DO NOT PUBLISH THIS PAGE

Title of Rule: **Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Transitional Living, Section 8.516.30**
Rule Number: **MSB 21-01-21-A**
Division / Contact / Phone: **Community Options Benefits Section** / **Cassandra Keller** / **303-866-5181**

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: 21-01-21-A, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Transitional Living, Section 8.516.30

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected): 8.516.30

   Sections(s) 8.516.30, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.516.30 with the proposed text beginning at 8.516.30.D.2 through the end of 8.516.30.D.2. Replace the current text at 8.516.30.I with the proposed text beginning at 8.516.30.I through the end of 8.516.30.I. This rule is effective August 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: **Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Transitional Living, Section 8.516.30**
Rule Number: **MSB 21-01-21-A**
Division / Contact / Phone: **Community Options Benefits Section** / **Cassandra Keller** / **303-866-5181**

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Revision to the regulations pertaining to the Transitional Living Program (TLP) within the Home and Community Based Services (HCBS) Brain Injury (BI) Waiver. The Transitional Living benefit is a post-acute residential setting for members with recent neurologic damage. The Department reimburses providers through a per diem payment. Members are responsible for paying room and board directly to the provider. All the other HCBS residential benefits adhere to the annually established the room and board amount set by the Department. Revisions to these regulations will align the TLP room and board amount to the established process utilized for all the residential settings.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021) and Section 25.5-6-704, C.R.S.

Initial Review **05/14/21** Final Adoption **06/11/21**
Proposed Effective Date **08/10/21** Emergency Adoption

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: **Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Transitional Living, Section 8.516.30**
Rule Number: **MSB 21-01-21-A**
Division / Contact / Phone: **Community Options Benefits Section** / **Cassandra Keller** / **303-866-5181**

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members in the Brain Injury waiver may be impacted by this change. Any member residing in a residential setting is required to pay room and board to the provider. The current 2021 established room and board amount for the other residential settings is $700. However, in regulation the room and board amount for the TLP providers is capped at $400. The approximately two to four BI waiver members residing in the TLP setting each year would be required pay the increased room and board rate. As part of the Department's rate setting the process for room and board, it may only increase in a dollar for dollar relationship to Social Security Income (SSI). By increasing the room and board rate for TLPs, providers will receive an appropriate reimbursement for food and lodging by the member.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   This change will have a positive impact on providers, as they will be more appropriately reimbursed for room and board. Waiver members will be required to increase the amount they must pay to the provider. However, that amount will never exceed the Department's established rate.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There will be no costs to the Department from this rule change. This revision only applies to the room and board amount, which a member pays directly to the provider.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

The economic impact of implementing this rule change would be to members. They would be required to pay an increased amount of room and board to the provider. However, the benefit of appropriately reimbursing the room and board rate for TLPs outweighs that cost to members.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or intrusive methods that would align the room and board rate among all HCBS residential settings.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There is not an alternative method in aligning the room and board rates as the TLP rates is regulatorily prohibited from being more than $400.

8.516.30 TRANSITIONAL LIVING

A. DEFINITIONS

1. Transitional living means programs, which occur outside of the client's residence, designed to improve the client's ability to live in the community by provision of 24 hour services, support and supervision.

2. Program services include but are not limited to assessment, therapeutic rehabilitation and habilitation, training and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household.

3. Extraordinary therapy needs mean, for purposes of this program, a client who requires more than three hours per day of any combination of therapeutic disciplines. This includes, but is not limited to, physical therapy, occupational therapy, and speech therapy.

B. INCLUSIONS

1. All services must be documented in an approved plan of care and be prior authorized by the Department.

2. Clients must need available assistance in a milieu setting for safety and supervision and require support in meeting psychosocial needs.

3. Clients must require available paraprofessional nursing assistance on a 24 hour basis due to dependence in activities of daily living, locomotion, or cognition.

4. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this level of care. If a client requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for the Transitional Living Program service for a client must be documented and authorized individually by the Department.

C. EXCLUSIONS

1. Transportation between therapeutic tasks in the community, recreational outings, and activities of daily living is included in the per diem reimbursement rate and shall not be billed as separate charges.

2. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.

3. Room and board charges are not a billable component of transitional living services.

4. Items of personal need or comfort shall be paid out of money set aside from the client's, income, and accounted for in the determination of financial eligibility for the HCBS-BI program.

5. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the Department.

D. CERTIFICATION STANDARDS

Transitional living programs shall meet all standards established to operate as an Assisted Living Residence according to C.R.S. 25-27-104.

1. The Department of Public Health and Environment shall survey and license the physical facility of Transitional Living Programs.

2. Transitional living programs shall adhere to all additional programmatic, and policy requirements listed in the following sections entitled POLICIES, TRAINING, DOCUMENTATION, and HUMAN RIGHTS.

3. The Department of Health Care Policy and Financing shall review and provide certification of programmatic, standards.

4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site reviews of all programs shall occur on at least a yearly basis.

5. The building shall meet all local and state fire and safety codes.

E. POLICIES

1. Clients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.

2. Clients, families, medical proxies, or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.

3. Understanding that clients of transitional living programs frequently experience behavior which may be a danger to himself/herself or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a client who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal.

4. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve clients for whom they lack adequate resources to ensure safety of program participants and staff.

5. Upon entry into the program, discharge planning shall begin with the client and family. Transitional living programs shall work with the client and case manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living services.

6. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

7. During daytime hours, the ratio of staff to clients shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.

8. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Department.

F. TRAINING

1. At a minimum, the program director shall have an advanced degree in a health or human service related profession plus three years experience providing direct services to individuals with brain injury. A bachelor's degree with five years experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.

2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the client. These staff members will have successfully completed a training program of at least 40 hours duration.

3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility.

4. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

G. DOCUMENTATION

1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from impatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals.

2. Initial treatment plan development and evaluations will occur within a two week period following admission.

3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate.

5. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

6. All transitional services must utilize licensed psychologists win two years experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the client and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment.

7. Programs shall have a process verified in writing by which a client is made aware of the process for filing a grievance. Complaints by the client or family shall be handled via telephone or direct contact with the client or family.

8. Customer satisfaction surveys will be regularly performed and reviewed.

9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered.

10. Client safety in the community will be assessed: safety status and recommendations will be documented.

11. Progress towards the accomplishment of goals is monitored and reported in objective measurable terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis.

H. HUMAN RIGHTS

All people receiving HCBS-BI transitional living services have the following rights:

1. All Human Rights listed in 8.515.80 C. apply.

2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility.

I. REIMBURSEMENT

Providers of Transitional Living shall agree to accept the acuity-based per diem reimbursement rate established by the Department.

Providers shall not charge a Medicaid participant more than the Department's annually established room and board rate. ~~and will not bill the client in excess of his/her SSI payment or $400 per month, whichever is less for room and board charges.~~

All transitional living services shall be prior authorized through submission to the Department. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services.

Transitional living services which extend beyond ~~six months~~ a duration of 180 days must be reauthorized with treatment plan justification and shall be submitted through the reconsideration process established by the Department.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Telehealth in Home and Community-Based Services, to add Section 8.615
Rule Number: MSB 20-08-10-A
Division / Contact / Phone: Office of Community Living / Lindsay Westlund / 303-866-5463

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-08-10-A, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Telehealth in Home and Community-Based Services, to add Section 8.615.

3. This action is an adoption of: a rule

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.615 The Office of Community Living (OCL), Benefits and Services Management Division is requesting to revise regulations to include the addition of Telehealth service delivery to select Home and Community-Based Services (HCBS). The addition of Telehealth as a service delivery option is a policy change and rule revision that will give HCBS waiver members an additional choice in how waiver services are delivered. During the COVID - 19 Public Health Emergency (PHE) and through the Department's completion of Appendix K, the Department has temporarily allowed for select HCBS to be delivered through Telehealth. As we near the end of Appendix K's authority, the Department is looking to sustain Telehealth as a service delivery option for select HCBS, in efforts to continue to offer our members additional flexibilities in how they are supported in the community of their choice. The addition of regulations will give members and providers regulatory parameters for how Telehealth can be utilized in HCBS to maintain service integrity, and ensure our member's health and safety.

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

*to be completed by MSB Board Coordinator

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PUBLICATION INSTRUCTIONS*

Insert the newly proposed text beginning at 8.615 through the end of 8.615.6. This rule is effective August 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Telehealth in Home and Community-Based Services, to add Section 8.615
Rule Number: MSB 20-08-10-A
Division / Contact / Phone: Office of Community Living / Lindsay Westlund / 303-866-5463

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The Office of Community Living (OCL), Benefits and Services Management Division is requesting to revise regulations to include the addition of Telehealth service delivery to select Home and Community-Based Services (HCBS). The addition of Telehealth as a service delivery option is a policy change and rule revision that will give HCBS waiver members an additional choice in how waiver services are delivered. During the COVID - 19 Public Health Emergency (PHE) and through the Department's completion of Appendix K, the Department has temporarily allowed for select HCBS to be delivered through Telehealth. As we near the end of Appendix K's authority, the Department is looking to sustain Telehealth as a service delivery option for select HCBS, in efforts to continue to offer our members additional flexibilities in how they are supported in the community of their choice. The addition of regulations will give members and providers regulatory parameters for how Telehealth can be utilized in HCBS to maintain service integrity, and ensure our member's health and safety.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 441.300

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021); Sections 25.5-6-101 et seq. and Sections 25.5-10-101 et seq.

