DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Maternity Services Episode Based Payments, Section 8.733
Rule Number: MSB 22-04-27-A
Division / Contact / Phone: Managed Care Rates and Payment Reform / Ke Zhang / 2748

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 22-04-27-A, Revision to the Medical Assistance Rule concerning Maternity Services Episode Based Payments, Section 8.733

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

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.733 with the proposed text beginning at 8.733 through the end of 8.733. This rule is effective July 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Maternity Services Episode Based Payments, Section 8.733
Rule Number: MSB 22-04-27-A
Division / Contact / Phone: Managed Care Rates and Payment Reform / Ke Zhang / 2748

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 Department implemented a maternity bundled payment program in 2020 with a detailed program rule in place under the Medical Assistance Rule concerning Maternity Services Episode Based Payments, Section 8.733. The goal of the program is to improve pregnant and birthing members' health outcomes by improving obstetrical care service quality while reducing cost. The program gives providers performance linked opportunities to earn extra incentive payments besides the fee-for-service reimbursement for maternity services. A few key program implementation updates have been implemented during the first program year (Nov. 2020 – Oct. 2021), including adding mental health considerations into the current threshold setting process, and removing downside risk implementation. This rule update aims to include those program updates and fix a few language alignments issues.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Maternity Services Episode Based Payments, Section 8.733
Rule Number: MSB 22-04-27-A
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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.

   This rule update will impact pregnant and birthing members and neonates who utilize services from participating obstetrical practices. The impacted members will benefit from an improved care experience throughout the episode and the program will incentivize the participating obstetricians to promote screening, referral and treatment for deliveries with substance use disorder and mental health conditions. Participating obstetricians will also be impacted. They will have a higher chance to receive a greater incentive shared savings by coordinating and improving care for the members throughout the episode and will not face any financial penalties because of the removal of downside risk in the program, which was originally included in the initial rule.

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

   Participating obstetricians have the opportunity to earn extra incentive payments besides the fee-for-service reimbursement through the program. The updated rule will provide the participating providers a higher chance to receive a greater amount of incentive shared savings if they meet the program's quality improvement and cost saving goals. In addition, the updated rule removes the downside risk, so providers will not be liable for negative incentives.

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.

   Probable costs include budget for providing future stakeholder engagement, program data and performance reporting, program evaluation, and future program updates. With the updated rule, the program is expected to save the state money in the long term as providers learn to improve care quality and reduce unnecessary cost.

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

   If this rule update were not implemented, key program updates based on internal and external stakeholders' feedback will not be correctly and formally reflected by the administrative rules of the program. Thus, there would be confusion and misunderstanding from providers and stakeholders in terms of the operational details of the program moving forward, which will negatively impact the Department's accountability and credibility as the administrative party of this program.

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

   This rule update is a revision of an existing program rule. Thus, there is no less costly or less intrusive methods. Bundled payments are used nationally by commercial health plans, employer insurance, and government agencies to improve outcomes for patients. Bundled payments have been shown to be effective at improving care quality and eliminating unnecessary cost. The program updates reflected by this rule update is essential for program success moving forward.

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 program updates reflected by this rule update is based on external and internal stakeholders' feedback and the Department's leadership decisions on a few program operational details. The Department is not aware of any alternative methods/updates for improving this program at the moment.

8.733 EPISODE BASED PAYMENTS

8.733.1 DEFINITIONS

8.733.1.A. **Episode** means a defined group of related Medicaid ~~-~~covered services provided to a specific patient over a specific period of time. ~~An~~A Maternal Episode includes the Delivery Episode Trigger; Prenatal Pre-Trigger Window; Delivery Trigger Window; and Post-Partum Post-Trigger Window.

1. **Delivery Episode Trigger** means the date of a qualifying live delivery event.

2. **Prenatal Pre-Trigger Window** means the 280-day period prior to the delivery episode trigger window and includes all relevant care for the patient provided during that period.

3. **Delivery Trigger Window** means the time period ~~of time~~ when the mother is in the hospital for the delivery episode trigger.

4. **Postpartum Post-Trigger Window** means the ~~90~~60-day time period following the delivery episode trigger window and includes all relevant care and any complications that might occur for the mother during that period.

8.733.1.B. **Episode Cohort** means a Principal Accountable Provider's (PAP) maternity Episodes eligible for either positive or negative incentives after exclusions, ~~high~~ cost outliers, and services not relevant to the Prenatal Pre-Trigger, Delivery Trigger, and Post-Partum Post-Trigger Windows have been removed~~-~~.

