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: **08-019**

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 07/01/2008

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 440.70

7. FEDERAL BUDGET IMPACT
a. FFY 2008 $198,620
b. FFY 2009 $372,528
c. FFY 2010 $ 99,749

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19B
pages 1, 2, 2E; pages 3.1 – 3.6; pages 3a, 3b, 3c

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT

State's methodology for calculation of Medicaid supplemental payments to public home health agencies.

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

GOVERNOR'S OFFICE REPORTED NO COMMENT

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

X OTHER, AS SPECIFIED

Governor's letter dated August 10, 2007

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
John Bartholomew

14. TITLE
Director, Budget and Finance Office

15. DATE SUBMITTED
9/30/08

16. RETURN TO

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

Attn: Barbara Prehmus

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 9/30/08

18. DATE APPROVED 2/8/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/08

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Richard C. Allen

22. TITLE
ARA, DMCHO

23. REMARKS

FORM CMS-179 *(07/92)*

Instructions on Back

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

7. PAYMENT RATES FOR HOME HEALTH CARE SERVICES

A. Payment rates for the home health services of skilled nursing, home health aide, physical therapy, occupational therapy, and speech/language pathology services are established as follows:

1. The unit of reimbursement for home health services shall be one visit up to two and one half hours in length, except that the unit of reimbursement for home health aide services shall be changed effective March 1, 2000. For dates of service on or after March 1, 2000, home health aide services shall be billed in basic and extended units. A basic unit is the first part of a visit up to one hour. The extended units are additional increments up to one-half hour each for visits lasting more than one hour. All basic units and all extended units must be at least 15 minutes in length to be reimbursable.

2. Payment for home health services other than nursing visits shall be the lower of the billed charges or the maximum interim unit rate of reimbursement. Effective October 10, 2003, the payment for nursing visits shall be the lower of the billed charges, the maximum interim unit rate of reimbursement, or prior authorized charges. Prior authorized charges for stable clients requiring daily visits shall not exceed $50.00 for the first brief nursing visit of the day and $35.00 for the second or subsequent brief nursing visit of the day.

3. Maximum unit rates were established for home health services January 1, 1990 based on a single flat rate (the average weighted rate in effect July 1, 1989 plus 4.5%) for each type of home health service, with the home health aide rate phased in using a step-down rate. Agencies, which were projected to have a significant financial loss in the base year, received the step-down rate defined as the flat rate plus .57%. The base year was the only year a step down rate was applied.

METHODS AND STANDARDS FOR ESTABLISHLNG PROSPECTIVE PAYMENT RATES OTHER TYPES OF CARE

7. PAYMENT RATES FOR HOME HEALTH CARE SERVICES- (CONTINUED)

The maximum interim unit rates for the basic and extended home health aide units, effective March 1, 2000, were calculated based on a statistically valid representative sample of visits which were reviewed to collect data on visit length. The rates were calculated to be budget neutral, and are intended to re-distribute the reimbursement proportional to actual visit length, while allowing some extra dollars for the first part of the visit to account for the fixed per-visit costs.

The cost of supplies used during visits by home health agency staff for the practice of universal precautions, excluding gloves used for bowel programs and catheter care, is included in the maximum per visit rate.

4. Effective February 1, 2000, interim payment rates shall be adjusted to equal no more than a department specified percentage average increase per unduplicated client for each State Fiscal Year. The interim rates shall not be reduced, if total Medicaid home health expenditures in each State Fiscal Year do not exceed appropriations. If total expenditures for the Home Health budget do exceed appropriations, the Department shall determine which Home Health Agencies received average per unduplicated client payments for State Fiscal Year Home Health services which were more than the specified percentage over the previous State Fiscal Year average per unduplicated client increase. This shall be accomplished by decreasing each agency's average payment per unduplicated client for the State Fiscal Year by a percentage that will bring each agency's average payment per unduplicated client for the State Fiscal Year to no more than the specified percentage increase over its previous State average per unduplicated client payment. Agencies that became newly certified as Medicare/Medicaid providers in each State Fiscal Year and have no Medicaid Home Health payment history for the previous State Fiscal Year shall be exempt for one Fiscal Year.