Initial Review	**05/14/21**	Final Adoption	**06/11/21**
Proposed Effective Date	**08/10/21**	Emergency Adoption	

DOCUMENT #07

DO NOT PUBLISH THIS PAGE

Initial Review	**05/14/21**	Final Adoption	**06/11/21**
Proposed Effective Date	**08/10/21**	Emergency Adoption	

DOCUMENT #07

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Telehealth in Home and Community-Based Services, to add Section 8.615
Rule Number: MSB 20-08-10-A
Division / Contact / Phone: Office of Community Living / Lindsay Westlund / 303-866-5463

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Individuals to be affected are those that utilize select Home and Community-Based Services, under the Elderly Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Spinal Cord Injury (SCI), and Brain Injury (BI), Supported Living Services (SLS), Developmental Disabilities (DD), Children with Life Limiting Illness (CLLI), Children's Extensive Supports (CES) and the Children's Residential Habilitative Program (CHRP) waivers. Members and providers will benefit from this rule change, but they will not bear any cost from this rule change.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Qualitatively, these rules will allow for Telehealth to be used in the provision of HCBS that are available in 9 out of the 10 HCBS waivers, Colorado operates. The services that can be delivered using Telehealth are those that maintain service integrity when delivered using technology in a distanced manner. Many of our members and providers have expressed this increased flexibility to provide services during the COVID-19 PHE have provided a welcomed alternative to providing all services in person. Members and providers have expressed that having policy that sustains Telehealth flexibility for HCBS provision will benefit our member's even after the PHE. Based on this feedback the Department understands that impact to our members will be positive, giving individuals additional service options, increasing access across the state of Colorado, and ensuring our most vulnerable members are able to continue to receive services without exposing themselves to increased risk by being around the general public. The Department anticipates quality of life to increase for our members by having access to increased options, increased access and increased control over their lives.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

Preliminary data suggests that there will be not an increased cost to the Department to provide this additional flexibility in service provision. Our sister agency, the Department of Public Health and Environment, which provides oversight to our providers, has reviewed and provided input to ensure policy is sound and does not adversely affect their agency.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The allowance of Telehealth will continue to offer members flexibility and increased options in selecting services and supports that will enhance their ability to remain independent in the community of their choice. While COVID 19 has disrupted much of society's "normal," it has accelerated technology use for the delivery of many services. Telehealth has enabled a number of individuals the ability to continue to receive services and supports in a way that also maintained their health and safety. This is a positive benefit and change for many individuals. Inaction on this rule revision will mean that there will be no regulatory parameters for the use of Telehealth when the Appendix K expires. From a regulatory perspective, the Department does not prohibit the use of Telehealth for service delivery. Without Department developed parameters, there will not exist policy, to ensure the health, safety and welfare of our members is prioritized or used in HCBS delivery regarding technology use.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There do not appear to be any less costly methods or less intrusive methods for achieving technology incorporation into HCBS waivered services as this current option does not include any additional costs to the Department.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose for the proposed rule.

8.615 TELEHEALTH DELIVERY OF HOME AND COMMUNITY-BASED SERVICES

8.615.1 DEFINITIONS

A. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends, and/or caregivers), chosen by the individual, conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources.

B. Case Management means the assessment of an individual seeking or receiving long-term services and supports' needs, the development and implementation of a Support Plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs.

C. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

D. Community Centered Board (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 25.5-10-209~~27-10.5-105~~, C.R.S., provides case management services to Members with developmental disabilities, is authorized to determine eligibility of such Members within a specified geographical area, serves as the single point of entry for Members to receive services and supports under Section 25.5-10-201~~27-10.5-101~~, C.R.S. et seq , and provides authorized services and supports to such Members either directly or by purchasing such services and supports from service agencies.

E. Department means the Department of Health Care Policy and Financing.

F. Home and Community-Based Services (HCBS) means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Member who requires a level of institutional care that would otherwise be provided in an institutional setting.

G. Home and Community-Based Services Telehealth (HCBS Telehealth) is a method of service delivery of those HCBS services listed at Section 8.615.2.

H. Medicaid State Plan means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

I. Member means an individual who meets long-term services and support eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

J. Prior Authorization Request (PAR) means the Department prescribed form to authorize the reimbursement for services.

K. Support Plan means the document used for Support Planning.

L. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking services of his or her rights and responsibilities.

M. Telehealth means the broad use of technologies to provide services and supports through HCBS waivers, when the Member is in a different location from the provider.

N. Waiver Service means optional services defined in the current federally approved waiver documents and do not include Medicaid State Plan benefits.

8.615.2 INCLUSIONS

A. HCBS Telehealth may be used to deliver support through the following authorized HCBS waiver services:

1. Adult Day Services - Basic, Tier 1; defined at Section 8.491.1;

2. Adult Day Services - Brain Injury, Tier 1; defined at Sections 8.515.3 and 8.515.70;

3. Behavioral Management and Education; defined at Section 8.516.40;

4. Behavioral Services - Behavioral Consultation; defined in Sections 8.500.5.B.1. and, ~~A.1,~~ 8.500.94.B.2, ~~and 8.503.4.A.3~~;

5. Behavioral Services - Behavioral Counseling, Group, defined in Sections 8.500.5.B.1~~A.1~~, and 8.500.94.B.2, ~~and 8.503.4.A.3~~;

6. Behavioral Services - Behavioral Counseling, Individual, defined in Sections 8.500.5.B.1~~A.1~~, and 8.500.94.B.2, ~~and 8.503.4.A.3~~;

7. Behavioral Services - Behavioral Plan Assessment; defined in Sections 8.500.5.B.1 and ~~A.1~~, 8.500.94.B.2, ~~and 8.503.4.A.3~~;

