DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 20-06-29-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: MSB 19-11-05-A, Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement

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) 8.3000, 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)? Yes
   If yes, state effective date: 7/10/20
   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 through the end of 8.3000. This rule is effective July 10, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 20-06-29-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) 2019-20 Healthcare Affordability and Sustainability (HAS) fee and supplemental payment amounts. 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 fee to fund Colorado Medicaid and CHP+ expansions and HAS supplemental payments.

   The Rule change includes the creation of the Inpatient supplemental payment and Essential Access supplemental payment.

   The Inpatient Base Rate supplemental payment is now the Inpatient supplemental payment. The new Inpatient supplemental payment is calculated using a hospital's Medicaid patient days not their Medicaid Base Rate, allowing for greater fluctuation in payments based on changing Medicaid utilization. The Uncompensated Care Cost (UCC) Medicaid payment is now the Essential Access supplemental payment. The new Essential Access supplemental payment was one of two parts creating the UCC supplemental payment in prior years. The Essential Access part continues while the non-Essential access part is removed with its funding being absorbed into the Inpatient supplemental payment.

   The Rule also includes revisions to the Disproportionate Share Hospital (DSH) supplemental payment for the FFY 2021 DSH allotment reduction, 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, and revisions to language used throughout to increase transparency and understanding.

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption **07/10/2020**

DOCUMENT #06

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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:

HAS Fee revenue serves as the state share to fund health coverage for more than 500,000 Coloradans currently enrolled in Medicaid and CHP+. The COVID-19 pandemic has increased the state share necessary to fund health care coverage to these Medicaid and CHP+ expansion populations. In addition, House Bill (H.B.) 20-1386 authorizes the use of HAS fee revenue to offset General Fund expenditures for Colorado's Medicaid program due to the budget shortfall created by the COVID-19 pandemic. Rules must be established on an emergency basis to ensure continuing coverage of the Medicaid and CHP+ expansion populations, to begin offsetting General Fund expenditures, and to continue monthly supplemental payments to hospitals.

2. Federal authority for the Rule, if any:

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

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 20-06-29-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.

   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 also benefits with HAS fee revenue now used to offset General Fund expenditures 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.

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

   The HAS fee, with federal matching funds, will result in approximately $2 billion in annual health care expenditures for more than 400,000 Coloradans and will provide more than $50 million new federal funds to Colorado hospitals. Has Fee will offset $114 million in General Fund expenditures.

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. The proposed rule will offset $114 million in General Fund expenditures.

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

   The benefits of the proposed rule are the funding of approximately $2 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, General Fund expenditures, 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. 1386.

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

   There are no alternative resources to fund HAS supplemental payments or health coverage for Medicaid and CHP+ expansion populations. 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.

   The CHASE Act directs the Medical Services Board to promulgate rules for the implementation of the HAS fee and supplemental payments. No other alternatives to rule making are available.

"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" means a county outside a Metropolitan Statistical Area ~~or an area within an outlying county of a Metropolitan Statistical Area~~ 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 Payment" means any of the payments described in 10 CCR 2505-10, Sections 8.3004.B., 8.3004.C., 8.3004.E., and 8.3004.F.

"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%.

8.3002: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS

8.3002.A. DATA REPORTING

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Enterprise shall distribute a data reporting template to all hospitals. The Enterprise shall include instructions for completing the data reporting template, including definitions and descriptions of each data element to be reported. Hospitals shall submit the requested data to the Enterprise within thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Enterprise may estimate any data element not provided directly by the hospital.

    a. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the collection of fees, payments to hospitals shall be processed by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

    b. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the disbursement of payments, payments to hospitals shall be processed through a warrant (paper check) by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

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.~~8119~~8664% of total hospital outpatient charges with the following exception.~~.~~

    a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted ~~by~~ to 1.8507~~0.84~~% 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 $~~93.07~~91.39 per day for Managed Care Days and $~~416.07~~408.56 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 $~~48.59~~47.71 per day for Managed Care Days and $~~217.23~~213.31 per day for all Non-Managed Care Days, and.

b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~37.23~~36.56 per day for Managed Care Days and $~~166.43~~163.42 per day for Non-Managed Care Days.

