DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.700 Federally Qualified Health Centers, Women's Health Services

10 CCR 2505-10 8.700

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

8.700.1.A. Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule:

8.700.1.B. Visit means a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and physician, dentist, dental hygienist, dental therapist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor providing the services set forth in Section 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

1. A visit includes a one-on-one or face-to-face encounter, or an interactive audio, interactive video, or interactive data communication encounter in accordance with Section 8.095, between a center client and a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado providing services set forth in Section 8.700.3.A. The supervised person must hold a candidate permit as a licensed professional counselor or a candidate permit as a licensed marriage and family therapist, or a candidate permit as a psychologist, or a candidate permit as a clinical social worker candidate (SWC), or a be a licensed social worker. Group sessions do not generate a billable encounter for any FQHC services.

8.700.1.C. The visit definition includes interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounters in accordance with Section 8.095.

1. Any health benefits provided through interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) must meet the same standard of care as in-person care in accordance with Section 8.095.

8.700.2 CLIENT CARE POLICIES

8.700.2.A The FQHCs health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the FQHC staff.

8.700.2.B The policies shall include:

1. A description of the services the FQHC furnishes directly and those furnished through agreement or arrangement. See Section 8.700.3.A.3.

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the FQHC.

3. Rules for the storage, handling and administration of drugs and biologicals.

8.700.3 SERVICES

8.700.3.A The following services may be provided by a certified FQHC:

1. General services

   a. Outpatient primary care services that are furnished by a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse midwife visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed addiction counselor or supervised person pursuing mental health licensure as defined in their respective practice acts.

      i. Outpatient primary care services that are furnished by a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado as defined in their respective practice acts.

   b. Part-time or intermittent visiting nurse care.

   c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under Section 8.700.3.A.1.a and b.

2. Emergency services. FQHCs furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

3. Services provided through agreements or arrangements. The FQHC has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the FQHC.

8.700.3.B A certified FQHC may also provide any service authorized for payment outside the per visit encounter rate by Section 8.700.6.B.

8.700.4 PHYSICIAN RESPONSIBILITIES

8.700.4.A A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on patient referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.700.5 ALLOWABLE COST

8.700.5.A The following types and items of cost for primary care services are included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor and licensed addiction counselor and licensure candidates for clinical psychologist, clinical social worker, licensed marriage and family therapist, and licensed professional counselor who owns, is employed by, or furnishes services under contract to an FQHC.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies related to the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor or licensed addiction counselor.

4. Overhead cost, including clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs.

5. Costs of services purchased by the clinic or center.

8.700.5.B Unallowable costs include but are not limited to expenses that are incurred by an FQHC and that are not for the provision of covered services, according to applicable laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per visit encounter rate for Medicaid clients.

Unallowable costs, include, but are not necessarily limited to, the following:

1. Offsite Laboratory/X-Ray;

2. Costs associated with clinics or cost centers which do not provide services to Medicaid clients; and,

3. Costs of services reimbursed separately from the FQHC encounter rate as described in Section 8.700.6.B.

8.700.6 REIMBURSEMENT

8.700.6.A FQHCs shall be reimbursed separate per visit encounter rates based on 100% of reasonable cost for physical health services, dental services, and specialty behavioral health services. An FQHC may be reimbursed for up to three separate encounters with the same client occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: physical health encounter, dental encounter, or specialty behavioral health encounter. Distinct dental encounters are allowable only when rendered services are covered and paid by the Department's dental Administrative Service Organization (ASO). Distinct specialty behavioral health encounters are allowable only when rendered services are covered and paid by either the Regional Accountable Entity (RAE) or through the short-term behavioral health services in the primary care setting policy.

8.700.6.B The following services are reimbursed separately from the FQHC encounter rate. These services shall be reimbursed in accordance with the following:

1. Long-Acting Reversible Contraception (LARC) devices shall be reimbursed separately from the FQHC encounter rate. In addition to payment of the encounter rate for the insertion of the device(s), the LARC device(s) must be billed in accordance with Section 8.730 and shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

2. Services provided in an inpatient hospital setting shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

3. The provision of complete dentures and partial dentures must be billed in accordance with Section 8.201. and Section 8.202. and shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

4. Dental services provided in an outpatient hospital setting shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

5. The Prenatal Plus Program shall be billed and reimbursed in accordance with Section 8.748.

6. The Nurse Home Visitor Program shall be billed and reimbursed in accordance with Section 8.749.

7. An FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number in accordance with Section 8.800.

8. Antagonist injections for substance use disorders provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

9. COVID-19 vaccine administration provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department

10. Monoclonal Antibody COVID-19 infusion administration provided at the FQHC shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

11. COVID-19 antiviral medication, remdesivir, provided at the FQHC shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

8.700.6.C A physical health encounter, a dental encounter, and a specialty behavioral health encounter on the same day and at the same location shall count as three separate visits.

1. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.700.6.D Encounter rates calculations

Effective July 1, 2018, FQHCs will be paid three separate encounter rates for three separate services: physical health services, dental services, and specialty behavioral health services. Physical health services are covered services reimbursed through the Department's MMIS, except the short-term behavioral health services in the primary care setting policy. Dental services are services provided by a dentist or dental hygienist that are reimbursed by the Department's dental ASO. Specialty behavioral health services are behavioral health services covered and reimbursed by either the RAE or by the MMIS through the short-term behavioral health services in the primary care setting policy. The Department will perform an annual reconciliation to ensure each FQHC has been paid at least their per visit Prospective Payment System (PPS) rate. If an FQHC has been paid below their per visit PPS rate, the Department shall make a one-time payment to make up for the difference.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, Dec. 21, 2000. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for a reasonable charge and for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. Each alternative payment rate shall be the lower of the service specific annual rate or the service specific base rate. The annual rate and the base rate shall be calculated as follows:

   a. The annual rate for the physical health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for physical health services and visits. The annual rate for the dental rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for dental services and visits provided by a dentist or dental hygienist. The annual rate for the specialty behavioral health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for behavioral health services and visits either covered and reimbursed by the RAE or by the short-term behavioral health services in the primary care setting policy.

   b. The new base rates shall be the audited, calculated, inflated, and weighted average encounter rate for each separate rate, for the past three years. Base rates are recalculated (rebased) annually. Initial Base rates shall be calculated when the Department has two year's data of costs and visits.

   c. Beginning July 1, 2020, a portion of the FQHCs physical health alternative payment methodology rates are at-risk based on the FQHC's quality modifier. An FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous Calendar Year.

3. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set reimbursement base rates for the first year. The base rates shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as an FQHC. These shall be the FQHCs base rates until the FQHC's final base rates are set.

    a. New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

4. The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

    a. Freestanding and hospital-based FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. An extension of up to 75 days may be granted based upon circumstances. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

    b. The new reimbursement encounter rates for FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement encounter rates (if less than the new audited rate) shall remain in effect for an additional day above the 120-day limit for each day the required information is late; if the old reimbursement encounter rates are more than the new rate, the new rates shall be effective the 120th day after the FQHCs fiscal year end.

    c. Effective December 11, 2020, FQHC cost reports with fiscal year ends between May 31, 2020 and March 31, 2021 will be set using the previous year's rates multiplied by the Medicare Economic Index (MEI).

    d. Effective September 28, 2021, FQHC cost reports with fiscal year ends between May 31, 2021 and March 31, 2022 will be set using the previous year's rates multiplied by 2.7%.

    e. Starting with FQHC cost reports with fiscal year end May 31, 2022 the Department will restart the base rate setting process. For the first cost report submitted by an FQHC with fiscal year end May 31, 2022 and after, base rates will be set based on one year's worth of data. For the second cost report submitted by an FQHC with fiscal year end May 31, 2022 and after, base rates will be set as a weighted average of two years' worth of data. After this, base rates will be set as specified in 8.700.6.D.2.

5. If an FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.

a. An FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC. The documented change in the scope of service of the FQHC must meet all of the following conditions:

i. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

ii. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5.

iii. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

iv. The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.

v. The change in scope of service must have existed for at least a full six (6) months.

b. A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.700.6.D.5.b and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.

i. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;

ii. The addition or deletion of a covered Medicaid service under the State Plan;

iii. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

iv. Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;

v. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;

vi. Changes resulting from a change in the provider mix, including, but not limited to:

a. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;

b. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the FQHC (e.g. delivery services);

c. Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and/or residents; or,

d. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

c. The following items do not prompt a scope-of-service rate adjustment:

i. An increase or decrease in the cost of supplies or existing services;

ii. An increase or decrease in the number of encounters;

iii. Changes in office hours or location not directly related to a change in scope of service;

iv. Changes in equipment or supplies not directly related to a change in scope of service;

v. Expansion or remodel not directly related to a change in scope of service;

vi. The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;

vii. The addition or removal of administrative staff;

viii. The addition or removal of staff members to or from an existing service;

ix. Changes in salaries and benefits not directly related to a change in scope of service;

x. Change in patient type and volume without changes in type, duration, or intensity of services;

xi. Capital expenditures for losses covered by insurance; or,

xii. A change in ownership.

d. An FQHC must apply to the Department by written notice within ninety (90) days of the end of the FQHCs fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.D.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. An FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

f. The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:

    i. The Department's application form for a scope-of-service rate adjustment, which includes:

        a. The provider number(s) that is/are affected by the change(s) in scope of service;

        b. A date on which the change(s) in scope of service was/were implemented;

        c. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;

        d. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

        e. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC;

ii. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

g. The reimbursement rate for a scope-of-service change applied for January 30, 2017 or afterwards will be calculated as follows:

i. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also calculate the Adjustment Factor (AF = covered health care costs/total cost of FQHC services) associated with the change in scope of service of the FQHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the FQHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the FQHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

ii. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.

iii. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The “current PPS rate” means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.

iv. The Department will check that the adjusted PPS rate meets the 3% threshold described above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.

v. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.

h. The Department will review the submitted documentation and will notify the FQHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC’s fiscal year end.

i. Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified by the Department through an audit or review process.

i. If the Department identifies a change in scope of services, the Department may request the documentation as described in Section 8.700.6.D.5.g from the FQHC. The FQHC must submit the documentation within ninety (90) days from the date of the request.

ii. The rate adjustment methodology will be the same as described in Section 8.700.6.D.5.h.

iii. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

iv. The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.

j. An FQHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, an FQHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

6. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If an FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

7. The Department offers a second Alternative Payment Methodology (APM 2) that is able to pay FQHCs through a Per Member Per Month (PMPM) rate. This reimbursement methodology will convert the FQHC's current Physical Health cost per visit rate into an equivalent PMPM rate using historical patient utilization, member designated attribution, and the Physical Health cost per visit rate for the specific FQHC. FQHCs may opt into APM 2 PMPM annually. Physical health services rendered to patients not attributed to the FQHC, or attributed based on geographic location, will pay at the appropriate encounter rate. Members who are dually eligible for Medicare and Medicaid are excluded APM 2 member populations and attribution because Medicare is the primary payer. Dental and specialty behavioral health services for all patients will be paid at the appropriate encounter rate. Year 2 rates for FQHCs participating in APM 2 will be set using trended data. Year 3 rates will be set using actual data.

