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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 23-0042

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

March 26, 2024

Adela Flores-Brennan
State Medicaid Director
Colorado Department of Health Care
Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Re: Colorado 23-0042

Dear Adela Flores-Brennan:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 23-0042. Effective for dates of services on or after January 1, 2024, this amendment updates the pricing methodology for hospital services utilizing certain specialty drugs delivered in the inpatient hospital setting.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 23-0042 is approved effective January 1, 2024. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at Christine.storey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0042

2. STATE: CO

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act, Section 1905(a)(1) / 42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 24,239,678
b. FFY 2025 $ 54,482,203

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A -- Pages 4-4b, 4c (NEW)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A -- Pages 4-4b (TN 23-0003)

9. SUBJECT OF AMENDMENT
Updates the pricing methodology for hospital services utilizing certain specialty drugs delivered in the inpatient hospital setting, paying a percentage of net invoice cost or full invoice cost, depending on the drug.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
Governor's letter dated
5 April 2023

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Bettina Schneider

13. TITLE
Chief Financial Officer

14. DATE SUBMITTED
January 2, 2024

15. RETURN TO
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Alex Lyons

FOR CMS USE ONLY

16. DATE RECEIVED: January 2, 2024

17. DATE APPROVED
March 26, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2024

19. SIGNATURE OF APPROVING OFFICIA [redacted]

20. TYPED NAME OF APPROVING OFFICIAL: Rory Howe

21. TITLE OF APPROVING OFFICIAL: Director, Financial Management Group

22. REMARKS

Indirect Medical Education (IME) / Value Based Purchasing Adjustment (VBP) Factor / Readmission Adjustment Factor and Hospital Acquired Conditions (HAC) Reduction:

1. For PPS hospitals, Operating IME% will be multiplied by Adjusted Operating Federal Portion and the Capital IME% will be multiplied by the Adjusted Federal Capital Rate. The VBP Adjustment Factor and Readmission Adjustment Factor taken from CMS Final Rule Correcting Amendment Tables 16B and 15 respectively will be multiplied by the Adjusted Operating Federal Portion. The Hospital Acquired Conditions Reduction taken from the most recent CMS.gov Data Set as of January 1 will be applied against the Medicare Federal Base Rate with Wage Index/GAF Adjustments.
2. For non-PPS hospitals, Operating & Capital IME % are not calculated in the CMS corrected IMPACT File so the Department's Contractor will compute their Operating and Capital IME using the most recently available cost report as of January 1 in rebasing years and will require that hospitals have a CMS approved teaching program as detailed below in paragraphs 8.e.1-2. The VBP Adjustment Factor, Readmission Adjustment Factor and HAC Reduction will not be applied to non-PPS hospitals since they are not calculated by CMS. The result of this calculation in rebasing years will be posted for hospital stakeholder review to be used as input into the rate model in rebasing years and can be found on the Department website located at https://hcpf.colorado.gov/inpatient-hospital-payment.

Effective January 1, 2024, for services meeting the criteria of selected Inpatient Hospital Physician Administered Drugs, as defined by the list of drugs included in the Colorado Department of Health Care Policy and Financing's billing manual accessed through the Department's web site, that would have otherwise been compensated through the DRG methodology, a hospital must submit a request for authorization to the Department prior to administration of the drug. If the request is approved and the drug is administered to the patient, then the hospital must submit an invoice showing the actual acquisition cost of the drug before payment will be rendered by the Department. The Department will pay the provider 97% of the net invoice cost. If a pediatric drug or therapy requires a treatment center to be certified or qualified by a drug manufacturer in order to administer the specialty drug and there is only one certified or qualified pediatric treatment center in Colorado, then the Department will pay the hospital 100% of net invoice cost.

c. Mutually Exclusive Medicaid Add-ons:

Four Add-ons will be mutually exclusive and applied as a percentage against the Medicare Federal Base Rate w/Wage Index/GAF Adjustments as detailed below.

1. Critical Access Hospital (CAH) Add-on will be set at 25% and is only open to those hospitals categorized as CAH by Medicare,
2. Sole Community Hospital (SCH)/Medicare Dependent Hospital (MDH) will be set

at 20% and is only open those hospitals categorized as SCH/MDH by Medicare,

3. Low Discharge Add-on based on the average of up to three years of Total Discharges of most recently available full-year cost reports on Healthcare Cost Reporting Information System (HCRIS) as of January 1 of rebasing years and excludes hospitals that are classified as Pediatric, SCH/MDH or CAH.
4. The Pediatric Add-on is open only to hospitals defined as a Pediatric by Medicare and the percentage add-on is set at 25%.

d. Remaining Medicaid Add-ons:

The remaining add-ons are open to all hospitals who qualify and are applied as a percentage of the Medicare Federal Base Rate with Wage Index/GAF Adjustments and distributed on a sliding scale.

