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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 20-0039

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th Street, Suite 355
Kansas City, MO 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid & CHIP Operations Group

March 16, 2021

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

RE: Colorado State Plan Amendment (SPA) 20-0039

Dear Ms. Bimestefer:

We have reviewed the State Plan Amendment (SPA) submitted under transmittal number 20-0039. This amendment aligns the home health services rule with the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, and federal regulation, by adding nurse practitioners, clinical nurse specialists, and physician assistants to the list of practitioners who can order home health services.

Please be informed that this SPA was approved on March 16, 2021, with an effective date of November 13, 2020. Enclosed are an additional Companion Letter, the CMS-179, and the amended plan pages.

Should you have any questions about this amendment, please contact Curtis Volesky at (303) 844-7033.

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2021.03.16 15:43:30 -05'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Dr. Tracy Johnson, Tracy.Johnson@state.co.us
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Centers for Medicare & Medicaid Services
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March 16, 2021

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

RE: Colorado State Plan Amendment (SPA) 20-0039

Dear Ms. Bimestefer:

We are sending this letter as a companion to our approval of CO-20-0039, which amends the state plan to align the home health services rule with the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, and federal regulation, by adding nurse practitioners, clinical nurse specialists, and physician assistants to the list of practitioners who can order the home health services.

During the review of CO-20-0039, CMS inquired about the certain service limitations affecting the SPA, and whether the state completed a sufficiency review of those services. We were informed that a sufficiency review had not been completed for this SPA. Accordingly, we are sending this Companion Letter to address the following questions and requested changes.

1. **Supplement to Attachment 3.1-A, item B.** In accordance with section 1902(a)(10)(B) and 42 CFR 440.240, plans must provide that the services available to any individual in the categorically needed and the medically needy groups are equal in amount, duration, and scope for all beneficiaries within the group. The state's home health benefit is comprised of "acute home health services" and "long-term home health services". Acute Home Health is the first 60 days of service and includes both mandatory (nursing, home health aide, medical supplies, equipment and appliances) and optional (therapies) services of the home health benefit. Long-term home health includes both mandatory and optional services for individuals age 0 to 20, however, only the mandatory components are provided to individuals 21 and older. To help CMS understand the impact of the way the state has

structured the home health benefit, and if this structure meets the comparability requirements at 42 CFR 440.240, please answer the following questions:

a. What is the reason for not including therapy services for individuals 21 and older who continue to receive home health services after day 60?
b. How will those affected by this limitation obtain the therapy services they need beyond the stated limits? If individuals can receive therapy services under another Medicaid benefit, are those services provided in the same manner as it would be provided under the home health benefit? If no, what are the differences?
c. If the beneficiary's covered services are being reduced, will the beneficiary be notified of their appeal rights per 42 CFR 431.206?

2. **Supplement to Attachment 3.1-A, item 5.** In accordance with 42 CFR 440.230(a), the plan must specify the amount, duration, and scope of each service it provides. The plan page states, "maximum daily reimbursement limits are set for long-term home health and for acute-home health services." This language does not specify the actual limitation that is applied. This appears to be a coverage limitation that, in accordance with 42 CFR 440.230(a), must be specified on the plan page. Please revise the plan page to specify the actual daily reimbursement limit. CMS also requests the state replace the term "reimbursement" with "coverage".

3. **Supplement to Attachment 3.1-A, item 5.** The state has verbally explained that, "maximum daily reimbursement limits are set for long-term home health and for acute-home health services," is a service limitation. Services above the limitation will not be approved regardless of medical necessity.

   While a state may implement amount, duration and scope limitations on Medicaid benefits, when limitations are applied regardless of medical necessity, they are considered hard limitations and a sufficiency determination is necessary. 42 CFR 440.230(b) sets forth the requirement that services must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The sufficiency of mandatory services should be demonstrated by ensuring that the proposed limitation meets the needs of at least 90% of beneficiaries. Please provide data to support that the proposed limitation would meet the needs of at least 90% of beneficiaries by responding to the questions below.

   A. BACKGROUND- What is the reason for this limitation? If the reason for the limitation is duplication of services, abuse or inappropriate utilization, please provide the evidence that supports this reasoning. What other approaches/initiatives/processes have you tried or considered to address this matter?

   B. DATA SUPPORT- Using data within the last 12 months, what percentage of Medicaid beneficiaries utilized the maximum amount of the service?

   Please provide this information for the following eligibility groups:
   a. Aged, Blind and Disabled
   b. Non-Dually Eligible Adults (for analyses of services for which Medicare

would not be primary payer, otherwise the analysis would include dually eligible individuals)

c. Pregnant Women
d. Parents/Caretakers /Other Non-Disabled Adults
e. Adult expansion group, if applicable

C. CLINICAL SUPPORT- If the data requested above is not available, or is not relevant to demonstrating the sufficiency of the limited benefit, please indicate support for this proposed scope of services through clinical literature or evidence-based practice guidelines, or describe your consultation with your provider community or others that resulted in an assurance that this proposed scope of services has meaningful clinical merit to achieve its intended purpose.

D. EXCEPTIONS- Are there any exemptions to the proposed limitations? If so, how was this exemption determined to be appropriate? Does the state have a process for granting other exemptions if similar circumstances warrant? (e.g., if there is an exemption for individuals with one condition because their needs are greater, is there a process for other individuals with conditions that result in greater needs to request an exemption?) Can additional services beyond the proposed limit be provided based on a determination of medical necessity? That is, will there be an exception or prior authorization process for beneficiaries that require services beyond the limitation?