8. FQHCs may voluntarily elect to join APM 2 PMPM or the Chronic Condition Incentive Payment, or both. FQHCs will be eligible to earn incentive payment, which will not factor into rate-setting for APM 1 or APM 2, for participating in Chronic Condition Incentive Payment. Incentive payment thresholds will be specific to each FQHC. The Department will share thresholds each FQHC must meet to be eligible to receive incentive payments. Services that comprise the targets will also be published. FQHCs may opt into the APM 2 Chronic Conditions Incentive Payment quarterly on the first date of the calendar quarter. FQHCs will agree to the thresholds and services for incentive payments in the letter sent annually by the Department which confirms participation in the program. The Chronic Conditions Incentive Payment will be paid when FQHCs provide physical health services to full benefit Medicaid beneficiaries attributed to the FQHC, who are not geographically attributed or dually eligible for Medicare, and must also be diagnosed with one or more the following chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, hypertension, arrythmia/heart blockage, heart failure, gastro-esophageal reflux disease, Crohn's disease, ulcerative colitis, low back pain, osteoarthritis, and/or diabetes.

9. The Department will perform an annual reconciliation to ensure the PMPM reimbursement compensates APM 2 providers in an amount that is no less than their PPS per visit rate. The Department shall perform PPS reconciliations should the FQHC participating in APM 2 realize additional cost, not otherwise reimbursed under the PMPM, incurred as a result of extraordinary circumstances that cause traditional encounters to increase to a level where PMPM reimbursement is not sufficient for the operation of the FQHC.

10. PMPM and encounter rates for FQHC participating in APM 2 shall be effective on the 1st day of the month that falls at least 120 days after an FQHC's fiscal year end.

8.700.6.E The Department shall notify the FQHC of its rates.

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process. Beginning with the 2019 Cost Report Cycle, this outstationing payment shall be made based upon actual cost and is included as an allowable cost in an FQHC cost report.

8.700.8.B

1. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

2. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. Effective with the hospital cost report year 2010 and forward, the Department will make an interim payment to Denver Health Medical Center for estimated

reasonable costs associated with outstationing activities based on the costs included in the as-filed Medicare cost report. This interim payment will be reconciled to actual costs after the cost report is audited. Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the interim estimated administrative costs and the final audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

8.711.1 through 8.712 Repealed, effective June 30, 2005

8.715 BREAST AND CERVICAL CANCER PROGRAM

8.715.1 DEFINITIONS

Breast and Cervical Cancer Program (BCCP) means the Medicaid program established, operated and monitored by the Department.

Colorado Women's Cancer Control Initiative (CWCCI) means the program administered by the Colorado Department of Public Health and Environment and funded by the Centers for Disease Control and the National Breast and Cervical Cancer Early Detection Program.

In Need of Treatment means services necessary to determine the extent and proper course of cancer or precancerous treatment as well as definitive cancer treatment itself. Treatment can include surgery, radiation, chemotherapy and approved medications following treatment as determined by the client's physician and the Department.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP) means the program where the Centers for Disease Control (CDC) provides breast and cervical screening services to underserved women. In Colorado, the CDC provider is the Department of Public Health and Environment's Colorado Women's Cancer Control Initiative.

Presumptive Eligibility for BCCP means the temporary eligibility for benefits that begin on the date a Qualified Entity determines the client meets eligibility requirements for the BCCP and the client signs the presumptive eligibility form. Women identified by the CWCCI as being In Need of Treatment for breast or cervical cancer or a precancerous condition shall apply for presumptive eligibility on a simplified Medicaid application.

Qualified Entity means a provider contracted with the Department of Public Health and Environment under a cooperative agreement with the CDC to support activities related to the NBCCEDP. A qualified entity shall provide breast and cervical cancer assessment services for the CWCCI.

State Designated Entity means an agency acting on behalf of and at the direction of the Department and whose function may include, but is not limited to, processing eligibility determinations and assisting clients with the application process.

8.715.2 ELIGIBILITY REQUIREMENTS

8.715.2.A. Clients shall meet all requirements of the CWCCI program.

8.715.2.B. Clients shall enroll for screening at participating Breast and Cervical Cancer assessment sites through the CWCCI.

8.715.2.C. Clients shall:

1. Be a woman who has not yet attained the age of 65.

2. Be a resident of Colorado.

3. Be a citizen of the United States or a qualified alien as described in 8.100.53(A)(2) through 8.100.53(A)(4).

4. Have been screened by a Qualified Entity and found to be In Need of Treatment for breast or cervical cancer, including precancerous conditions as determined through pathological tests.

5. Not have creditable coverage as described in 8.715.3.

6. Not be eligible under another Medicaid program.

7. Be a client who has previously qualified and enrolled in a NBCCED program in another state and chooses to transfer her enrollment to CWCCI.

8.715.2.D. Clients shall not have been previously screened or received treatment for breast or cervical cancer prior to July 1, 2002.

8.715.2.E. Clients shall not be considered to be In Need of Treatment if it is determined she only requires routine follow-up monitoring services.

8.715.2.F. Clients shall be willing to seek Medicaid approved breast or cervical cancer or precancerous treatment within three months of the date of eligibility. If a client does not seek such treatment within three months of the date of presumptive eligibility, the client shall be removed from the program on the last day of the third month. The client will be re-entered in the BCCP program at such time as treatment is scheduled to begin. If treatment has not been started within one month of the scheduled date, the client will be disenrolled.

8.715.3 CREDITABLE COVERAGE

8.715.3.A. Creditable coverage shall include coverage of any individual as defined at 10-16-102, C.R.S. (2002).

8.715.3.B. The following are not considered creditable coverage:

1. Limited scope coverage such as that which covers only dental, vision or long term care;

2. Coverage only for a specific disease or illness (unless the specific disease or illness includes breast or cervical cancer); or

3. A medical care program run by the Indian Health Services or a tribal organization.

8.715.3.C. An individual who otherwise has creditable coverage may qualify for the program if:

1. The individual is in a period of exclusion for treatment of breast or cervical cancer; or

2. The individual has exhausted her lifetime limits on benefits under the plan for breast or cervical cancer.

8.715.3.D. Individuals who have coverage that contains yearly limited drug benefits, yearly limits on outpatient visits or high deductibles shall be considered to have creditable coverage.

8.715.4 PRESUMPTIVE ELIGIBILITY

8.715.4.A. Presumptive eligibility shall be determined by Qualified Entities.

8.715.4.B. The Department shall make available to Qualified Entities:

1. Information on the BCCP presumptive eligibility form and card;

2. Information on how to obtain the Medicaid application; and

3. Information on how to assist CWCCI personnel and individuals on application completion and filing.

8.715.4.C. Qualified Entities shall determine presumptive eligibility based on verbal confirmation by the potential client that she meets CWCCI criteria and shall enroll the clients who appear to be eligible.

8.715.4.D. Presumptive eligibility shall begin on the date the client completes the BCCP presumptive eligibility form and the Qualified Entity determines the client meets all eligibility criteria.

8.715.4.E. All potential clients shall be required to complete the BCCP presumptive eligibility form and the Medicaid application at the same time.

8.715.4.F. The Qualified Entity shall submit the presumptive eligibility form, a copy of the presumptive eligibility card, the CWCCI history and physical, the diagnosis pathology report and the signed consent form to the Department.

8.715.4.G. The Designated Entity shall process the Medicaid application within thirty calendar days of receipt.

8.715.4.H. The presumptive eligibility period shall end on the following:

1. The date on which a formal determination is made on the client's Medicaid application; or

2. If a full determination cannot be made on the basis of the BCCP presumptive eligibility form and the client fails to complete the Medicaid application, then eligibility will end on last day of the month following the month in which the client was determined to be presumptively eligible.

8.715.5 ELIBILITY PERIOD

8.715.5.A. Eligibility shall begin on the date the client is determined to be presumptively eligible.

8.715.5.B. The client shall be eligible to receive services for up to one year from the date of initial eligibility unless she is no longer In Need of Treatment or no longer meets program eligibility requirements.

8.715.5.C. If the client remains in treatment beyond one year, renewed eligibility shall be determined consistent with BCCP and Medicaid requirements.

8.715.5.D. A period of renewed eligibility begins each time the client is screened under the CWCCI program and is found to be In Need of Treatment for breast or cervical cancer and meets all other eligibility criteria.

8.715.5.E. A client may be determined no longer eligible for the program if:

1. She does not complete the Medicaid application; or

2. She is no longer In Need of Treatment for breast or cervical cancer or qualified precancerous conditions when the client's provider notifies the Department; or

3. She reaches the age of 65; or

4. She obtains other creditable coverage describe in 8.715.3.

8.715.5.F. Clients who are determined no longer eligible shall be notified in writing as described in 8.715.6(B).

8.715.6 NOTIFICATION

8.715.6.A. The BCCP presumptive eligibility form shall include a statement of the applicant's rights and responsibilities.

8.715.6.B. The Department shall notify clients who are no longer In Need of Treatment for the BCCP in writing thirty days prior to their disenrollment date. This notice will be provided only to those clients who have completed their course of treatment per their provider.

1. Copies of the notice shall be sent to the client, her designated representative if applicable, the CWCCI site, the State Designated Entity and the client's provider.

2. The notification shall include information regarding appeal rights described in 10 C.C.R. 2505-10, Section 8.057.

8.715.6.C. The Department shall notify clients who no longer meet the BCCP eligibility criteria at least ten days prior to program termination.

8.715.7 BENEFITS

8.715.7.A. Eligible clients shall receive all Medicaid benefits included in the State Plan.

8.715.7.B. Breast reconstructive surgery shall be a covered benefit when completed up to seven months following a mastectomy.

8.715.7.C. Breast or cervical cancer or precancerous treatment provided prior to the NBCCED program implementation or client enrollment into the BCCP is not a covered benefit.

8.715.7.D. Clients eligible for this program shall receive all mental health services through the Mental Health Assessment Service Agency of the county in which the client resides.

8.715.8 ROLES/RESPONSIBILITIES

8.715.8.A. County Departments of Human/Social Services shall:

1. Assist in providing information to the client about services and benefits available through the program;

2. Assist the client in accessing health care services or contact the appropriate agencies for services, such as the enrollment broker, mental health provider and transportation provider;

3. Assist the client in applying for and accessing other benefits for which she may qualify, such as home care allowance, food stamps and financial assistance; and

4. Assist the Department by notifying the Department when a client's eligibility status changes.

8.715.8.B. Clients shall notify the Department and healthcare providers if the client receives creditable coverage or if a third party is responsible for illness or injury to the client.

8.715.8.C. Providers shall respond to inquiries from the Department and provide information required to verify the client's In Need of Treatment status within ten calendar days of the Department's request.

8.715.8.D. Provider's shall follow Medicaid billing instructions and obtain prior authorizations when necessary.

