DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Redetermination of Eligibility and Transferring Requirements at 8.100.3
Rule Number: MSB 18-07-13-A
Division / Contact / Phone: Health Information Office / Jennifer VanCleave / 303-866-6204

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 18-07-13-A, Revision to the Medical Assistance Rule Concerning Redetermination of Eligibility and Transferring Requirements at 8.100.3
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) 8.100.3C and 8.100.3P, 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.C with the proposed text beginning at 8.100.3.C.1 through the end of 8.100.3.C.7. Replace the current text at 8.100.3.P with the proposed text beginning at 8.100.3.P.1 through the end of 8.100.3.P.5. This rule is effective 11/30/2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Redetermination of Eligibility and Transferring Requirements at 8.100.3
Rule Number: MSB 18-07-13-A
Division / Contact / Phone: Health Information Office / Jennifer VanCleave / 303-866-6204

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 will amend 10 CCR 2505-10 8.100.3.C and 8.100.3.P to remove incorrect references. Currently, the rules guide individuals to review the User Reference Guide to determine timeline requirements when transferring a case to another county, as well as processing an eligibility redetermination. The User Reference Guide is no longer used by the Department, and the deletion of the obsolete reference is needed to comply with an audit finding. Other training documents and processing guidance are now in place, and eligibility sites have their cases reviewed for timely processing of applications, redeterminations, and other changes. Additionally, 8.100.3.P.5 indicates that documents received in relation to eligibility redeterminations must be thoroughly reviewed within ten working days. The deletion of this language will not change how eligibility is determined or who would be determined eligible.

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. §435.912

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-4-205, C.R.S. (2017)

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 Rule Concerning Redetermination of Eligibility and Transferring Requirements at 8.100.3
Rule Number: MSB 18-07-13-A
Division / Contact / Phone: Health Information Office / Jennifer VanCleave / 303-866-6204

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.

   This rule change will only delete language that references a document no longer in use by the Department. It does not change eligibility rules or eligibility site processes, so there is no anticipated cost. The benefit will be that our rules will be in compliance with an audit finding.

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

   Because eligibility rules and processes are not affected by this rule change, there are no anticipated costs/impacts. The language must be updated to comply with an audit finding.

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 as the update only removes language referring to an obsolete document.

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

   There are no costs of the proposed rule, though benefits include the Department coming into compliance with audit findings. Not implementing the proposed rule change would mean the Department would remain out of compliance with the audit finding requiring this change.

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 for achieving the purpose of the proposed rule.

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6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There were no alternative methods considered for the proposed rule.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.3.C. Transferring Requirements

1. When a family or individual moves from one county to another within Colorado, the client shall report the change of address to the eligibility site responsible for the current active Medical Assistance Program case(s). If a household applies in the county in which they live and then moves out of that county during the application determination process, the originating eligibility site shall complete the processing of that application before transferring the case. The originating eligibility site shall electronically transfer the case to the new county of residence in CBMS.

2. The originating eligibility site must notify the receiving eligibility site of the client's transfer of Medical Assistance. The originating eligibility site may notify the receiving eligibility site by telephone that a client has moved to the receiving county. If the family or individual wishes to apply for other types of assistance, they shall submit a new application to the receiving eligibility site.

3. If the household is transferring the current Medical Assistance case, the receiving eligibility site cannot mandate a new application, verification, or an office visit to authorize the transfer. The receiving eligibility site can request copies of specific case documents to be forwarded from the originating eligibility site to verify the data contained in CBMS.

4. If the originating eligibility site closes a case for the discontinuation reason of “unable to locate,” the applicant shall reapply at the receiving eligibility site for the Medical Assistance Program.

5. If a case is closed for any other discontinuation reason than “unable to locate” and the client provides appropriate information to overturn the discontinuation with the originating eligibility site, then, upon transfer, the receiving eligibility site shall reopen the case with case comments in CBMS. These actions shall be performed according to timeframes defined by the Department. ~~Please review the Department User Reference Guide for timeframes.~~

6. When a recipient moves from his/her home to a nursing facility in another county or when a recipient moves from one nursing facility to another in a different county:

    a. the initiating eligibility site will transfer the case electronically in the eligibility system to the eligibility site in which the nursing facility is located when the individual is determined eligible; and

    b. The following items shall be furnished by the initiating eligibility site to the new eligibility site in hard copy format:

        i) 5615 that was sent to the nursing facility indicating the case transfer; and

        ii) Identification and citizenship documents; and

        iii) The ULTC 100.2.

