file.

8.580.8.A REIMBURSEMENT

1. To receive reimbursement, provider records must include, but are not limited to:

a. All oxygen therapy and oxygen equipment orders, and prescriptions, and Certificates of Medical Necessity;

i. Oxygen therapy and oxygen equipment provided for Post Acute Oxygen Therapy of less than ninety days does not require a Certificate of Medical Necessity, but does requires a documented assessment of Hypoxia under Section 8.580.5.B.1.a.

b. Record of oxygen-related items provided;

c. Documentation that the client, or the client's caregiver, was provided with manufacturer instructions, warranty information, service manual, and operating instructions for the rendered oxygen therapy and oxygen equipment.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Bariatric Surgery, Section 8.300.3.C
Rule Number: MSB 23-07-26-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

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 23-07-26-A, Revision to the Medical Assistance Act Rule concerning Bariatric Surgery, Section 8.300.3.C

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(s) 8.300.3.C, 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*

Replace the current text beginning at 8.300.3.C with the proposed text beginning at 8.300.3.C through the end of 8.300.3.C.5.g. This rule is effective October 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Bariatric Surgery, Section 8.300.3.C
Rule Number: MSB 23-07-26-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).

   Senate Bill 23-176, at C.R.S. § 25.5-5-336, prohibits the use of Body Mass Index (BMI) when determining medical necessity for individuals diagnosed with certain types of eating disorders. To align with the statute, the proposed rule removes the use of BMI in determining bariatric surgery medical necessity for individuals diagnosed with those types of eating disorders.

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:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Section 25.5-5-336, C.R.S. (2023)

Initial Review — Final Adoption **09/08/23**
Proposed Effective Date **10/30/23** — Emergency Adoption

DOCUMENT #05

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Bariatric Surgery, Section 8.300.3.C
Rule Number: MSB 23-07-26-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

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 diagnosed with the eating disorders identified in C.R.S. § 25.5-5-336, who are candidates for bariatric surgery, are affected by the proposed 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.

   Body Mass Index will not be considered when determining bariatric surgery for members diagnosed with eating disorders identified in C.R.S. § 25.5-5-336.

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 Department assumes no fiscal impact. It also assumes that only a small number of members will be affected by this bill. Furthermore, the Department believes that prohibiting providers from using BMI to determine medical necessity will have a minimal effect on the number of members with eating disorders being admitted and discharged from residential facilities, as well as the length of time these members stay in such facilities. Any changes in utilization resulting from the bill would be accounted for through the budget process.

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

   The costs of the proposed rule are included in the response to question #3. The benefits of the proposed rule are aligning Department rule with state statute. The cost of inaction is misalignment between Department rule and state statute. There are no benefits to inaction.

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

   There is no less costly method to align Department rule with state statute.

DO NOT PUBLISH THIS PAGE

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 is no alternative method for aligning Department rule with state statute.

8.300 HOSPITAL SERVICES

8.300.3 Covered Hospital Services

8.300.3.C. Bariatric Surgery

1. Eligible ~~Clients~~Members

   a. All currently enrolled Medicaid ~~clients~~ members over the age of sixteen when:

      i) The ~~client~~ member has clinical obesity; and

      ii) It is Medically Necessary.

2. Eligible Providers

   a. Providers must enroll in Colorado Medicaid.

   b. Surgeons must be trained and credentialed in bariatric surgery procedures.

   c. Preoperative evaluations and treatment may be performed by:

      i) Primary care physician,

      ii) Nurse Practitioner,

      iii) Physician Assistant,

      iv) Registered dietician,

      v) ~~Mental~~ Behavioral health providers available through the ~~Client~~member's Behavioral Health Organization.

3. Eligible Places of Service

   a. All surgeries shall be performed at a Hospital, as defined at 8.300.1.

      i) Facilities must have safety protocols in place specific to the care and treatment of bariatric ~~client~~members.

   b. Pre- and Post- operative care may be performed at a physician's office, clinic, or other medically appropriate setting.

4. Covered Services and Limitations

a. Colorado Medicaid covers participating providers for one bariatric procedure per ~~client~~member lifetime unless a revision is appropriate based one of the identified complications.

i) Appropriate revision procedures are identified at section 8.300.3.C.4.d.

b. Covered primary procedures Include:

i) Roux-en-Y Gastric Bypass;

ii) Adjustable Gastric Banding;

iii) Biliopancreatic Diversion with or without Duodenal Switch;

iv) Vertical-Banded Gastroplasty;

v) Vertical Sleeve Gastroplasty.

c. Criteria for Primary Procedures

When determining medical necessity or the appropriate level of care for members diagnosed with an eating disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, the Body Mass Index (BMI), ideal body weight, or any other standard requiring an achieved weight must not be used, in accordance with the requirements of Sections 25.5-5-336(1-2) (2023). Such members must meet criteria in Sections 8.300.3.C.4.c.iii-iv, and Section 8.300.3.C.4.c.v if under age 18. All ~~Clients~~ other members must meet the first four following criteria, ~~clients~~ members under age 18 must also meet criteria five:

i) The ~~client~~member is clinically obese with one of the following:

1) BMI of 40 or higher, or

2) BMI of 35-40 with objective measurements documenting one or more of the following co-morbid conditions:

a) Severe cardiac disease;

b) Type 2 diabetes mellitus;

c) Obstructive sleep apnea or other respiratory disease;

d) Pseudo-tumor cerebri;

e) Hypertension;

f) Hyperlipidemia;

g) Severe joint or disc disease that interferes with daily functioning;

h) Intertriginous soft-tissue infections, nonalcoholic steatohepatitis, stress urinary incontinence, recurrent or

persistent venous stasis disease, or significant impairment in Activities of Daily Living (ADL).

ii) The BMI level qualifying the ~~client~~member for surgery (>40 or >35 with one of the above co-morbidities) must be of at least two years' duration. A ~~client~~member's BMI may fluctuate around the required levels during this period around the required levels, and will be reviewed on a case-by-case basis.

iii) The ~~client~~member must have made at least one clinically supervised attempt to lose weight lasting at least six consecutive months or longer within the past eighteen months of the prior authorization request, monitored by a registered dietician that is supervised by a physician, nurse practitioner, or physician's assistant.

iv) Medical and psychiatric contraindications to the surgical procedure must have been ruled out through:

1) A complete history and physical conducted by or in consultation with the requesting surgeon; and

2) A psychiatric or psychological assessment, conducted by a licensed ~~mental~~ behavioral health professional, no more than three months prior to the requested authorization. The assessment must address both potential psychiatric contraindications and ~~client~~member's ability to comply with the long-term postoperative care plan.

v) For ~~client~~members under the age of eighteen, the following must be documented:

1) The exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome;

2) Whether female ~~client~~members have attained Tanner stage IV breast development; and

3) Whether bone age studies estimate the attainment of 95% of projected adult height.

4) Mental health evaluations for ~~client~~members age 17 must address issues specific to these ~~client~~members' maturity as it relates to compliance with postoperative instructions.

d. Revision Procedures

i) Colorado Medicaid covers Revisions of a surgery for clinical obesity if it is used to correct complications such as slippage of an adjustable gastric band, intestinal obstruction, or stricture, following a primary procedure.

ii) Indications for surgical revision:

1) Weight loss to 20% below the ideal body weight;

2) Esophagitis, unresponsive to nonsurgical treatment;

3) Hemorrhage or hematoma complicating a procedure;

4) Excessive bilious vomiting following gastrointestinal surgery;

5) Complications of the intestinal anastamosis and bypass;

6) Stomal dilation, documented by endoscopy;

7) Documented slippage of the adjustable gastric band;

8) Pouch dilation documented by upper gastrointestinal examination or endoscopy producing weight gain of 20% of more, provided that:

a) The primary procedure was successful in inducing weight loss prior to the pouch dilation; and

b) The ~~client~~member has been compliant with a prescribed nutrition and exercise program following the procedure (weight and BMI prior to surgery, at lowest stable point, and at current time must be submitted along with surgeon's statement to document compliance with diet and exercise);

9) Other and unspecified post-surgical non-absorption complications.

e. Non-Covered Services:

i) For ~~Client~~Members with clinically diagnosed COPD (Chronic Obstructive Pulmonary Disease), including Chronic Bronchitis or Emphysema.

ii) Repeat procedures not associated with surgical complications.

iii) Cosmetic Follow-up: Weight loss following surgery for clinical obesity can result in skin and fat folds in locations such as the medial upper arms, lower abdominal area, and medial thighs. Surgical removal of this skin and fat for solely cosmetic purposes is not a covered benefit.

iv) During pregnancy.

5. Prior Authorization Requirements

All bariatric surgical procedures require prior authorization, which must include:

a) The ~~Client~~Member's height, weight, BMI with duration.

b) A list and description of each co-morbid condition, with attention to any contraindication which might affect the surgery including all objective measurements.

c) A detailed account of the ~~Client~~Member's clinically supervised weight loss attempt(s), including duration, medical records of attempts, identification of the supervising clinician, and evidence of successful completion and compliance.

d) A current psychiatric or psychological assessment regarding contraindications for bariatric surgery, as described in 8.300.3.C.4.c(iv)(2).

e) A statement written or agreed to by the ~~client~~member, detailing for the interdisciplinary team the ~~client~~member's:

i) Commitment to lose weight;

ii) Expectations of the surgical outcome;

iii) Willingness to make permanent life-style changes;

iv) Be willing to participate in the long-term postoperative care plan offered by the surgery program, including education and support, diet therapy, behavior modification, and activity/exercise components; and

v) If female, ~~client~~member's statement that she is not pregnant or breast-feeding and does not plan to become pregnant within two years of surgery.

f) A description of the post-surgical follow-up program.

g) For ~~client~~members under the age of eighteen, documentation of the physical criteria requirements at 8.300.3.C.4.c(v).