8.3003.C. ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

1. The Enterprise shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Inpatient Services Fee and Outpatient Services Fee 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 fee to be collected each year, the methodology to calculate such fee, and the fee assessment be retroactively distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-Specific DSH ~~Disproportionate Share Hospital~~ Limit.

3. In order to receive a Supplemental Medicaid Payment or DSH ~~Disproportionate Share Hospital~~ Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.3004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing outpatient 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 outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. Outpatient billed costs equal ~~Hospital-specific o~~outpatient billed charges ~~from the Colorado MMIS are~~ multiplied by ~~the hospital's~~ the Medicare cost-to-charge ratio ~~to arrive at hospital-specific outpatient billed costs~~. ~~For each qualified hospital, the annual Outpatient Hospital Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor.~~ The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to qualified hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital ~~will~~ shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.C. INPATIENT HOSPITAL ~~BASE RATE~~ SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient 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~~s the hospital's~~ Medicaid Days ~~expected Medicaid discharges, multiplied by the hospital's~~

~~average Medicaid case mix, multiplied by the hospital's Medicaid base rate before add-ons,~~ multiplied by an ~~percentage~~ adjustment factor. ~~The percentage adjustment factor may vary by hospital such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit.~~ The ~~percentage~~ adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Pediatric Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to qualified hospitals shall not exceed the Inpatient Upper Payment Limit. The ~~percentage~~ adjustment factor for each qualified hospital ~~will~~ shall be published annually in the Colorado Medicaid Provider Bulletin.

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)~~(ii)~~ 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)~~(ii)~~ are qualified to receive this payment.

   c. Critical Access Hospital 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 ~~Disproportionate Share Hospital payment~~ payment shall ~~be~~ equal ~~to the $216,338,548Disproportionate Share Hospital allotment as published by CMS annually~~.

   b. All qualified hospitals with CICP write-off costs greater than 1,000.00% of the state-wide average shall receive a payment equal to 96.00% 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 Pediatric Hospital shall receive a payment equal to 45.00% of its estimated hospital-specific Disproportionate Share Hospital limit. A Respiratory Hospital shall receive a payment equal to 75.00% of its estimated hospital-specific Disproportionate Share Hospital limit. A new CICP hospital shall receive a payment equal to 10.00% of its estimated hospital-specific Disproportionate Share Hospital limit. A low MIUR hospital shall receive a payment equal to 10.00% of its estimated hospital-specific Disproportionate Share Hospital limit.~~

      ~~i. A new CICP hospital is a hospital approved as a CICP provider between July 1, 2017 and June 30, 2018.~~

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

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

d. No qualified hospital shall receive a payment exceeding 96.00% of their~~its estimated hH~~ospital-~~specific~~ Specific DSH ~~Disproportionate Share Hospital lL~~imit as specified in federal regulation. If ~~upon review, the~~ a qualified hospital's ~~Disproportionate Share Hospital Supplemental~~ payment exceeds 96.00% of their ~~estimated hH~~ospital-~~specific~~ Specific DSH ~~Disproportionate Share Hospital lL~~imit ~~for any qualified hospital~~, ~~that hospital's~~the payment ~~payment~~ shall be reduced to 96.00% of the ~~their~~the ~~estimated hH~~ospital-~~specific~~ Specific DSH ~~Disproportionate Share Hospital lL~~imit. The amount of the reduction shall then be redistributed to ~~the~~ other qualified hospitals not exceeding 96.00% of their ~~estimated hH~~ospital-~~Ss~~pecific DSH ~~Disproportionate Share Hospital lL~~imit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding 96.00% of their ~~estimated HH~~ospital-~~sS~~pecific DSH ~~Disproportionate Share Hospital~~ 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 L~~l~~imit equal 10.00%.

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

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

8.3004.E. ~~UNCOMPENSATED CARE~~ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. ~~General Hospitals and Critical~~Essential Access Hospitals ~~shall~~ are qualified receive this payment.

