COLORADO
Department of Health Care Policy & Financing
Medical Services Board

NOTICE OF PROPOSED RULES

The Medical Services Board of the Colorado Department of Health Care Policy and Financing will hold a public meeting on Friday, May 11, 2018, beginning at 9:00 a.m., at 700 Main St, Wray, CO 80758. Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303- 866-4416 or chris.sykes@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting.

A copy of the full text of these proposed rule changes is available for review from the Medical Services Board Office, 1570 Grant Street, Denver, Colorado 80203, (303) 866-4416, fax (303) 866-4411. Written comments may be submitted to the Medical Services Board Office on or before close of business the Wednesday prior to the meeting. Additionally, the full text of all proposed changes will be available approximately one week prior to the meeting on the Department's website at www.colorado.gov/hcpf/medical-services-board.

This notice is submitted pursuant to § 24-4-103(3)(a) and (11)(a), C.R.S.

MSB 17-09-22-B, Revision to the Medical Assistance Durable Medical Equipment Rule Concerning DMEPOS Reimbursement, Section 8.590.7

Medical Assistance. The proposed rule will increase the Durable Medical Equipment (DME) encounter rate by 1.402% to account for General Assembly funding appropriation, pursuant to SB17-254; and will bring the Department into compliance with the Consolidated Appropriations and the 21st Century Curest Act (Acts). The Acts require the Department to set their resimbursement for certain DME items to Medicare payment rates. These rule revisions implement the portion of the Acts that pertain solely to used DME items. The proposed revisions will also correct a numeration error.

The authority for this rule is contained in Consolidated Appropriations Act; Section 1903(i)(27) of the Social Security Act; 21st Century Cures Act; 25.5-1-301 through 25.5-1-303, C.R.S. (2017) and Senate Bill 17-254.

MSB 17-11-22-A, Revision to the Medical Assistance Rule concerning Outpatient Fee-for-Service SUD Providers Eligible Providers, Section 8.746.2

Medical Assistance. Requirements for outpatient fee-for-service substance use disorder providers changed, removing additional certification requirements for licensed clinicians. The limits for several behavioral health services were removed to align with the State Plan and the Community Behavioral Health Services Program. Therefore, 10 C.C.R. 2505-10, Section 8.746, is being amended to reflect these changes.

The authority for this rule is contained in 42 CFR §440.130(d); 25.5-1-301 through 25.5-1-303, C.R.S. (2017) and 25.5-5-202(s)(i), C.R.S (2017).

MSB 18-01-30-A, Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Medical Assistance. This rule change incorporates a change to restorative code, D2330; periodontic code D4355, prosthodontic (removable) codes D5621 and D5622; oral and maxillofacial surgery codes D7220, D7230, D7240, and D7241; and anethesia codes, D9219, D9223 and D9243 and program payments into Appendix A.

The authority for this rule is contained in 25.5-1-301 through 25.5-1-303, C.R.S. (2017); 25.5-3-404, C.R.S. (2017).

MSB 18-01-30-B, Revision to the Medical Assistance Rule concerning the FQHC Rule, Section 8.700
Medical Assistance. This change will revise the Federally Qualified Health Center rules. Federally Qualified Health Centers are currently reimbursed a single, all-inclusive, cost-based encounter rate for one-one-one, face-to-face services with an eligible provider. Federally Qualified Health Centers are also separately reimbursed for Outstationing services. This rule revision contains multiple changes to current FQHC rules, including: adding new billable behavioral health provider types; revising outstationing payment to FQHCs; changing the current Alternative Payment Methodology (APM) to reimburse different cost-based rates for physical health, dental, and specialty behavioral health services; and adding a quality component to FQHC rates that will be effective July 1, 2020.

The authority for this rule is contained in Section 1902(bb) of the Social Security Act and 25.5-1-301 through 25.5-1-303, C.R.S. (2017).

MSB 18-02-09-B, Revision to the Medical Assistance Rule Concerning Community Clinic and Community Clinic with Emergency Center, Section 8.741
Medical Assistance. A new provider type for Community Clinic and Community Clinic with Emergency Center facilities (CC/CCEC) is being added to Health First Colorado rule. The rule identifies the requirements CC/CCEC must fulfill to be reimbursed for services to Health First Colorado clients.

The authority for this rule is contained in 42 USC 1396a(a)(32)(A); 42 CFR §447.321; 25.5-1-301 through 25.5-1-303, C.R.S. and 25.5-4-403, C.R.S (2017).