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Updates to the Agreement Not to Sponsor for Section 8.100.3.D.6
Rule Number: MSB 23-07-26-B
Division / Contact / Phone: Office of Medicaid Operations / Nicole Mason / 303-866-5052

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 23-07-26-B Revision to the Medical Assistance Rule Concerning Updates to the Agreement Not to Sponsor for Section 8.100.3.D.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(s) 8.100.3.D.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*

Replace the current text at 8.100.3.D with the proposed text beginning at 8.100.3.D through the end of 8.100.3.D.7. This rule is effective October 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Updates to the Agreement Not to Sponsor for Section 8.100.3.D.6
Rule Number: MSB 23-07-26-B
Division / Contact / Phone: Office of Medicaid Operations / Nicole Mason / 303-866-5052

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 change aims to amend 10 CCR 2505-10 Section 8.100.3.D.6 to align with Senate Bill 23-1117 effective August 7, 2023. This change will remove the rule requirement for legal immigrants to agree to execute an affidavit of support when enrolling or receiving Medical Assistance. By removing this requirement, legal immigrants who receive Medical Assistance will no longer face the risk of losing their benefits if they choose to sponsor someone for immigration purposes. The U.S. Centers for Medicare & Medicaid Services (CMS) informed Colorado in 2014 the rule to execute an agreement not to sponsor may violate the equal protection clause under the 14th amendment of Constitution. Federal regulations do not exist for legal immigrants or U.S. citizens to sign an agreement not to sponsor, thereby leaving Colorado susceptible to federal audits. The removal of this rule provides legal Colorado immigrants equitable access in enrolling and receiving Medical Assistance while ensuring Colorado aligns with federal health equity standards. The Department will update the Colorado Benefits Management System (CBMS) to reflect this change.

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:

   There is no federal policy for this rule.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   C.R.S 25.5-3-105, 25.5-5-101(5), and 26-2-111.8(5.5)

Initial Review — Final Adoption **09/08/23**
Proposed Effective Date **10/30/23** — Emergency Adoption

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Updates to the Agreement Not to Sponsor for Section 8.100.3.D.6
Rule Number: MSB 23-07-26-B
Division / Contact / Phone: Office of Medicaid Operations / Nicole Mason / 303-866-5052

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.

   The rule update benefits legal Colorado immigrants who are applying for or are enrolled in Medical Assistance coverage. This includes individuals who may have been previously deterred from seeking Medical Assistance due to the sponsorship agreement requirement. By removing this barrier, the proposed rule will enable a broader range of individuals to receive the necessary healthcare and assistance they require. The proposed rule change does not anticipate any negative impacts on any classes of persons as it is designed to promote equitable access to benefits and ensure that legal immigrants in Colorado are not unfairly burdened by unnecessary restrictions.

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 impacts of the proposed rule in removing the requirement to sign an agreement not to sponsor will lead to an increase in the utilization of Medical Assistance resulting in higher enrollment rates and greater access to healthcare services. Legal permanent residents who were previously hesitant to apply for Medical Assistance due to the sponsorship agreement requirement may experience financial relief and improve their overall well-being in having accessibility to timely medical care, preventive services, and necessary treatments. They will no longer need to make the difficult choice between sponsoring a family member and accessing essential healthcare. The proposed rule can contribute to a more inclusive and equitable society by ensuring that legal immigrants have equal access to necessary healthcare and critical assistance.

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 Department expects that removing the prohibition on legal permanent residents enrolled in Medicaid executing an Affidavit of Support to sponsor an immigrant, will have no costs to the Department because this will only require minimal system changes to the Colorado Benefits Management System (CBMS), which could be absorbed within current appropriated resources for system changes. In addition, the Department does not expect this to impact the eligibility of current Medicaid members because there is no specific federal requirement that prevents a sponsor from receiving medical assistance if they choose to sponsor an immigrant, while the law placed limits on Medicaid eligibility for immigrants, it did not specifically place limits on sponsors.

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

   There is no cost to the Department associated with this policy. The probable benefit of this policy is to be in line with state regulations and eligibility criteria. The cost of inaction is that the Department will not be in compliance with state statutes. There are no obvious benefits to inaction.

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 methods of removing the prohibition on sponsorship.