8. Bereavement Counseling; defined at Section 8.504.1;

9. Community Connector; defined at Section 8.503.40.A.3;

10. Day Habilitation; defined at Section 8.500.5.B.2;

11. Expressive Therapy - Art and Play Therapy, Group; defined at Sections 8.504.1 and 8.504.2.D;

12. Expressive Therapy - Art and Play Therapy, Individual; defined at Sections 8.504.1 and 8.504.2.D;

13. Expressive Therapy - Music Therapy, Group; defined at Sections 8.504.1 and 8.504.2.D;

14. Expressive Therapy - Music Therapy, Individual; defined at Sections 8.504.1 and 8.504.2.D;

15. Independent Living Skills Training; defined at Section 8.516.10;

16. Mental Health Counseling, Family; defined at Section 8.516.50;

17. Mental Health Counseling, Group; defined at Section 8.516.50;

18. Mental Health Counseling, Individual; defined at Section 8.516.50;

19. Mentorship; defined at Section 8.500.94~~.~~B.10~~7~~;

20. Movement Therapy; defined in Sections 8.500.94~~.~~B.15~~A.11~~ and 8.503.40.A.8~~9~~;

21. Palliative Supportive Care - Care Coordination; defined at Section 8.504.1;

22. Substance Abuse Counseling, Family; defined at Section 8.516.60;

23. Substance Abuse Counseling, Individual; defined at Section 8.516.60;

24. Supported Employment - Job Coaching, Individual, defined in Sections 8.500.5.B.9 ~~A.7~~ and 8.500.98.C~~4.A. 14~~;

25. Supported Employment - Job Development, Levels 1-6, Individual, defined in Sections 8.500.5.B.9~~A.7~~ and 8.500.98.C~~4.A.14~~;

26. Transition Services - Life Skills Training; defined at Section 8.553.1;

27. Transition Services - Peer Mentorship; defined at Section 8.553.1;

28. Therapeutic Life Limiting Illness Support, Family; defined at Sections 8.504.1 and 8.504.2.B;

29. Therapeutic Life Limiting Illness Support, Group; defined at Sections ~~.~~8.504.1 and 8.504.2.B;

30. Therapeutic Life Limiting Illness Support, Individual; defined at Sections 8.504.1 and 8.504.2.B;

31. Wrap Around Service - Intensive Support; defined at Section 8.508.100.H; and,

32. Wrap Around Service - Transition Support; defined at Section 8.508.100.M.

B. HCBS Telehealth may only be used to deliver consultation for the following services:

1. Adaptive Therapeutic Recreational Fees and Equipment, defined at Section 8.503.40.A.1;

2. Assistive Technology; defined in Sections 8.500.94.B~~A~~.1 and, 8.503.40.A.2;

3. Home Modification and Adaptation; defined in Sections 8.493.~~,~~1, 8.500.94.B.6~~A.5~~, and 8.503.40.A.5; and

4. Vehicle Modifications, defined in Sections 8.500.94.B.20~~A.15~~ and 8.503.40.A.12.

5. Providers shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules and may not bill separately for consultation.

8.615.3 LIMITATIONS

A. HCBS Telehealth is subject to the limitations of the respective service it supports as referenced in this rule at Section 8.615.2~~.1~~.

B. HCBS Telehealth is not a duplication of Health First Colorado Telehealth or Telemedicine services.

C. HCBS Telehealth is not permitted to be used for any service not listed in this rule at Section 8.615.2.~~1.~~

~~HCBS Telehealth is not an available delivery method of those services defined under C.R.S. 25.5-5-320 (7).~~

8.615.4 PROVIDER REQUIREMENTS

A. HCBS waiver providers that choose to use HCBS Telehealth shall develop and make available a written HCBS Telehealth Policy which at a minimum shall include the following:

1. The Member may refuse telehealth delivery at any time without affecting the Member's right to any future services and without risking the loss or withdrawal of any service to which the Member would otherwise be entitled;

2. All required and applicable confidentiality protections that apply to the services;

3. The Member shall have access to all collected information resulting from the services utilized as required by state law;

4. How utilization of HCBS Telehealth will be made available to those Members who require assistance with accessibility, translation, or have limited visual and/or auditory capabilities;

5. A contingency plan for service delivery if technology options fail; and,

6. HCBS waiver providers shall maintain a copy of the HCBS Telehealth Policy signed by the Member in their records.

B. HCBS waiver providers shall ensure the use of HCBS Telehealth is the choice of the Member. The HCBS waiver provider shall maintain a consent form for the use of HCBS Telehealth in the Member's record.

C. The HCBS waiver provider shall complete a provider developed evaluation~~assessment~~ of the Member and caregiver prior to using HCBS telehealth services that identifies a Member's ability to participate and outlines any accommodations needed while utilizing HCBS Telehealth.

~~-~~HCBS waiver providers must comply with all HIPAA and confidentiality procedures~~. and private payer requirements listed at C.R.S. 10-16-123.~~

D. HCBS waiver providers must be able to use a technology solution~~platform~~ that allows real-time interaction with the Member which may include audio, visual and/or tactile technologies.