7. When transferring a case, the initiating eligibility site will send an AP-5615 form to the nursing facility administrator of the new nursing facility showing the date of case closure and the current patient payment at the time of transfer. Should the Medical Assistance Program reimbursement

be interrupted, the receiving eligibility site will have the responsibility to process the application and back date the Medical Assistance eligibility date to cover the period of ineligibility.

8.100.3.P. Redetermination of Eligibility

1. A redetermination of eligibility shall mean a case review and necessary verification to determine whether the Medical Assistance Program client continues to be eligible to receive Medical Assistance. Beginning as of the case approval date, a redetermination shall be accomplished each 12 months for Title XIX Medical Assistance only cases. An eligibility site may redetermine eligibility through telephone, mail, or electronic means. The use of telephone or electronic redeterminations should be noted in the case record and in CBMS case comments.

2. The eligibility site shall promptly redetermine eligibility when:

   a. it receives and verifies information which indicates a change in a client's circumstances which may affect continued eligibility for Medical Assistance; or

   b. it receives direction to do so from the Department.

   The eligibility site shall redetermine eligibility according to timelines defined by the Department. ~~Please review the Department User Reference Guide for timeframes.~~

3. A redetermination form is not required to be sent to the client if all current eligibility requirements can be verified by reviewing information from another assistance program, verification system, and/or CBMS. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the three months prior to redetermination month, no request shall be made of the client and a notice of the findings of the review will go to the client. If not all verification or information is available, the eligibility site shall only request the additional minimum verification from the client. This procedure is referenced as Ex Parte Review.

4. A redetermination form, approved by the Department, shall be mailed to the person at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed, but the form itself cannot be required to be returned. The only verification that can be required at redetermination is the minimum verification needed to complete a redetermination of eligibility.

   The redetermination form shall direct clients to review current information and to take no action if there are no changes to report in the household. Eligibility sites and CBMS shall view the absence of reported changes from the client at this redetermination period as confirmation that there have been no changes in the household. This procedure is referenced as automatic reenrollment.

   The following procedures relate to mail-out redetermination:

a. A Redetermination Form shall be mailed to the client together with any other forms to be completed;

b. Required verification shall be returned by the client to the eligibility site no later than ten working days after receipt of request;

c. When the individual is unable to complete the forms due to physical, mental or emotional disabilities, or other good cause, and has no one to help him/her, the eligibility site shall either assist the client or refer him/her to a legal or other resource. When initial arrangements or a change in arrangements are being made, an extension of up to thirty days shall be allowed. The action of the eligibility site in assistance or referral shall be recorded in the case record and CBMS case comments.

d. The redetermination form shall require that a recipient and community spouse of a recipient of HCBS, PACE or institutional services disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006 for the total amount of Medical Assistance provided to the individual.

e. The eligibility site shall notify in writing the issuer of any annuity or financial instrument that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of Medical Assistance provided to the individual. This notice shall require the issuer to notify the eligibility site when there is a change in the amount of income or principal that is being withdrawn from the annuity.

5. When the redetermination verification information is received by the eligibility site, it shall be date stamped. Within ten working days, the verification information shall be thoroughly reviewed for completeness, accuracy, and consistency. All factors shall be evaluated as to their effect on eligibility at that time. Verifications shall be documented in the case file and CBMS case comments. The case file shall be used as a checklist in the redetermination process, and shall be used to keep track of matters requiring further action. When additional information is needed:

a. due to incomplete information, the request form shall be mailed back to the client with a letter specifying the items that require completion;

b. due to incomplete, inaccurate or inconsistent data, the Medical Assistance client shall be contacted by telephone or in writing so that the worker may secure the proper information according to timelines defined by the Department. ~~Please review the Department User Reference Guide for timeframes.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Community Clinic and Community Clinic and Emergency Center, Section 8.320
Rule Number: MSB 18-02-09-B
Division / Contact / Phone: Operations Section / 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 18-02-09-B, Revision to the Medical Assistance Rule Concerning Community Clinic and Community Clinic and Emergency Center, Section 8.320
3. This action is an adoption of:	new rules

