Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: 20-0024

This file contains the following documents in the order listed:

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,

[redacted]

For

Rory Howe
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **20 – 0024**

2. STATE: **COLORADO**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 1, 2020**

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN | AMENDMENT TO BE CONSIDERED AS A NEW PLAN | **X AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.272 42 CFR 447.297 42 CFR 447.325

7. FEDERAL BUDGET IMPACT:

a. FFY 2021: $ 8,000,000
b. FFY 2022: $ 2,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A – Pages 29d, 57c
Attachment 4.19A – Pages 57d, 65, 66 (NEW)
Attachment 4.19B – Outpatient Hospital Transformation Program (Pages 1 & 2) (NEW)
Attachment 4.19B - Rural Support Payment (Page 1) (NEW)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19A – 29d, 57c (TN 19-0031-A)

10. SUBJECT OF AMENDMENT:

Revise Inpatient supplemental payments, establish Hospital Transformation Program (HTP), and establish Rural Support Payment (RSP).

11. GOVERNOR'S REVIEW *(Check One)*:

GOVERNOR'S OFFICE REPORTED NO COMMENT | **X OTHER, AS SPECIFIED**

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED | **Governor's letter dated 11 October, 2019**

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

[redacted]

13. TYPED NAME:

Tracy Johnson

14. TITLE:

Medicaid Director

15. DATE SUBMITTED: Initial: December 23, 2020
Update #1: May 13, 2021

16. RETURN TO:

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

Attn: Amy Winterfeld

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
7/26/21

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
10/01/20

20. SIGNATURE OF REGIONAL OFFICIAL

[redacted] For

21. TYPED NAME

Rory Howe

22. TITLE

Acting Director, FMG

23. REMARKS

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 reduction shall then be redistributed to other remaining 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 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 hospital-specific 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 hospital-specific 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 reduction shall then be redistributed to other remaining 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 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.

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.

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

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 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.

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.

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.

ATTACHMENT 4.19B

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

Outpatient Hospital Transformation Program

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 Hospital 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 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.

Outpatient Hospital Transformation Program

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.

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.