~~2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.~~

~~3~~2. Calculation methodology for payment. ~~A~~ For each qualified ~~Essential Access Hh~~ospital, the annual payment shall equal ~~shall receive a payment based on its~~ the percentage of beds to ~~percentage of beds to~~ total beds for all qualified ~~Essential Access Hospitals~~hospitals, multiplied by the available Essential Access funds. ~~**A qualified non-Essential Access Hospital shall receive a payment based on its percentage of Uninsured Costs to total Uninsured Costs for all qualified non-Essential Access hospitals.**~~

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.~~General Hospitals and Critical Access Hospitals 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 100 points for measures a hospital is not eligible to complete. There are fifteen measures separated into six measure groups. The measures and measure groups are:

      ~~Measures. Quality incentive payment measures include nine measures. Qualified hospitals must report for the first and second measures. A hospital then reports for the remaining measures in which they are eligible~~

      ~~a. The measurefor the quality incentive payment are:~~

      ~~i. Active participation in the Regional Care Collaborative Organizations (RCCO) or Regional Accountable Entities (RAE),~~

      ~~ii. Culture of Safety/Patient Safety,~~

      ~~iii. Discharge Planning (Advance Care Planning (ACP)/Transition Activities),~~

      ~~iv. Rate of Cesarean Section,~~

      ~~v. Breastfeeding Practices,~~

      ~~vi. Tobacco and Substance Use Screening and Follow-Up,~~

      ~~vii. Emergency Department Process,~~

      ~~viii. Percentage of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and~~

      ~~ix. 30-Day All-Cause Readmission.~~

~~4. The hospital shall certify that based on best information, knowledge, and belief, the data included in the data reporting template is accurate, complete, and truthful, is based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.~~

~~5. Calculation methodology for payment.~~

~~a. Determine total points earned.~~

~~i. *Total points earned are the sum of the points earned for the first and second measures and the next three sequential measures for which the hospital is eligible.*~~ *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

Patient Safety Measure Group

6. Clostridium Difficile
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
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 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:

~~b. Normalize the total points for hospitals that are exempted from reporting requirements or have limited data available for certain measures.~~
~~c. Calculate adjusted Medicaid discharges.~~
~~i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by a discharge adjustment factor.~~

ii. The discharge adjustment factor is calculated as gross Medicaid billed charges divided by gross inpatient Medicaid billed charges. The Discharge Adjustment Factor is limited to 5.

iii. For hospitals with fewer than 200 annual Medicaid discharges, the total number of discharges is multiplied by 125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare prospective payment system calculation.

d. Calculate total adjusted discharge points.

i. Adjusted discharge points are calculated as the total points earned for all measures multiplied by the adjusted Medicaid discharges.

e. Determine the dollars per discharge point.

i. Dollars per discharge point are tiered such that hospitals with higher quality points earned receive more dollars per discharge point than hospitals with lower quality points earned. There are five tiers delineating the dollar value of a discharge point with each tier assigned at certain quality point increments. For each tier increase, the dollars per discharge point increase by a multiplier.

ii. The multiplier for the five tiers of quality points are shown in the table below:

Tier	Normalized Points AwardedHospital Quality Points Earned	Dollars Per-Adjusted Discharge PointMultiplier
1	1-19	$0.000(x)
2	20-3920-35	$3.131(x)
3	40-5936-50	$6.262(x)
4	60-7951-65	$9.393(x)
5	80-10066-80	$12.524(x)

g. Calculate payment by hospital by multiplying the adjusted discharge points by the dollars per discharge point.

6. The dollars per discharge point for tier 2 (x) shall be set toequal an amount so such that the total quality incentive payments made to all qualified hospitals shall equal seven percent (7.00%) of the total hospital payments in the previous state fiscal year.

8.3004.G. REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENT AND DISPROPORTIONATE SHARE HOSPITAL PAYMENT

1. The Enterprise shall calculate the Supplemental Medicaid Payment and DSH Disproportionate Share Hospital 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 Payment and DSH Disproportionate Share Hospital 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 Payment or the DSH ~~Disproportionate Share Hospital~~ Payment to be reimbursed.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Rule Concerning Nursing Facility Per Diem Rates, Section 8.443
Rule Number: MSB 20-06-19-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: MSB 20-06-19-A, Revision to the Medical Assistance Rule Concerning Nursing Facility Per Diem Rates, Section 8.443

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) 8.443.1.B, 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)? Yes
   If yes, state effective date: 7/10/20
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.443.1.B.1 with the proposes text beginning at 8.443.1.B.1 through the end of 8.443.1.B.1. This rule is effective July 10, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Rule Concerning Nursing Facility Per Diem Rates, Section 8.443
Rule Number: MSB 20-06-19-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).