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

   Sections(s) 8.320, 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).	<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.320 with the proposed text beginning at 8.320 through the end of 8.320.4.A. This rule is effective 11/30/2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Community Clinic and Community Clinic and Emergency Center, Section 8.320
Rule Number: MSB 18-02-09-B
Division / Contact / Phone: Operations Section / 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 rule will add a Community Clinic and Community Clinic and Emergency Center (CC/CCEC) provider type eligible to be reimbursed for services to Health First Colorado clients. CCs and CCECs currently bill under the hospital provider type, however, the CC/CCEC license does not meet the definition of a hospital. In order to cover services from a CC/CCEC, a new provider type is necessary. CC/CCEC facilities are licensed under Colorado Department of Public Health and Environment rule 6 CCR 1011, Chapter IX. By adding this provider type, CC/CCEC facilities must re-enroll with Health First Colorado to be reimbursed for services under a distinct provider identification number. The rule also requires CC/CCEC facilities to be Medicare certified as part of a Medicare participating hospital to be reimbursed for services to Health First Colorado clients.

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 USC 1396a(a)(32)(A) / 42 CFR 447.321

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);

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Title of Rule: Revision to the Medical Assistance Rule Concerning Community Clinic and Community Clinic and Emergency Center, Section 8.320
Rule Number: MSB 18-02-09-B
Division / Contact / Phone: Operations Section / 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.

   Community Clinic and Community Clinic and Emergency Center (CC/CCEC) facility owners will be affected by the proposed rule. CC/CCEC facility owners will bear the cost of enrolling the facilities under a new provider identification number and billing under that number. CC/CCEC facilities will also bear the cost of being Medicare certified as part of a Medicare participating hospital to be reimbursed for services to Health First Colorado clients. By creating a new provider type that allows CC/CCECs to bill Medicaid clients, rather than restricting them from billing Medicaid, the rule preserves client access to care, both for emergency services and for other services available at the locations.

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

   CC/CCEC owners will bear the administrative costs of enrollment and billing under the unique identification number, and of Medicare certification as part of a Medicare participating hospital. The Department will reimburse these new provider types for claims in the same way it reimburses hospitals, so clients will not see additional out-of-pocket bills for services provided at these facilities.

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 must establish a unique CC/CCEC provider type in interChange (the Department's Medicaid Management Information System). There are no additional costs to the Department or any other agency.

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

   The proposed rule will allow providers with this licensure to continue to bill Medicaid and receive reimbursement at the hospital rate, but will allow the Department to identify the types of services provided by CC/CCEC facilities, the utilization patterns of

our members, and other factors unique to these facilities. Prior to distinguishing claims by provider type, the Department was unable to differentiate between the services that originated at a CC/CCEC from those that originated at a parent hospital. Accordingly, inaction would continue to perpetuate these transparency and service location issues.

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

   There are no less costly or less intrusive methods to add a provider type for CC/CCEC facilities.

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.

   Originally, the Department directed the entities with a CC/CCEC license to enroll as a physician office. The entities strongly objected, a physician office does not receive dedicated payment covering facility expenses. The Department agreed to create a provider type that will be able to receive dedicated payment for facility expenses.

8.310.3.C. Non-Covered Services

The following are non-covered services under the Colorado Medicaid Dialysis Center benefit:

1. Personal care items such as slippers or toothbrushes.

8.320 COMMUNITY CLINIC AND COMMUNITY CLINIC AND EMERGENCY CENTER

8.320.1 Definitions

A. Community Clinic (CC) means a health care facility that provides health care services on an ambulatory basis and

is not licensed as an on-campus department or service of a hospital,

is not listed as an off-campus location under a hospital's license,

is not a facility that functions only as an office for the practice of medicine or only for the delivery of primary care services by other licensed or certified practitioners,

is not licensed as an Ambulatory Surgery Center,

is not a federally qualified health center,

is not a rural health clinic,

and is not operated by the Department of Corrections.

