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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 20-0024

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-26-12 Baltimore, MD 21244-1850



Financial Management Group

July 26, 2021

Tracy Johnson Medicaid Director Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818

Re: Colorado 20-0024

Dear Ms. Johnson,

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 20-0024. Effective for services on or after October 1, 2020, this amendment provides updates to the disproportionate share hospital (DSH) methodology, revises inpatient hospital supplemental payments, establishes the Hospital Transformation Program (HTP) and establishes the Rural Support Payment for outpatient hospital services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 20-0024 is approved effective October 1, 2020. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044 or Lajoshica Smith at (214) 767-6453.

Sincerely,

For

Rory Howe Acting Director

TRANSMITTAL AND NOTICE OF APPROVAL OF 1. TRANSMITTAL NUMBER: 2. STATE: COLORADO 20024 COLORADO STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES 3. PROGRAM IDENTIFICATION: 10. REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES 3. PROGRAM IDENTIFICATION: 11. TRANSMITTAL NUMBER: 2. STATE 2. STATE 10. REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES 4. PROPOSED EFFECTIVE DATE: COLDER 1, 2020 5. TYPE OF PLAN MATERIAL (CROK OND): 4. PROFOSED EFFECTIVE DATE: October 1, 2020 S. TYPE OF PLAN MATERIAL (CROK OND): 4. PROFOSED EFFECTIVE DATE: 0. COMPLETE BLOCKS 8 THRU 10 IF THIS IS AN AMENDMENT (Suparativ transmittal for each amendment) 6. FEDERAL STATUTE/REGULATION GTATION 7. FEDERAL BUDGET IMPACT: 8. PFY 2021: \$ 8,000,000 6. FEDERAL STATUTE/REGULATION GTATION 7. FEDERAL BUDGET IMPACT: 8. PFY 2022: \$ 2,000,000 7. Attachment 4.19A - Pages 29d, 57c Attachment 4.19B - Pages 29d, 57c Attachment 4.19B - Pages 27d, 65, 66 (NEW) Attachment 4.19B - Pages 29d, 57c Attachment 4.19B - Pages 27d, 65, 66 (NEW) Attachment 4.19B - Pages 27d, 65, 66 (NEW) Attachment 4.19B - Pages 27d, 65, 66 (NEW) Attachment 4.19B - Pages 27d, 65, 66 (NEW) Attachment 4.19B - Pages 27d, 65, 66 (NEW) Attachment 4.19B - Pages 27d, 65	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0193			
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Rory Howe						
	Rory Howe					
23. REMARKS	23. REMARKS					

State of Colorado

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Effective October 1, 2019, total funds for the DSH payment shall equal an amount such that federal DSH funds shall not exceed the allowable FFY 2019-20 Colorado DSH allotment.

Qualified hospitals with CICP write-off costs greater than or equal to 1,000% of the statewide average and qualified Critical Access Hospitals shall receive a payment equal to at least 90% of their estimated hospital-specific DSH limit but not exceeding 100% of their estimated hospital-specific DSH limit.

Remaining qualified hospitals shall receive a payment equal to their percent of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. No remaining qualified hospital shall receive a payment exceeding 96% of their hospital-specific DSH limit as specified in federal regulation. If a remaining qualified hospital's DSH Supplemental payment exceeds 96.00% of their hospital-specific DSH limit, the payment shall be reduced to 96.00% of their hospital-specific DSH limit, the payment shall be reduced to 96.00% of their hospital-specific DSH limit based on the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals not 96.00% of exceeding their hospital-specific DSH limit.

Notwithstanding the above, a qualified hospital with a MIUR less than or equal to 15% shall have their hospital-specific DSH limit equal to 10%. A qualified new CICP-participating hospital shall have their hospital-specific DSH limit equal to 10%.

Effective October 1, 2020, total funds for the DSH payment shall equal an amount such that federal DSH funds shall not exceed the allowable FFY 2020-21 Colorado DSH allotment.

Certain hospital groups shall receive a DSH payment equal to at least 90.00% of their estimated hospitalspecific DSH limit but not exceeding 100% of their estimated hospital-specific DSH limit. The hospitals groups, requirements for a hospital to be included in each hospital group, and the percentage of hospitalspecific DSH limit reimbursed through the DSH payment for each group shall be published to the Colorado Medicaid Provider Bulletin found on the Department's website at: www.colorado.gov/hcpf/bulletins.

Remaining qualified hospitals shall receive a payment equal to their percent of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining DSH funds. No remaining qualified hospital shall receive a payment exceeding 96% of their hospital-specific DSH limit as specified in federal regulation. If a remaining qualified hospital's DSH Supplemental payment exceeds 96.00% of their hospital-specific DSH limit, the payment shall be reduced to 96.00% of their hospital-specific DSH limit, the payment shall be reduced to 96.00% of their hospital-specific DSH limit based on the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals not 96.00% of exceeding their hospital-specific DSH limit.