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 were no alternative methods considered for the proposed rule.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.D. Processing Requirements

1. The eligibility site shall process a Single Streamlined Application for Medical Assistance Program benefits within the following deadlines:

    a. 90 days for persons who apply for the Medical Assistance Program and a disability determination is required.

    b. 45 days for all other Medical Assistance Program applicants.

    c. The above deadlines cover the period from the date of receipt of a complete application to the date the eligibility site mails a notice of its decision to the applicant.

    d. In unusual circumstances, documented in the case record and in CBMS case comments, the eligibility site may delay its decision on the application beyond the applicable deadline at its discretion. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action such as submitting required documentation, or an administrative or other emergency beyond the agency's control.

    e. Due to the Coronavirus COVID-19 Public Health Emergency, required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all Medical Assistance categories, regardless of changes made for a redetermination or additional documentation for current Medicaid enrollees. The Department will allow these individuals to continue eligibility through the period of the COVID-19 pandemic federal emergency declaration. Once the federal emergency declaration has concluded, the Department will process eligibility redeterminations and /or changes for all members whose eligibility was maintained during the emergency declaration. Effective May 11, 2023 the coronavirus COVID-19 pandemic federal emergency has been declared to end. To ensure the Department Maintains access to State and Federal funding provided by the Federal ‘Families First Coronavirus Response Act” Pub.L. 116-127, and the Federal “Consolidated Appropriations Act, 2023”, the Department will process eligibility redeterminations and take appropriate action for all members whose eligibility was maintained during the emergency declaration. By May 2024 all members whose eligibility has been maintained due to the Public Health Emergency will have completed the renewal process. A member’s eligibility may no longer be maintained after May 31, 2023 if they have completed the renewal process and/or a change is reported, and they are found ineligible. Members whose eligibility has been maintained during the Public Health Emergency and whose renewal is not due yet will remain in their current category until their renewal due month, regardless if there is a change reported that makes them ineligible.

2. Upon request, applicants will be given an extension of time within the application processing timeframe to submit requested verification. Applicants may request an extension of time beyond the application processing timeframe to obtain necessary verification. The extension may be granted at the eligibility site's discretion. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

3. The eligibility site shall not use the above timeframes as a waiting period before determining eligibility or as a reason for denying eligibility.

4. For clients who apply for the Medical Assistance Program and a disability determination is required, the eligibility site shall send a notice informing the applicant of the reason for a delay beyond the applicable deadline, and of the applicant's right to appeal if dissatisfied with the delay. The eligibility site shall send this notice no later than 91 days following the application for the Medical Assistance Program.

5. For information regarding continuation of benefits during the pendency of an appeal to the Social Security Administration (SSA) based upon termination of disability benefits see section 8.057.5.C.

~~6. Effective July 1, 1997, as a condition of eligibility for the Medical Assistance Program, any legal immigrant who is applying for or receiving Medical Assistance shall agree in writing that, during the time period the client is receiving Medical Assistance, he or she will not sign an affidavit of support for the purpose of sponsoring an alien who is seeking permission from the United States Immigration and Citizenship Services to enter or remain in the United States. A legal immigrant's eligibility for Medical Assistance shall not be affected by the fact that he or she has signed an affidavit of support for an alien before July 1, 1997.~~

6~~7~~. Eligibility sites at which an individual is able to apply for Medical Assistance benefits shall also provide the applicant the opportunity to register to vote.

a. The eligibility site shall provide to the applicant the prescribed voter registration application.

b. The eligibility site shall not:

i) Seek to influence the applicant's political preference or party registration;

ii) Display any political preference or party allegiance;

iii) Make any statement to the applicant or take any action, the purpose or effect of which is to discourage the applicant from registering to vote; and

iv) Make any statement to an applicant which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

c. The eligibility site shall ensure the confidentiality of individuals registering and declining to register to vote.

d. Records concerning registration and declination to register to vote shall be maintained for two years by the eligibility site. These records shall not be part of the public assistance case record.

e. A completed voter registration application shall be transmitted to the county clerk and recorder for the county in which the eligibility site is located not later than ten (10) days

after the date of acceptance; except that if a registration application is accepted within five (5) days before the last day for registration to vote in an election, the application shall be transmitted to the county clerk and recorder for the county not later than five (5) days after the date of acceptance.

7~~8~~. Individuals who transfer from one Colorado county to another shall be provided the same opportunity to register to vote in the new county of residence. The new county of residence shall follow the above procedure. The new county of residence shall notify its county clerk and recorder of the client's change in address within five (5) days of receiving the information from the client.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medicaid Assistance Rule Concerning the Health Care Affordability and Sustainability Fee, Section 8.3000
Rule Number: MSB 23-07-26-C
Division / Contact / Phone: Special Financing Division / Nancy Dolson / 303-866-3698

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 23-07-26-C, Revisions to the Medicaid Assistance Rule Concerning the Health Care Affordability and Sustainability Fee, Section 8.3000

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(s) 8.3000, 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*

Replace the current text at 8.3000.1 with the proposed text beginning at 8.3000.1 through the end of 8.3000.1. Replace the current text at 8.3000.4- with the proposed text beginning at 8.3000.4.B through the end of 8.3000.4.C. This rule is effective October 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medicaid Assistance Rule Concerning the Health Care Affordability and Sustainability Fee, Section 8.3000
Rule Number: MSB 23-07-26-C
Division / Contact / Phone: Special Financing Division / Nancy Dolson / 303-866-3698

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 proposed rule change will define a new Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) hospital classification for the safety net hospital that serves Pueblo and the southern Colorado region, Parkview Medical Center. This rule change will ensure continuity of Parkview's CHASE provider fee-funded payments upon its expected acquisition by UCHealth, allowing continuity of health care services, including birthing services, for the Pueblo region.