B. A Community Clinic and Emergency Center (CCEC) is a Community Clinic that delivers emergency care services.

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

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

E. 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, for which the absence of immediate medical attention could reasonably be expected 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.

F. Observation Stay means a stay in the CC or CCEC 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.

8.320.2 Requirements for Participation

8.320.2.A.

1. The facility is licensed as a CC or CCEC by the Colorado Department of Public Health and Environment (CDPHE) in accordance with CDPHE rule at 6 CCR 1011-1, Chapter IX; and

2. The facility location is Medicare-certified by CMS and owned by a Medicare participating hospital.

8.320.3 Services

8.320.3.A The following services provided by a CC or CCEC are eligible for reimbursement:

1. Outpatient services, as defined in the Department's rule at 10 CCR 2505-10, section 8.300.3.B, section 8.300.B.2, 8.300.B.3; and

2. Observation stays no longer than 24 hours.

8.320.4 Reimbursement

8.320.4.A CC and CCEC services are reimbursed as:

1. Outpatient services, in accordance with the Department's rule at 10 CCR 2505-10, section 8.300.6, using the hospital base rate for the hospital that is identified in the CMS certification of the CC or CCEC.

8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM

The long term care Single Entry Point system consists of Single Entry Point agencies, representing geographic districts throughout the state, for the purpose of enabling persons in need of long term services and supports to access appropriate services and supports.

8.390.1 DEFINITIONS

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Drug Payment Methodology for Outpatient Hospitals, Section 8.300
Rule Number: MSB 18-07-23-B
Division / Contact / Phone: Payment Reform / Andrew Abalos / (303)866-2130

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 18-07-23-B, Revision to the Medical Assistance Rule concerning Drug Payment Methodology for Outpatient Hospitals, Section 8.300
3. This action is an adoption of:	new rules

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

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	8/11/2018
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 8.300.1. Replace the current text at 8.300.6 with the proposed text beginning at 8.300.6.A.3 through the end of 8.300.6.A.3. This rule is effective 11/30/2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Drug Payment Methodology for Outpatient Hospitals, Section 8.300
Rule Number: MSB 18-07-23-B
Division / Contact / Phone: Payment Reform / Andrew Abalos / (303)866-2130

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).

   Currently, the Department reimburses outpatient hospital drugs using the EAPG methodology. However, the EAPG methodology does not adequately account for certain new-to-market specialty drugs, which can result in underpayment to the Department's hospital providers. The proposed rule update will allow for certain specialty drugs to be reimbursed at rates in greater alignment with hospital cost experience and maintain existing levels of access to care. The proposed changes will be effective August 11, 2018.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   The existing payment methodology is placing financial strain on hospitals, which is in turn affecting how hospitals are providing care to Health First Colorado's Medicaid members

3. Federal authority for the Rule, if any:

   2 U.S.C. 1396a(a)(30)(A); 42 C.F.R. 447.321

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   24-4-103(6), C.R.S., (2018), 25.5-4-401, C.R.S (2018);

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

DOCUMENT #

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Title of Rule: Revision to the Medical Assistance Rule concerning Drug Payment Methodology for Outpatient Hospitals, Section 8.300
Rule Number: MSB 18-07-23-B
Division / Contact / Phone: Payment Reform / Andrew Abalos / (303)866-2130

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 providing certain new-to-market specialty drugs to Medicaid members in an outpatient setting will receive reimbursement in greater alignment with their costs. The Department will bear the costs of 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.

   The annual aggregate increase in outpatient hospital expenditures (including state funds and federal funds) is $8,564,768 in FFY 2018-19 and $21,346,040 in FFY 2019-20.

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 annual aggregate increase in outpatient hospital expenditures (including state funds and federal funds) is $8,564,768 in FFY 2018-19 and $21,346,040 in FFY 2019-20.

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

   Inaction would preserve the state's current forecasted expenditure, but this would have the consequence of driving hospital behavior to reduce access to care with certain specialty drugs delivered in an outpatient hospital setting for Medicaid members.

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

   The Department determined that this was the least costly and least intrusive method for achieving the purpose of the proposed rule through discussions with hospital providers.