   House Bill (H.B.) 20-1362 limits the annual increase in the General Fund share of the per diem rates for nursing homes from 3.00% to 2.00% in SFY 2020-21 and SFY 201-22. The rule change makes necessary revisions to be compliant with state statute.

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:

   H.B. 20-1362 limits the annual increase in the General Fund share of the per diem rates for nursing homes effective July 1, 2020. Rules must be established on an emergency basis to ensure compliance with state statute and to begin generating savings for the state to partially offset the budget shortfall created by the COVID-19 pandemic.

3. Federal authority for the Rule, if any:

   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. (2020);

   Sections 25.5-6-202 & 25.5-6-203, C.R.S

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption **07/10/2020**

DOCUMENT #07

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Rule Concerning Nursing Facility Per Diem Rates, Section 8.443
Rule Number: MSB 20-06-19-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.

   Nursing homes will bear the costs of the proposed rule. Nursing home claims based reimbursement rates will increase less with the proposed rule. Nursing homes will now be reimbursed a smaller portion of their Core Component per diem rate (cost based rate) through the Colorado interChange (iC). The state will benefit from the proposed rule. The state will generate savings by limiting the increase in nursing home reimbursement rates

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

   The projected decrease in claims based reimbursement to nursing homes equals approximately $7 million in SFY 2020-21. The state will generate savings equal to approximately $3.3 million, after subtracting for federal matching dollars.

   The projected decrease in claims based reimbursement to nursing homes equals approximately $16.6 million in SFY 2021-22. The state will generate savings equal to approximately $8.3 million, after subtracting for federal matching dollars.

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 are no costs to the Department or any other agency to implement/enforce the proposed rule. The proposed rule will generate approximately $3.3 million in savings for the state in SFY 2020-21 and $8.3 million in SFY 2021-22.

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

   Benefits of proposed rule is being compliant with state statute and generating savings to state. Costs of proposed rule is a reduction to nursing home claims based reimbursement. Costs of inaction is not being compliant with state statute and not generating savings for the state.

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

   There are no other methods that are less costly or intrusive that still 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 alternative methods were seriously considered by the Department to achieve the desired goal of the proposed rule.

8.443 NURSING FACILITY REIMBURSEMENT

8.443.1.A Where no specific Medicaid authority exists, the sources listed below shall be considered in reaching a rate determination:

1. Medicare statutes.

2. Medicare regulations.

3. Medicaid and Medicare guidelines.

4. Generally accepted accounting principles.

8.443.1.B Effective July 1 of each year, a MMIS per diem reimbursement rate for Class I nursing facility providers shall be established for reimbursement of billed claims.

1. The MMIS per diem reimbursement rate shall equal the July 1 Core Component per diem rate multiplied by a percent factor. The percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by the statutory limit pursuant to C.R.S 25.5-6-202(9)(b)(VII)(2020) for SFY 2020-21 and SFY 2021-22. The increase for all subsequent years shall be limited pursuant to C.R.S 25.5-6-202(9)(b)(I)(2020).

2. For state fiscal year (SFY) 2019-20, if the MMIS per diem reimbursement rate is less than ninety-five percent (95%) of the SFY 2018-19 MMIS per diem reimbursement rate, the SFY 2019-20 MMIS per diem reimbursement rate shall be the lesser of 95% of the SFY 2018-19 MMIS per diem reimbursement rate or the SFY 2019-20 Core Component per diem rate.

3. In the event that MMIS per diem reimbursement rate is greater than the Core Component per diem rate, the Department shall reduce the rate to no greater than the Core Component per diem rate.

The Core Component per diem rate shall be determined using information on the MED-13, the Minimum Data Set (MDS) resident assessment information and information obtained by the Department or its designee retained for cost auditing purposes.

