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Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 22-03-31-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 22-03-31-A, Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300

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) Sections 8.300.3 and 8.300.5, 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: April 8, 2022

   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

*to be completed by MSB Board Coordinator

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Replace the current text at 8.300 with the proposed text beginning at 8.300.3.A.6 through the end of 8.300.A.6. Insert the proposed text beginning at 8.300.4 through the end of 8.300.4. Insert the proposed text beginning at 8.300.5.F through the end of 8.300.5.F. This rule is effective April 8, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 22-03-31-A
Division / Contact / Phone:Health Programs Office / Russ Zigler / 303-866-5927

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).

   During the Coronavirus Disease 2019 (COVID-19) public health emergency, subacute care may be administered by an enrolled hospital in its inpatient hospital or alternate care facilities. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Patients may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital. Subacute care will be paid at the rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State Plan. Adding subacute care to the covered hospital services in an inpatient hospital, or an associated alternate care facility, increases access to such services for the duration of the COVID-19 public health emergency.

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:

   Addition of subacute care to the list of the covered services for inpatient hospitals, and associated alternate care facilities, increases access to such care for the duration of the COVID-19 public health emergency and is imperatively necessary for the preservation of public health, safety, and welfare.

3. Federal authority for the Rule, if any:

   42 CFR §447, Subpart C (2020)

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   C.R.S. 25.5-5-102(1)(a) (2019)

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 22-03-31-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.

   Inpatient hospitals, and associated alternate care facilities (AFC), will be affected by, and benefit from, the proposed rule with the addition of subacute care as a covered treatment modality for the duration of the COVID-19 public health emergency. Clients receiving subacute care in an inpatient hospital, or in an AFC, for the duration of the COVID-19 public health emergency will also be affected by, and benefit from, the proposed rule. The Department will bear the cost of reimbursement for subacute care services authorized under the proposed 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.

   The qualitative impact of the proposed rule is adding the subacute care treatment modality to the inpatient hospital, and associated AFC, covered services for the duration of the COVID-19 public health emergency. The proposed rule increases access to such services during the COVID-19 public health emergency by allowing hospitals to treat clients that would normally be discharged from the hospital in order to receive a lower level of care. It may be difficult for hospitals to discharge and place such clients in a skilled nursing facility during the COVID-19 public health emergency due to COVID-19 positive or presumptive status. The proposed rule allows hospitals to treat such clients on-site and be reimbursed for such care. Because the clients are being treated at an inpatient hospital or alternate care facility for the

same care they would have otherwise received at a skilled nursing facility, the proposed rule is budget neutral.

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.

   Because the clients treated at an inpatient hospital or alternate care facility for the subacute care under the authority of this rule would have otherwise received such care at a skilled nursing facility, the proposed rule is budget neutral. There are no probable implementation or enforcement costs to the Department or to any other agency. There is no anticipated effect on state revenues.

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 is reimbursement for subacute care at inpatient hospitals and associated AFCs. The probable benefit of the proposed rule is increased access to subacute care for the duration of the COVID-19 public health emergency. There are no benefits to inaction. Diminished access to subacute care, as described in question two above, for the duration of the COVID-19 public health emergency could be a cost of inaction.

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 adding subacute care to the covered services for inpatient hospitals and associated AFCs for the duration of the COVID-19 public health emergency.

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 adding subacute care to the covered services for inpatient hospitals and associated AFCs for the duration of the COVID-19 public health emergency.

8.300 HOSPITAL SERVICES

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

Inpatient Hospital Services are a Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. Inpatient Hospital services include:

    a. bed and board, including special dietary service, in a semi-private room to the extent available;

    b. professional services of hospital staff;

    c. laboratory services, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;

    d. emergency room services;

    e. drugs, blood products;

    f. medical supplies, equipment and appliances as related to care and treatment; and

    g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.

2. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.

3. Prior to July 1, 2020, Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

    Beginning July 1, 2020, reimbursement for a mother's hospitalization for delivery does not include reimbursement for the newborn's hospitalization. Services shall be reimbursed under the identification number of each client.

4. Psychiatric Hospital Services

    Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-network Hospital.

    a. Inpatient care in a Psychiatric Hospital is limited to forty-five (45) days per state fiscal year, unless additional services are prior-authorized as medically necessary by the Department's utilization review vendor or other Department

representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.

b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:

i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and

ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.

c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

5. Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-network DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

a. an acute medical condition for which dialysis treatments are required; or

b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or

c. placement or repair of the dialysis route (“shunt”, “cannula”).

6. Inpatient Subacute Care

Administration of subacute care by an enrolled hospital in its inpatient hospital or alternate care facilities is covered for the duration of the Coronavirus Disease 2019 (COVID-19) public health emergency. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Members may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital.

8.300.4 Non-Covered Services

The following services are not covered benefits:

1. Inpatient Hospital Services defined as experimental by the United States Food and Drug Administration.

2. Inpatient Hospital Services which are not a covered Medicare benefit.

3. Court-ordered psychiatric Inpatient care which does not meet the Medical Necessity criteria established for such care by the Department's utilization review vendor or other Department representative.

~~4. Days awaiting placement or appropriate transfer to a lower level of care are not a covered benefit unless otherwise Medically Necessary.~~

~~5~~. ~~Substance abuse rehabilitation treatment is not covered unless individuals are aged 20 and under. Services must be provided by facilities which attest to having in place rehabilitation components required by the Department. These facilities must be approved by the Department to receive reimbursement.~~

8.300.5 Payment for Inpatient Hospital Services

8.300.5.F Payment for Inpatient Subacute Care

1. Inpatient Subacute Care days shall be paid at a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved by the Centers for Medicare and Medicaid Services (CMS), for the State in which such hospital is located.

DO NOT PUBLISH THIS PAGE

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

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)? Yes
   If yes, state effective date: 4/8/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.443.22 with the proposed text beginning at 8.443.22 through the end of 8.442.22. This rule is effective April 8, 2022.

*to be completed by MSB Board Coordinator

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

   H.B. 22-1247 requires the payments to be made to nursing homes in SFY 2021-22, if possible. This is necessary to get funding to nursing homes now to help address identified staffing issues and other issues due to 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. (2021);

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

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