E. HCBS waiver providers shall not use HCBS Telehealth to address a Member's emergency needs.

F. HCBS waiver providers shall use a HIPAA compliant technology solution~~platform~~ meeting all privacy requirements.

8.615.5 CASE MANAGEMENT REQUIREMENTS

A. Members eligible to use HCBS Telehealth are those enrolled in the waivers and services as defined in this rule at Section 8.615.2~~B~~.

B. The CMA shall ensure the use of HCBS Telehealth is the choice of the Member through the Support Planning process by indicating the Member's choice to receive HCBS Telehealth in the Department prescribed IT system.

C. Through the Support Planning process, the CMA shall identify and address the benefits and possible detriments to Members choosing to use HCBS Telehealth for service delivery.

D. HCBS Telehealth delivery must be prior authorized and documented in the Member's Support Plan.

E. Telehealth as a service delivery method for authorized HCBS waiver services, shall not interfere with any client rights or be used as any part of a Rights Modification or Suspension plan.

8.615.6 REIMBURSEMENT

A. HCBS Telehealth does not include reimbursement for the purchase or installation of telehealth equipment or technologies.

B. HCBS waiver service providers utilizing Telehealth shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules. This includes the prohibition on collecting copayments or charging Members for missing set times for services.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 20-21 Healthcare Affordability & Sustainability (HAS) Fees & Payments Amendment, Creation of Hospital Transformation Program (HTP) & Rural Support Program (RSP), Section 8.3000
Rule Number: MSB 21-01-28-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: Revision to the Medical Assistance Rule concerning FFY 20-21 Healthcare Affordability & Sustainability (HAS) Fees & Payments Amendment, Creation of Hospital Transformation Program (HTP) & Rural Support Program (RSP), Section 8.3000

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 3.8000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.3000 with the proposed text beginning at 8.3000.1 through the end of 8.3000.1. Replace the current text at 8.3000.3 with the proposed text beginning at 8.3000.3.A through the end of 8.3000.3.B. Replace the current text at 8.3000.4 with the proposed text beginning at 8.3000.4.D through the end of 8.3000.4.D. Replace the current text at 8.3000.4 with the proposed text beginning at 8.3000.4.F through the end of 8.3000.4.I. This rule is effective August 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 20-21 Healthcare Affordability & Sustainability (HAS) Fees & Payments Amendment, Creation of Hospital Transformation Program (HTP) & Rural Support Program (RSP), Section 8.3000
Rule Number: MSB 21-01-28-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The rule change makes necessary revisions for the federal fiscal year (FFY) 2020-21 Healthcare Affordability & Sustainability (HAS) fees and supplemental payments. Inpatient per-diem fees and Outpatient percentage fees are updated to account for changes to estimated Medicaid expansion costs, estimated administration costs, and HAS supplemental payments. Without the rule change there will not be enough HAS fees to fund Colorado Medicaid and CHP+ expansions and HAS supplemental payments. The rule change includes revisions to the Disproportionate Share Hospital (DSH) supplemental payment for the FFY 2022 DSH allotment and revisions to the Hospital Quality Incentive Payment (HQIP) supplemental payment for changes recommended by the HQIP sub-committee and approved by the Colorado Healthcare Affordability and Sustainably Enterprise (CHASE) Board.

   The rule change also includes the creation of the Hospital Transformation Program (HTP) and Rural Support Program (RSP). The HTP will leverage supplemental payments as incentives designed to improve patient outcomes and lower Medicaid cost. Hospitals must work to achieve certain milestones established by the hospital in the first year of the program. Hospitals not achieving milestones or completing activities will have their HAS supplemental payments reduced with the reduced payments going to hospitals achieving the milestones or completing the activities. The RSP will provide complementary funding to the HTP to prepare critical access and rural hospitals for future value-based environments.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

Initial Review	**05/14/21**	Final Adoption	**06/11/21**
Proposed Effective Date	**08/10/21**	Emergency Adoption	

DOCUMENT #09

42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

   25.5-4-402.4(4)(b), (g), C.R.S.

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Title of Rule: Revision to the Medical Assistance Rule concerning FFY 20-21 Healthcare Affordability & Sustainability (HAS) Fees & Payments Amendment, Creation of Hospital Transformation Program (HTP) & Rural Support Program (RSP), Section 8.3000
Rule Number: MSB 21-01-28-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   HAS Fees/Payments - Colorado hospitals benefit from increased Medicaid reimbursement made possible through HAS supplemental payments and the reduced number of uninsured Coloradans from expanded Medicaid and CHP+ eligibility. Low-income persons benefit from having healthcare coverage through the expanded Medicaid and CHP+ eligibility. The state benefits with HAS fee revenue used to offset General Fund expenditures for the medical assistance program due to the budget shortfall created by the COVID-19 pandemic.

   Colorado hospitals bear the costs of the proposed rule due to paying the HAS fee to fund HAS supplemental payments and expanded Medicaid and CHP+ eligibility expenditures before federal matching funds.