Notwithstanding the above, a qualified hospital with a MIUR less than or equal to 15% shall have their hospital-specific DSH limit equal to a designated percentage. A qualified new CICP-participating hospital shall have their hospital-specific DSH limit equal to a designated percentage. The designated percentages for both hospital groups shall be published to the Colorado Medicaid Provider Bulletin found on the Department's website at: www.colorado.gov/hcpf/bulletins.

The state shall not exceed the total of all the hospital-specific DSH limits even if the total reimbursement is below the state's annual DSH allotment.

TN No. <u>20-0024</u>
Supersedes
TN No. <u>19-0031-A</u>

Approval Date 7/26/21 Effective Date 10/1/2020

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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

Effective October 1, 2020, HQIP includes eleven (11) measures separated into three (3) measure groups. A hospital is required to complete all measures but is not required to complete a measure if they are not eligible. If a hospital is not eligible for a measure(s) their total points awarded from all eligible measures shall be normalized.

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 a 100 point scale.

The HQIP measure groups and measures 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. Clostridium Difficile
- 8. Adverse Event
- 9. Culture of Safety Survey

Patient Experience Measure Group

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

Dollars Per-Adjusted Discharge Point

The dollars per-adjusted discharge point 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 with each tier assigned a certain normalized points awarded range. For each tier, the dollars per-adjusted discharge point increase by a multiplier.

State of Colorado

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

The multiplier and normalized points awarded for each tier are shown in the table below:

The dollars per-adjusted discharge point shall equal an amount such that the total payment made to all hospitals shall equal seven percent (7.00%) of the total reimbursement made to hospitals in the previous state fiscal year.

Total Funds for this payment equal:

FFY 2012-13	\$32,000,000	FFY 2015-16	\$84,810,386	FFY 2018-19	\$90,496,734
FFY 2013-14	\$34,388,388	FFY 2016-17	\$89,775,895	FFY 2019-20	\$90,778,024
FFY 2014-15	\$61,488,873	FFY 2017-18	\$97,553,767	FFY 2020-21	\$89,149,838

In the event that HQIP payment calculation errors are realized after HQIP payments have been made, reconciliations and adjustments to impacted hospitals will be made retroactively.

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Inpatient Hospital Transformation Program

Effective October 1, 2020, qualified hospital shall participate in the Inpatient Hospital Transformation Program (HTP). The Inpatient HTP leverages supplemental Medicaid payments as incentives designed to improve patient outcomes and lower Medicaid cost. Qualified hospitals not completing a reporting activity shall have their Medicaid supplemental payments reduced. The reduced Medicaid supplemental payments shall be paid to qualified hospitals completing the reporting activity. The Inpatient HTP is a multi-year program with a program year (PY) being on a federal fiscal year (FFY) (October 1 through September 30) basis. The end date of the Inpatient HTP will be September 30, 2027.

Payments through the Inpatient HTP are made only if there is available federal financial participation under the Inpatient Upper Payment Limit after all other Medicaid Fee-for-Service payments and Medicaid supplemental payments are considered.

To qualify for the Inpatient HTP a hospital shall meet the following criteria:

- 1. Is state licensed as a General Hospital or Critical Access Hospital participating in Colorado Medicaid;
- 2. Is not licensed as a Psychiatric Hospital, Rehabilitation Hospital, or Long-Term Care Hospital by the Colorado Department of Public Health & Environment.

Inpatient HTP Supplemental Medicaid Payment Reduction/Distribution

Each PY includes reporting activities that a qualified hospital is required to complete. A qualified hospital not completing a reporting activity shall have their Inpatient Supplemental Medicaid Payment (discussed on Page 49a) and Essential Access Supplemental Medicaid Payment (discussed on Page 51c) reduced by a designated percent. The dollars not paid to those qualified hospitals shall be distributed to qualified hospitals completing the reporting activity. A qualified hospital's distribution shall equal their percentage of Inpatient Supplemental Medicaid Payment and Essential Access Supplemental Medicaid Payment to the total Inpatient Supplemental Medicaid Payment and Essential Access Supplemental Medicaid Payment for all qualified hospitals completing the reporting activity, multiplied by the total reduced dollars for qualified hospitals not completing the reporting activity.

The reduction and distribution shall be calculated using the Inpatient Supplemental Medicaid Payment and Essential Access Supplemental Medicaid Payment effective during the reporting activity period. The reduction and distribution shall both occur during the last quarter of the subsequent PY.

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State of Colorado

Inpatient HTP Reporting Activities

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

- 1. Application (1.5% at-risk total) Qualified hospitals must provide interventions and measures they shall address 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.
- 2. 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.
- 3. Quarterly Reporting (0.5% per quarter) Qualified hospitals must report quarterly on the 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.
- 4. Milestone Report (4.0% at-risk total in PY2, 8.0% at-risk total in PY3) 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.
- 5. Sustainability Plan (8.0% at-risk total) Qualified hospitals must submit a plan demonstrating how the transformation efforts will be maintained after the Inpatient HTP is over. The percent at-risk shall be scored on timely and satisfactory submission.