8.715.8.E. The State Designated Entities shall have the following responsibilities:

1. To determine whether a client is eligible for Medicaid in any other eligibility group;

2. To complete review of the Medicaid application form within fifteen days of receipt;

3. To notify the client she has thirty days to submit addition information if needed and if the information is not received the client will be found ineligible;

4. To inform the client of her appeal rights if eligibility is denied; and

5. To disenroll the client from the BCCP when notified the client is no longer in Need of Treatment.

8.726 TEEN PREGNANCY PREVENTION PILOT PROGRAM

8.726.1 DEFINITIONS

At Risk Teenager means a person under nineteen years of age who resides in a neighborhood in which there is a preponderance of poverty, unemployment and underemployment, substance abuse, crime, school dropouts, a significant public assistance population, teen pregnancies and teen parents or other conditions that put families at risk.

Support Services means individual or group counseling, which includes a component on delayed parenting, health guidance and health services such as home visits or visiting nurse services.

8.726.2 CLIENT ELIGIBILITY

The client shall be identified as an At Risk Teenager by a school, health care provider, social service or other community agency.

8.726.3 PROVIDER ELIGIBILITY

Eligible providers shall meet all the following criteria;

1. Be enrolled as a participating provider.

2. Submit an application to the Department and be approved as a Teen Pregnancy Prevention Pilot Program provider. The provider application shall include at a minimum:

a. A method of identifying and targeting At Risk Teenagers.

b. An overview of strategies and principles to promote self-sufficiency, self-reliance and the ability to make appropriate family planning decisions.

c. A method of securing a minimum of 10% local funds that will be reviewed by the Department for compliance with federal Medicaid matching requirements.

d. A specific package of Support Services.

e. A methodology for tracking teens to determine success in preventing pregnancy.

f. A description of established community support and collaboration to provide educational, vocational and other services that are not inclusive in the provider's package of Support Services.

8.726.4 REIMBURSABLE SERVICES

The Teen Pregnancy Prevention Pilot Program includes a package of support services developed to reduce teen pregnancy. The support service package may include, but shall not be limited to:

1. Intensive individual or group counseling, which includes a component on delayed parenting.

2. Guidance promoting self-sufficiency, self-reliance and the ability to make appropriate family planning decisions.

3. Home visits or visiting nurse services.

The service package must be specified in the Teen Pregnancy Prevention Pilot Program provider application and provided as approved. Teen Pregnancy Prevention Pilot Program services are in addition to the currently reimbursed family planning services available to clients.

8.726.5 REIMBURSEMENT

Reimbursement is dependent upon receipt of 90% federal financial funds under the family planning provision. Reimbursement shall be the lower of:

1. Submitted charges; or

2. Fee schedule as determined by the Department.

8.730 FAMILY PLANNING SERVICES

8.730.1 Definitions

Family Planning Services mean those services provided to individuals of child-bearing age, including sexually active minors, where the intent of that service is to delay, prevent, or plan for a pregnancy. Family Planning Services may include physical examinations, evaluation, treatments, counseling, supplies , prescriptions, and follow-up services.

Institutionalized Individual means an individual who is (a) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility (including a psychiatric hospital or other facility) for the care and treatment of a mental illness; or (b) confined, under a voluntary commitment in a psychiatric hospital or other facility, for the care and treatment of a mental illness.

Mentally Incompetent Individual means an individual who has been declared mentally incompetent by a federal, state, or local court for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

Sterilization means any medical procedure, treatment, or operation (except for a hysterectomy) for the purpose of rendering an individual permanently incapable of reproducing and that requires informed consent

8.730.2 Client Eligibility

8.730.2.A. All Medicaid clients of childbearing age are eligible for family planning services.

8.730.3 Provider Eligibility

8.730.3.A. The following Medicaid enrolled providers may offer family planning services:

1. Physician
2. Osteopath
3. Nurse Practitioner
4. Certified Nurse-Midwife
5. Physician Assistant
6. Clinical Nurse Specialist
7. Certified Registered Nurse Anesthetist
8. Family Planning Clinic
9. Public Health Agency
10. Non-physician Practitioner Group

8.730.3.B. Eligible places of service include:

1. Office
2. Clinic
3. Public Health Agency
4. Home
5. School
6. School-based Health Center
7. Federally Qualified Health Center
8. Rural Health Center
9. Hospital

10. Ambulatory Surgery Center

11. Telemedicine may be provided in accordance with Section 8.095.

8.730.4 Covered Services

8.730.4.A. Office Visits

1. A comprehensive, annual family planning visit (where the intent of the visit is related to pregnancy prevention or planning) is covered only once per state fiscal year, no less than ten months apart, and may include: physical examinations, evaluation, treatments, counseling, supplies, contraceptives and prescriptions. Additional family planning follow-up visits and services are covered when medically necessary.

8.730.4.B. Sterilization

1. Sterilization is covered for a client who is:

   a. 21 years of age or older;

   b. Is mentally competent;

   c. Is not institutionalized; and,

   d. Has given written informed consent where at least one of the following conditions apply:

      i. At least 30 days, but no more than 180 days have passed between the date of informed consent and the date of sterilization;

      ii. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery and at least 72 hours have passed since the date of informed consent; or

      iii. In the case of emergency abdominal surgery, at least 72 hours have passed since the date of informed consent.

2. A client with an intellectual and developmental disability is protected under C.R.S. 25.5-10-231 and C.R.S. 25.5-10-232 with respect to sterilization rights and competency to give consent for sterilization.

   a. The above statutes are applicable except for clients aged between eighteen and twenty-one years. For any signed sterilization consent to be considered valid, any client, including those with an intellectual and developmental disability, is required to be 21 years or older.

8.730.4.C. Contraceptives

1. All FDA-approved contraceptives, including emergency contraceptives, are a covered benefit.

8.730.5 Documentation

8.730.5.A. Services

1. For family planning services and supplies, the provider shall document the intention of the service as it relates to delay, prevention, or for planning a pregnancy.

8.730.5.B. Sterilization Consent Form

1. Submission of a valid signed sterilization consent form is required prior to reimbursement. The sterilization consent form shall be signed and dated by:

   a. The client to be sterilized;

   b. The interpreter, if one was provided;

   c. The person who obtained the consent; and

   d. The physician who will perform the sterilization procedure.

2. If an interpreter is provided, the interpreter shall, by signing the consent form, certify that he or she translated the information presented orally, read the consent form and explained its contents to the client, and that, to the best of the interpreter's knowledge, the client understood the information provided.

3. The person who obtained the consent shall, by signing the consent form, certify that he or she provided the client with all of the information set forth in 8.730.5.B.6. and, to the best of his or her knowledge, the client appeared mentally competent, and knowingly and voluntarily consented to be sterilized.

4. The physician performing the sterilization shall, by signing the consent form, certify that:

   a. He or she provided the client with all of the information set forth in 8.730.5.B.6;

   b. To the best of his or her knowledge the client appeared mentally competent, and knowingly and voluntarily consented to be sterilized;

   c. Except in the case of premature delivery or emergency abdominal surgery, the physician shall further certify that at least 30 days but less than 180 days have passed between the date of the client's signature on the consent form and the date upon which the sterilization was performed;

   d. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician shall certify that the sterilization was performed less than 30 days, but more than 72 hours, after informed consent was obtained because of premature delivery or emergency abdominal surgery; and,

   e. In the case of premature delivery, the physician shall state the expected date of delivery, or in the case of emergency abdominal surgery, the physician shall describe the emergency.

5. Informed consent for sterilization cannot be obtained when a client is:

   a. In labor or childbirth;

   b. Seeking to obtain or obtaining an abortion; or

c. Under the influence of substances that impair the individual's decision making capabilities.

6. Informed consent is valid only when the client has been offered and given:

a. Answers to any questions concerning the procedure;

b. A copy of the consent form;

c. A copy of the signed consent form; and,

d. Orally provided the following information:

i. The ability to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the client might otherwise be entitled.

ii. A description of available alternative methods of family planning and birth control.

iii. That the sterilization procedure is considered to be irreversible.

iv. An explanation of the specific sterilization procedure to be performed.

v. A description of the discomforts and risks that may accompany or follow the sterilization procedure including an explanation of the type and possible effects of any anesthetic to be used.

vi. A description of the benefits or advantages that may be expected as a result of the sterilization.

vii. That the sterilization will not be performed for at least 30 days but less than 180 days from consent except under the circumstances specified in 8.730.4.B.1.d.ii, or 8.730.4.B.1.d.iii.

7. The consent is not valid unless the information specified in 8.730.5.B.6. is effectively communicated to any client who is blind, deaf, or otherwise disabled.

8. An interpreter shall be provided if the client to be sterilized does not understand the language used on the consent form or the language used by the person obtaining consent.

9. The client to be sterilized may have a witness of his or her choice present when consenting to the procedure.

8.730.6. Non-covered Services

8.730.6.A. The following services are not covered benefits for Medicaid clients:

1. Sterilization reversal

2. Infertility treatment and testing

8.730.7. Prior Authorization

8.730.7.A. Prior authorization is not required for family planning services.

8.730.8. Reimbursement

8.730.8.A. Reimbursement for family planning services requires an appropriate Family Planning diagnostic code along with use of the family planning (FP) modifier.

8.731 WOMEN'S HEALTH SERVICES

8.731.1 Definitions

BRCA means a mutation in breast, ovarian, tubal, or peritoneal cancer susceptibility genes. The mutation may be either BRCA1 or BRCA2.

BRCA Screening means to assess whether a client has a documented biological family history of breast, ovarian, tubal, or peritoneal cancer that may be associated with an increased risk for potential mutation in breast cancer susceptibility genes (BRCA1 and BRCA2).

Sterile/Sterility means permanently rendered incapable of reproducing.

8.731.2 Client Eligibility

8.731.2.A. All female and transgender Medicaid clients are eligible for women's health services.

8.731.3. Provider Eligibility

8.731.3.A. All Colorado Medicaid enrolled providers are eligible to provide women's health services when it is within the scope of the provider's practice.

8.731.4. Covered Services

8.731.4.A. Women's Health Services are covered when medically necessary, as defined at Section 8.076.1.8, and within the limitations described in this section 8.731 and under 10 CCR 2505-10 as applicable.

8.731.4.B. All services are covered as often as clinically indicated, unless otherwise restricted under this rule.

8.731.4.C. The following services are covered:

1. Annual gynecological exam

2. Cervical cancer screening and follow-up

    a. Cervical cancer screenings are only covered once per state fiscal year, unless clinical indication requires additional screening.

    b. Further diagnostic and treatment procedures are covered as clinically indicated.

3. Sexually transmitted disease/infection testing, risk counseling, and treatment

4. Human Papillomavirus (HPV) vaccination

a. HPV vaccination is only covered for clients ages 9 through 26.

b. For clients ages 9 through 18 who are covered through the Vaccines for Children program, only the administration of the vaccine is covered in accordance with 8.200.3.C.2.

c. For clients ages 19 through 26, the administration of the vaccine and the vaccine are covered in accordance with 8.200.3.C.2.