   Creation of HTP/RSP – For HTP, Colorado hospitals will be affected by the proposed rule as their HAS supplemental payments will now be at-risk if they don't complete required HTP reporting deliverables. Hospitals completing the deliverables will experience an increase in Medicaid reimbursement. Colorado hospitals not completing the deliverables will experience a decrease in Medicaid reimbursement. For RSP, Critical Access hospitals and rural hospitals will experience an increase in Medicaid reimbursement through a new Medicaid supplemental payment.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   HAS Fees/Payments - The HAS fee, with federal matching funds, will result in approximately $2.8 billion in annual health care expenditures for more than 400,000 Coloradans and will provide more than $500 million new federal funds to Colorado hospitals. $63 million in HAS fees will be used to offset General Fund expenditures for the medical assistance program.

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Creation of HTP/RSP - The impact of HTP will be hospitals implementing quality-based initiatives, demonstrating meaningful community engagement, and improving health outcomes by incorporating value-based purchasing strategies into existing hospital quality and payment improvement initiatives. Rural hospital will now receive necessary resources to assist in the transition to a more value-based environment.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   While there are administrative costs, such costs are funded with HAS fees and federal matching funds. No state General Fund is used.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   HAS Fees/Payments - The benefits of the proposed rule are the funding of approximately $2.8 billion in annual health care expenditures for more than 400,000 Coloradoans and more than $500 million in new federal funds to Colorado hospitals. The cost of the proposed rule is the HAS fee paid by Colorado hospitals to fund the expanded Medicaid and CHP+ eligibility and HAS supplemental payments.

   If no action is taken, there will not be enough HAS fee to fund Colorado Medicaid and CHP+ expansions, affecting over 400,000 currently enrolled persons or the ability to fund the HAS supplemental payments. HAS fee revenue cannot be allocated to offset General Fund expenditures pursuant to H.B. 20-1386.

   HTP/RSP - If no action is taken, HAS supplemental payments will not be at-risk and there will be less incentive to improve health outcomes and to lower Medicaid costs. Rural hospitals will not receive additional funding to support their transition to a more value-based environment.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   No other methods are available to achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   No other alternatives to rule making are available.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

8.3001: DEFINITIONS

"Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-402.4, C.R.S.

"CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability Enterprise described in C.R.S. § 25.5-4-402.4(3).

"CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

"CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.

"CMS" means the federal Centers for Medicare and Medicaid Services.

"Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

"Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to qualified hospitals that serve a disproportionate share of Medicaid and uninsured individuals as required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that limits federal financial participation for total statewide DSH payments made to hospitals.

"Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described in C.R.S. § 25.5-4-402.4(7).

"Essential Access Hospital" means a Critical Access Hospital or General Hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget ~~located in a Rural Area~~ and ~~with~~ having 25 or fewer licensed beds.

"Exclusive Provider Organization" or "EPO" means a type of managed care health plan where members are not required to select a primary care provider or receive a referral to receive services from a specialist. EPOs will not cover care provided out-of-network except in an emergency.

"Fund" means the healthcare affordability and sustainability fee cash fund described in C.R.S. § 25.5-4-402.4(5).

"General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

"High Volume Medicaid and CICP Hospital" means a hospital with at least 27,500 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients.

"Health Maintenance Organization" or "HMO" means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency.

"Hospital-Specific Disproportionate Share Hospital Limit" or "Hospital-Specific DSH Limit" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.

"Hospital Transformation Program Supplemental Medicaid Payments" or "HTP Supplemental Medicaid Payments" means the:

1. Outpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.B.,
2. Inpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.C., and
3. Essential Access Hospital Supplemental Medicaid Payment described in Section 8.3004.E.

The HTP Supplemental Medicaid Payments does not include the Hospital Quality Incentive Payment described in Section 8.3004.F. or Rural Support Program Hospital Supplemental Medicaid Payment described in Section 8.3004.G.

"Inpatient Services Fee" means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

"Inpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

"Long Term Care Hospital" means a General Hospital that is certified as a long term care hospital by the Colorado Department of Public Health and Environment.

"Managed Care Day" means an inpatient hospital day for which the primary payer is a managed care health plan, including a HMO, PPO, POS, and EPO days.

"Medicaid Day" means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

"Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is Medicaid.

"Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.

"MMIS" means the Medicaid Management Information System, the Department's Medicaid claims payment system.

"MIUR" means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospital~~s~~ days.

"Non-Managed Care Day" means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.

"Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a local government.

"Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges.

"Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

"Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric populations.

"POS" or "Point of Service" means a type of managed care health plan that charges patients less to receive services from providers in the plan's network and requires a referral from a primary care provider to receive services from a specialist.

"PPO" or "Preferred Provider Organization" means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from

providers that belong to the network and may receive services from providers outside the network at an additional cost.

“Privately-Owned Hospital” means a hospital that is privately owned and operated.

“Psychiatric Hospital” means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

“Rehabilitation Hospital” means an inpatient rehabilitation facility.

“Respiratory Hospital” means a hospital that primarily specializes in respiratory related diseases.

“Rural ~~Area~~Hospital” means a hospital not located within a ~~county outside a~~ Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget.

“State-Owned Government Hospital” means a hospital that is either owned or operated by the State.