Non-Participation in the Inpatient HTP

A qualified hospital not participating in the Inpatient HTP may have the entirety of their Inpatient Supplemental Medicaid Payment and Essential Access Supplemental Medicaid Payment withheld. This includes the option of recovering any HTP Supplemental Medicaid Payments previously reimbursed to the qualified hospital during the HTP.

Approval Date <u>7/26/21</u> E

ATTACHMENT 4.19B

State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

OUTPATIENT HOSPITAL SERVICES

Outpatient Hospital Transformation Program

Page 1 of 2

Effective October 1, 2020, qualified hospitals shall participate in the Outpatient Hospital Transformation Program (HTP). The Outpatient HTP leverages supplemental Medicaid payments as incentives designed to improve patient outcomes and lower Medicaid cost. Qualified hospitals not completing a reporting activity shall have their Medicaid supplemental payments reduced. The reduced Medicaid supplemental payments shall be paid to qualified hospitals completing the reporting activity. The Outpatient HTP is a multi-year program with a program year (PY) being on a Federal Fiscal Year (FFY) (October 1 through September 30) basis. The end date of the Outpatient HTP will be September 30, 2027.

Payments through the Outpatient HTP are made only if there is available federal financial participation under the Outpatient Upper Payment Limit after all other Medicaid Fee-for-Service payments and Medicaid supplemental payments are considered.

To qualify for the Outpatient HTP a hospital shall meet the following criteria:

- 1. Is state licensed as a General Hospital or Critical Access Hospital participating in Colorado Medicaid;
- 2. Is not licensed as a Psychiatric Hospital, Rehabilitation Hospital, or Long-Term Care Hospital by the Colorado Department of Public Health & Environment.

Outpatient HTP Supplemental Medicaid Payment Reduction/Distribution

Each PY includes reporting activities that a qualified hospital is required to complete. A qualified hospital not completing a reporting activity shall have their Outpatient Supplemental Medicaid Hospital Payment reduced by a designated percent. The dollars not paid to those qualified hospitals shall be distributed to qualified hospitals completing the reporting activity. A qualified hospital's distribution shall equal their percent of Outpatient Supplemental Medicaid Hospital Payment to the total Outpatient Supplemental Medicaid Hospitals completing the reporting activity, multiplied by the total reduced dollars for qualified hospitals not completing the reporting activity.

The reduction and distribution shall be calculated using the Outpatient Supplemental Medicaid Payment effective during the reporting activity period. The reduction and distribution shall both occur during the last quarter of the subsequent PY.

Approval Date <u>7/26/21</u> Effective Date <u>10/1/2020</u>

ATTACHMENT 4.19B

State of Colorado METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

OUTPATIENT HOSPITAL SERVICES

Outpatient Hospital Transformation Program

Page 2 of 2

Outpatient HTP Reporting Activities

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

- 1. Application (1.5% at-risk total) Qualified hospitals must provide interventions and measures they shall address 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.
- 2. 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.
- 3. Quarterly Reporting (0.5% at-risk per quarter) Qualified hospitals must report quarterly on the 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.
- 4. Milestone Report (4.0% at-risk total in PY2, 8.0% at-risk total in PY3) 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.
- 5. Sustainability Plan (8.0% at-risk total) Qualified hospitals must submit a plan demonstrating how the transformation efforts will be maintained after the Outpatient HTP is over. The percent at-risk shall be scored on timely and satisfactory submission.

Non-Participation in the Outpatient HTP

A qualified hospital not participating in the Outpatient HTP may have the entirety of their Outpatient Supplemental Medicaid Hospital Payment withheld. This includes the option of recovering any HTP Supplemental Medicaid Payments previously reimbursed to the qualified hospital during the HTP.

ATTACHMENT 4.19B

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State of Colorado

Rural Support Program Supplemental Medicaid Payment

Effective October 1, 2020, qualified hospitals shall receive an additional supplemental Medicaid payment commonly referred to as "Rural Support Program" (RSP) supplemental Medicaid payment which shall be calculated once and reimbursed in monthly installments over the subsequent five federal fiscal years.

The payment is made only if there is available federal financial participation under the Outpatient Upper Payment Limit after all other Medicaid Fee-for-Service payments and Medicaid supplemental payments are considered.

The payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period.

To qualify for the payment a hospital shall meet all the following criteria:

- 1. Is state licensed as a Critical Access Hospital or is a Rural Hospital, participating in Colorado Medicaid;
- 2. Is a nonprofit hospital; and
- 3. Meets one of the below:
 - a. Their average net patient revenue for the three-year 2016, 2017, and 2018 cost reporting period is in the bottom ten percent (10%) for all Critical Access Hospitals or Rural Hospitals, or
 - b. Their fund balance for the 2019 cost report period is in the bottom two and one-half percent (2.5%) for all Critical Access Hospitals or Rural Hospitals not in the bottom 10% of the three-year average net patient revenue for all Critical Access Hospitals or Rural Hospitals.

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 qualified hospitals.

For a qualified hospital, the annual payment shall equal twelve million dollars (\$12,000,000) divided by the total number of qualified hospitals.