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; 42 CFR § 433.68

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Section 25.5-4-402.4(5)(g), C.R.S. (2023)

Initial Review
Proposed Effective Date **10/30/23**
Final Adoption **09/08/23**
Emergency Adoption

DOCUMENT #07

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medicaid Assistance Rule Concerning the Health Care Affordability and Sustainability Fee, Section 8.3000
Rule Number: MSB 23-07-26-C
Division / Contact / Phone: Special Financing Division / Nancy Dolson / 303-866-3698

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.

   The residents of Pueblo and the southern Colorado region are affected and will benefit from the proposed rule. Parkview Medical Center is the safety net hospital serving Pueblo and southern Colorado. Parkview is facing significant financial challenges: for FY 2022, Parkview recorded a net operating loss of ($34.6 million) and is projecting similar losses in FY 2023 and beyond. Parkview approached UCHealth about an acquisition to ensure financial viability for this important safety net for the community.

   UCHealth's acquisition of Parkview Medical Center was expected to occur on July 1, 2023. The acquisition is currently on hold due to the recent discovery of an unintended consequence in the CHASE hospital provider fee-funded supplemental payments for Parkview Medical Center that would be triggered on the occasion of its acquisition by UCHealth. Specifically, without the new CHASE hospital classification definition proposed by this rule, once acquired by UCHealth, Parkview and UCHealth would receive ($26 million) net impact to their CHASE reimbursement.

   There are no costs of the proposed rule: this rule will maintain current levels of CHASE provider fees and related for Parkview Medical Center, UCHealth, and all other hospitals in the state.

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 maintains the current level of CHASE provider fees and payments for Parkview Medical Center, UCHealth, and all other hospitals in the state.

   Pueblo area residents will continue to receive access to health care services at the region's largest Medicaid provider and only hospital participant in the Colorado Indigent Care Program. Parkview provides some services that otherwise would be nearly non-existent in Pueblo County, such as obstetrics and comprehensive women's health care. Parkview is the top 6th hospital in the state in number of Medicaid-covered births, with 1,124 Medicaid-covered births in 2022, which was more than 2/3rds of the 1,703 total births in Pueblo County. Moreover, besides

Colorado Springs 45 minutes to the north, the only other birthing hospitals within 1 hour of Pueblo are three, small critical access hospitals.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department or other agencies with this proposed rule. This rule maintains the current CHASE fees and payments for Parkview Medical Center and there are no additional administrative costs associated with this rule.

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

   The benefits of this proposed rule are maintenance of access to hospital services at the largest Medicaid provider, Colorado Indigent Care Program participant, and only hospital providing birthing services in Pueblo. There are no costs with this proposed rule as there are no changes in CHASE provider fees or payments with this proposed rule for any hospital. There are also no associated changes in administrative costs for the Department or other agencies. There are no benefits to inaction and the costs of inaction are substantial: without the proposed rule, access to hospital services including obstetrics and comprehensive women's care in the Pueblo region will be jeopardized.

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 intrusive methods to achieve the purpose of this proposed rule as it maintains current reimbursement levels for Parkview Medical Center and all other hospitals in the state with no increase in administrative costs.

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 cannot maintain the same CHASE provider fee-funded reimbursement for Parkview Medical Center, the safety net hospital that serves Pueblo and the southern Colorado region, without defining a new hospital classification in rule.

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 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 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.

"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 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%

8.3002: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS

8.3002.A. DATA REPORTING

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Enterprise shall distribute a data reporting template to all hospitals. The Enterprise shall include instructions for completing the data reporting template, including definitions and descriptions of each data element to be reported. Hospitals shall submit the requested data to the Enterprise within thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Enterprise may estimate any data element not provided directly by the hospital.

    a. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the collection of fees, payments to hospitals shall be processed by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

    b. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the disbursement of payments, payments to hospitals shall be processed through a warrant (paper check) by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

2. Hospitals shall submit days and charges for Medicaid Managed Care, out-of-state Medicaid, and uninsured patients, Managed Care Days, and any additional elements requested by the Enterprise.

3. The Enterprise shall distribute a data confirmation report to all hospitals annually. The data confirmation report shall include a listing of relevant data elements used by the Enterprise in calculating the Outpatient Services Fee, the Inpatient Services Fee and the supplemental payments. The data confirmation report shall clearly state the manner and timeline in which hospitals may request revisions to the data elements recorded by the Enterprise. Revisions to the data will not be permitted by a hospital after the dates outlined in the data confirmation report.

4. The hospital shall certify that based on best information, knowledge, and belief, the data included in the data reporting template is accurate, complete, and truthful, is based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

8.3002.B. FEE ASSESSMENT AND COLLECTION

1. Establishment of Electronic Funds Process. The Enterprise shall utilize an Automated Clearing House (ACH) debit process to collect the Outpatient Services Fee and Inpatient Services Fee from hospitals and an Electronic Funds Transfer (EFT) payment process to deposit supplemental payments in financial accounts authorized by hospitals. The Enterprise shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.