5. BRCA screening, genetic counseling, and testing

a. BRCA screening, genetic counseling, and testing is only covered for clients over the age of 18.

b. BRCA screening is covered and must be conducted prior to any BRCA-related genetic testing.

c. The provider shall make genetic counseling available to clients with a positive screening both before and after genetic testing, if the provider is able, and genetic counseling is within the provider's scope of practice. If the provider is unable to provide genetic counseling, the provider shall refer the client to a genetic counselor.

d. Genetic testing for breast cancer susceptibility genes BRCA1 and BRCA2 is covered for clients with a positive screening.

6. Mammography

a. Mammography is covered for clients who are age 40 and older; or, have been clinically assessed as at high risk for, or have a history of, breast disease.

7. Mastectomy

a. Mastectomy is covered for women who have a positive genetic test as a BRCA mutation carrier.

b. Bilateral mastectomy is a covered benefit when there is a known breast disease in either breast.

c. Prophylactic bilateral mastectomy is a covered benefit for women who have tested positive for the BRCA1 or BRCA2 mutation or have a personal history of breast disease.

d. For clients who have undergone a mastectomy, a maximum of two mastectomy brassieres are covered per year.

8. Breast reconstruction is covered within five years of a mastectomy.

9. Breast reduction procedures are covered for clients with macromastia and there is a documented failure of alternative treatment for macromastia.

10. Hysterectomy

a. Hysterectomy is covered when performed solely for medical reasons and when all of the following conditions are met:

i) The client is over the age of 20, or is a BRCA1 or BRCA2 carrier over the age of 18;

ii) The person who secures the authorization to perform the hysterectomy has informed the client, or the client's authorized representative, as defined in Section 8.057.1, orally and in writing that the hysterectomy will render the client Sterile;

iii) The client, or the client's authorized representative, as defined in Section 8.057.1, has acknowledged in writing, that the client or representative has been informed the hysterectomy will render the client Sterile; and

iv) The Department or its designee has been provided with a copy of the written acknowledgment under 8.731.4.C.10.a.iii. The acknowledgement must be received by the Department or its designee before reimbursement for any services related to the procedure will be made.

b. A written acknowledgment of Sterility from the client is not required if either of the following circumstances exist:

i) The client is already Sterile at the time of the hysterectomy; or,

ii) The client requires a hysterectomy because of a life-threatening emergency in which the physician determines prior acknowledgement is not possible.

c. If an acknowledgement of Sterility is not required because of the 8.731.4.C.10.b exceptions, the physician who performs the hysterectomy shall certify in writing that either:

i) The client was already Sterile, stating the cause of that sterility; or,

ii) The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgement was not possible. The physician must include a description of the emergency.

d. The Department or its designee must be provided with a copy of the physician's written certificate under 8.731.4.C.10.c. The acknowledgement must be received by the Department or its designee before reimbursement for any services related to the procedure will be made.

8.731.5 Non-Covered Services

8.731.5.A. Prophylactic bilateral mastectomy is not covered when:

1. There is no known breast disease present or personal history of breast disease**,** or**,**

2. The client does not test positive for the BRCA1 or BRCA2 mutation.

8.731.5.B. Hysterectomy for the sole purpose of sterilization.

1. If more than one purpose for the hysterectomy exists, but the purpose of sterilization is primary, the hysterectomy is not a covered service.

8.731.5.C. Routine BRCA genetic testing for clients whose family history is not associated with an increased risk of BRCA gene mutation is not covered.

8.731.6. Prior Authorization

8.731.6.A. All breast reconstruction and reduction procedures require prior authorization.

8.731.6.B. All BRCA genetic testing requires prior authorization.

8.732. MATERNITY SERVICES

8.732.1 DEFINITIONS

High-Risk Pregnancy means pregnancy that threatens the health or the life of the mother or her fetus. Risk factors can include existing health conditions, weight and obesity, multiple births, older maternal age, and other factors.

8.732.2. CLIENT ELIGIBILITY

8.732.2.A. Medicaid-enrolled pregnant or postpartum clients are eligible for maternity services. Women remain eligible throughout their pregnancy and maintain eligibility until the end of the month in which 60 days have passed post-pregnancy.

8.732.3. PROVIDER ELIGIBILITY

8.732.3.A. All Colorado Medicaid-enrolled providers are eligible to provide maternity services when it is within the scope of the providers' practice.

8.732.4. COVERED SERVICES

8.732.4.A. Maternity services are covered when medically necessary and within the limitations described in this section 8.732 and under 10 CCR 2505-10 as applicable.

8.732.4.B. Prenatal and Post-Partum Office Visits

1. One initial, comprehensive, prenatal visit including history and physical exam is covered.

2. Subsequent prenatal visits are covered at a frequency that follows nationally recognized standards of care based on client risk factors and complicating diagnoses.

3. Postpartum visits are covered at a frequency that follows nationally recognized standards of care. Generally, one to two postpartum visits are considered routine for uncomplicated pregnancies and deliveries. Guidelines for screening, diagnostic, and monitoring services are located at 8.732.4.D and 8.732.4.E, of this rule.

8.732.4.C. Ultrasounds

1. A maximum of two routine ultrasounds are covered per low-risk pregnancy.

2. Clients with High-Risk Pregnancies may receive more than two ultrasounds when clinically indicated in accordance with nationally recognized standards of care for indication and frequency. Clinical indication must be clearly documented in the client record.

8.732.4.D. Additional Screening, Diagnostic, and Monitoring Services

1. The following services are covered only when clinically indicated in accordance with nationally recognized standards of care for indications and frequency.

    a. Amniocentesis

    b. Fetal biophysical profile

    c. Fetal non-stress test

    d. Fetal echocardiogram

    e. Fetal fibronectin

    f. Chorionic villus sampling

2. The clinical indication must be clearly documented in the medical record.

8.732.4.E. Effective July 1, 2022, Genetic Screening, including but not limited to Non-Invasive Prenatal Testing (NIPT), and Genetic Counseling are covered in accordance with nationally recognized standards of care. Screening coverage is available for women carrying a singleton gestation who meet national standard guidelines.

8.732.4.F. Diabetic supplies are covered for clients diagnosed with gestational diabetes mellitus (GDM), in accordance with nationally recognized standards of care for GDM.

8.732.4.G. Labor and Delivery services including admission to the hospital, the admission history and physical examination, and management of labor and delivery services.

8.732.4.H. Home births may be performed by physicians and certified nurse-midwives carrying malpractice insurance that covers home births.

8.732.5 NON-COVERED SERVICES

8.732.5.A. The following services are not covered:

1. Home pregnancy tests

2. Three and four dimensional ultrasounds

3. Ultrasounds performed solely for the purpose of determining the sex of the fetus or to provide a keepsake picture

4. Paternity testing

5. Lamaze classes

6. Birthing classes

7. Parenting classes

8. Home tocolytic infusion therapy

8.732.6. PRIOR AUTHORIZATION

8.732.6.A. Prior Authorization is not required for services under § 8.732, with the following exception:

1. Services under Section 8.732.4.E may require prior authorization.

8.733 EPISODE BASED PAYMENTS

8.733.1 DEFINITIONS

8.733.1.A. **Episode** means a defined group of related Medicaid-covered services provided to a specific patient over a specific period of time. A Maternal Episode includes the Delivery Episode Trigger; Prenatal Pre-Trigger Window; Delivery Trigger Window; and Post-Partum Post-Trigger Window.

1. **Delivery Episode Trigger** means the date of a qualifying live delivery event.

2. **Prenatal Pre-Trigger Window** means the 280-day period prior to the delivery episode trigger window and includes all relevant care for the patient provided during that period.

3. **Delivery Trigger Window** means the time period when the mother is in the hospital for the delivery episode trigger.

4. **Postpartum Post-Trigger Window** means the 60-day time period following the delivery episode trigger window and includes all relevant care and any complications that might occur for the mother during that period.

8.733.1.B. **Episode Cohort** means a Principal Accountable Provider's (PAP) maternity Episodes eligible for either positive or negative incentives after exclusions, cost outliers, and services not relevant to the Prenatal Pre-Trigger, Delivery Trigger, and Post-Partum Post-Trigger Windows have been removed.

8.733.1.C. **Gross Episode Performance** means the aggregated average performance of a PAP compared to each prospective target set by each Threshold without the Department's share calculated, for either the Behavioral Health or Non-Behavioral Health subsets of Episodes.

8.733.1.D. **High-Risk Pregnancy** means pregnancy that threatens the health or the life of the mother or her fetus. Risk factors can include existing health conditions, weight and obesity, multiple births, older maternal age, and other factors.

8.733.1.E. **Net Episode Performance** means the Gross Episode Performance of a PAP multiplied by the Department's share of fifty percent, for either the Behavioral Health or Non-Behavioral Health subsets of Episodes.

8.733.1.F. **Performance Period** means a twelve-month period, beginning on November 1 of each year, for which the Department will measure Episode performance of all providers delivering services during the course of a specific Episode. For an Episode to be included within the Performance Period, the end date for the Episode must fall within the Performance Period.

8.733.1.G. **Principal Accountable Provider (PAP)** means the provider that is held accountable for both the quality and cost of care delivered to a patient for an entire Episode. PAPs for maternity Episodes are willing obstetrical groups who agree in writing to participate in the program with the Department.

8.733.1.H. **Threshold** means the prospective cost target for performance for both the upper and lower incentive benchmarks for the Behavioral Health and non-Behavioral Health subsets within a PAP's Episode Cohort.

1. **Acceptable** means the dollar value such that a provider with an average reimbursement below the dollar value incurs a positive incentive payment.

2. **Commendable** means the specific dollar value such that a provider with an average reimbursement below the dollar value is eligible for a positive incentive payment if all Quality Metrics linked to the incentive payment are met.

8.733.1.I. **Quality Metrics** means measures determined by the Department that will be used to evaluate the quality of care delivered during a specific Episode, including the extent to which care reduces disparate outcomes based on race and ethnicity and improves patient experience.

8.733.2 MATERNITY

8.733.2.A. Maternity Bundled Payment Pilot Program

1. Using Episode-based payments, the Department modifies its payment methodology for maternity services, as defined in Section 8.732, for PAPs to recognize the quality and efficiency of maternity services provided, including the extent to which services reduce health disparities and improve the patient experience.

2. Maternity Episode definitions and appropriate Quality Metrics are based on evidence-based practices derived from peer-reviewed medical literature, public health data on infant and maternal morbidity and mortality and effective responses, historical provider performance, and clinical information furnished by providers rendering services during maternity Episodes.

3. Medicaid-covered services during a maternity Episode will be included in the Prenatal Pre-Trigger Window, Delivery Trigger Window, and Post-Partum Post-Trigger Window. The services considered as a part of the episode shall not be limited solely to those provided by the PAP.

4. The Department through a stakeholder advisory process that is majority currently or former Medicaid members who have received maternity services and majority people of color shall review the maternity bundled payment pilot. The process shall meet and review data on the maternity bundled payment pilot at least quarterly.