MSB 18-02-12-A, Revision to the Medical Assistance Rule Concerning Adding the Reasonable Compatibility Methodology to Non-MAGI Verification Requirements. Section 8.100.5.B.1.c
Medical Assistance. The purpose of this rule update is to further align Non-MAGI and MAGI eligibility verification policy by applying the Reasonable Compatibility to the Non-MAGI groups. The Reasonable Compatibility Methodology is an allowable difference between the income that a person self-attests and what is reported through an electronic data source. The Colorado Department of Labor and Employment (CDLE) income record is the electronic data source and is already being used to verify the income for Non-MAGI eligibility. Adding Reasonable Compatibility to the Non-MAGI groups will align the records that are being used for the MAGI and non-MAGI eligibility determination.

By applying reasonable compatibility to these groups, it will reduce the amount of physical verifications required. This will help with streamlining the eligibility determination and ease the burden on county staff when reviewing CDLE records for Reasonable Compatibility for MA purposes. In order to implement this rule there will be costs from the associated change to the CBMS eligibility system. However, since the rule does not change any of the core eligibility income standards, an increase of Medicaid eligible individuals is not anticipated.
Since this is streamlining the eligibility process, concerns from the Medical Services Board or the Public are not anticipated.

The authority for this rule is contained in 42 CFR §435.952; 25.5-1-301 through 25.5-1-303, C.R.S. and 25.5-4-205 C.R.S. (2017).

MSB 18-02-12-B, Revision to the Medical Assistance Rule concerning Long-Term Care Institution Recipient Income - Other Deductions Reserved from the Recipient's Income Section 8.100.7.V.3.g.ii

Medical Assistance. The purpose of changing the rule at 10 CCR 2505-10 § 8.100.7.V.3.g.ii is to increase Home Maintenance Allowance (HMA) which is an adjustment to patient liability for Medicaid recipients in a nursing facility. The intent of this allowance is to provide individuals with no family in the home, to maintain their home during temporary nursing facility stays. The benefit is limited to 6 months and requires a physician statement documenting return to the community is reasonable within 6 months. By increasing this allowance for maintaining the home, it eases and accelerates the transition back to community placement. The philosophy is in line with the Department's focus on maintaining home based placement whenever possible.
The rule changes the methodology that establishes the HMA. Currently, it is set as being no more than the Shelter and Utilities component of the Old Age Pension assistance amount. The new methodology aligns the HMA with rules that allow for a spouse who remains in the community from becoming impoverished when the other spouse becomes institutionalized in a nursing facility. Referred to as the Minimum Monthly Maintenance Needs Allowance (MMMNA), this is an amount of the institutionalized spouse's income that the community spouse may keep to meet living expenses in the community. The MMMNA is based on the 150% Federal Poverty Limit (FPL) for a household of 2; the new HMA methodology is adjusted and calculated on the FPL for a household of 1. This also allows for the HMA to adjust for cost of living since the MMMNA is adjusted yearly.

Although there is an increase in the HMA, the change is expected to be budget neutral due to speedier placement back in the community and avoiding short-term stays from unnecessarily becoming long-term stays due to the loss of a community residence and the increasing cost of finding a replacement.

The authority for this rule is contained in 42 CFR §435.725 and 25.5-1-301 through 25.5-1-303, C.R.S. (2017).

MSB 18-02-12-D, Revision to the Medical Assistance Rule concerning Update to the 340B Drug Discount in EAPGs and EAPG Rate Maintenance Methodology, Section 8.300.6

Medical Assistance. Medical Assistance. Since the implementation of the EAPG methodology for the reimbursement of outpatient hospital services, the Department has received feedback from its stakeholder community that reimbursement for drugs purchased through the 340B Drug Pricing Program is inadequate. After analysis, the Department determined that the discount applied during the pricing of these drugs should be reduced in order to adequately reimburse for these services. Therefore, the rules for the reimbursement for outpatient hospital services, 10 C.C.R. 2505-10 Section 8.300.6 are being revised to include the increased reimbursement. Additionally, the rules will be revised to include non-specific language regarding future EAPG rate updates which will allow the Department to more easily implement updated rates as appropriated by the General Assembly. The rule revisions will be effective July 1, 2018.

The authority for this rule is contained in 24-4-103(6), C.R.S., (2016), 25.5-4-402.3(4)(B)(I) C.R.S (2016 and 25.5-1-301 through 25.5-1-303, C.R.S. (2017).

MSB 18-02-16-A, Revision to the Medical Assistance Rule concerning Stiripentol Coverage, Section 8.800.4.C.5.a

Medical Assistance. Stiripentol is an investigational/experimental drug used to treat a medical condition known as Dravet Syndrome. The Department covers this drug for children under the EPSDT benefit and must revise 10 C.C.R. 2505-10, Section 8.800.4.C.5.a., to expand coverage for members past the age of 20 years old.

The authority for this rule is contained in 42 CFR §440.120; 42 CFR §447.502 and 25.5-1-301 through 25.5-1-303, C.R.S. (2017).