2. The Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and collected in twelve monthly installments. Payments to hospitals will be calculated on an annual basis and disbursed in twelve monthly installments.

    a. For those hospitals that participate in the electronic funds process utilized by the Enterprise, fees will be assessed and payments will be disbursed on the second Friday of the month, except when State offices are closed during the week of the second Friday, then fees will be assessed and payment will be disbursed on the following Friday of the month. If the Enterprise must diverge from this schedule due to unforeseen circumstances, the Enterprise shall notify hospitals in writing or by electronic notice as soon as possible.

        i. The Enterprise may assess fees and disburse payments for Urban Center Safety Net Specialty Hospitals on an alternate schedule determined by the Department.

    b. At no time will the Enterprise assess fees or disburse payments prior to the state fiscal year for which they apply.

3. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds process utilized by the Enterprise for the collection of fees and the disbursement of payments unless the Enterprise has approved an alternative process. A hospital requesting to not participate in the electronic fee collection process and/or payment process must submit a request in writing or by electronic notice to the Enterprise describing an alternative fee collection process and/or payment process. The Enterprise shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

a. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the collection of fees, payments to hospitals shall be processed by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

b. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the disbursement of payments, payments to hospitals shall be processed through a warrant (paper check) by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

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% of total hospital outpatient charges with the following exception.

    a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to 1.8548% 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 per day for Managed Care Days and $510.05 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 per day for Managed Care Days and $266.30 per day for all Non-Managed Care Days, and.

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

8.3003.C. ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

1. The Enterprise shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Inpatient Services Fee and Outpatient Services

Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be assessed.

2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the data confirmation report. The Enterprise will prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

3. In order to receive a Supplemental Medicaid Payment or DSH Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.3003.D. REFUND OF EXCESS FEES

1. If, at any time, fees have been collected for which the intended expenditure has not received approval for federal Medicaid matching funds by CMS at the time of collection, the Enterprise shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Enterprise shall notify each hospital of its refund amount in writing or by electronic notice. The refunds shall be paid to each hospital according to the process described in Section 8.3002.B.

2. After the close of each federal fiscal year the Enterprise shall present a summary of fees collected, expenditures made or encumbered, and interest earned in the Fund during the federal fiscal year to the Enterprise Board.

    a. If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Enterprise has not expended or encumbered those fees at the close of each federal fiscal year:

        i. The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less the minimum Fund reserve recommended by the Enterprise Board.

        ii. The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the federal fiscal year.

        iii. The Enterprise shall notify each hospital of its refund in writing or by electronic notice 30 days before payment is made. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.3002.B.

8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.A. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

1. All Supplemental Medicaid Payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting

errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Enterprise.

2. No hospital shall receive a DSH Payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the Disproportionate Share Hospital Payment, described in 10 CCR 2505-10, Section 8.3004.D, exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, the hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-Specific Disproportionate Share Hospital Limit.

3. In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.3004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients are qualified to receive this payment except as provided below.

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

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. Outpatient billed costs equal outpatient billed charges multiplied by the Medicare cost-to-charge ratio. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Pediatric Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications, except that the adjustment factor for a Safety Net Metropolitan Hospital shall be equal to the adjustment factor for a Privately-Owned Independent Metropolitan Hospital. Total payments to qualified hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.C. INPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients are qualified to receive this payment, except as provided below.

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

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal Medicaid Non-Managed Care Days multiplied by an adjustment factor. The adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Pediatric Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications, except that the adjustment factor for a Safety Net Metropolitan Hospital shall be at least equal to the adjustment factor for a Privately-Owned Independent Metropolitan Hospital. Total payments to qualified hospitals shall not exceed the Inpatient Upper Payment

Limit. The adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

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.

   b. A qualified hospital with CICP write-off costs greater than 700% of the state-wide average shall receive a payment equal to 96.00% of their Hospital-Specific DSH Limit. A qualified Critical Access Hospital shall receive a payment equal to 96.00% of their Hospital Specific DSH Limit. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than 2,400 Medicaid days shall receive a payment equal to 96.00% of their Hospital-Specific DSH Limit.

   c. 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. 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%.

8.3004.E. ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Essential Access Hospitals are qualified receive this payment.

2. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal the available Essential Access funds divided by the total number of qualified Essential Access Hospitals.

8.3004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients are qualified to receive this payment except as provided below.

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

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal adjusted discharge points multiplied by dollars per-adjusted discharge point.

   a. Adjusted discharge points equal normalized points awarded multiplied by adjusted Medicaid discharges. Normalized points awarded equals the sum of points awarded, normalized to a 100-point scale for measures a hospital is not eligible to complete. The measures and measure groups are published annually in the Colorado Medicaid Provider Bulletin.

