DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-91

CONCERNING THE METHODOLOGY FOR CALCULATING REIMBURSEMENT RATES TO SUPPORT PREMIUM RATE REDUCTIONS FOR COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-109, 10-16-1306, and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish a hospital and health-care provider reimbursement rate setting methodology for the Colorado Option premium rate reduction requirements on standardized health benefits plans.

Section 3 Applicability

This regulation applies to contracted reimbursement rates for standardized plans between carriers and hospitals or health-care providers in Colorado.

Section 4 Definitions

A. "Adjusted Discharges" shall mean, for the purposes of this regulation, a measure of the overall volume of services provided by a hospital inpatient and outpatient departments. Adjusted discharges are calculated as

(Total Revenue/Total Inpatient Revenue) * Inpatient Discharges

Where Total Revenue is found in Worksheet G-2, Column 3, Line 28 of 2552-10 Medicare Cost Reports; Total Inpatient Revenue is found in Worksheet G-2, Column 1, Line 28 of 2552-10 Medicare Cost Reports; Inpatient Discharges are found in Worksheet S-3 Part 1, Column 15, Lines 14 and 16 through 18 in 2552-10 Medicare Cost Reports.

B. “All-Payer Health Claims Database” or “APCD” shall have the same meaning as found at § 25.5-1-204.7(1)(b), C.R.S.

C. “Aggregate Medicare Reimbursement Rate” shall mean, for the purposes of this regulation, the average of Medicare Reimbursement Rates, outlined in Section 4.X, for all services, as a percentage of Medicare, weighted by utilization in the plan.

D. “Aggregate Negotiated Rate” shall mean, for the purposes of this regulation, the average of negotiated reimbursement rates for all services, weighted by the utilization in the plan as a percentage of the Aggregate Medicare Reimbursement Rate.

E. “Applicable plan year” shall mean, for the purposes of this regulation, the plan year for which the carrier is filing a notification on March 1 regarding compliance with Premium Rate Reduction Requirements or network adequacy requirements.

F. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

G. “Colorado Option Standardized Plan” or “Standardized Plan” shall have the same meaning as found at § 10-16-1303(14), C.R.S.

H. “Critical Access Hospital” shall have the same meaning as found at § 10-16-1303(2), C.R.S.

I. “Equivalent Rate” shall have the same meaning as found at § 10-16-1303(3), C.R.S.

J. “Essential Access Hospital” shall have the same meaning as found at § 10-16-1303(4), C.R.S.

K. “Hospital” shall have the same meaning as found at § 10-16-1303(6), C.R.S.

L. “Health-Care Provider” shall have the same meaning as found at § 10-16-1303(8), C.R.S.

M. “Health-Care Provider Reimbursement Floor” shall mean, for the purposes of this regulation, the lowest reimbursement rate, as an aggregate percent of the Medicare Reimbursement Rate, the Commissioner may set for a specific health-care provider.

N. “Health System” shall have the same meaning as found at § 10-16-1303(9), C.R.S.

O. “Hospital Medicare/Medicaid Payer Mix” shall mean, for the purposes of this regulation, the proportion of total charges represented in the Medicare Cost Report in the previous three years that were for Medicaid or Medicare patients. An average of the hospital’s three most recent Medicare Cost Reports will be used as of each October prior to the year in which a public hearing may be held. If an included hospital does not have this information reported, inpatient bed days or a payer mix from the APCD will be used.

P. “Hospital Net Income” shall mean, for the purposes of this regulation, the excess or net patient revenue and other income over total operating and other expenses. Net Income is found in Worksheet G-3, Column 1, Line 29 in 2552-20 Medicare Cost Reports. The hospital’s three most recent Medicare Cost Reports will be used as of each October prior to the year in which a public hearing may be held.

Q. “Hospital Net Patient Revenue” shall mean, for the purposes of this regulation, the revenue from providing services to patients and is found in Worksheet G-3, Column 1, Line 3 from Medicare Cost Reports 2552-10. An average of the hospital’s three most recent Medicare Cost Reports will be used as of each October prior to the year in which a public hearing may be held.

R. “Hospital Operating Expenses” shall mean, for the purposes of this regulation, the total cost associated with hospital-related services and patient care, which is Operating Expenses for Reimbursable Departments plus Reasonable Compensation Equivalent disallowance. Operating Expenses for Reimbursable Departments are found in Worksheet B Part I, Column 26, Line 118 of 2552-10 Medicare Cost Reports. An average of the hospital’s three most recent Medicare Cost Reports will be used as of each October prior to the year in which a public hearing may be held.