8.733.1.C. **Gross Episode Performance** means the aggregated average performance of a PAP compared to each prospective target set by each Threshold without the Department's share calculated, for either the ~~Substance Use Disorder (SUD)~~Behavioral Health or Non-~~SUD~~Behavioral Health subsets of Episodes.

8.733.1.D. **High-Risk Pregnancy** means pregnancy that threatens the health or the life of the mother or her fetus. Risk factors can include existing health conditions, weight and obesity, multiple births, older maternal age, and other factors.

8.733.1.E. **Net Episode Performance** means the Gross Episode Performance of a PAP multiplied by the Department's share of fifty percent, for either the ~~SUD~~Behavioral Health or Non-~~SUD~~Behavioral Health subsets of Episodes.

8.733.1.F. **Performance Period** means a twelve-month period, beginning on ~~the first day~~November 1 of ~~a calendar~~each year, for which the Department will measure Episode performance of all providers delivering services during the course of a specific Episode. For an Episode to be included within the Performance Period, the end date for the Episode must fall within the Performance Period.

8.733.1.G. **Principal Accountable Provider (PAP)** means the provider that is held accountable for both the quality and cost of care delivered to a patient for an entire Episode. PAPs for maternity Episodes are willing obstetrical groups who agree in writing to participate in the ~~model~~program with the Department.

8.733.1.H. **Threshold** means the prospective cost target for performance for both the upper and lower incentive benchmarks for the ~~SUD~~Behavioral Health and non-~~SUD~~Behavioral Health subsets within a PAP's Episode Cohort.

1. **Acceptable** means the dollar value such that a provider with an average reimbursement ~~above~~below the dollar value incurs a ~~negative~~positive incentive payment.

2. **Commendable** means the specific dollar value such that a provider with an average reimbursement below the dollar value is eligible for a positive incentive payment if all Quality Metrics linked to the incentive payment are met.

8.733.1.I. **Quality Metrics** means measures determined by the Department that will be used to evaluate the quality of care delivered during a specific Episode, including the extent to which care reduces disparate outcomes based on race and ethnicity and improves patient experience.

8.733.2 MATERNITY

8.733.2.A. Maternity Bundled Payment Pilot Program

1. Using Episode-based payments, the Department modifies its payment methodology for maternity services, as defined ~~at~~in Section 8.732, ~~to~~for PAPs to recognize the quality and efficiency of maternity services provided~~.~~, including the extent to which services reduce health disparities and improve the patient experience.

2. Maternity Episode definitions and appropriate Quality Metrics are based on evidence-based practices derived from peer-reviewed medical literature, public health data on infant and maternal morbidity and mortality and effective responses, historical provider performance, and clinical information furnished by providers rendering services during maternity Episodes.

3. Medicaid-covered services during a maternity Episode will be included ~~from~~in the Prenatal Pre-Trigger Window, Delivery Trigger Window, and Post-Partum Post-Trigger Window. The services considered as a part of the episode shall not be limited solely to those provided by the PAP.

4. The Department through a stakeholder advisory process that is majority currently or former Medicaid members who have received maternity services and majority people of color shall review the maternity bundled payment pilot. The process shall meet and review data on the maternity bundled payment pilot at least quarterly.

8.733.2.B. Maternity Episode Program Incentive Payments

1. Incentive payments to a PAP are based upon an Episode Cohort within a Performance Period.

2. ~~Incentive~~Since program participation is voluntary, PAPs are only subject to positive incentives. Positive incentive payments may be ~~positive or negative and are~~ made retrospectively after the end of the Performance Period. ~~Negative incentives are financial penalties incurred the PAP.~~

   ~~a. In a PAP's first year of participation in the Maternity Bundled Payment Pilot Program, only positive incentives will apply while the PAP learns pathways to improve the quality, efficiency, and economy of care provided.~~

   ~~b. In a PAP's second year of participation in the Maternity Episode Program positive incentives and negative incentives in the form of financial penalties for the PAP will apply.~~

3. When calculating a PAP's Episode Cohort, the Department excludes the Episodes which have the presence of the following:

    a. The member is dually eligible for Medicare and Medicaid at any time during the Episode.

    b. Third-party liability on any claim within a maternity Episode.

    c. PAP provided no prenatal services for to the member.

    d. Member died during Episode.

    e. Incomplete set of claims for an Episode.

    f. No professional claim for delivery.

4. When calculating a PAP's Episode Cohort, the Department will remove ~~high-~~cost outliers via a statistical methodology determined by the Department's actuarial contractor.