METHODS A1D STANDARDS FOR ESTABLISHING PROSPECTIVE PAYMENT RATES-OTHER TYPES OF CARE

7. PAYMENT RATES FOR HOME HEALTH CARE SERVICES- (CONTINUED)

B. Medical supplies, equipment and appliances suitable for use in the home, not including those which are the responsibility of the home health agency, as described at A.4 above, are reimbursed at the lower of billed charges or the amount from the State-established fee schedule. When a maximum reimbursable cost has not been established for an item, reimbursement shall be the lower of billed charges or the providers invoice cost plus 20% plus documented freight costs.

C. Effective March 15, 2002, public home health agencies shall be reimbursed for skilled nursing, home health aide, physical therapy, occupational therapy, and speech/Language pathology services up to 100% of the Medicare Home Health Prospective Payment System Low Utilization Payment Adjustment.

As of July 1, 2009, Attachment 4.19-B pages 1, 2 and 2E covering Payment Rates for Home Health Care Services 7.A through 7.C are no longer in effect and are replaced by 7.D. through 7.F on pages 3a, 3b and 3c of this Attachment 4.19-B.

Effective July 1, 2008, public home health agencies will receive supplemental Medicaid payments (Public Home Health Agency Supplemental Payment) to provide reimbursement to public providers for uncompensated care related to home health services for Medicaid clients. Public home health agencies will certify their uncompensated cost for providing home health services for Medicaid clients based on the Department's demonstration of the uncompensated Medicaid cost calculations performed for each provider. Payments shall not exceed the Medicaid costs any public home health agency incurs providing home health services to Medicaid clients.

Interim Payments for the Payment calendar year (January through December) will be made by June 30 of the following calendar year using as-filed cost reports to calculate uncompensated costs. In the event that errors are detected, a revised cost report has been filed by the home health agency, or a change in the State Plan affects the Public Home Health Agency Supplemental Payment, adjustments to impacted provider payments will be made retroactively.

Uncompensated costs will be calculated for Final Payments using audited cost reports. Final Payments will be made by June 30 for those home health agencies for which the Department received an audited cost report between the previous November 2 and May 1. Final Payments will be made by December 31 for those home health agencies for which the Department received an audited cost report between the previous May 2 and November 1. Final Payments will serve to adjust the Interim Payment such that the sum of the Interim and Final Payments to each provider shall equal the Payment amount calculated based on uncompensated costs calculated through audited cost reports. In the event that data entry errors are detected after the Final Payment has been made, or other unforeseen payment calculation errors are detected after the Final Payment has been made, reconciliations and adjustments to impacted provider payments will be made retroactively. Prior to making the Final Payment, the Department will present a demonstration of the uncompensated Medicaid costs calculations performed to each provider for purposes of authorizing certification. Each provider shall sign an acknowledgment of agreement to the uncompensated costs being certified for purposes of the Payment.

Uncompensated Medicaid costs are calculated as follows:

1. Skilled Nursing Care

   a. For hospital-based home health agencies, total home health agency costs for skilled nursing care are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 3, line 1. For free-standing home health agencies, total home health agency costs for skilled nursing care are as

reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 1.

b. For hospital-based home health agencies, total home health agency visits for skilled nursing care are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 4, line 1. For free-standing home health agencies, total home health agency visits for skilled nursing care are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 1.

c. Total Medicaid home health visits for skilled nursing care are as recorded in the Medicaid Management Information System (MMIS).

d. Total Medicaid home health payments for skilled nursing care are as recorded in the MMIS. The average cost per home health visit for skilled nursing care is calculated by dividing total home health agency costs for skilled nursing care by total home health agency visits for skilled nursing care.

e. Total Medicaid home health costs for skilled nursing care are calculated by multiplying total Medicaid home health visits for skilled nursing care by the average cost per home health visit for skilled nursing care.

f. Uncompensated Medicaid home health agency cost for skilled nursing care is the greater of the difference between total Medicaid home health costs for skilled nursing care less total Medicaid home health payments for skilled nursing care, or zero dollars.