E. BENEFICIARY IMPACT- Please describe what will or is likely to occur to beneficiaries who will be impacted by this limitation. If the limit cannot be exceeded based on a determination of medical necessity:

a. How will those affected by the limitation obtain the medical services they need beyond the stated limits?
b. Will beneficiaries be billed and expected to pay for any care that may not be covered? Or, instead will the provider or practitioner be expected to absorb the costs of the provided services?
c. Will beneficiaries be reassessed to determine need for the service prior to the plan amendment's effective date?
d. If the beneficiary's covered services are being reduced, will the beneficiary be notified of their appeals rights per 42 CFR 431.206?

F. DELIVERY SYSTEM- Will the proposed limitation apply to services performed through managed care contracts, fee-for-service (FFS) or both? If applied in managed care, indicate whether or not the capitation rates will be adjusted to reflect the change.

G. TRACKING- How is the limitation tracked? Will both providers and beneficiaries be informed in advance so they know they have reached the limit? Please summarize the process.

Should you have any questions about this letter, please contact Curtis Volesky at (303) 844-7033.

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2021.03.16 15:44:08 -05'00'

James G. Scott, Director
Division of Program Operations

cc: Dr. Tracy Johnson, Tracy.Johnson@state.co.us
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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 – 0039**

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: **November 13, 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:

SOCIAL SECURITY ACT 1905(a)(7) / CARES Act, PL. 116-136 § 3708, March 27, 2020, 134 Stat 281; 42 CFR 440.70(a)(2)

7. FEDERAL BUDGET IMPACT:

a. FFY 2021: $ 0
b. FFY 2022: $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement to Attachment 3.1-A – Limitations to Care and Services – Item 7 – Home Health Services – Pages 1-2 of 2

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

Supplement to Attachment 3.1-A – Limitations to Care and Services – Item 7 – Home Health Services (TN 11-012)

10. SUBJECT OF AMENDMENT:

This amendment aligns the home health services rule with the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, and federal regulation, by adding nurse practitioners, clinical nurse specialists, and physician assistants to the definition of "ordering physician."

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:

Tracy L. Johnson

13. TYPED NAME:

Tracy Johnson

14. TITLE:

Medicaid Director

15. DATE SUBMITTED: December 18, 2020

Update No. 1: March 1, 2021

16. RETURN TO:

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

Attn: Lauren Reveley

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 18, 2020

18. DATE APPROVED: March 16, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: November 13, 2020

20. SIGNATURE OF REGIONAL OFFICIAL

[redacted]

Digitally signed by James G. Scott -S
Date: 2021.03.16 15:46:28 -05'00'

21. TYPED NAME: James G. Scott

22. TITLE: Director, Division of Program Operations

23. REMARKS

FORM CMS-179 *(07/92)* ***Instructions on Back***

LIMITATIONS TO CARE AND SERVICES

7 Home Health Services

A Service Limitations

1. Acute Home Health shall be assessed for medical necessity and is provided during a 60 calendar day episode

2 Long Term Home Health is provided for 61 calendar days or longer for chronic conditions. Medicaid clients receiving Long Term Home Health shall be assessed for medical necessity and services shall be prior authorized by the State designated agency

3 All services provided by a home care agency must be medically necessary and ordered as part of a written plan of care, reviewed every 60 days, indicating the amount, duration and scope of the home care services the client can receive. Orders for services may be written by physicians, nurse practitioners, clinical nurse specialists, or physician assistants.

4 Sample post-pay review applies to all Home Health services

5 Effective January 1, 2000, maximum daily reimbursement limits are set for long term home health and for acute home health. These maximum reimbursement limits are based upon type and cost of long term home health services (primarily aide visits) and acute home health services (primarily nursing visits). These maximums will be adjusted in accordance with rate changes

B Services

a Skilled nursing services provided by a home health agency	Provided to Medicaid clients who receive Acute or Long Term Home Health
b Home health aide services provided by a home health agency	Provided to Medicaid clients who receive Acute or Long Term Home Health
c Physical therapy services provided by a home health agency	Provided to adults in Acute Home Health and children in both Long Term Home Health and Acute Home Health
d Occupational therapy services provided by a home health agency	Provided to adults in Acute Home Health and children in both Long Term Home Health and Acute Home

LIMITATIONS TO CARE AND SERVICES

7 Home Health Services

e Speech/language pathology services provided by a home health agency	Provided to adults in Acute Home Health and children in both Long Term Home Health and Acute Home
f Home health telehealth services provided by a home health agency	Provided to Medicaid clients who receive Acute or Long Term Home Health
g Medical supplies, equipment and applicants suitable for use in the home	Provided to Medicaid clients for use in any setting in which normal life activities take place

C Provider Qualifications

1 Physical therapists and Speech therapists are licensed by the State of Colorado

i Physical therapists must meet the provider qualifications for Medicaid found at 42 CFR 440.110

ii Speech therapists must meet the provider qualifications for Medicaid found at 42 CFR 440.110

2 Occupational therapists are not licensed in Colorado but must be registered at the Colorado Department of Regulatory Agencies (DORA)

i. Occupational therapists must meet the provider qualifications for Medicaid found at 42 CFR 440.110

D All Home Care agencies are required to meet the conditions of participation in Medicare found at 42 CFR 484

E Provider Choice

1 Clients are free to choose from any qualified Colorado Medicaid provider