



Inpatient Subacute Care, Home Health, and Transportation Options During the COVID-19 Public Health Emergency

Fact Sheet May 4, 2020

Inpatient Subacute Care - Hospital

The Department of Health Care Policy and Financing (the Department) passed an emergency rule and is pursuing a corresponding State Plan Amendment (SPA) to allow hospitals enrolled as General Hospitals (Provider Type 01) to provide Inpatient Subacute Care in their hospital and [CDPHE approved](#) alternate care sites during the COVID-19 Public Health Emergency.

What is Inpatient Subacute Care?

Inpatient Subacute Care is equivalent to the medically necessary level of care administered by a skilled nursing facility (SNF) for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409.

When can a hospital provide Inpatient Subacute Care?

- If the member requires the level of care that would normally be provided by a SNF, but they cannot or should not be transferred to a SNF,
 - the hospital may provide Inpatient Subacute Care.
- If the member requires the level of care that would normally be provided by a SNF, but they cannot or should not be transferred to a SNF *and* the hospital does not have capacity, the member may be transferred to a,
 - CDPHE approved alternate care site;
 - another hospital that can provide Inpatient Subacute Care; or,
 - a state designated field hospital (e.g., Colorado Convention Center, The Ranch – Larimer County Fairgrounds and Events Complex) that can provide Inpatient Subacute Care.
- Members may be admitted to Inpatient Subacute Care,
 - after an inpatient admission;



- from an emergency department;
- from observation status; or
- by primary care referral to the administering hospital.
 - Please note, patients may not be referred from a non-facility provider, such as a primary care referral, to state designated field hospitals. These sites **will only accept patients who are being transferred from hospitals and health care facilities** and will not be open for members of the public seeking medical care or diagnosis.

When can't a hospital provide Inpatient Subacute Care?

- If the member's principal diagnosis is a RAE-covered mental health diagnosis; or,
- the hospital is a Psychiatric Hospital (Provider Type 02).

Where can Inpatient Subacute Care be provided?

Inpatient Subacute Care can be provided in the following locations:

- a hospital;
- a hospital's CDPHE approved alternate care sites; and
- a state designated field hospital.

What payment methodology will be used for Inpatient Subacute Care?

Inpatient Subacute Care will be paid at a per diem rate comparable to the skilled nursing facility rate. If a hospital has designated swing beds, the hospital should bill these services as swing beds and will be paid under their existing per diem rate.

How does a hospital bill for Inpatient Subacute Care?

Hospitals will need to bill a separate inpatient claim for the Inpatient Subacute Care days using revenue code 190. If the member came from an inpatient status the first inpatient claim will need to indicate that the patient was transferred to a lower level of care by using patient status code 70. The Department is awaiting SPA approval for Inpatient Subacute care. Until the Department has SPA approval providers are asked to hold claims.

COMING SOON: Detailed billing instructions for Inpatient Subacute Care are not yet available, but will be released soon and will be found in the [Inpatient/Outpatient Billing Manual](#).

Home Health:

The existing Home Health benefit provides options for treatment during the Public Health Emergency without additional rule or SPA authority. Home Health services are available for



eligible clients discharged from a hospital.

What is Home Health?

Home Health services consist of skilled nursing, certified nurse aide (CNA) services, physical therapy, occupational therapy, and speech/language pathology services that are provided by a licensed and certified Home Health agency.

When can Home Health services be provided?

Home Health services are available to Colorado Medicaid members who need intermittent skilled care in their place of residence, a temporary place of residence, or in the community, and is provided by a licensed and certified Home Health Agency.

Where can Home Health services be provided?

- Assisted Living Facilities (ALFs) and Alternative Care Facilities (ACFs);
- Group Residential Services and Supports (GRSS) homes and Individual Residential Services and Supports (IRSS) homes;
- Hotels, or similar temporary accommodations; and
- Any setting in which normal life activities take place, other than any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Home Health services are divided into two service types:

Acute Home Health services are provided for the treatment of acute conditions/episodes (such as post-surgical care) for up to 60 days without prior authorization.

- Acute Home Health Services are provided for 60 or fewer calendar days or until the acute medical condition is resolved, whichever comes first.
- Acute Home Health Services are provided for the treatment of the following acute medical conditions/episodes:
 - i) Infectious disease (e.g., COVID-19);
 - ii) Pneumonia;
 - iii) New diagnosis of a life-altering disease;
 - iv) Post-heart attack or stroke;
 - v) Care related to post-surgical recovery;
 - vi) Post-hospital care provided as follow-up care for medical conditions that required hospitalization, including neonatal disorders;
 - vii) Post-nursing home care, when the nursing home care was provided primarily for rehabilitation following hospitalization and



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- viii) the medical condition is likely to resolve or stabilize to the point where the client will no longer need Home Health Services within 60 days following initiation of Home Health Services;
- ix) Complications of pregnancy or postpartum recovery; or
- Individuals who experience an acute incident related to a chronic disease may be treated under the acute home health benefit. Specific information on the acute incident shall be documented in the record.

Long-Term Home Health is available for clients who require ongoing Home Health Services beyond the 60-day Acute Home Health period. Long-Term Home Health services require prior authorization and clients must meet LTC (Long-Term Care) 100.2 level of care criteria.

Emergency Medical Transportation (EMT) and Non-Emergent Medical Transportation (NEMT):

The existing EMT and NEMT benefits provide transportation options that can be expanded by rule and SPA authority.

The Department is pursuing emergency rulemaking and SPA to allow transportation providers to expand the list of destinations allowed for ambulance transport in alignment with guidance issued by CMS. Specifically, the Department will expand upon the list of facilities currently allowed in rule. Through the SPA, the Department hopes to allow for ambulance trips to any destination that is able to provide treatment to the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services are being furnished. The Department is also reviewing interfacility transportation life support and covered place of services requirements in rule and SPA. Under existing rule, ambulance transportation from one facility to another is allowed if the patient requires basic or advanced life support. The Department's goal is to temporarily waive the life support requirement so that providers can move patients between facilities as needed. Relatedly, NEMT trips must be to covered places of service. The Department has requested approval through the SPA to temporarily lift the covered place of service requirement. More information will be released as it is available.

What is EMT?

Emergency Medical Transportation is a benefit for all members who have a critical or unknown illness or injury that demands immediate medical attention to prevent permanent injury or loss of life.



What is NEMT?

Non-emergent medical transportation (NEMT) is transportation to and from medically necessary covered services for members who have no other means of transportation, including free transportation. NEMT can only be utilized to access non-emergency services.

When can EMT services be provided?

EMT services can be provided when a member needs immediate ground or air ambulance transportation to prevent permanent injury or loss of life. EMT services are also available when a member needs transportation from one facility to another and requires basic or advanced life support.

When can NEMT services be provided?

NEMT services can be provided when a member has no other means of transportation and needs transportation to and from Medicaid covered services at covered places of service.

Where can EMT services be provided?

EMT services can be provided from a member's location (e.g., their home or an accident site) to a general hospital, hospital unit, psychiatric hospital, rehabilitation hospital, Acute Treatment Unit (ATU), or Crisis Stabilization Unit (CSU). EMT services can also be provided from one facility to another if the member requires basic or advanced life support en route.

Where can NEMT services be provided?

NEMT services can be provided to and from Medicaid covered services at covered places of service. NEMT can only be utilized to transport eligible members to and from Health First Colorado provider service locations that are enrolled to provide the service the member is transported to receive.

For more information contact

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