2. Physical Therapy

a. For hospital-based home health agencies, total home health agency costs for physical therapy are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 3, line 2. For free-standing home health agencies, total home health agency costs for physical therapy are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 2.

b. For hospital-based home health agencies, total home health agency visits for physical therapy are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 4, line 2. For free-standing home health agencies, total home health agency visits for physical therapy are as reported

on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 2.

c. Total Medicaid home health visits for physical therapy are as recorded in the MMIS.

d. Total Medicaid home health payments for physical therapy are as recorded in the MMIS.

e. The average home health agency cost per visit for physical therapy is total home health agency costs for physical therapy divided by total home health agency visits for physical therapy.

f. Total Medicaid home health costs for physical therapy is calculated by multiplying total Medicaid home health visits for physical therapy by the average home health agency cost per visit for physical therapy.

g. Uncompensated Medicaid home health agency cost for physical therapy is the greater of the difference between total Medicaid home health costs for physical therapy less total Medicaid home health payments for physical therapy, or zero dollars.

3. Occupational Therapy

a. For hospital-based home health agencies, total home health agency costs for occupational therapy are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 3, line 3. For free-standing home health agencies, total home health agency costs for occupational therapy are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 3.

b. For hospital-based home health agencies, total home health agency visits for occupational therapy are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 4, line 3. For free-standing home health agencies, total home health agency visits for occupational therapy are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 3.

c. Total Medicaid home health visits for occupational therapy are as recorded in the MMIS.

d. Total Medicaid home health payments for occupational therapy are as recorded in the MMIS.

e. The average home health agency cost per visit for occupational therapy is total home health agency costs for occupational therapy divided by total home health agency visits for occupational therapy.

f. Total Medicaid home health costs for occupational therapy is calculated by multiplying total Medicaid home health visits for occupational therapy by the average home health agency cost per visit for occupational therapy.

g. Uncompensated Medicaid home health agency cost for occupational therapy is the greater of the difference between total Medicaid home health costs for occupational therapy less total Medicaid home health payments for occupational therapy, or zero dollars.

4. Speech Pathology

a. For hospital-based home health agencies, total home health agency costs for speech pathology are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 3, line 4. For free-standing home health agencies, total home health agency costs for speech therapy are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 4.

b. For hospital-based home health agencies, total home health agency visits for speech pathology are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 4, line 4. For free-standing home health agencies, total home health agency visits for speech pathology are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 4.

c. Total Medicaid home health visits for speech pathology are as recorded in the MMIS.

d. Total Medicaid home health payments for speech pathology are as recorded in MMIS.

e. The average home health agency cost per visit for speech pathology is total home health agency costs for speech pathology divided by total home health agency visits for speech pathology.

f. Total Medicaid home health costs for speech pathology is calculated by multiplying total Medicaid home health visits for speech pathology by the average home health agency cost per visit for speech pathology.

g. Uncompensated Medicaid home health agency cost for speech pathology is the greater of the difference between total Medicaid home health costs for speech pathology less total Medicaid home health payments for speech pathology, or zero dollars.

5. Home Health Aides

a. For hospital-based home health agencies, total home health agency costs for home health aides are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 3, line 6. For free-standing home health agencies, total home health agency costs for home health aides are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 2, line 6.

b. For hospital-based home health agencies, total home health agency visits for home health aides are as reported on the CMS 2552-96 Hospital Cost Report worksheet H-6, part I, column 4, line 6. For free-standing home health agencies, total home health agency visits for home health aides are as reported on the CMS 1728-94 Home Health Agency Cost Report worksheet C, part I, column 3, line 6.

c. Total Medicaid home health visits for home health aides are as recorded in the MMIS.

d. Total Medicaid home health payments for home health aides are as recorded in the MMIS.

e. The average home health agency cost per visit for home health aides is total home health agency costs for home health aides divided by total home health agency visits for home health aides.

f. Total Medicaid home health costs for home health aides is calculated by multiplying total Medicaid home health visits for home health aides by the average home health agency cost per visit for home health aides.

g. Uncompensated Medicaid home health agency cost for home health aides is the greater of the difference between total Medicaid home health costs for home health aides less total Medicaid home health payments for home health aides, or zero dollars.

