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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 24-0011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

October 9, 2024

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

RE: TN 24-0011

Dear Adela Flores-Brennan:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Colorado state plan amendment (SPA) to Attachment 4.19-A, CO 24-0011, which was submitted to CMS on August 12, 2024. This plan amendment updates the plan by making adjustments to the All Patient Refined-Diagnosis Related Group (APR-DRG) to align with Version 40.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 and 1923 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of October 1, 2024. 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 Christine Storey at Christine.storey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

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: 24-0011

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
October 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act, Section 1905(a)(1) / 42 CFR 447.253

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 0
b. FFY 2025 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19A -- Methods and Standards for Establishing Prospective Payment Rates-Inpatient Hospital Services -- Pages 1-2, 5-6

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19A -- Methods and Standards for Establishing Prospective Payment Rates-Inpatient Hospital Services -- Pages 1-2, 5-6 (TN# 04-007, 18-0038)

9. SUBJECT OF AMENDMENT
Adjusts the All Patient Refined-Diagnosis Related Group (APR-DRG) to align with the Version 40 and future updates as it changes with new medical technology and how hospitals assign resources within their hospitals.

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
August 12, 2024

15. RETURN TO
Colorado Department of Health Care Policy and Financing
303 E. 17th Avenue, Suite 1100
Denver, CO 80203

Attn: Alex Lyons

FOR CMS USE ONLY

16. DATE RECEIVED: August 12, 2024

17. DATE APPROVED
October 9, 2024

PLAN APPROVED - ONE COPY ATTACHED

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

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL: Rory Howe

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

22. REMARKS

Instructions on Back

I. Methods and Standards for Establishing Prospective Payment Rates - Inpatient Hospital Services

A. Payment Methods for Hospitals

Effective December 15, 1989 (unless otherwise specified in this plan) the following prospective. payment method shall apply to all Colorado participating hospitals except those specialty hospitals and units within general acute care hospitals designated by the State agency as exempt.

B. Definitions

1. 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.

2. Principal Diagnosis: The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

3. Relative Weight: Refers to the DRG weight, which represents a numerical value that reflects the relative resource consumption for the DRG 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. Relative weights are intended to be cost effective, and based upon national data, as available.

   Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight.

4. Hospital Peer Groups: A grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. The peer groups are defined as follows:

   a. Pediatric Specialty Hospitals: all hospitals providing care exclusively to pediatric populations.

   b. Rehabilitation Hospitals: hospitals providing rehabilitation (excluding distinct part units and satellite locations).

   c. Specialty-Acute Hospitals: hospitals providing specialty-acute care (excluding distinct part units and satellite locations).

   d. Spine/Brain Injury Treatment Specialty Hospital: hospitals providing specialty-acute care and/or rehabilitation care specializing in treatment of a current spine and/or brain injury

   e. Rural Hospitals: Colorado Hospitals not located within a federally designated Metropolitan Statistical Area (MSA).

   f. Urban Hospitals: all Colorado hospitals in MSA's including those in the Denver MSA. Also included would be the Rural Referral Centers in Colorado, as defined by HCFA. (SSAS, 1886 (d) (5) (c) (I); Reg. 412.90 (c) and 412.96).

   Facilities which do not fall into the peer groups described in a. through d. will default to the peer groups described in e. and f. based on geographic location.

5. Medicare Base Rate: The hospital specific Medicare base rate is not utilized by the Inpatient Hospital Base Rate.

6. Disproportionate Share Hospital (DSH) factors: These factors are specific payments made by Medicare to Disproportionate Share Hospitals within the Medicare base rate. The operating and capital Disproportionate Share Hospital factors will be obtained from the Medicare Intermediaries. The operating Disproportionate Share Hospital factor is multiplied by the federal portion of the operating subtotal to get the operating Disproportionate Share Hospital amount. The capital Disproportionate Share Hospital factor is multiplied by the capital portion of the federal payment to get the capital Disproportionate Share Hospital amount.

10. Outlier Days: The days in a hospital stay which occur after the trim point. The trim point is that day which would occur at 1.94. standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996, the number of standard deviations may be adjusted when changes are made to the DRG grouper methodology. For periods beginning on or after July 1, 2024, the Trim Point Day for all DRGs is equal to the Trim Point Day as calculated in the applicable DRG version data sources effective during the last day of the inpatient hospitalization. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by the DRG average length of stay.

C. DRG Method of Payment

1. The DRG will be assigned to an inpatient claim on the basis of the principal diagnosis for which the patient was treated, surgical procedures involved, and complication of the illness. Every DRG has been assigned a relative weight and trim point,. based primarily on Colorado-specific cost data. The State Agency shall periodically rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG.

2. The DRG relative weight will be multiplied by the base rate for the hospital to generate the payment amount.

3. When outlier days occur, 80% of the DRG per diem will be paid for each additional outlier day. The DRG per diem is the total DRG base payment divided by the average length of stay. The percentage will be determined by the State Agency.

4. All State-operated facilities will be exempt from the DRG-based prospective payment . system.

5. Abbreviated patient stays will be paid as follows:

   a. The hospital will receive the full DRG payment for all patient deaths and cases in which the patient left against medical advice.

b. In cases involving transfers, each hospital involved will be paid a DRG per diem for each covered day based upon the full DRG base payment divided by the average length of stay for the DRG (up to a maximum of one full DRG payment.) These discharges may also qualify for outlier payment.

c. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's medical needs are best met at another PPS facility. Documented emergency cases are exempt from prior authorization.

D. Adjustments To The Payment Formula

1. Adjustments to the DRG classification system, weights, and trim points will be made when appropriate.

2. In order to continue to meet the Federal Boren Amendment requirements, the information used to calculate each prospective payment system (PPS) facility's cost per discharge will be updated. The following rebasing and payment protocol for payments is established:

a. Effective September 19, 1990, the base rate for each facility shall be calculated based upon the most recently audited cost report available for each facility (as of 12/31/87). Changes made to audited cost reports after the rebasing calculations will not constitute the basis for a provider appeal. For the time period between July 1, 1990 and September 18, 1990, those hospital whose base rate increased by 7% or less. as a result of the implementation of State Plan Amendment 90-02, should be assured a rate increase of at least 7% (not to exceed their FY 91 payment rate) during this 80 day period (July 1, 1990 to September 18, 1990).

b. Beginning July, 1991, an annual inflater shall be applied to each facility's cost per discharge. This annual inflater shall be derived as follows:

i. The HCFA Hospital Market Basket Index for the most recent year (in this case FY 1990-91) shall be used as the basis for the inflator.