8.733.2.B. Maternity Episode Program Incentive Payments

1. Incentive payments to a PAP are based upon an Episode Cohort within a Performance Period.

2. Since program participation is voluntary, PAPs are only subject to positive incentives. Positive incentive payments may be made retrospectively after the end of the Performance Period.

3. When calculating a PAP's Episode Cohort, the Department excludes the Episodes which have the presence of the following:

a. The member is dually eligible for Medicare and Medicaid at any time during the Episode.

b. Third-party liability on any claim within a maternity Episode.

c. PAP provided no prenatal services for to the member.

d. Member died during Episode.

e. Incomplete set of claims for an Episode.

f. No professional claim for delivery.

4. When calculating a PAP's Episode Cohort, the Department will remove cost outliers via a statistical methodology determined by the Department's actuarial contractor.

5. When calculating a PAP's Episode Cohort, the Department will remove services that are not part of the relevant care for the Prenatal Pre-Trigger, Delivery Episode, and Post-Partum Post-Trigger Windows.

6. Each participating PAP will have two sets of Acceptable and Commendable Thresholds calculated based on their historical costs for Episodes.

   a. The first set of Thresholds will be calculated based on historical costs for Episodes that contain a flag for Behavioral Health (including Substance Use Disorder (SUD) or Mental Health).

   b. The second set of Thresholds will be calculated based on historical costs for Episodes that do not contain a flag for Behavioral Health (SUD and Mental Health).

   c. It is the responsibility of the PAP to review each set of Acceptable and Commendable Thresholds provided by the Department before the start of the Performance Period.

7. Incentive payments for a PAP's Episodes within the Performance Period will be calculated in two separate subsets.

   a. The first subset comprises Episodes that have a flag for Behavioral Health (SUD or Mental Health).

   b. The second subset comprises Episodes that do not have a flag for Behavioral Health (SUD or Mental Health).

8. In order for a PAP to be eligible for positive incentives for a subgroup, the PAP must do the following:

   a. Meet the Quality Metrics set for each Performance Period by the Department. The Department shall present on quality measures to the Program Improvement Advisory Committee (PIAC) before measures are tied to payment. Subject to data availability and quality limitations, the Department at a minimum shall monitor the following within the limitations of data availability and data quality:

      i. Patient education

      ii. All cause readmissions

      iii. Severe maternal morbidity

iv. Maternal Gestational Hypertension, Pre-eclampsia, HELLP syndrome, eclampsia

v. Premature birth

vi. Patient Experience

The Department shall review all findings through the stakeholder advisory process identified in 8.733.2.A (4). If warranted, the Department may update the list of quality metrics monitored. Subject to the limitations of data availability, if the Department seeks improved PAP performance for a quality metric, that quality metric may be tied to payment.

b. During the first year that a PAP joins the program, the PAP's performance relative to quality metrics (including metrics tied to payment) will only be tracked and reported to the provider to create a baseline. Starting the second year of a PAP's participation in the program, the Department will apply quality metrics tied to payment.

c. In determining a PAP's incentive payments, starting the second year the Department will also consider whether the PAP provided the same or a greater number of services and/or resources to members within the subgroup who experience racism as compared to members in the subgroup who do not experience racism.

9. If the PAP's aggregated average Gross Episode Performance for each subset is lower than each Commendable Threshold, the PAP shall receive a positive incentive payment.

10. If the PAP's aggregated average Gross Episode Performance for each subset is higher than each Acceptable Threshold, the PAP will not be liable for a negative incentive payment as a financial penalty.

11. If the average Episode reimbursement for each subset is between each set of Acceptable and Commendable Thresholds, the PAP shall not receive a positive incentive payment or incur a negative incentive payment.

12. Incentive payments are separate from, and do not alter, the reimbursement methodology for Medicaid-covered services set forth in Department rules and guidance.

13. Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular member.

14. Nothing in this rule prohibits the Department from engaging in any retrospective review or other program integrity activity.

15. PAPs may contest the Department's incentive payment determination. PAPs who contest the Department's determination must submit in writing the reason for contesting the determination within 60 calendar days of receiving the notice of payment. The Department will review all contested determinations within 30 calendar days of receipt of the notice. The PAP has the right to file an appeal with the Office of Administrative Courts in accordance with Section 8.050.3.

8.733.2.C Maternity Bundled Payment Program Participation

1. Participation is not mandatory in the Maternity Bundled Payment program for qualified obstetrical groups.

2. Participation by obstetrical groups in the Maternity Bundled Payment program does not limit a patient's ability to change providers mid-episode for any reason,

3. Medicaid-covered obstetrical groups who participate in the maternity bundled payment program will allow the Department to extract clinical data from their electronic medical records. Information extracted from electronic medical records will be used by the Department to monitor the quality of care and the number of services being provided to members within the subgroup who experience health disparities based on race and ethnicity.

4. Obstetrical groups who participate in the maternity bundled payment will be required to participate in cultural competency training selected by the Department, to be inclusive of the importance of racial congruence between patients and providers and hiring and retention strategies for maintaining a diverse staff.

5. Obstetrical groups that are interested in becoming PAPs will do the following:

    a. Submit a letter of intent to participate in the pilot program application on the program webpage (https://docs.google.com/forms/d/e/1FAIpQLSdKvszulXC-ZMSOe8xpCJKaCwN4Z52D-HiVVGpHp21yoJ_8zg/viewform) to start the application process.

    b. The Department will notify PAP applicants that it received their applications. The Department will contact applicants to arrange meetings for a collaborative review of their preliminary cost thresholds.

    c. Following this meeting, when the applicant reviews and accepts the program's cost thresholds, details, and requirements, the applicant may sign a Program Participation Agreement and a Thresholds Acceptance Letter to confirm their participation.

8.735 GENDER-AFFIRMING CARE

8.735.1 Definitions

Gender-Affirming Hormone Therapy means a course of hormone replacement therapy intended to induce or change secondary sex characteristics.

Gender-Affirming Surgery means a surgery to change primary or secondary sex characteristics to affirm a person's gender identity. Also known as gender confirmation surgery or sex reassignment surgery.

Gender Dysphoria means either: gender dysphoria, as defined in the Diagnostic Statistical Manual of Mental Disorders, 5th Edition (DSM-5), codes 302.85 or 302.6; or gender identity disorder, as defined in the International Classification of Disease, 10th Edition (ICD-10), codes F64. 1-9, or Z87.890.

Gonadotropin-Releasing Hormone Therapy means a course of reversible pubertal or gonadal suppression therapy used to block the development of secondary sex characteristics in adolescents.

8.735.2 Client Eligibility

8.735.2.A. Clients with a clinical diagnosis of Gender Dysphoria are eligible for the gender-affirming care benefit, subject to the service-specific criteria and restrictions detailed in Section 8.735.4.

8.735.3 Provider Eligibility

8.735.3.A. Enrolled providers are eligible to provide gender-affirming care if:

1. Licensed by the Colorado Department of Regulatory Agencies or the licensing agency of the state in which the provider practices;

2. Services are within the scope of the provider's practice; and

3. Knowledgeable about gender diverse identities and expressions, and the assessment and treatment of Gender Dysphoria.

8.735.4 Covered Services

8.735.4.A. The following requirements apply to all covered gender-affirming care:

1. Client has a clinical diagnosis of Gender Dysphoria;

2. Requested service is medically necessary, as defined in Section 8.076.1.8.;

3. Any co-existing physical and behavioral health conditions do not interfere with diagnostic clarity or capacity to consent, and associated risks and benefits have been discussed;

4. Client has given informed consent for the service; and

5. Subject to the exceptions in §13-22-103, C.R.S., if client is under 18 years of age, client's parent(s) or legal guardian has given informed consent for the service.

8.735.4.B. Requests for services for clients under 21 years of age are evaluated in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program criteria detailed in Section 8.280.

8.735.4.C. Behavioral health services are covered in accordance with Section 8.212.

8.735.4.D. Hormone Therapy

1. Covered hormone therapy services are limited to the following:

   a. Gonadotropin-Releasing Hormone (GnRH) Therapy

      i) GnRH therapy is a covered service for a client who:

         1) Meets the criteria at Section 8.735.4.A.;

         2) Meets the applicable pharmacy criteria at Section 8.800; and

         3) Has reached Tanner Stage 2.

   b. Gender-Affirming Hormone Therapy

i) Gender-Affirming Hormone Therapy is a covered service for a client who:

1) Meets the criteria at Section 8.735.4.A.;

2) Meets the applicable pharmacy criteria at Section 8.800;

3) Has been informed of the possible reproductive effects of hormone therapy, including the potential loss of fertility, and the available options to preserve fertility;

4) Has reached Tanner Stage 2; and

5) If under 18 years of age, demonstrates the emotional and cognitive maturity required to understand the potential impacts of the treatment.

ii) Other Gender-Affirming Hormone Therapy requirements

1) Prior to beginning Gender-Affirming Hormone Therapy, a licensed health care professional who has competencies in the assessment of transgender and gender diverse people must determine that any behavioral health conditions that could negatively impact the outcome of treatment have been assessed and the risks and benefits have been discussed with the client; and

2) For the first twelve (12) months of Gender-Affirming Hormone Therapy, client must receive medical assessments at a frequency determined to be clinically appropriate by the prescribing provider.

8.735.4.E. Permanent Hair Removal

1. Permanent hair removal is a covered service when:

a. Client meets the criteria at Section 8.735.4.A.; and

b. Used to treat a surgical site.

8.735.4.F. Surgical Procedures

1. Gender-Affirming Surgery is a covered service for a client who:

a. Meets the criteria at Section 8.735.4.A.1.–4;

b. Is 18 years of age or older;

c. Has completed six (6) continuous months of hormone therapy, unless hormone therapy is not clinically indicated or is inconsistent with the client's desires, goals, or expressions of individual gender identity;

i) This requirement does not apply to mastectomy surgeries;

ii) Twelve (12) continuous months of hormone therapy are required for mammoplasty, unless hormone therapy is not clinically indicated or is inconsistent with the client's desires, goals, or expressions of gender identity;

d. Understands the potential effect of the Gender-Affirming Surgery on fertility.

2. Requests for surgery for clients under 18 years of age will be reviewed by the Department and considered based on medical circumstances and clinical appropriateness of the request;

3. Rendering surgical providers must retain the following documentation for each client:

a. A signed statement from a licensed health care professional who has competencies in the assessment of transgender and gender diverse people, demonstrating that:

i) Criteria in Section 8.735.4.F.1.a.–d. have been met; and

ii) A post-operative care plan is in place.

4. Covered Gender-Affirming Surgeries include:

a. Genital surgery;

b. Breast/chest surgery; and

c. Facial and neck surgery.

5. Requests for other medically necessary Gender-Affirming Surgeries will be reviewed by the Department and considered based on medical circumstances and clinical appropriateness of the request.

6. Pre- and post-operative services are covered when:

a. Related to a surgical procedure covered under Section 8.735.4.F; and

b. Medically necessary, as defined in Section 8.076.1.8.