The Core Component per diem rate shall be the sum of the following per diem rates:

1. Health care per diem rate described in Section 8.443.7.D,

2. Administrative and general per diem rate described in Section 8.443.8.E, and

3. Fair rental allowance per diem rate described in Section 8.443.9.B.

In addition to the MMIS claims reimbursement, a Class 1 nursing facility provider may be reimbursed supplemental payments. Supplemental payments are funded using available provider fee dollars collected as described in Section 8.443.17. Supplemental payments shall be funded in the subsequent order based upon the statutory hierarchy pursuant to C.R.S § 25.5-6-203(2)(b).

1. Medicaid utilization supplemental payment described in Section 8.443.10.C,

2. Acuity Adjusted Core Component supplemental payment described in Section 8.443.11.B,

3. Pay-For-Performance supplemental payment described in Section 8.443.12,

4. Cognitive Performance Scale supplemental payment described in Section 8.443.10.A,

5. Preadmission Screening and Resident Review II Resident supplemental payment described in Section 8.443.10.B,

6. Preadmission Screening and Resident Review II Facility supplemental payment described in Section 8.443.10.B, and

7. Core Component supplemental payment described in Section 8.443.11.A.

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Title of Rule: Revision to the Medical Assistance Rule concerning Telemedicine, Sections 8.520.4.B, 8.700.1, 8.730.3.B, 8.740.1, 8.750.3.B
Rule Number: MSB 20-07-01-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 20-07-01-A, Revision to the Medical Assistance Rule concerning Telemedicine, Sections 8.520.4.B, 8.700.1, 8.730.3.B, 8.740.1, 8.750.3.B

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) 8.520.4.B, 8.700.1, 8.730.3.B, 8.740.1, 8.750.3.B, 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)? Yes
   If yes, state effective date: 7/10/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.520.4.B.1 with the proposed text beginning at 8.520.4.B.1.g through the end of 8.520.4.B.1.g. Replace the current text at 8.700.1.B with the proposed text beginning at 8.700.1.B through the end of 8.700.1.B.2. Replace the current text at 8.730.3.B with the proposed text beginning at 8.730.3.B.12 through the end of 8.730.3.B.12. Replace the current text at 8.740.1 with the proposed text beginning at 8.740.1 through the end of 8.740.1. Replace the current text at 8.750.3.B with the proposed text beginning at 8.750.3.B through the end of 8.750.3.B.3. This rule is effective July 10, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Telemedicine, Sections 8.520.4.B, 8.700.1, 8.730.3.B, 8.740.1, 8.750.3.B
Rule Number: MSB 20-07-01-A
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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).

   This rule revision permits telemedicine for select home health, Federally-Qualified Health Center, Family Planning, Rural Health Clinic, and Community Mental Health Centers/Clinic services using interactive audio, interactive video, or interactive data communication in lieu of face-to-face visits between clients and health professionals. The purpose of the rule revision is to limit face-to-face visits between clients and providers, where appropriate, to help contain the spread of the 2019 Novel Coronavirus Disease (COVID-19). Telemedicine also increases efficiency for providers with a high volume of clients.

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:

   Permitting the utilization of telemedicine through interactive audio, interactive video, or interactive data communication, where appropriate, to limit face-to-face visits between clients and health professionals and to help contain the spread of COVID-19 is imperatively necessary for preservation of public health, safety, and welfare.

3. Federal authority for the Rule, if any:

   42 CFR 410.78 (2020)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   Section 25.5-5-320, C.R.S. (2019)

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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.

   Clients receiving services for telemedicine-eligible home health, Federally-Qualified Health Center, family planning, Rural Health Clinic, and Community Mental Health Center/Clinic services, and the providers that render such services, will be benefit from the proposed rule. Providers of such services will bear the cost of maintaining any technology resources required to provide telemedicine services to clients.

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

   Affected clients and providers will benefit from reduced face-to-face visits, and the associated in-person visits to medical facilities, where exposure to COVID-19 may occur. Providers will also benefit from the efficiencies of telemedicine at a time when the volume of clients seeking care is high.

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 are no costs to the Department or to any other agency to implement and enforce the proposed rule.

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

   The probable cost of the proposed rule to a provider is setting up and maintaining the technology resources necessary to implement telemedicine, if such technology is not already utilized by a provider. The benefits of the proposed rule are limiting face-to-face visits between clients and providers to help contain the spread of COVID-19, where appropriate, and increased efficiency for providers rendering care to a high volume of clients.