5. When calculating a PAP's Episode Cohort, the Department will remove services ~~which~~that are not part of the relevant care for the Prenatal Pre-Trigger, Delivery Episode, and Post-Partum Post-Trigger Windows.

6. Each participating PAP will have two sets of Acceptable and Commendable Thresholds calculated based on their historical ~~Episode payments~~costs for Episodes.

    a. The first set of Thresholds will be calculated based on historical ~~spending~~costs for Episodes ~~which~~that contain a flag for Behavioral Health (including Substance Use Disorder (SUD~~.~~) or Mental Health).

    b. The second set of Thresholds will be calculated based on historical costs for Episodes ~~which~~that do not contain a flag for Behavioral Health (SUD~~.~~ and Mental Health).

    c. It is the responsibility of the PAP to review each set of Acceptable and Commendable Thresholds provided by the Department before the start of the Performance Period.

7. Incentive payments for a PAP's Episodes within the Performance Period will be calculated in two separate subsets.

    a. The first subset ~~is~~comprises Episodes ~~which~~that have a flag for Behavioral Health (SUD~~.~~ or Mental Health).

    b. The second subset ~~is~~comprises Episodes ~~which~~that do not have a flag for Behavioral Health (SUD~~.~~ or Mental Health).

8. In order for a PAP to be eligible for positive incentives for a subgroup, the PAP must do the following:

    a. Meet the Quality Metrics set for each Performance Period by the Department. The Department shall present on quality measures to the Program Improvement Advisory Committee (PIAC) before measures are tied to payment. ~~The~~Subject to

data availability and quality limitations, the Department at a minimum shall monitor the following within the limitations of data availability and data quality:

i. Patient education

ii. All cause readmissions

iii. Severe maternal morbidity

iv. Maternal Gestational Hypertension, Pre-eclampsia, HELLP syndrome, eclampsia

v. Premature birth

vi. Patient Experience

. The Department shall review all findings through the stakeholder advisory process identified in 8.733.2.A (4) and if performance improvement is warranted tie the measure to payment:). If warranted, the Department may update the list of quality metrics monitored. Subject to the limitations of data availability, if the Department seeks improved PAP performance for a quality metric, that quality metric may be tied to payment.

i. i. Patient education

ii. ii. All cause readmissions

iii. iii. Severe maternal morbidity

iv. iv. Maternal Gestational Hypertension, Pre-eclampsia, HELLP syndrome, eclampsia

v. v. Premature birth

vi. vi. Patient Experience

b. Provide During the first year that a PAP joins the program, the PAP's performance relative to quality metrics (including metrics tied to payment) will only be tracked and reported to the provider to create a baseline. Starting the second year of a PAP's participation in the program, the Department will apply quality metrics tied to payment.

c. In determining a PAP's incentive payments, starting the second year the Department will also consider whether the PAP provided the same or a greater number of services and the same or higher level of/or resources to members within the subgroup who experience racism as are providedcompared to members in the subgroup who do not experience racism.

9. 9. If the PAP's aggregated average Gross Episode Performance for each subset is lower than each Commendable Threshold, the PAP shall receive a positive incentive payment.

10. ~~10.~~ If the PAP's aggregated average Gross Episode Performance for each subset is higher than each Acceptable Threshold, the PAP ~~shall incur~~will not be liable for a negative incentive payment ~~inf the form of~~as a financial penalty.

~~11. A PAP's Net Episode Performance for incentives is calculated by multiplying the Gross Episode Performance of each subset by fifty percent.~~

11. ~~12.~~ If the average Episode reimbursement for each subset is between each set of Acceptable and Commendable Thresholds, the PAP shall not receive a positive incentive payment or incur a negative incentive payment.

12. ~~13.~~ Incentive payments are separate from, and do not alter, the reimbursement methodology for Medicaid ~~-~~covered services set forth in Department rules and guidance.

13. ~~14.~~ Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular member.

14. ~~15.~~ Nothing in this rule prohibits the Department from engaging in any retrospective review or other program integrity activity.

15. ~~16. In a PAP's second year of participation when negative incentives apply, the PAP~~PAPs may contest the Department's incentive payment determination ~~of Episodes above the Acceptable Threshold~~. PAPs who contest the Department's determination must submit in writing the reason for contesting the determination within 60 calendar days of receiving the notice of ~~negative incentive limit.~~payment. The Department will review all contested determinations within 30 calendar days of receipt of the notice. The PAP has the right to file an appeal with the Office of Administrative Courts in accordance with Section 8.050.3.