8.735.5 Prior Authorization

8.735.5.A. Prior authorization is required for hormone therapy services listed in Section 8.735.4.D. in accordance with pharmacy benefit prior authorization criteria at Section 8.800.7.

8.735.5.B. Surgical services may require prior authorization.

8.735.5.C. All prior authorization requests must provide documentation demonstrating that the applicable requirements in Section 8.735.4 have been met.

8.735.6 Non-Covered Services

8.735.6.A. The following services are not covered under the gender-affirming care benefit:

1. Any items or services excluded from coverage under Section 8.011.1.

2. Reversal of surgical procedures covered under Section 8.735.4.F.

8.740 RURAL HEALTH CLINICS

8.740.1 DEFINITIONS

Rural Health Clinic (RHC) means a clinic or center that:

1. Has been certified as a Rural Health Clinic under Medicare.

2. Is located in a rural area, which is an area that is not delineated as an urbanized area by the Bureau of the Census.

3. Has been designated by the Secretary of Health and Human Services as a Health Professional Shortage Area (HPSA) through the Colorado Department of Public Health and Environment.

4. Is not a rehabilitation facility or a facility primarily for the care and treatment of mental diseases.

Visit means a face-to-face encounter, or an interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounter in accordance with Section 8.095, between a clinic client and a health professional providing the services set forth in 8.740.4. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care.

8.740.2 REQUIREMENTS FOR PARTICIPATION

8.740.2.A. A Rural Health Clinic shall be certified under Medicare.

8.740.2.B. A Rural Health Clinic providing laboratory services shall be certified as a clinical laboratory in accordance with 10 C.C.R 2505-10, Section 8.660.

8.740.3 CLIENT CARE POLICIES

8.740.3.A. The Rural Health Clinic's health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the Rural Health Clinic staff.

8.740.3.B. The policies shall include:

1. A description of the services the Rural Health Clinic furnishes directly and those furnished through agreement or arrangement. See section 8.740.4.A.4.

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the Rural Health Clinic.

3. Rules for the storage, handling and administration of drugs and biologicals.

8.740.4 SERVICES

8.740.4.A. The following services may be provided by a certified Rural Health Clinic:

1. General services

   a. Outpatient primary care services that are furnished by a physician assistant, clinical psychologist, clinical social worker, nurse practitioner, nurse midwife, licensed professional counselor, licensed marriage and family therapist, or licensed addiction counselor as defined in their respective practice acts.

   b. Part-time or intermittent visiting nurse care.

   c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.740.4.A.1.a and b.

2. Laboratory services. Rural Health Clinics furnish basic laboratory services essential to the immediate diagnosis and treatment of the client.

3. Emergency services. Rural Health Clinics furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

4. Services provided through agreements or arrangements. The Rural Health Clinic has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including inpatient hospital care; physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the Rural Health Clinic.

8.740.5 PHYSICIAN RESPONSIBILITIES

8.740.5.A. A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on client referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.740.6 ALLOWABLE COSTS

8.740.6.A. The following types and items of cost shall be included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician who owns, is employed by, or furnishes services under contract to a Rural Health Clinic.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies incident to the services of a physician, physician assistant, clinical psychologist, clinical social worker, nurse practitioner, nurse-midwife, licensed professional counselor, licensed marriage and family therapist, or licensed addiction counselor.

4. Overhead costs, including clinic or center administration, costs applicable to use and maintenance of the entity and depreciation costs.

5. Costs of services purchased by the Rural Health Clinic.

8.740.7 REIMBURSEMENT

8.740.7.A. The Department shall reimburse Rural Health Clinics a per visit encounter rate. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. An RHC may be reimbursed for up to two separate encounters with the same client occurring in the same day and at the same location, so long as the two encounters submitted for reimbursement are a physical health and a behavioral health service.

8.740.7.B. Rural Health Clinic rates are updated annually on January 1st.

The encounter rate shall be the higher of:

1. The Prospective Payment System (PPS), as defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, BIPA is incorporated herein by reference. No amendments or later editions are incorporated. The Acute Care Benefits Section Manager at the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of BIPA, or the materials may be examined at any publications depository library.

2. The Alternative Payment Methodology (APM) rate.

   a. The APM rate for hospital based Rural Health Clinics shall be based on actual costs.

      i. The interim rate for Rural Health Clinics shall be the higher of the current year PPS rate and the most recent audited and finalized cost per visit from the Medicare cost report.

      ii. After a Rural Health Clinic's Medicare cost report has been audited and finalized, the Department shall perform a reconciliation for the services provided by the Rural Health Clinic during the year the cost report covers. If the Department's interim rate was below the finalized rate, a one-time payment will be made to the Rural Health Clinic. If the Department's interim rate was above the finalized rate and the PPS rate, the Department will recoup the difference from the RHC.

   b. The APM rate for freestanding Rural Health Clinics is the Medicare upper payment limit for Rural Health Clinics.

8.740.7.C. New RHCs shall be reimbursed an interim per visit encounter rate, which shall be calculated as follows:

1. For new freestanding RHCs, the interim rate will be the average of other freestanding RHC's APM rates in the new RHC's Regional Accountable Entity (RAE).

2. For new hospital-based RHCs, the interim rate will be calculated based on the following options in the following order:

a. The per visit encounter rate established by a Medicare rate letter; or

b. A sister clinic's per visit encounter rate.

A hospital-based RHC's interim rate will be updated if the RHC provides an updated Medicare rate letter. The new rate will be effective the following January 1st.

8.740.7.D. PPS rates for new RHCs shall be calculated as follows:

1. For new freestanding RHCs, the PPS rate shall be calculated based on the average of other freestanding RHC's PPS rates in the new RHC's RAE.

2. For new hospital-based RHCs, the PPS rate shall be calculated based on an average of two year's audited cost and visit data from the RHC's Medicare cost report.

8.740.7.E. The Department will reimburse Long-Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices separate from the Rural Health Clinic per visit encounter rate. Reimbursement will be the lower of:

1. 340B acquisition costs;

2. Submitted charges; or

3. Fee schedule as determined by the Department.

8.740.7.F. PPS Change in Scope

1. If an RHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the RHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.

a. An RHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the RHC. The documented change in the scope of service of the RHC must meet all of the following conditions:

i. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act and is furnished by the RHC.

ii. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5

iii. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

iv. The net change in the RHC's per-visit encounter rate equals or exceeds 3% for the affected RHC. For RHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with the scope-of-service change.

v. The change in scope must have existed for at least a full six (6) months.

b. A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.740.7.F.1.a. and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.

i. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;

ii. The addition or deletion of a covered Medicaid service under the State Plan;

iii. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

iv. Changes in service due to a change in applicable technology and/or medical practices utilized by the RHC;

v. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;

vi. Changes resulting from a change in the provider mix, including, but not limited to:

a. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the RHC;

b. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the RHC (e.g. delivery services);

c. Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and/or residents; or,

d. Changes in the operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the RHC, provided that those expenditures result in a change in the services provided by the RHC.

c. The following are examples of items that do not prompt a scope-of-service rate adjustment:

i. An increase or decrease in the cost of supplies or existing services;

ii. An increase or decrease in the number of encounters;

iii. Changes in office hours or location not directly related to a change in scope of service;

iv. Changes in equipment or supplies not directly related to a change in scope of service;

v. Expansion or remodel not directly related to a change in scope of service;

vi. The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;

vii. The addition or removal of administrative staff;

viii. The addition or removal of staff members to or from an existing service;

ix. Changes in salaries and benefits not directly related to a change in scope of service.

x. Change in patient type and volume without changes in type, duration, or intensity of services;

xi. Capital expenditures for losses covered by insurance; or,

xii. A change in ownership.

d. An RHC must apply to the Department by written notice within one hundred and fifty (150) days of the end of the RHC's fiscal year in which the change in scope of service occurred. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.740.7.F.1.a.iv, the RHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY 2021 fails to reach the threshold needed for the rate adjustment, and the RHC implements another valid change in scope of service during FY 2022, the RHC may submit a scope-of-service rate adjustment application that captures both of those changes. An RHC may only combine changes in scope of service that occur within a three-year time frame and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope of service rate adjustment.

f. The documentation for the scope-of-service rate adjustment is the responsibility of the RHC. Any RHC requesting a scope-of-service rate adjustment must submit the following to the Department:

i. The Department's application form for a scope-of-service rate adjustment, which includes;

a. The provider number(s) that is/are affected by the change(s) in scope of service;

b. A date on which the change(s) in scope of service was/were implemented;

c. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;

d. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

e. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the RHC;

ii. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the RHC must provide the additional documentation within thirty (30) days. If the RHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

g. The reimbursement rate for a scope-of-service change applied for January 1, 2022 or afterwards will be calculated as follows:

i. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also calculate the Adjustment Factor (AF = covered health care costs/total cost of RHC services) associated with the change in scope of service of the RHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the RHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the RHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

ii. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.

iii. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The “current PPS rate” means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.

iv. The Department will check that the adjusted PPS rate meets the 3% threshold above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.

v. Once the Department has determined that the Adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.

h. The Department will review the submitted documentation and will notify the RHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect the following January 1st.

j. An RHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, an RHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The RHC should also include any documentation that supports its positions. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

8.745 SPECIAL CONNECTIONS

8.745.1 DEFINITIONS

A. Assessment means an evaluation that is designed to determine the level of substance use and the comprehensive treatment needs of a pregnant member with a substance use disorder.

B. Case Management means medically necessary coordination and planning services provided with or on behalf of a member who is pregnant or parenting (up to child's first birthday) with a substance use disorder. This includes treatment/service planning, linkage to other service agencies and monitoring.

C. Individual/Family Counseling and Therapy means planned therapeutic activity or counseling and outlining the treatment/service plan of a member who is pregnant or parenting (up to child's first birthday) with a substance use disorder. Problem(s) identified by an assessment are listed in the treatment/service plan. The intended outcome is the management, reduction/resolution of the identified problem(s).

D. Group Counseling means a planned therapeutic or counseling activity in a group setting with 2 or more pregnant and parenting (up to child's first birthday) women with substance use disorders (other than a family therapy session) in an effort to change the individual behavior of each person in the group through interpersonal exchange. Group services are designed to assist members with a primary substance use disorder in achieving their treatment goals.

E. Enhanced Prenatal Care education means services to help a member develop health and life management skills.

F. Residential Treatment means a structured treatment program to provide therapy and treatment toward rehabilitation. Residential Treatment Includes a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for pregnant and parenting (up to child's first birthday) women with substance use disorders.

8.745.2 DETERMINATION OF CLIENT ELIGIBILITY

8.745.2.A. To receive an Assessment, the client shall be:

1. Medically verified to be pregnant.

2. Determined either presumptively eligible or eligible for Medicaid.

3. Self-referred or referred by a health care practitioner as being at risk of a poor birth outcome due to substance use during the prenatal period and in need of special assistance in order to reduce such risk.