      Adjusted Medicaid Discharges equal inpatient Medicaid discharges multiplied by a discharge adjustment factor.

      i. The discharge adjustment factor equals total Medicaid charges divided by inpatient Medicaid charges. The discharge adjustment factor is limited to 5.

      ii. For qualified hospitals with less than 200 inpatient Medicaid discharges, inpatient Medicaid discharges shall be multiplied by 125%.

   b. Dollars per-adjusted discharge point are determined using a qualified hospital's normalized points awarded. Dollars per-adjusted discharge point are tiered so that qualified hospitals with more normalized points awarded receive more dollars per-adjusted discharge point. There are five tiers delineating the dollars per-adjusted discharge point with each tier assigned a certain normalized points awarded range. For each tier the dollars per-adjusted discharge point increase by a multiplier.

      The multiplier and normalized points awarded for each tier are:

Tier	Normalized Points Awarded	Dollars Per-Adjusted Discharge Point
1	1-19	0(x)
2	20-39	1(x)
3	40-59	2(x)
4	60-79	3(x)
5	80-100	4(x)

The dollars per discharge point shall equal an amount such that the total quality incentive payments made to all qualified hospitals shall equal seven percent (7.00%) of total hospital payments in the previous state fiscal year.

4. A hospital shall have the opportunity to request a reconsideration of points awarded that are provided with the preliminary scoring letter.

   a. To be considered for payment, a hospital shall submit a survey through the data collection tool on or before May 31 of each year.

   b. A preliminary scoring letter containing the scores and scoring rationale shall be provided to a hospital that submits a survey within ninety calendar days of May 31. The preliminary scoring letter will be delivered to each hospital that submitted a survey via the data collection tool.

   c. A hospital that believes a measure in the preliminary scoring letter was inaccurately scored may submit a reconsideration request within ten business days of delivery of the preliminary scoring letter. The request must be made by electronic notice.

      i. The reconsideration request must be provided following the process established through the HQIP scoring review and reconsideration period user guide. Reconsideration requests may not be accepted if they are not provided through this process.

   d. A response to the reconsideration request shall be provided within ten business days upon receipt of the reconsideration request via electronic notice. The response shall provide whether a change to a measure score was made or if the reconsideration request was denied.

   e. If a hospital is not satisfied with the reconsideration response, the hospital may request the reconsideration be escalated to the Special Financing Division Director within five business days of delivery of the reconsideration response. Any escalations must be provided to the Department via electronic notice.

      i. The escalation request must be provided following the process established through the HQIP scoring review and reconsideration period user guide. Escalation requests may not be accepted if they are not provided through this process.

   f. A response to the escalation request shall be provided to the hospital within ten business days via electronic notice. The response shall provide whether a change to a measure score was made or if the escalation request was denied. The escalation response is final, and points awarded may not be reconsidered further.

   g. No other reconsiderations of points awarded, both preliminary and final, may be accepted by the Department outside of this process. The Department’s decision is not an adverse action subject to administrative or judicial review under the Colorado Administrative Procedure Act (ACA).

8.3004.G. RURAL SUPPORT PROGRAM HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals that meet all the following criteria:

a. Is state licensed as a Critical Access Hospital or is a Rural Hospital, participating in Colorado Medicaid,

b. Is a nonprofit hospital, and

c. Meets one of the below:

i. Their average net patient revenue for the three-year 2016, 2017, and 2018 cost report period is in the bottom ten percent (10%) for all Critical Access Hospitals and Rural Hospitals, or

ii. Their funds balance for the 2019 cost report period is in the bottom two and one-half percent (2.5%) for all Critical Access Hospitals and Rural Hospitals not in the bottom 10% of the three-year average net patient revenue for all Critical Access Hospitals and Rural Hospitals,

2. Calculation methodology for payment. For a qualified hospital, the annual payment shall equal twelve million dollars ($12,000,000) divided by the number of qualified hospitals.

3. The payment shall be calculated once and reimbursed in monthly installments over the subsequent five federal fiscal years.

4. A qualified hospital must submit an attestation form every year to receive the available funds. If a qualified hospital does not submit the required attestation form their funds for the year shall be redistributed to other requalified hospitals.

8.3004.H REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENTS AND DISPROPORTIONATE SHARE HOSPITAL PAYMENT

1. The Enterprise shall calculate the Supplemental Medicaid Payments and DSH Payment under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Supplemental Medicaid Payments and DSH Payment shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the annual payment made each year, the methodology to calculate such payment, and the payment reimbursement schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Supplemental Medicaid Payments or the DSH Payment to be reimbursed.

8.3004.I HOSPITAL TRANSFORMATION PROGRAM

Qualified hospitals shall participate in the Hospital Transformation Program (HTP). The HTP leverages supplemental payments as incentives designed to improve patient outcomes and lower Medicaid cost. Qualified hospitals are required to complete certain reporting activities. Qualified hospitals not completing a reporting activity shall have their supplemental Medicaid payments reduced. The reduced supplemental Medicaid payments shall be paid to qualified hospitals completing the reporting activity. The HTP is a multi-year program with a program year (PY) being on a federal fiscal year (October 1 through September 30) basis.