8.733.2.C Maternity Bundled Payment ~~Pilot~~ Program Participation

1. Participation is not mandatory in the Maternity Bundled Payment ~~pilot~~ program for qualified obstetrical groups.

~~2.~~

2. Participation by obstetrical groups in the Maternity Bundled Payment program does not limit a patient's ability to change providers mid-episode for any reason~~.~~.

3. ~~Obstetrical~~Medicaid-covered obstetrical groups who participate in the maternity bundled payment program will allow the Department to extract clinical data from their electronic medical records ~~by their second performance year in the program~~. Information extracted from electronic medical records will be used by the Department to monitor the quality of care and the number of services being provided to members within the subgroup who experience health disparities based on race and ethnicity.

4. Obstetrical groups who participate in the maternity bundled payment will be required to participate in cultural competency training selected by the Department, to be inclusive of the importance of racial congruence between patients and providers and hiring and retention strategies for maintaining a diverse staff.

5. Obstetrical groups that are interested in becoming PAPs will do the following:

    a. Submit a letter of intent to participate in the pilot program ~~to the following address:~~

~~i. Bundled Payment Pilot Program, 1570 Grant St. Denver, CO 80203~~

~~b. The letter shall outline the following:~~

~~ii. The reason for wanting to participate in~~application on the program~~.~~

~~iii. The number of Medicaid covered births the group delivered in the most recent two years.~~

~~iv. The number of non-Medicaid covered births the group delivers.~~

~~v.~~ ~~Whether the group is~~ webpage (https://docs.google.com/forms/d/e/1FAIpQLSdKvszulXC-ZMSOe8xpCJKaCwN4Z52D-HiVVGpHp21yoJ_8zg/viewform) to start the application process.

~~6. The Department will notify all potential PAPs who meet the criteria listed above in writing of their Acceptable and Commendable Thresholds for both subsets of Episodes.~~

~~7. The potential PAP shall review the Thresholds and notify the Department in a final acceptance letter of their intent to join the Maternity Bundled Payment Pilot Program.~~

~~8. The acceptance letter shall be binding for the PAP unless the PAP is disenrolled or unable to continue providing Medicaid services.~~

b. The Department will notify PAP applicants that it received their applications. The Department will contact applicants to arrange meetings for a collaborative review of their preliminary cost thresholds.

c. Following this meeting, when the applicant reviews and accepts the program's cost thresholds, details, and requirements, the applicant may sign a Program Participation Agreement and a Thresholds Acceptance Letter to confirm their participation.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules concerning Skilled Nursing Facility Enhanced Supplemental Payments, Section 8.443
Rule Number: MSB 22-04-28-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 22-02-16-A, Revision to the Medical Assistance Rules concerning Skilled Nursing Facility Enhanced Supplemental Payments, Section 8.443

3. This action is an adoption of: New Rules

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

   Sections 8.400, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.443 beginning at 8.443.22 through the end of 8.443.2. This rule is effective July 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules concerning Skilled Nursing Facility Enhanced Supplemental Payments, Section 8.443
Rule Number: MSB 22-04-28-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

STATEMENT OF BASIS AND PURPOSE

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

   House Bill (H.B) 22-1247 authorizes the State to reimburse skilled nursing homes a one-time Medicaid enhanced payment, workforce enhanced payment, and hospital discharge payment. The Medicaid enhanced payment will pay nursing homes for serving a disproportionate share of Medicaid and high-needs populations. The workforce enhanced payment will pay nursing homes to support hiring new employees and increasing workforce retention. The hospital discharge payment will pay nursing homes to incentivize admitting new Medicaid members from hospitals. The proposed rule change establishes the reimbursement calculation methodology for the three payments. The proposed rule change also establishes the requirement for nursing homes to provide data and financial statements to evaluate the effectiveness of the different payments.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

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

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

Initial Review — Final Adoption **06/10/22**
Proposed Effective Date **07/30/22** — Emergency Adoption

DOCUMENT #02

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules concerning Skilled Nursing Facility Enhanced Supplemental Payments, Section 8.443
Rule Number: MSB 22-04-28-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

REGULATORY ANALYSIS

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

   Nursing homes will benefit from the proposed rule change with additional payments made to address identified staffing and other COVID 19 pandemic driven issues. Approximately 190 nursing homes are eligible to receive a portion of the available payments. The state and federal governments will bear the cost of the proposed rule change by funding the payments made to nursing homes.