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6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department considered updating the EAPG software to a new version which would include the costs of some specialty drugs which have entered the market after 7/1/2014, but this was rejected as the EAPG methodology depends on historical cost data to determine pricing, and therefore could not incorporate the costs of all specialty drugs released after that date. Additionally, the time required to implement a new version of the EAPG software would not mitigate the concerns around access to care in the interim.

8.300 HOSPITAL SERVICES

8.300.1 Definitions

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

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.

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

Department means the Department of Health Care Policy and Financing.

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.

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, Rehabilitation Hospitals, and Long-Term Care Hospitals.

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.

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

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, for which the absence of immediate medical attention could reasonably be expected 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.

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.

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:

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.

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.

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.

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.

A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital. In general, Long-Term Care Hospitals have an average length of stay of greater than twenty-five (25) days.

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.

Inpatient 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.

Inpatient Hospital Services means 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.

Medical Necessity is defined at Section 8.076.1..

Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals are considered Non-DRG Hospitals since their reimbursement is based on a per diem rate.

Observation Stay means 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.

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

Outpatient means a 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-a-day basis.

Outpatient Hospital Services means 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.

Outpatient Hospital Specialty Drug means a drug identified on the carve-out drug list as found on the Colorado Department of Health Care Policy & Financing's web page.

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

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.

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.

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.

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

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.

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."

Trim Point Day (Outlier Threshold Day) means the day which would occur 2.58 standard deviations above the mean (average) length of stay (ALOS) for each DRG.

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

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.

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

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

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

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

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

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

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

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

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

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

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

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

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

    (1) Per Diem

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

        (a) General Significant Procedures

        (b) Physical Therapy and Rehabilitation

        (c) Mental Health and Counseling

        (d) Dental Procedure

        (e) Radiologic Procedure

        (f) Diagnostic Significant Procedure

    (3) Medical Visit

(4) Ancillary

(5) Incidental

(6) Drug

(7) Durable Medical Equipment

(8) Unassigned

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

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

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

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

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

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

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

k. The Hospital-specific Medicaid Outpatient base rate for the year of the methodology implementation for each hospital is calculated using the following method.

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

(a) Pediatric Hospitals

(b) Urban Hospitals

(c) Rural Hospitals

(2) Process Medicaid outpatient hospital claims from state fiscal year 2015, known as the Base Year, through the methodology described in 8.300.6.A.1.a-j using Colorado's EAPG Relative Weights. For lines with incomplete data, estimations of EAPG Adjusted Weights will be used.

(3) Calculate costs from hospital charge data using the computation of the ratio of costs to charges from the CMS-2552-10 Cost Report. After the application of inflation factors to account for the difference in cost and caseload from state fiscal year 2015 to the implementation period, costs and EAPG Adjusted Weights are aggregated by peer group and are used to form peer group base rates. Each hospital is assigned the peer group base rate depending on their respective peer group assigned in 8.300.6.A.1.k.(1).

(4) For each hospital, calculate the projected EAPG payment by multiplying its peer group base rate by its hospital-specific EAPG Adjusted Weights as calculated in 8.300.6.A.1.k.(2). If the projected payment exceeds a +/- 10% difference in payment from the prior outpatient hospital reimbursement methodology, the hospital will receive an adjustment to their base rate to cap its resulting gains or losses in projected EAPG payments to 10%.

(5) For all hospitals, the Medicaid Outpatient base rate, as determined in 8.300.6.A.k.(1)-(4), shall be adjusted by an equal percentage, when required due to changes in the available funds appropriated by the General Assembly. The application of this change to the Medicaid Outpatient base rate shall be determined by the Department.

2. Payments to Out-of-Network DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional

reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

Effective October 31, 2016, Out-of-Network DRG Hospitals will be reimbursed for Outpatient Hospital Services based the system of Enhanced Ambulatory Patient Grouping described in 10 CCR 2505-10 Section 8.300.6.A.1. Such hospitals will be assigned to a Rural or Urban peer group depending on hospital location and will receive a base rate of 90% of the respective peer group base rate as calculated in 8.300.6.A.1.k.(3). Out-of-Network DRG Hospitals will periodically have their Medicaid Outpatient base rates adjusted as determined in 8.300.6.A.k.(5).~~,~~

3. Payments for Outpatient Hospital Specialty Drugs

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