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State/Territory Name: CO

State Plan Amendment (SPA) CO: 23-0020

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

July 24, 2023

Bettina Schneider, Chief Financial Officer
Attn: Alex Lyons
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

RE: **Colorado State Plan Amendment (SPA) Transmittal Number 23-0020**

Dear Ms. Schneider:

We have reviewed the proposed Colorado State Plan Amendment (SPA) to Attachment 4.19-B of your state plan, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 05, 2023. This plan amendment establishes a 3.0% rate increase for outpatient hospital services per state budget bill.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 01, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact LaJoshica (Josh) Smith via 214-767-6453 or lajoshica.smith@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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: 23-0020

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
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
SSA Section 1905(a)(2); 42 CFR 440.20, 42 CFR 447.321

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 1,093,586
b. FFY 2024 $ 4,556,757

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B: Methods and Standards for Establishing Payment Rates – Other Types of Care – 2a. Outpatient Hospital Services (Page 2 of 8)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B: Methods and Standards for Establishing Payment Rates – Other Types of Care – 2a. Outpatient Hospital Services (Page 2 of 8) (TN 22-0020)

9. SUBJECT OF AMENDMENT
3.0% rate increase for outpatient hospital services per state budget bill, effective July 1, 2023.

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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Bettina Schneider

13. TITLE
Chief Financial Officer

14. DATE SUBMITTED

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
06/05/2023

17. DATE APPROVED
July 24, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
07/01/2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Instructions on Back

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

2a. OUTPATIENT HOSPITAL SERVICES (continued)

4. For Critical Access Hospitals, a weighted average base rate by outpatient hospital visits is calculated. EAPG payments for Critical Access Hospitals under both versions of EAPGs are calculated using this weighted average base rate, then an inflation factor is applied to determine a revenue neutral rate for the Critical Access Hospital group. This inflation factor is then applied to all Critical Access Hospital rates that were in effect prior to January 1, 2022. For all other hospitals, with the exception of Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, a revenue neutral rate is calculated which aligns payment under version 3.16 of EAPGs to payments calculated under version 3.10.
5. For Critical Access Hospitals with a rate above 2 standard deviations of the average of their group is given a rate at 2 standard deviations above the average of their group. For each other hospital group, except Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, the average and standard deviation of their rates are calculated. For hospitals that have a rate below 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations below the group's average rate. For hospitals that have a rate above 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations above the group's average rate.
6. Each newly enrolled In-State hospital is assigned to a Pediatric, Long-Term Acute Care, or Rehabilitation peer group depending on hospital type as validated through the hospital's CMS Certification Number. If the hospital is not any of these types, then the hospital will be assigned to a rural or urban grouping based on location. The hospital will be assigned a base rate of the average peer group rate based on hospital-type. If the hospital cannot be assigned a base rate due to its type, then it will be assigned a base rate of the average peer group rate based on location.
    a. Effective September 1, 2022, out of state hospitals will be assigned a base rate that is 90% of the peer group average rate. Such hospitals will have their peer groups assigned based on the same logic as Section 6.
7. Effective July 1, 2022, all hospital-rates as calculated in sections 1-6 of this subsection will be increased by 2.0%.
8. Effective July 1, 2023, all hospital-rates as calculated in sections 1-7 of this subsection will be increased by 3.0%.
9. Effective June 1, 2020, by the modification of the EAPG Weights, the allowed reimbursement of outpatient hospital drugs shall be increased by 42.93% for drugs provided in Critical Access Hospitals and Medicare Dependent Hospitals and decreased by 3.47% for drugs provided at non-independent urban hospitals.

iii. Uses the EAPG software to assign line items to EAPGs. EAPGs can have the following types:

1. Per Diem
2. Significant Procedure. Subtypes of Significant Procedures are:
    a. General Significant Procedures
    b. Physical Therapy and Rehabilitation
    c. Behavioral Health and Counseling
    d. Dental Procedure
    e. Radiologic Procedure

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE
2a. OUTPATIENT HOSPITAL SERVICES (continued)

f. Diagnostic or Therapeutic Significant Procedure
3. Medical Visit
4. Ancillary
5. Incidental
6. Drug
7. Durable Medical Equipment
8. Unassigned

iv. Uses the EAPG software to determine when payment for a line assigned a Significant Procedure EAPG type should be consolidated. A consolidated payment will be calculated using an EAPG Adjusted Relative Weight of 0. Payment may not be consolidated when a procedure or service is distinct or independent from other services performed on the same day. Otherwise, a payment is consolidated when:

1. The same Significant Procedure EAPG is present on another line for that visit, or

2. The procedure is determined to be clinically similar to another EAPG present for that visit on the claim.

v. Uses the EAPG software to determine when payment should be packaged. A packaged payment will be calculated using an EAPG Adjusted Relative Weight of 0. A payment for a line is packaged when:

0. The assigned EAPG is considered an ancillary service to a Significant Procedure or Medical Visit EAPG present on the claim for that visit and its cost is included into the EAPG Relative Weight, except for instances of additional undifferentiated medical visits/services present on the claim, or

1. The assigned EAPG is a Medical Visit and is present with a General Significant Procedure EAPG.

vi. Uses the EAPG software to calculate the following discounts for any non-packaged or non-consolidated payments. The types of discounting and percentages are as follows:

1. Multiple Surgery / Significant Procedure - 100%, 50%, then 25%

a. For Multiple Significant Procedures of the same subtype on the same visit:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE
2a. OUTPATIENT HOSPITAL SERVICES (continued)

i. Payment for a line assigned the Significant Procedure EAPG of that subtype with the highest EAPG Relative Weight will be calculated using an EAPG Adjusted Relative Weight of 100% of that EAPG's Relative Weight.

ii. Payment for a line assigned the Significant Procedure EAPG of that subtype with the next highest EAPG Relative Weight will be calculated using an EAPG Adjusted Relative Weight of 50% of that EAPG Relative Weight.

iii. Payment for all remaining lines assigned Significant Procedure EAPGs of that subtype will be calculated using an EAPG Adjusted Relative Weight of 25% of that EAPG's Relative Weight.

2. Bilateral Pricing - 150%

a. Payments for lines describing bilateral services may be calculated using an EAPG Adjusted Relative Weight of 150% of that EAPG Relative Weight or EAPG Adjusted Relative Weight calculated by discounting. Bilateral discounting occurs after Multiple Significant Procedure Discounting.

3. Repeat Ancillary Procedures - 50%, then 25%

a. For multiple lines assigned the same ancillary procedure EAPGs on a visit on a claim:

i. Payment for the first occurrence will be calculated using an EAPG Adjusted Relative Weight of 100% of the EAPG Relative Weight.

ii. Payment for the second occurrence will be calculated using an EAPG Adjusted Weight of 50% of the EAPG Relative Weight.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

2a. OUTPATIENT HOSPITAL SERVICES (continued)

iii. Payment for all remaining occurrences will be calculated using an EAPG Adjusted Relative Weight of 25% of the EAPG Relative Weight.

4. Terminated Procedures - 50%

a. Payment for lines describing terminated procedures may be calculated using an EAPG Adjusted Relative Weight of 50% of that EAPG's Relative Weight. Terminated procedures cannot be considered bilateral procedures for the purpose of discounting. Terminated procedures are not subject to other types of discounting.

5. 340B Drug Discounting - 80%

a. Payment for lines describing 340B drugs may be calculated using an EAPG Adjusted Relative Weight of 80% of that EAPG's Relative Weight.

ii. Uses the EAPG software to determine if multiple visits are present on the claim. Visits are differentiated based on the date of service of each line item. Claims with revenue codes describing emergency room or specialty services may be considered single visits.

b. Outpatient physical therapy services shall be reimbursed under the EAPG methodology.

c. Outpatient occupational therapy services shall be reimbursed under the EAPG methodology.

d. Outpatient speech/language therapy services shall be reimbursed under the EAPG methodology.

e. Outpatient laboratory/pathology services shall be reimbursed under the EAPG methodology.

f. Outpatient radiology services shall be reimbursed under the EAPG methodology.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE
2a. OUTPATIENT HOSPITAL SERVICES (continued)

g. Outpatient nuclear medicine/computerized tomography scans shall be reimbursed under the EAPG methodology.

h. Any service not listed here is reimbursed under the existing state plan methodology elsewhere in this section.

2. Effective August 11, 2018, for services meeting the criteria of selected Outpatient 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 EAPGE 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 72% of the net invoice cost.

3-6. These sections are reserved for future use.