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 less intrusive methods for achieving 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.

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

8.520 HOME HEALTH SERVICES

8.520.4. Covered Services

8.520.4.B. Place of Service

1. Services shall be provided in the client's place of residence or one of the following places of service:

   a. Assisted Living Facilities (ALFs);

   b. Alternative Care Facilities (ACFs);

   c. Group Residential Services and Supports (GRSS) including host homes, apartments or homes where three or fewer clients reside. Services shall not duplicate those that are the contracted responsibility of the GRSS;

   d. Individual Residential Services and Supports (IRSS) including host homes, apartments or homes where three or fewer clients reside Services shall not duplicate those that are the contracted responsibility of the IRSS; or

   e. Hotels, or similar temporary accommodations while traveling, will be considered the temporary place of residence for purposes of this rule.

   f. Nothing in this section should be read to prohibit a client from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

   g. Services may be provided using interactive audio or interactive video instead of in-person contact.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

A. Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the

United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule:

B. Visit means a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor providing the services set forth in Section 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

1. A visit includes a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado providing services set forth in Section 8.700.3.A. The supervised person must hold a candidate permit as a licensed professional counselor or a candidate permit as a licensed marriage and family therapist, or a candidate permit as a psychologist, or a be a licensed social worker. Group sessions do not generate a billable encounter for any FQHC services.

8.730 FAMILY PLANNING SERVICES

8.730.3 Provider Eligibility

8.730.3.A. The following Medicaid enrolled providers may offer family planning services:

1. Physician
2. Osteopath
3. Nurse Practitioner
4. Certified Nurse-Midwife
5. Physician Assistant
6. Clinical Nurse Specialist
7. Certified Registered Nurse Anesthetist
8. Family Planning Clinic
9. Public Health Agency
10. Non-physician Practitioner Group

8.730.3.B. Eligible places of service include:

1. Office

2. Clinic

3. Public Health Agency

4. Home

5. School

6. School-based Health Center

7. Federally Qualified Health Center

8. Rural Health Center

9. Hospital

10. Ambulatory Surgery Center

11. Telemedicine

8.740 RURAL HEALTH CLINICS

8.740.1 DEFINITIONS

Rural Health Clinic means a clinic or center that:

1. Has been certified as a Rural Health Clinic under Medicare.

2. Is located in a rural area, which is an area that is not delineated as an urbanized area by the Bureau of the Census.

3. Has been designated by the Secretary of Health and Human Services as a Health Professional Shortage Area (HPSA) through the Colorado Department of Public Health and Environment.

4. Is not a rehabilitation facility or a facility primarily for the care and treatment of mental diseases.

Visit means a face-to-face, interactive audio, interactive video, or interactive data communication encounter between a clinic client and any health professional providing the services set forth in 8.740.4.

8.750 COMMUNITY MENTAL HEALTH CENTERS/CLINICS

8.750.3 COVERED SERVICES

8.750.3.A. Services shall include but are not limited to prevention, diagnosis and treatment of emotional or mental disorders. Such services shall be rendered primarily on an outpatient and consultative basis for clients residing in a particular community in or near the facility so situated.

8.750.3.B. Community Mental Health Centers/Clinics shall provide medically necessary rehabilitation services in an outpatient setting. Covered services shall include:

1. Case management services, including but not limited to:

   a. Service planning and program linkage.

   b. Referral recommendations.

   c. Monitoring and follow up.

   d. Client advocacy.

   e. Crisis management.

2. Group psychotherapy services shall be face-to-face, interactive audio, interactive video, or interactive data communication services that are insight-oriented, behavior modifying, and that involve emotional interactions of the group members. Group psychotherapy services shall assist in providing relief from distress and behavior issues with other clients who have similar problems and who meet regularly with a practitioner.

3. Individual psychotherapy services shall be face-to-face, interactive audio, interactive video, or interactive data communication services that are tailored to address the individual needs of the client. Services shall be insight-oriented, behavior modifying and/or supportive with the client in an office or outpatient facility setting. Individual psychotherapy services are limited to thirty-five visits per State fiscal year.