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

   An additional $27 million will be paid to nursing homes with this proposed rule change. The Medicaid enhanced payment will equal $7 million, the workforce enhanced payment will equal $17.6 million, and the hospital discharge payment will equal $2.4 million.

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.

   The state funding obligation is approximately $14 million. Additional costs include increased administration burden on Department staff to make the payments and to collect employment data and financial statements from nursing homes to analyze the effectiveness of the payments.

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 change include additional reimbursement to nursing homes to address staffing and other COVID-19 pandemic driven issues. The costs of the proposed rule change are a $14 million state funding obligation and an increased state administrative burden required to make the payments without additional resources.

The costs of inaction include not being compliant with state statute and not reimbursing nursing homes additional funds necessary to address staffing issues currently experienced by nursing homes.

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

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

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

   No other alternatives to rule making are available.

8.443 NURSING FACILITY REIMBURSEMENT

8.443.22 SKILLED NURSING FACILITY ENHANCED PAYMENTS

8.443.22.A The Department will make one-time payments to eligible Class 1 nursing facility providers, pursuant to C.R.S. § 25.5-6-210. The one-time payments will take effect only upon the passage and effective date of House Bill (H.B.) 22-1247. The payments are separated into a Medicaid enhanced payment, a workforce enhanced payment, and a hospital discharge payment.

1. The Medicaid enhanced payment will pay nursing facility providers for serving a disproportionate share of Medicaid and high-need populations.

   a. The payment will equal $7,000,000, divided by the number of eligible nursing facility providers. Eligible nursing facility providers will meet all the following criteria:

      i. Medicaid resident count is equal to or greater than 90% of total resident count. Medicaid resident count and total resident count determined using the most recently finalized quarterly case mix index (CMI) report.

      ii. Preadmission Screening & Resident Review (PASRR) II Medicaid resident count is greater than the statewide average PASRR II Medicaid resident count, plus one standard deviation. PASRR II Medicaid resident count determined using the most recently completed comprehensive minimum data set (MDS) resident assessment for calendar year 2021.

2. The workforce enhanced payment will pay nursing facility providers to support hiring new employees and increase workforce retention.

   a. The payment will equal $17,588,000, multiplied by the percentage of Medicaid patient days to total statewide Medicaid patient days.

   b. Medicaid patient days are determined using MMIS pulled data for calendar year 2021.

   c. The payment will be reported as revenue and offset against expenses on the cost report, for the cost reporting period in which the payment is received.

3. The hospital discharge payment will pay nursing facility providers to incentivize admitting Medicaid members from hospitals.

   a. The payment will equal a per-Medicaid discharge rate, multiplied by hospital Medicaid residents discharged to a nursing home provider.

      i. The per-Medicaid discharge rate will equal an amount such that the total hospital discharge payment made to all nursing facility providers will equal $2,413,000. The per-Medicaid discharge rate for complex discharges will be increased by a multiplier.

ii. Medicaid discharges are equal to Medicaid residents discharged from a hospital to a nursing facility provider during the period May 1, 2022 through June 30, 2022 and remaining within the nursing facility provider for at least sixty (60) calendar days. Both Medicaid discharges and length-of-stay will be determined using MMIS pulled data.

iii. A complex discharge is a discharge for a Medicaid resident with a PASRR II designation and/or a Medicaid resident deemed too difficult to place.

iv. The PASRR II designation will be determined using the most recently completed comprehensive MDS resident assessment during the period July 1, 2021 through June 30, 2022.

4. The payments will only be made if there is available federal financial participation under the Upper Payment Limit after all other nursing facility provider MMIS and supplemental payments are considered.

5. Nursing facility providers will provide data necessary to administer and to evaluate the effectiveness of the payments.

a. Nursing facility providers will provide:

i. Employment and wage data within thirty (30) calendar days of request.

ii. Quarterly financial statements will be due within thirty (30) calendar days of quarter end. Financial statements are due beginning with the quarter following the most recent cost report submission.

b. Reporting instructions will be provided to nursing facility providers before any data or financial statements are due.

c. Management companies, or other corporate structures, operating a nursing facility provider will provide quarterly financial statements will be due within thirty (30) calendar days of quarter end. Financial statements are due beginning with the quarter following the most recent cost report submission.

d. Submissions will be certified by the nursing home provider's Chief Executive Officer, Chief Financial Officer, or an individual with delegated signatory authority.

e. A skilled nursing facility provider not providing employment/wage data or financial statements may have the entirety of their payments recovered.