8.745.2.B. To receive substance use disorder services, the client shall meet the following conditions:

1. Received an Assessment and met the screening criteria as determined by the Office of Behavioral Health of the Colorado Department of Human Services.

2. Received a prior authorization from the Office of Behavioral Health of the Colorado Department of Human Services.

8.745.3 PROVIDER ELIGIBILITY

8.745.3.A. Eligible providers shall meet the following criteria:

1. Be enrolled as a Colorado Medicaid provider

2. Contract with and obtain certification from the Office of Behavioral Health of the Colorado Department of Human Services as a substance use disorder treatment program for the delivery of these specialized substance use disorder services

8.745.4 REIMBURSABLE SERVICES

8.745.4.A. Special Connections Program services are limited to services performed by or under the supervision of licensed clinicians or licensed health care practitioners as defined in 10 CCR 2505-10, Section 8.746.1. Reimbursable services are:

1. One Assessment per pregnancy.

2. Substance use disorder treatment services including case management, substance use disorder individual and family counseling, substance use disorder group counseling, residential treatment and/or enhanced prenatal care education.

3. Urine screening and monitoring.

8.745.4.B. Services may be provided as outpatient or residential. Room and board are not covered services.

8.745.5 REIMBURSEMENT

Reimbursement for services provided shall be the lowest of:

1. Submitted charges; or

2. Fee schedule as determined by the Department.

8.746 OUTPATIENT FEE-FOR-SERVICE SUBSTANCE USE DISORDER TREATMENT

8.746.1 DEFINITIONS

Community Behavioral Health Services Program means the program described at 10 CCR 2505-10 Section 8.212, by which program-enrolled Medicaid clients receive behavioral health treatment services.

Day Treatment Program means a non-residential treatment program designed for children and adolescents under the age of 21 who have an emotional, behavioral, and neurobiological, or substance use disorder diagnosis, and may be at high risk for out-of-home placement. Day Treatment Program services include family, group, and individual psychotherapy; parent-child education; skill and socialization training focused on improving functional and behavioral deficits; and intensive coordination with schools or other child service agencies.

Health First Colorado is Colorado's Medicaid Program, the free or low cost public health insurance program that provides health care coverage to low-income individuals, families, children, pregnant women, seniors, and people with disabilities. Colorado Medicaid is funded jointly by the federal and state government, and is administered by the Colorado Department of Health Care Policy and Financing.

Intensive Outpatient Psychiatric Rehabilitation Services are those that focus on maintaining and improving functional abilities for the client through a time-limited, multi-faceted approach to treatment.

Licensed Clinician means a provider who is a clinical social worker licensed pursuant to CRS 12-43-404, marriage and family therapist licensed pursuant to CRS 12-43-504, professional counselor licensed pursuant to CRS 12-43-603, addiction counselor licensed pursuant to CRS 12-43-804, or psychologist (Psy.D/Ph.D) licensed pursuant to CRS 12-43-304.

Licensed Health Practitioner means an advanced practice nurse licensed pursuant to CRS 12-38-111.5, physician/psychiatrist licensed pursuant to CRS 12-36-101, or physician assistant licensed pursuant to CRS 12-36-107.4.

Residential Treatment means a short-term residential treatment program offering 24-hour intensive residential treatment, habilitative, and rehabilitative services for up to 30 days in a highly structured, community-oriented environment.

State Fiscal Year (SFY) is July 1 – June 30.

8.746.2 ELIGIBLE PROVIDERS

1. Providers eligible to render services are limited to the following:

    a. Licensed Health Practitioners who are also:

        i) Certified in addiction medicine by the American Society of Addiction Medicine (ASAM), the American Board of Addiction Medicine (ABAM), or the American Board of Preventive Medicine (ABPM); or

ii) Certified Addiction Counselors (CAC II or CAC III) or Licensed Addiction Counselors (LAC) by the Department of Regulatory Agencies (DORA); or

iii) National Certified Addiction Counselors II (NCAC II) or Master Addiction Counselors (MAC) by the National Association of Alcohol and Drug Abuse Counselors (NAADAC); or

iv) Certified in addiction psychiatry by the American Board of Psychiatry and Neurology certified in Addiction Psychiatry (ABPN).

b. Licensed Clinicians.

8.746.3 TREATMENT PLANNING

8.746.3.A. An approved treatment plan must be in place for each client prior to the client receiving services. An initial assessment is required to establish a treatment plan. Treatment plans require approval from a licensed provider indicated in Section 8.746.2 with the authority to approve treatment plans within their scope of practice.

8.746.3.B. All rendered services must be medically necessary, as defined in Section 8.076.1.8., and must be detailed in the client's treatment plan and progress notes. Initial substance use disorder assessments are exempt from inclusion in the approved treatment plan.

8.746.3.C. Approved treatment plans must identify treatment goals and must explain how the proposed treatment services will achieve those stated goals.

8.746.3.D. Approved treatment plans must identify the treatment services planned for use over the course of treatment. The amount, frequency, and duration of these treatment services must be included in the approved treatment plan.

8.746.4 ELIGIBLE CLIENTS

1. To be eligible for the Outpatient Fee-for-Service Substance Use Disorder Treatment benefit, client:

   a. Must currently be enrolled in Colorado Medicaid; and

   b. Must not be enrolled in the Community Behavioral Health Services program pursuant to 10 C.C.R. 2505-10 Section 8.212.

      i) All Colorado Medicaid clients are automatically enrolled in the Community Behavioral Health Services program, unless one of the following is true:

         1) Client is not eligible for enrollment in the Community Behavioral Health Services program, per 10 CCR 2505-10 Section 8.212.1.A.; or

         2) Client is approved for an individual enrollment exemption, as set forth at 10 CCR 2505-10 Section 8.212.2.

8.746.5 LIMITATIONS

1. Clients are not required to obtain a referral from their Primary Care Physician (PCP) or Primary Care Medical Provider (PCMP) to receive these services.

2. Clients must have a treatment plan that is approved by a licensed practitioner listed in Section 8.746.2.

3. Outpatient Fee-for-Service Substance Use Disorder Treatment services may only be rendered by providers outlined in Section 8.746.2, with an exception for certain providers of Medication Assisted Treatment described below.

4. Services are covered only when the client has been diagnosed with at least one of the following:

    a. Alcohol use or induced disorder

    b. Amphetamine use or induced disorder

    c. Cannabis use or induced disorder

    d. Cocaine use or induced disorder

    e. Hallucinogen use or induced disorder

    f. Inhalant use or induced disorder

    g. Opioid use or induced disorder

    h. Phencyclidine use or induced disorder

    i. Sedative Hypnotic or Anxiolytic use or induced disorder

    j. Tobacco use disorder

8.746.6 COVERED SERVICES

8.746.6.A. Substance Use Disorder Assessment

1. A substance use disorder assessment is an evaluation designed to determine the most appropriate level of care based on criteria established by the American Society of Addiction Medicine (ASAM), the extent of drug or alcohol use, abuse, or dependence and related problems, and the comprehensive treatment needs of a client with a substance use disorder diagnosis.

    a. Course of treatment and changes in level of care must be based on best practices as defined by the current ASAM Patient Placement Criteria.

    b. Re-assessments must be spaced appropriately throughout the course of treatment to ensure the treatment plan is effectively managing the client's changing needs.

    c. Each complete assessment corresponds to one unit of service.

d. An assessment may involve more than one session and may span multiple days. If the assessment spans multiple days, the final day of the assessment is reported as the date of service.

8.746.6.B. Individual and Family Therapy

1. Individual and family therapy is the planned treatment of a client's problem(s) as identified by an assessment and listed in the treatment/service plan. The intended outcome is the management and reduction, or resolution of the identified problem(s).

2. Individual and family therapy is limited to one client per session.

   Individual and family therapy are billed at 15 minutes per unit.

   a. A session is considered a single encounter with the client that can encompass multiple timed units.

3. Family therapy must be directly related to the client's treatment for substance use disorder or dependence.

4. Individual therapy and family therapy sessions are allowed on the same date of service.

8.746.6.C. Group Therapy

1. Group therapy refers to therapeutic substance use disorder counseling and treatment services, administered through groups of people who have similar needs, such as progression of disease, stage of recovery, and readiness for change.

2. Group therapy must include more than one patient.

3. A session of group therapy may last up to three hours and is billed in units of one hour each (e.g., a three hour group session would consist of three units).

   a. A unit of service may be billed separately for each client participating in the group therapy session.

8.746.6.D. Alcohol / Drug Screening and Counseling

1. Alcohol / drug screening and counseling is the collection of urine followed by a counseling session with the client to review and discuss the results of the screening.

   a. The analysis of the urine specimen (urinalysis) may only be billed by a provider with the appropriate CLIA certification for the test performed. Urinalysis is not part of the Outpatient Fee-For-Service SUD benefit.

   b. Substance use disorder providers will only be reimbursed for collecting the urine specimen and providing a counseling session to review and discuss the results of the urinalysis. Claims submitted for the collection of the urine sample without the subsequent counseling of urinalysis results will not be reimbursed.

      i. If the client does not return for the counseling of their urinalysis results, the collection of the sample cannot be claimed.

c. Substance use disorder counseling services to discuss and counsel the client on the test results must be provided by an eligible rendering provider, as outlined in Section 8.746.2.

d. The counseling portion of the service may be conducted during a session of individual or family therapy.

e. Multiple urine collections per date of service are not additionally reimbursed.

f. Alcohol / drug screening and counseling is limited to one unit per date of service.

i. A unit of service is the single collection and subsequent counseling session.

8.746.6.E. Targeted Case Management

1. Targeted case management refers to coordination and planning services provided with, or on behalf of, a client with a substance use disorder diagnosis.

a. The client does not need to be physically present for this service to be performed if it is done on the client's behalf.

2. Targeted case management services are limited to service planning, advocacy, and linkage to other appropriate medical services related to substance use disorder diagnosis, monitoring, and care coordination.

3. A unit of service equals one 15-minute increment of targeted case management, and consists of at least one documented contact with a client or person acting on behalf of a client, identified during the case planning process.

8.746.6.F. Social / Ambulatory Detoxification

1. Facilities licensed by the Office of Behavioral Health (OBH) to provide detoxification services are the only provider eligible to render social / ambulatory detoxification services.

2. Social / ambulatory detoxification services:

a. Include supervision, observation, and support from qualified personnel for clients exhibiting intoxication or withdrawal symptoms.

b. Are provided when there is minimal risk of severe withdrawal (including seizures and delirium tremens) and when any co-occurring mental health or medical conditions can be safely managed in an ambulatory setting.

3. A session is defined as the continuous treatment time from the first day to the last day of social/ambulatory detoxification.

a. Each session may last a maximum of three days.

Room and board is not a covered social / ambulatory detoxification service. Claims billed for room and board will not be reimbursed.

5. Social / ambulatory detoxification is divided into four distinct services—physical assessment of detoxification progress, evaluation of level of motivation, safety

assessment, and provision of daily living needs—with corresponding procedure codes, which may be provided and billed on the same date of service if medically necessary, as defined in rule at 10 CCR 2505-10 Section 8.076.1.8.