1. Payer Mix Add-on is based on the percentage of Medicaid patient days treated at the hospital using up to three years of the most recently available full-year cost reports. The add-on is set at up to 10%.
2. Operating Cash Flow Margin Percent Add-on (also known as the solvency metric) is set at 20%. The source for this data is up to 3 years of Hospital Transparency Data that is generated by each hospital and sent into the Department. The Operating Cash Flow Margin Percent Add-on is calculated for all hospitals and is based on the maximum of the hospital or the hospital system's operating cash flow margin percent. System hospital list can be found on the Department's website. Operating Cash Flow Margin Percent is calculated by taking (Total Operating Net Income + Depreciation Expense) / Total Operating Revenue.

e. Application of Graduate Medical Education (GME) Cost Add-on to Determine Medicaid Inpatient Base Rate:

The Medicaid Inpatient base rate shall be equal to the rate as calculated in Section 4.19A.8.a - d plus the GME Medicaid hospital-specific cost add-on. The GME Medicaid hospital-specific cost add-on is calculated from the most recently available Medicare/Medicaid cost report (CMS 2552) worksheet B, Part I. Partial year cost reports shall not be used to calculate the GME cost add-on. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals.

State University Teaching Hospitals shall receive reimbursement for GME costs as follows. Effective May 23, 2008, the Graduate Medical Education add-on will not be applied directly to the Medicaid inpatient base rate for Denver Health Medical Center and University of Colorado Hospital. These hospitals will receive reimbursement for Graduate Medical Education costs through a direct payment as they qualify to receive a State University Teaching Hospital payment as specified under this Attachment 4.19A. The State University Teaching Hospital payment is a fixed amount subject to annual appropriation by the Colorado General Assembly.

The GME Medicaid hospital-specific cost add-on shall be an estimate of the cost per discharge for

GME based on: Medicare approved GME program where legitimate GME expenses have been reported in accordance with Medicare's rules detailed in 42 C.F.R. § 413.75, et. seq. Ten percent of the GME Medicaid hospital-specific cost add-on shall be applied when the following two criteria are met:

1. Hospitals that appear on the most recent list as of January 1 of CMS qualified teaching hospitals on the CMS Open Payments website or the hospital will need to provide documentation to the State by proving Medicare approval of the GME program.
2. Have countable GME costs in the most recent cost report available as of January 1 of rebasing years in worksheet B, part 1 and discharges from worksheet S-3, part I.

The results of the GME calculation will be posted to the Department website for hospital stakeholder review to be used as input into the rate model in rebasing years and can be found at this link: https://hcpf.colorado.gov/inpatient-hospital-payment.

f. Application of Adjustment Based on General Assembly Funding

In rebasing years, for all in-state, Colorado DRG Hospitals (both PPS and non-PPS), the starting point for the Medicaid Inpatient base rate, as determined in Section 4.19A.8.a - e, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Additionally, a 10% corridor has been implemented to prevent any hospital's inpatient base rate from increasing or decreasing more than 10% each rebasing year.

g. Annual Adjustments

Rebasing years are every other odd year starting in state fiscal year 2023-24. Non-rebasing years are every other even year starting in state fiscal year 2024-25. The Medicaid Inpatient base rates are rebased every other year as described in Section 4.19A.8.a - f and are effective each July 1. In non-rebasing years, the Medicaid Inpatient base rates will be adjusted by the State Budget Action as set by Legislature and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department and/or adjustments necessary to balance the DRG payment equation.

Any changes to the rate setting methodology will be approved by the Medical Services Board and the Centers for Medicare and Medicaid Services prior to implementation. Once funds and rate setting methodology have been established, rates will be posted to the Department website at https://hcpf.colorado.gov/inpatient-hospital-payment.

Posted rates will document the Medicaid base rate and other relevant figures for the specific providers so that providers may understand and independently calculate their payment. Posted rates allow providers to dispute the payment on the basis that payment was not calculated correctly given the established funds and rate setting methodology.

9. Effective for inpatient hospital claims with discharge dates on or after October 1, 2009, Serious

Reportable Events will not be used for Colorado Medicaid DRG assignment when the condition was not present on admission. When applicable, reimbursement to a hospital will be adjusted automatically or via retrospective reviews.