“State University Teaching Hospital” means a High Volume Medicaid and CICP Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

“Supplemental Medicaid Payments” means ~~any of the payments~~the: ~~described in 10 CCR 2505-10,~~

1. Outpatient Hospital Supplemental Medicaid Payment described in Sections 8.3004.B.,
2. Inpatient Hospital Supplemental Medicaid Payment described in 8.3004.C.,
3. Essential Access Hospital Supplemental Medicaid Payment described in 8.3004.E., ~~and~~
4. Hospital Quality Incentive Payment described in 8.3004.F., and
5. Rural Support Program Hospital Supplemental Medicaid Payment described in 8.3004.G.

“Uninsured Cost” means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.

“Urban Center Safety Net Specialty Hospital” means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total inpatient hospital days, rounded to the nearest percent, equals or exceeds 65%.

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as ~~1.8664~~1.7592% of total hospital outpatient charges with the following exception.

    a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to ~~1.8507~~1.7444% of total hospital outpatient charges.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $~~91.39~~96.42 per day for Managed Care Days and $~~408.56~~431.01 per day for all Non-Managed Care Days with the following exceptions:

    a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $~~47.71~~50.34 per day for Managed Care Days and $~~213.31~~225.03 per day for all Non-Managed Care Days, and.

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~36.56~~38.56 per day for Managed Care Days and $~~163.42~~172.41 per day for Non-Managed Care Days.

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

   a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

   b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

   c. Critical Access Hospitals with at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment.

   a. Total funds for the payment shall equal $~~216,338,548~~219,367,288.

   b. ~~All~~ A qualified hospital~~s~~ with CICP write-off costs greater than 1,000.00% of the state-wide average shall receive a payment equal to ~~96~~88.00% of their Hospital-Specific DSH Limit. A qualified Critical Access Hospital shall receive a payment equal to 96% of their Hospital Specific DSH Limit. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than 2,000 Medicaid Days shall receive a payment equal to 88.00% of their Hospital-Specific DSH Limit.

   c. All remaining qualified hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining funds.

   d. No remaining qualified hospital shall receive a payment exceeding 96.00% of their Hospital-Specific DSH Limit as specified in federal regulation. If a qualified hospital's payment exceeds 96.00% of their Hospital-Specific DSH Limit, the payment shall be reduced to 96.00% of the Hospital-Specific DSH Limit. The amount of the reduction shall then be redistributed to other qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit.

   e. A new CICP hospital shall have their Hospital-Specific DSH Limit equal to 10.00%. A Low MIUR hospital shall have their Hospital-Specific DSH Limit equal 10.00%.

      i. A new CICP hospital is a hospital approved as a CICP provider after October 1, ~~2018~~2019.

      ii. A low MIUR hospital is a hospital with a MIUR less than or equal to 15.00%.

8.3004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal adjusted discharge points multiplied by dollars per-adjusted discharge point.

   a. Adjusted discharge points equal normalized points awarded multiplied by adjusted Medicaid discharges. Normalized points awarded equals the sum of points awarded, normalized to a 100 point~~s~~ scale for measures a hospital is not eligible to complete. There are ~~fifteen~~ eleven measures separated into ~~six~~ three measure groups.

   b. Due to the COVID-19 pandemic, not all measures were implemented resulting in only 65 available awarded points. Every qualified hospital's points awarded shall be normalized to the 100-point scale.

   The measures and measure groups are:

Maternal Health and Perinatal Care Measure Group

1. Exclusive Breast Feeding
2. Cesarean Section
3. Perinatal Depression and Anxiety
4. Maternal Emergencies
5. Reproductive Life/Family Planning
6. Incidence of Episiotomy

Patient Safety Measure Group

7~~6~~. Clostridium Difficile
8~~7~~. Adverse Event
~~8. Falls with Injury~~
9. Culture of Safety Survey

Patient Experience Measure Group

10. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
11. Advance Care Plan

~~*Regional Accountable Entity (RAE) Engagement Measure Group*~~
~~12. RAE engagement on Physical and Behavioral Health~~

~~*Substance Abuse Measure Group*~~
~~13. Substance Use Disorder Composite~~
~~14. Alternatives to Opioids~~

~~*Addressing Cost of Care Measure Group*~~
~~15. Hospital Index~~

Adjusted Medicaid Discharges equal inpatient Medicaid discharges multiplied by a discharge adjustment factor.

i. The discharge adjustment factor equals total Medicaid charges divided by inpatient Medicaid charges. The discharge adjustment factor is limited to 5.

ii. For qualified hospitals with less than 200 inpatient Medicaid discharges, inpatient Medicaid discharges shall be multiplied by 125%.

b. Dollars per-adjusted discharge point ~~is~~ are determined using a qualified hospital's normalized points awarded. Dollars per-adjusted discharge point are tiered so that qualified hospitals with more normalized points awarded receive more dollars per-adjusted discharge point. There are five tiers delineating the dollars per-adjusted discharge point with each tier assigned a certain normalized points awarded range. For each tier the dollars per-adjusted discharge point increase by a multiplier.