Total uncompensated Medicaid home health agency costs is the sum of the uncompensated Medicaid home health agency costs for skilled nursing care, physical therapy, occupational

therapy, speech pathology and home health aides. Costs included on the CMS 2552-96 Hospital Cost Report worksheet H-6 and the CMS 1728-94 Home Health Agency Cost Report worksheet C for medical social services, medical supplies, drugs, and administration of vaccines are not included in the calculations for this Public Home Health Agency Supplemental Payment.

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

7. PAYMENT RATES FOR HOME HEALTH CARE SERVICES

D. Effective July 1, 2009, pages 1, 2, and 2E of this Attachment 4.19-B are no longer in effect and payment rates for the home health services of skilled nursing, home health aide, physical therapy, occupational therapy, and speech/language pathology services are established as follows:

1. The unit of reimbursement for home health services shall be one visit up to two and one half hours in length. Effective March 1, 2000, home health aide services shall be billed in basic and extended units. A basic unit is the first part of a visit up to one hour. The extended units are additional increments up to one-half hour each for visits lasting more than one hour. All basic units and all extended units must be at least 15 minutes in length to be reimbursable.

2. Payment for home health services other than nursing visits shall be the lower of the billed charges or the maximum unit rate of reimbursement.

3. The cost of supplies used during visits by home health agency staff for the practice of universal precautions, excluding gloves used for bowel programs and catheter care, is included in the maximum unit rate.

E. Effective July 1, 2009, except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for dates of service on or after July 1, 2009, dates of service on or after September 1, 2009, dates of service on or after December 1, 2009, and dates of service on or after July 1, 2010, for these services can be found on the official Web site of the Department of Health Care Policy and Financing at www.colorado.gov/hcpf.

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

7. PAYMENT RATES FOR HOME HEALTH CARE SERVICES- (CONTINUED)

Home health care services provided by home health providers shall be reimbursed at the lower of the following:

1. Submitted charges; or
2. Home health fee schedule determined by the Department of Health Care Policy and Financing.

F. Effective July 1, 2009, durable medical equipment and supplies shall be reimbursed at the lower of the following:

1. Submitted charges or
2. Fee schedule for durable medical equipment and supplies as determined by the Department of Health Care Policy and Financing.

Durable medical equipment and supplies that require manual pricing shall be reimbursed at the lower of the following for dates of service on or after September 1, 2009:

1. Submitted charges;
2. Manufacturer's suggested retail price (MSRP) less 20.82 percent;
3. Actual invoiced acquisition cost plus 15.87 percent when no MSRP is available.

Durable medical equipment and supplies that require manual pricing shall be reimbursed at the lower of the following for dates of service on or after December 1, 2009:

1. Submitted charges;
2. Manufacturer's suggested retail price (MSRP) less 21.61 percent;
3. Actual invoiced acquisition cost plus 14.71 percent when no MSRP is available.

METHODS AND STANDARDS FOR ESTABLISHLNG PAYMENT RATES -- OTHER TYPES OF CARE

7. PAYMENT RATES FOR HOME HEALTH CARE SERVICES- (CONTINUED)

Durable medical equipment and supplies that require manual pricing shall be reimbursed at the lower of the following for dates of service on or after July 1, 2010:

1. Submitted charges;
2. Manufacturer's suggested retail price (MSRP) less 22.39 percent;
3. Actual invoiced acquisition cost plus 13.56 percent when no MSRP is available.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for these services for dates of service on or after September 1, 2009, dates of service on or after December 1, 2009, dates of service on or after July 1, 2010, and dates of service on or after August 11, 2010 (for items previously manually priced that were moved to the fee schedule), can be found on the official Web site of the Department of Health Care Policy and Financing at www.colorado.gov/hcpf.