S. “Hospital Reimbursement Floor” shall mean for the purposes of this regulation, the lowest reimbursement rate, as an aggregate percent of the Medicare Reimbursement Rate, the Commissioner may set for a specific hospital. This floor will be calculated as outlined in § 10-16-1306, C.R.S., and detailed in Section 5 of this regulation below.

T. “Independent Hospital” shall mean, for the purposes of this regulation, any hospital that is not a part of a larger health system with more than two hospitals as of January 1 of the applicable plan year.

U. “Low Volume Medicare Services” shall mean, for the purposes of this regulation, any service that is low volume statewide relative to other Medicare services.

V. “Medicare fee schedule” shall mean, for the purposes of this regulation, a complete listing of fees used by the Centers for Medicare & Medicaid Services to pay doctors or other providers and suppliers under the Medicare program.

W. “Medicare Inpatient and Outpatient Prospective Payment Systems” shall mean, for the purposes of this regulation, a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount for a particular inpatient or outpatient service based on a classification system of that service.

X. “Medicare Reimbursement Rate” shall have the same meaning as found at § 10-16-1303(11) and § 10-16-1303(3), C.R.S. Specifically:

1. For hospitals that Medicare reimburses under its Hospital Inpatient Prospective Payment System (IPPS) and the Hospital Outpatient Prospective Payment System (OPPS), the Medicare Reimbursement Rate will be based on the applicable Prospective Payment System fee schedule effective as of each October prior to the year in which a public hearing may be held.

2. Long-term Care, Psychiatric, and Rehabilitation Hospitals’ Medicare Reimbursement Rates will be determined using the appropriate Medicare Prospective Payment System rates for each hospital effective as of each October prior to the year in which a public hearing may be held.

3. For Critical Access Hospitals, the Medicare Reimbursement Rate will be 101 percent of allowable costs, as determined using the cost-to-charge ratio, for hospital based services as reported in an average of the hospital’s three most recent Medicare Cost Reports as of each October prior to the year in which a public hearing may be held. The Division may also consider additional information provided by a Critical Access Hospital to determine if further adjustments are required, such as, but not limited to, unreimbursed cost items.

4. For Pediatric Hospitals, as detailed in § 10-16-1303(3), C.R.S., the Medicare Reimbursement Rate shall be calculated using the Medicaid fee schedule effective as of each October prior to the year in which a public hearing may be held multiplied by 1.52, adjusted annually for cumulative inflation by a factor equal to the average percentage increase of the Medicare Inpatient and Outpatient Prospective Payment Systems over the previous three years.

5. For Health-care providers, the Medicare Reimbursement Rate shall equal the payment rates for the appropriate Medicare fee schedule for the provider type or service effective as of October prior to the year in which a public hearing will be held.

6. For any health-care service without an existing Medicare Reimbursement Rate and for any Low Volume Medicare Services an equivalent rate will be determined utilizing the ratio of Medicaid Payment Rates to existing Medicare Payment Rates, whenever possible.

7. For Sole Community Hospitals, the Medicare Reimbursement Rate will be the higher of the Prospective Payment Rate outlined in U.1 above or the Sole Community Hospital Rate outlined in 42 C.F.R. §§ 412.92(d)(1) and (2).

Y. "Negotiated Rate" shall mean, for the purposes of this regulation, the reimbursement rate, as a percent of Medicare, agreed upon between the carrier and hospital or health-care provider for a given plan year.

Z. "Pediatric Hospital" shall mean, for the purposes of this regulation, a hospital that is part of a pediatric specialty hospital system where over ninety (90) percent of the hospital's population is under eighteen (18) years of age and that has a Level One Pediatric Trauma Center.

AA. "Premium" shall have the same meaning as found at § 10-16-102(51), C.R.S.

AB. "Premium Rate Reduction Requirements" shall mean the rates set forth in § 10-16-1305, C.R.S., and calculated pursuant to Colorado Insurance Regulation 4-2-85.

AC. "Sole Community Hospital" shall have the same meaning as found at 42 C.F.R. § 412.92(a).

AD. "Statewide Average Medicare/Medicaid Payer Mix" shall mean, for the purposes of this regulation, the proportion of total charges across all hospitals in the state that filed a Medicare Cost Report in the previous three years, as of each October prior to the year in which a public hearing may be held, that were for Medicaid or Medicare patients, excluding psychiatric, long-term care, and rehabilitation hospitals, weighted by total charges.

AE. "State Average Net Income" shall mean, for the purposes of this regulation, the average Net Income per Adjusted Discharge across all hospitals in the state that filed a Medicare Cost Report in the previous three years, as of each October prior to the year in which a public hearing may be held, excluding psychiatric, long-term care, and rehabilitation hospitals, weighted by adjusted discharges.