1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients shall participate in the HTP except as provided below.

2. Excluded hospitals. Psychiatric Hospitals, Rehabilitation Hospitals, or Long-Term Care Hospitals shall not participate in the HTP.

3. Calculation methodology for payment.

a. Each program year includes reporting activities that a qualified hospital is required to complete. A qualified hospital not completing a reporting activity shall have their HTP Supplemental Medicaid Payments reduced by a designated percent.

b. The dollars not paid to those qualified hospitals shall be redistributed to qualified hospitals completing the reporting activity. A qualified hospital's distribution shall equal their percent of HTP Supplemental Medicaid Payments to the total HTP Supplemental Medicaid Payments for all qualified hospitals completing the reporting activity, multiplied by the total reduced dollars for qualified hospitals not completing the reporting activity.

c. The reduction and redistribution shall be calculated using the HTP Supplemental Medicaid Payments effective during the reporting activity period. The reduction and redistribution for reporting activities shall occur at the same time during the last quarter of the subsequent program year.

e. There are five HTP reporting activities. The reporting activities are listed below, along with the total percent at-risk associated with each reporting activity.

i. Application (1.5% at-risk total) – Qualified hospitals must provide interventions and measures focusing on improving processes of care and health outcomes and reducing avoidable utilization and cost. The percent at-risk shall be scored on timely and satisfactory submission.

ii. Implementation Plan (1.5% at-risk total) – Qualified hospitals must submit a plan to implement interventions with clear milestones that shall impact their measures. The percent at-risk shall be scored on timely and satisfactory submission.

iii. Quarterly Reporting (0.5% at-risk per report) – Qualified hospitals must report quarterly on the different activities that occurred in that quarter. For any given quarter, this includes interim activity reporting, milestone reporting, self-reported data associated with the measures, and Community and Health Neighborhood Engagement (CHNE) reporting. The percent at-risk shall be scored on timely and satisfactory submission.

iv. Milestone Report (2.0% at-risk per report in PY 2, 4.0% at-risk per report in PY 3) – Qualified hospitals must report on achieved/missed milestones over the previous two quarters. The percent at-risk shall be scored on timely and satisfactory submission and for achievement of milestones. Qualified hospitals that miss a milestone can have the reduction for the milestone reduced by 50% if they submit a course correction plan with the subsequent Milestone Report. A course correction reduction for a missed milestone can only be done once per intervention.

v. Sustainability Plan (8.0% at-risk total) – Qualified hospitals must submit a plan demonstrating how the transformation efforts will be maintained after the HTP is over. The percent at-risk shall be scored on timely and satisfactory submission.

f. A qualified hospital not participating in the HTP may have the entirety of their HTP Supplemental Medicaid Payments withheld.

4. A hospital shall have the opportunity to request a reconsideration of scores for reporting compliance, milestone completion (including milestone amendments and course corrections), and performance measure data accuracy.

   a. The scoring review and reconsideration period begins when the Department notifies hospitals of initial scores. This period consists of multiple steps that will span 45 business days.

      i. The Department completes initial review of reports within 20 business days of report due date.

      ii. The Department notifies hospital of scores available for viewing and the scoring review and reconsideration period begins within 21 business days of report due date.

      iii. The hospital request for reconsideration is due within 10 business days of release of initial scores.

      iv. The Department issues final scores and reconsideration decisions within 14 business day of the scoring review and reconsideration period close date.

   b. All hospitals will receive electronic notification when initial scores are released to the Department's web portal.

   c. To submit a request for reconsideration of an initial score, a hospital must utilize the scoring review and reconsideration form available on the Department's web portal. It must identify the specific scoring elements the hospital would like reconsidered and the rationale for the reconsideration request. The form must be emailed following the proper guidelines as mentioned on the form.

      i. Late report submissions and report revisions are not accepted through the reconsideration process.

      ii. The hospital will receive an electronic notification of the outcome of the reconsideration request.

   d. If a hospital is not satisfied with the reconsideration response, the hospital may request the reconsideration be escalated to the Project Manager or the Special Financing Division Director. Initial escalations to the Project Manager must be made within five business days of delivery of the reconsideration response. Final escalations to the Special Financing Division Director must be made within 15 business days of delivery of the reconsideration response. Any escalations must be provided to the Department via electronic notice.

      i. The escalation request must be provided following the process established through the HTP scoring review and reconsideration period user guide. Escalation requests may not be accepted if they are not provided through this process.

   e. A response to the initial escalation request shall be provided to the hospital within ten business days via electronic notice. A response to the final escalation request shall be provided to the hospital within 20 business days via electronic notice. Any response shall provide whether a change to a measure score was made or if the escalation request was

denied. The escalation response is final, and points awarded may not be reconsidered further.

f. No other reconsiderations of scores, both preliminary and final, may be accepted by the Department outside of this process. The Department's decision is not an adverse action subject to administrative or judicial review under the Colorado Administrative Procedure Act (ACA).