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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-16-0011

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294

Region VIII

April 25, 2017

Susan E. Birch, MBA, BSN, RN, Executive Director
Department of Health Care Policy & Financing
303 East 17th Avenue, 7th Floor
Denver, CO 80203

RE: Colorado #16-0011

Dear Ms. Birch:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 16-0011. This Amendment changes the methods and standards for establishing payment rates for hospice services, reflecting the rate increases effective October 1, 2016.

In order to track expenditures associated with this amendment, Colorado should follow the CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM).

For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage report on the Form CMS- 64.9 VIII and those not enrolled in the new adult group, claims should be reported on the Form CMS-64.9 Base.

This amendment would affect expenditures reported on Line 26 – Hospice Benefits.

Please be informed that this State Plan Amendment was approved today with an effective date of October 1, 2016. We are enclosing the CMS-179 and the amended plan page(s).

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

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Gretchen Hammer
Pat Connally
John Bartholomew
Amanda Forsythe

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: 16-0011

2. STATE: COLORADO

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

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

4. PROPOSED EFFECTIVE DATE: OCTOBER 1, 2016

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:
Section 1905(a)(18) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2016-17: $ 1,059,562
b. FFY 2017-18: $ 1,103,818

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: Methods and Standards for Establishing Payment Rates – Other Types of Care – 18. Hospice Services, Page 1

Attachment 4.19-B: Methods and Standards for Establishing Payment Rates – Other Types of Care – 18. Hospice Services, Page 2 (NEW)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: Methods and Standards for Establishing Payment Rates – Other Types of Care – 18. Hospice Services (TN 15-0014)

10. SUBJECT OF AMENDMENT:
Methods and standards for establishing payment rates for hospice services, reflecting the rate increases effective October 1, 2016.

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 15 January, 2015

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Gretchen Hammer

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
Initial: October 25, 2016 Revised: April 25, 2017

16. RETURN TO:
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: David DeNovellis

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
October 25, 2016

18. DATE APPROVED
April 25, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2016

[redacted]IAL

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

18. HOSPICE SERVICES

1. The Department begins with the annual change in Medicaid hospice payment rates, applies the current hospice CMS wage index, and increases the final rate by a specified percentage.

2. Services that are included in the hospice reimbursement are:
   a. Routine Home Care where most hospice care is provided-Days 1-60
   b. Routine Home Care where most hospice care is provided-Days over 61
   c. Continuous Home Care
   d. Hospice Inpatient Respite Care
   e. Hospice General Inpatient Care
   f. Service Intensity Add-On (SIA), effective for hospice services with dates of service on or after October 1, 2016, will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member's life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS.

3. Hospice nursing facility room-and-board per diem rates are reimbursed to the hospice provider at a rate equal to 95% of the skilled nursing facility rate, less any Post Eligibility Treatment of Income (PETI) amount, for Medicaid clients who are receiving hospice services. The hospice provider is responsible for passing the room-and-board payment through to the nursing facility.

4. Physician services are not included in Hospice reimbursement but are reimbursed directly to the provider of the service.

Except as otherwise noted in the State Plan, state-developed rates are the same for both governmental and private providers. As of October 1, 2016, the applied percentage increase will be 10.98% and the resulting rates are effective for services provided on or after that date.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –

OTHER TYPES OF CARE

The provider rate is available on the Department of Health Care Policy and Financing's website at: https://www.colorado.gov/hcpf/provider-rates-fee-schedule. The rate table reflects one rate for full payment for providers that comply with quality data reporting requirements, as well as the rate for the two-percentage-point payment reduction specific for any Medicaid hospice provider that failed to comply with Section 3004 of the Affordable Care Act [Section 1814(i)(5)(A)(i)] and the Hospice Quality Reporting Program (HQRP).

Upon notice from CMS that a provider has failed to comply with HQRP the previous fiscal year, the State directs the provider to submit all hospice claims to the Colorado Department of Health Care Policy and Financing for the ensuing federal fiscal year using rates posted online for providers that failed to comply with quality reporting requirements. The two-percentage- point payment reduction is reflected in categories of hospice care, including routine home care, continuous home care, inpatient respite, and general inpatient care. The provider rate reflecting the two-percentage-point payment reduction specific for any Medicaid hospice provider that failed to comply with Section 3004 of the Affordable Care Act [Section 1814(i)(5)(A)(i)] and the Hospice Quality Reporting Program (HQRP) is available on the Department of Health Care Policy and Financing's website at: https://www.colorado.gov/hcpf/provider-rates-fee-schedule.

Aggregate payment to the Hospice provider is subject to an annual indexed aggregate cost cap. The method for determining and reporting the cost cap shall be identical to the Medicare Hospice Benefit requirements as contained in 42 C.F.R. Sections 418.308 and 418.309 (2005). Total Medicaid payments made to the Hospice for services provided by physicians who are Hospice employees, along with total payments made at the various Hospice daily rates, will be counted in determining whether the cap amount has been exceeded. Payments made for the services of physicians who are not Hospice employees and for payments made for room and board will not be included in the cap calculation. A hospice will not be reimbursed for inpatient days (general and respite) beyond 20 percent of the total days of care it provides to Medicaid beneficiaries during the "cap year."