The multiplier and normalized points awarded for each tier are:

Tier	Normalized Points Awarded	Dollars Per-Adjusted Discharge Point
1	1-19	0(x)
2	20-39	1(x)
3	40-59	2(x)
4	60-79	3(x)
5	80-100	4(x)

The dollars per discharge point ~~(x)~~ shall equal an amount such that the total quality incentive payments made to all qualified hospitals shall equal seven percent (7.00%) of total hospital payments in the previous state fiscal year.

8.3004.G. RURAL SUPPORT PROGRAM HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals that meet all the following criteria:

   a. Is state licensed as a Critical Access Hospital or is a Rural Hospital, participating in Colorado Medicaid,

   b. Is a nonprofit hospital, and

   c. Meets one of the below:

      i. Their average net patient revenue for the three-year 2016, 2017, and 2018 cost report period is in the bottom ten percent (10%) for all Critical Access Hospitals and Rural Hospitals, or

      ii. Their funds balance for the 2019 cost report period is in the bottom two and one-half percent (2.5%) for all Critical Access Hospitals and Rural Hospitals not in the bottom 10% of the three-year average net patient revenue for all Critical Access Hospitals and Rural Hospitals,

2. Calculation methodology for payment. For a qualified hospital, the annual payment shall equal twelve million dollars ($12,000,000) divided by the number of qualified hospitals.
3. The payment shall be calculated once and reimbursed in monthly installments over the subsequent five federal fiscal years.
4. A qualified hospital must submit an attestation form every year to receive the available funds. If a qualified hospital does not submit the required attestation form their funds for the year shall be redistributed to other requalified hospitals.

8.3004.H REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENTS AND DISPROPORTIONATE SHARE HOSPITAL PAYMENT

1. The Enterprise shall calculate the Supplemental Medicaid Payments and DSH Payment under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Supplemental Medicaid Payments and DSH Payment shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the annual payment made each year, the methodology to calculate such payment, and the payment reimbursement schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Supplemental Medicaid Payments or the DSH Payment to be reimbursed.

8.3004.I HOSPITAL TRANSFORMATION PROGRAM

Qualified hospitals shall participate in the Hospital Transformation Program (HTP). The HTP leverages supplemental payments as incentives designed to improve patient outcomes and lower Medicaid cost. Qualified hospitals are required to complete certain reporting activities. Qualified hospitals not completing a reporting activity shall have their supplemental Medicaid payments reduced. The reduced supplemental Medicaid payments shall be paid to qualified hospitals completing the reporting activity. The HTP is a multi-year program with a program year (PY) being on a federal fiscal year (October 1 through September 30) basis.

1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients shall participate in the HTP except as provided below.
2. Excluded hospitals. Psychiatric Hospitals, Rehabilitation Hospitals, or Long-Term Care Hospitals shall not participate in the HTP.
3. Calculation methodology for payment.
    a. Each program year includes reporting activities that a qualified hospital is required to complete. A qualified hospital not completing a reporting activity shall have their HTP Supplemental Medicaid Payments reduced by a designated percent.

    b. The dollars not paid to those qualified hospitals shall be redistributed to qualified hospitals completing the reporting activity. A qualified hospital's distribution shall equal their percent of HTP Supplemental Medicaid Payments to the total HTP Supplemental Medicaid Payments for all qualified hospitals completing the reporting activity, multiplied by the total reduced dollars for qualified hospitals not completing the reporting activity.

    c. The reduction and redistribution shall be calculated using the HTP Supplemental Medicaid Payments effective during the reporting activity period. The reduction and redistribution for reporting activities shall occur at the same time during the last quarter of the subsequent program year.

    e. There are five HTP reporting activities. The reporting activities are listed below, along with the total percent at-risk associated with each reporting activity.

        i. Application (1.5% at-risk total) – Qualified hospitals must provide interventions and measures focusing on improving processes of care and health outcomes and reducing avoidable utilization and cost. The percent at-risk shall be scored on timely and satisfactory submission.

        ii. Implementation Plan (1.5% at-risk total) – Qualified hospitals must submit a plan to implement interventions with clear milestones that shall impact their measures. The percent at-risk shall be scored on timely and satisfactory submission.

        iii. Quarterly Reporting (0.5% at-risk per report) – Qualified hospitals must report quarterly on the different activities that occurred in that quarter. For any given quarter, this includes interim activity reporting, milestone reporting, self-reported data associated with the measures, and Community and Health Neighborhood Engagement (CHNE) reporting. The percent at-risk shall be scored on timely and satisfactory submission.

        iv. Milestone Report (2.0% at-risk per report in PY 2, 4.0% at-risk per report in PY 3) – Qualified hospitals must report on achieved/missed milestones over the previous two quarters. The percent at-risk shall be scored on timely and satisfactory submission and for achievement of milestones. Qualified hospitals that miss a milestone can have the reduction for the milestone reduced by 50% if they submit a course correction plan with the subsequent Milestone Report. A

course correction reduction for a missed milestone can only be done once per intervention.

v. Sustainability Plan (8.0% at-risk total) – Qualified hospitals must submit a plan demonstrating how the transformation efforts will be maintained after the HTP is over. The percent at-risk shall be scored on timely and satisfactory submission.

f. A qualified hospital not participating in the HTP may have the entirety of their HTP Supplemental Medicaid Payments withheld.