AF. "State Average Net Patient Revenue" shall mean, for the purposes of this regulation, the average Net Patient Revenue per Adjusted Discharge across all hospitals in the state that filed a Medicare Cost Report in the previous three years, as of each October prior to the year in which a public hearing may be held, excluding psychiatric, long-term care, and rehabilitation hospitals, weighted by adjusted discharges.

AG. "State Average Operating Expenses" shall mean, for the purposes of this regulation, the average Operating Expenses per Adjusted Discharge across all hospitals in the state that filed a Medicare Cost Report in the previous three years, as of each October prior to the year in which a public hearing may be held, excluding psychiatric, long-term care, and rehabilitation hospitals, weighted by adjusted discharges.

Section 5 Hospital Reimbursement Floor Methodology

A. The Division will calculate a hospital reimbursement floor using the following methodology.

1. The Hospital Reimbursement Floor will be equal to 155% of the Aggregate Medicare Reimbursement Rate for that specific hospital with additional percentage points added as detailed below.

2. Percentage-points will be added to the Hospital Reimbursement Floor based on the following hospital-specific characteristics:

   a. Independent Hospitals will receive a twenty-percentage-point increase.

   b. Essential Access Hospitals will receive a twenty-percentage-point increase.

   c. Hospitals with a combined percentage of patients who receive services through programs established through the "Colorado Medical Assistance Act," Articles 4 to 6 of Title 25.5, or Medicare, Title XVIII of the Federal "Social Security Act," as amended, that exceeds the statewide average will receive up to a thirty-percentage-point increase. The actual percentage point increase, not to be less than zero, is determined based on the hospital's percentage share of such patients using the following formula:

$$Hospital\ Payer\ Mix\ = \frac{(Hospital\ \ Payer\ Mix) - (Statewide\ Average\ Payer\ Mix)}{0.99 - (Statewide\ Average\ Payer\ Mix)}\ X\ 30$$

   d. Hospitals efficient in managing the underlying cost of care as determined by the hospital's net patient revenue, operating expenses, and total margins will receive up to a forty-percentage point increase. The actual percentage point increase, not to be less than zero, is determined based on the following:

      (1) A ten-percentage-point increase may be received to account for a hospital's net patient revenue (NPR) using this formula:

$$NPR\ = \frac{(State\ Average\ NPR\ Per\ Adj.Discharge) - (Hospital\ \ NPR\ per\ Adj.Discharge)}{(State\ Average\ NPR\ Per\ Adj.Discharge)}\ X\ 10$$

      (2) A ten-percentage-point increase may be received to account for a hospital's operating expenses (OE) using this formula:

$$OE = \frac{(State\ Average\ OE\ Per\ Adj.Discharge) - (Hospital\ \ OE\ per\ Adj.Discharge)}{(State\ Average\ OE\ Per\ Adj.Discharge)}\ X\ 10$$

      (3) A twenty-percentage-point increase may be received to account for a hospital's net income using this formula:

$$Net\ Income = \frac{(State\ Average\ Net\ Income\ Per\ Adj.Discharge) - (Hospital\ \ Net\ Income\ per\ Adj.Discharge)}{(State\ AverageNet\ Income\ Per\ Adj.Discharge)}\ X\ 20$$

B. If using the formula detailed in Subsection A above would yield a Hospital Reimbursement Floor less than 165% of the Aggregate Medicare Reimbursement Rate for a specific hospital, the hospital reimbursement floor shall be equal to 165% of the Aggregate Medicare Reimbursement Rate.

C. For a Pediatric Hospital, the Hospital Reimbursement Floor shall be calculated using the Equivalent Rate as outlined in Section 4.I of this regulation and § 10-16-1303(3)(a) and (b), C.R.S. and § 10-16-1306(4)(a)(V), C.R.S.

Section 6 Health-Care Provider Reimbursement Floor

The Health-Care Provider Reimbursement Floor may not be less than 135% of the Aggregate Medicare Reimbursement Rate.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Incorporation by Reference

42 C.F.R. § 412.92 published by the Government Printing Office shall mean 42 C.F.R. § 412.92 as published on the effective date of this regulation and does not include later amendments to or editions of 42 C.F.R. § 412.92. A copy of 42 C.F.R. § 412.92 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 42 C.F.R. § 412.92 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes.

Section 10 Effective Date

This regulation shall be effective February 1, 2025.

Section 11 History

New regulation effective January 14, 2023.

Amended regulation effective February 1, 2024.

Amended regulation effective February 1, 2025.