Nov. 27, 2023

Commissioner Michael Conway
Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Conway:

On behalf of Colorado Hospital Association (CHA) and its more than 100 member hospitals and health systems statewide, I am writing to provide feedback on the proposed changes to Rule 4-2-91 Concerning the Methodology for Calculating Reimbursement Rates to Support Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans and Rule 4-2-92 Concerning Colorado Option Public Hearings.

CHA submitted a comment letter on Oct. 3 on a previous version of these regulations with recommendations to improve the operation of the Colorado Option. CHA appreciates the inclusion in the updated regulations of some of our recommendations from our last letter; however, many of our most important recommendations were not incorporated into the updated draft recommendations without any dialogue or rationale behind those omissions.

CHA urges the DOI to reconsider our comments (listed out in appendix), especially our top two priority items that 1) the DOI lacks authority to bring claims or cross claims against hospitals, and 2) Medicare reimbursement rates must be based on the most recent time period.

In regard to the updated regulations, CHA has the following recommendations:

1. In Regulation 4-2-91, update the definition of “Aggregate Negotiated Rate” to align with the definition of “Aggregate Medicare Reimbursement Rate” in 4.C.

   CHA recommends modifying the language to read as follows:

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

2. In Regulation 4-2-92, either define negotiated reimbursement rate or reference back to the “Aggregate Negotiated Rate” definition.

CHA recommends modifying the language in 9.A.2.b.i and ii:

"i. ~~The negotiated reimbursement rate~~ The Aggregate Negotiated Rate in aggregate for each Material Provider expressed as both a dollar and as a percentage of Medicare;
ii. ~~The negotiated reimbursement rate~~ The Aggregate Negotiated Rate by service expressed as both a dollar amount and as a percentage of Medicare."

CHA recommends modifying the language in 9.A.2.c:

"For each Material Provider, the carrier must also identify in a separate table whether the ~~negotiated reimbursement rate~~ Aggregate Negotiated Rate for the applicable plan year is"

The above recommendations combined with our previous recommendations are important to ensure consistency with the statute and operational success for implementation of the Colorado Option. Our recommendations are intended to ensure adequate and sustainable reimbursement to hospitals as well as safeguard due process during the public hearing process. CHA is equally invested in making health care more affordable for patients, but it must be done in a way that preserves access to care. As such, CHA asks for your reconsideration of our previous recommendations, which can be found in the appendix, and welcomes further dialogue with the DOI on these issues.

Sincerely,

Katherine Blair Mulready
SVP & Chief Strategy Officer

Appendix

Below are two top priority items that CHA reiterates from our prior comment letter, and requests response, dialogue, or resolution to prior to the current draft rule being finalized.

1. **The DOI lacks authority to bring claims or cross-claims against hospitals.**

The statutory framework for the Standardized Plan at 10-16-1306, C.R.S. does not enable the DOI to bring claims directly against hospitals. To the contrary, pursuant to 10-16-1306(2) and (3), if a carrier is unable to meet the PRR targets, it is required to notify the Commissioner of the reasons why, the steps it is taking, and documentation related to the hospitals or providers that are the cause of the failure. Subsection (3)(a) states that if the carrier notifies the Commissioner that the PRR cannot be met or the Commissioner otherwise makes this determination, the DOI may hold a public hearing prior to approving the carrier's final rates. Neither of these provisions permits the DOI to add any hospital as a party to the public hearing.

Subsection (c)(I) specifies that the Commissioner shall give notice of the public hearing to carriers, hospitals, as well as other parties, while (c)(II) sets out the items that the Commissioner shall establish by rule, including significantly:

> (D) The manner in which a carrier shall notify the division and affected hospitals, health-care providers, and the insurance ombudsman of a carrier's failure to meet the network adequacy requirements or the premium rate requirements in section 10-16-1305;

There is no similar provision allowing the DOI to identify affected hospitals and health care providers with respect to the carrier's failure to meet PRR requirements. The statute contains no support for the concept that the DOI is able to independently identify hospitals or other health care providers that it believes may be able to reduce the carrier's rates such that they should become parties to a public hearing.

As such, **CHA requests** the division strike Sections 5.B, 10.B, 10.C as inconsistent with statutory authority, as well as make conforming amendments as needed throughout the rule.

2. **Medicare reimbursement rates must be based on the most recent time period.**

In Section 4.W of proposed rule 4-2-92, the division proposes using outdated payment rates without accounting for data lags or routine inflationary factors, such that the 2025 plan year payments would be based on 2023 rates, creating a de facto rate cut to providers inconsistent with the statutory methodology for establishing hospital payment rates and creating the circumstances for unjust enrichment of the carriers. While CHA understands the need for carriers to know what rates to calculate for rate filing, for purposes of the Commissioner's imposition of mandatory payment rates, they must be the most current Medicare rates, as CHA has noted in prior comments.

The Medicare reimbursement rates established through the rate hearing process must be established using the most current Medicare prospective or cost-based payment rates available, trended forward to the applicable plan year and accounting for rate modifications through recent fiscal intermediary letters and/or Centers for Medicare and Medicaid Services (CMS) published trend factors applicable to the proposed rating period.

CHA recommends modifying the language under 4-2-92 Section 4.W to read as follows:

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 the Commercial Utilization Weighted Average of ~~the hospital specific rates for services~~ payment rate from the appropriate Hospital Inpatient Prospective Payment System (IPPS) and the Hospital Outpatient Prospective Payment System (OPPS) effective as of each October prior to the year in which a public hearing may be held, and trended forward to the benefit year for which the Division will calculate rates in Section 5 and 6 using the geometric average of the annual percentage increase, as of May, for each of the last three years of the Medical Care Index of the Consumer Price Index for Denver-Aurora-Lakewood, Colorado for all urban consumers (CPI-U). Note: This is sourced from the Amended Bulletin No. B-4.121.

2. Long-term Care, Psychiatric, and Rehabilitation Hospitals' Medicare Reimbursement Rates will be determined using the Commercial Utilization Weighted Average of payment rates for services from the appropriate Medicare Prospective Payment System rates for each hospital and trended forward to the benefit year for which the Division will calculate rates in Section 5 and 6 using the geometric average of the annual percentage increase, as of May, for each of the last three years of the Medical Care Index of the Consumer Price Index for Denver-Aurora-Lakewood, Colorado for all urban consumers (CPI-U).

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 servicesas 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 Medicare rates for the applicable plan year shall be trended forward to the benefit year for which the Division will calculate rates in Section 5 and 6 using the geometric average of the annual percentage increase, as of May, for each of the last three years of the Medical Care Index of the Consumer Price Index for Denver-Aurora-Lakewood, Colorado for all urban consumers (CPI-U). The DOI 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.