8.746.6.G. Medication-Assisted Treatment (MAT)

1. Medication Assisted Treatment (MAT) is a benefit for opioid addiction that includes a medication approved by the U.S. Food and Drug Administration (FDA) for opioid addiction detoxification or maintenance treatment.

2. When methadone is administered for MAT, the reimbursement for the medication's acquisition is bundled with the reimbursement for administration and dispensing under a single billing code. When other medications are used for MAT (e.g. Suboxone), the reimbursement for the medication is billed separately from the administration and dispensing using physician administered drug billing codes.

   a. Only licensed physicians, physician assistants, or nurse practitioners are eligible to administer MAT. All providers must comply with the Office of Behavioral Health's Opioid Medication Assisted Treatment program requirements set forth at 2 C.C.R. 502-1 21.320.

   b. Take-home dosing is permitted in accordance with Office of Behavioral Health rules at 2 CCR 502-1 21.320.8. Therefore, one unit of MAT must be reported for each date of service the client ingests the dose of methadone.

   c. If the client ingests their dose at the facility, the place of service must be reported as office. If the client ingests their dose at home, the place of service must be reported as home. Records must include documentation to substantiate claims for take-home doses.

8.746.7 PRIOR AUTHORIZATION REQUIREMENTS

8.746.7.A. There are no prior authorization requirements for the Outpatient Fee-for-Service Substance Use Disorder Treatment benefit.

8.746.8 NON-COVERED SERVICES

8.746.8.A. The following services are not covered under the Outpatient Fee-for-Service Substance Use Disorder Treatment benefit:

1. Day treatment program services.

2. Intensive outpatient psychiatric rehabilitation.

3. Peer advocate services.

4. Residential treatment services, with the exception of those provided in a Residential Child Care Facility, as set forth in Section 8.765.

5. Services provided by a third party that is under contract with the provider.

6. Any substance use disorder treatment service not specified as covered in Section 8.746.6.

8.747 SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT SERVICES

8.747.1 DEFINITIONS

Brief Intervention means a provider interaction with a client that is intended to induce a positive change in a health-related behavior. Brief intervention may include an initial intervention, a follow-up intervention and/or a referral.

Brief Screen or Pre-screen means several short questions related to the client's substance use. A brief screen or pre-screen is designed to determine if a full screen is necessary.

Follow-up Intervention means services to reassess a client's status, assess progress and promote or sustain a reduction in substance use. Follow-up services may also be used to assess a client's need for additional services.

Full Screen means the use of a Colorado Medicaid approved evidence-based screening tool to identify clients at risk for substance abuse problems.

Screening, Brief Intervention and Referral to Treatment (SBIRT) means comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

8.747.2 CLIENT ELIGIBILITY

8.747.2.A. All clients 12 years of age and older are eligible to receive this service.

8.747.3 PROVIDER REQUIREMENTS

8.747.3.A. Screening, Brief Intervention and Referral to Treatment services must be provided by, or under the supervision of, a licensed health care professional.

8.747.3.B. The following licensed professionals are eligible to provide services or supervise staff that are providing services:

1. Licensed Physician
2. Physician Assistant
3. Nurse Practitioner
4. Dentist
5. Psychologist with PhD. or PsyD.
6. Licensed Clinical Social Worker (LCSW)
7. Marriage and Family Therapist
8. Licensed Professional Counselor (LPC)
9. Licensed Addiction Counselor (LAC)
10. Certified Addictions Counselor III

8.747.3.C. All licensed individuals must be trained in order to provide or supervise individuals providing Screening, Brief Intervention and Referral to Treatment services.

1. A minimum of four (4) hours Screening, Brief Intervention and Referral to Treatment training is required.

8.747.3.D. All non-licensed individuals must be trained in Screening, Brief Intervention and Referral to Treatment services in order to provide services; including the following requirements:

1. Be under the supervision of a licensed and trained Screening, Brief Intervention and Referral to Treatment services provider.

2. Complete a minimum of 60 hours professional experience such as coursework, internship, practicum, education or professional work within their respective field. This experience should include a minimum of 4 hours of training that is directly related to Screening, Brief Intervention and Referral to Treatment services.

3. Complete a minimum of 30 hours of face-to-face client contact within their respective field. This may include internships, on the job training, or professional experience. This contact may include, but does not have to be directly related to Screening, Brief Intervention and Referral to Treatment services training.

8.747.4 COVERED SERVICES

8.747.4.A Screening, Brief Intervention and Referral to Treatment services are covered for risky substance use or abuse including alcohol and drugs.

1. A full screen, using a Colorado Medicaid approved screening tool, shall be limited to two (2) per client per state fiscal year.

8.747.4.B. Brief intervention services may be provided on the same date of service as the full screen, or on subsequent days.

1. The Brief Intervention shall be limited to two (2) sessions per client per state fiscal year. Each session is limited to two (2) units per session, at 15 minutes per unit.

8.747.5 NON-COVERED SERVICES

8.747.5.A Non-covered services include:

1. Pre-screen or brief screen.

8.747.6 REIMBURSEMENT

8.747.6.A Providers may submit for reimbursement under either CPT or HCPC codes, but not both.

8.747.6.B Screening, Brief Intervention and Referral to Treatment services provided by Federally Qualified Health Centers under supervision, as defined in Section 8.700.1, will be reimbursed in the encounter rate.

8.747.6.C Screening, Brief Intervention and Referral to Treatment services may be provided on the same day as other Evaluation & Management services.

8.747.6.D Any claims reimbursed for more than the maximum units per year are subject to recovery by the Department.

8.748 PRENATAL PLUS PROGRAM

8.748.1 DEFINITIONS

Initial Assessment Form means the Prenatal Plus Program risk assessment tool that must be used by all Prenatal Plus Program Providers to further assess and document a client's needs.

Program Eligibility Screening Form means the Prenatal Plus Program eligibility tool that must be used by all Prenatal Plus Program Providers to determine if a client is eligible for Prenatal Plus Program services.

Prenatal Plus Program Provider means an entity or agency that meets the qualifications described in Section 8.748.4 and has been accepted as such by the Department of Health Care Policy and Financing (the Department).

8.748.2 PROGRAM PURPOSE

The purpose of the Prenatal Plus Program is to improve the maternal and infant health outcomes of at-risk Medicaid clients by providing comprehensive and coordinated prenatal and early postpartum support services that complement traditional clinical prenatal care. The primary goal of the program is to reduce the incidence of low birth weight babies while also addressing other lifestyle, behavioral, and non-medical aspects of a woman's life that may affect her and/or her baby's health and well-being. By focusing on case management, nutrition counseling and support, psychosocial counseling and support, client education and health promotion, the Prenatal Plus Program seeks to ensure that women have access to the services and information needed to have healthy pregnancies and healthy babies.

8.748.3 CLIENT ELIGIBILITY

8.748.3.A To be eligible for services provided through the Prenatal Plus Program, a Colorado Medicaid client shall:

1. Be pregnant (self-declared or medically verified) or in the postpartum period (but participated in the Prenatal Plus Program during the prenatal period); and

2. Be determined by a Prenatal Plus Program Provider using the Program Eligibility Screening Form to be at risk of having a negative maternal and/or infant health outcome(s) due to identified risk factors which shall be further assessed and documented using the Initial Assessment Form.

8.748.4 PROVIDER ELIGIBILITY AND QUALIFICATIONS

8.748.4.A Providers wishing to render and be reimbursed for Prenatal Plus Program services, as a condition of being a Prenatal Plus Program Provider, shall:

1. Be a Colorado Medicaid provider enrolled as one of the following Colorado Medicaid Billing Provider Types: Clinic, Federally Qualified Health Center, Rural Health Center, Non-Physician Practitioner Group, Physician, Nurse Practitioner, Certified Nurse-Midwife, or Physician's Assistant;

2. Execute and submit a Prenatal Plus Program addendum to the Colorado Medical Assistance Program Provider Participation Agreement for review and acceptance by the Department; and

3. Manage a Prenatal Plus Program multidisciplinary team(s) of personnel. The multidisciplinary team shall include:

   a. A care coordinator(s) who acts as the hub of the multidisciplinary team and is the person primarily responsible for organizing resources and assisting clients in accessing services to meet their individual needs. The care coordinator(s) shall, at minimum, hold a bachelor's degree in a relevant human/social services discipline or be a registered nurse;

   b. A registered dietitian(s) who is currently registered with the Commission on Dietetic Registration as a registered dietitian, or a dietetic intern(s) in an internship accredited by the American Dietetic Association and supervised by a registered dietitian who has agreed to serve as a preceptor for the dietetic intern;

   c. A mental health professional(s) who, at minimum, is a master's level professional in the field of social work, marriage and family therapy, professional counseling, or other mental health specialty, or an intern(s) in an accredited mental health internship and supervised by a master's level mental health professional; or the Prenatal Plus Program Provider must have a consistent, documented referral relationship with a mental health provider(s) not part of the multidisciplinary team but participating with the Colorado Medicaid Community Mental Health Services Program. Prenatal Plus Program Providers who do not include a mental health professional as part of their multidisciplinary team shall not be eligible for reimbursement of psychosocial counseling and support through the Prenatal Plus Program; and

   d. A Colorado Medicaid-enrolled physician, nurse practitioner, certified nurse-midwife, or physician's assistant who is the rendering provider that delegates the provision of Prenatal Plus Program services to the multidisciplinary team.

4. Retain in the record of each client to whom Prenatal Plus Program services are rendered:

   a. Identification of qualifying risk factors using the Program Eligibility Screening Form; and

   b. A client risk assessment using the Initial Assessment Form.

8.748.5 REIMBURSABLE SERVICES

8.748.5.A Services reimbursable through the Prenatal Plus Program include:

1. Nutrition counseling and support provided by the registered dietitian/dietetic intern consisting of the following components which may be provided on an individual basis or in a group setting based on client need:

   a. Nutrition screening;

   b. General nutrition education;

   c. Comprehensive nutrition status assessment; and

d. Nutrition counseling and targeted nutrition education based on client-specific need. Nutrition counseling shall be considered inclusive of nutrition care-planning, goal-setting, monitoring, follow-up, and nutrition care plan revision.

2. Psychosocial counseling and support provided by the mental health professional consisting of the following components which may be provided on an individual basis or in a group setting based on client need:

a. Psychosocial health screening;

b. Comprehensive psychosocial health assessment; and

c. Psychosocial health counseling and support. Psychosocial counseling and support shall be considered inclusive of psychosocial care-planning, goal-setting, monitoring, follow-up, and psychosocial care plan revision.

i. Psychosocial counseling and support does not include clinical psychotherapy services, traditional medication management, or other clinical services specifically related to treatment of a diagnosed mental health disorder. When clinical mental health disorders are identified, including substance use disorders, clients shall be referred to a provider who participates in the Colorado Medicaid Community Mental Health Services Program or a Medicaid-enrolled substance use disorder treatment provider.

3. General client education and health promotion provided by the care coordinator which may be provided on an individual basis or in a group setting based on client need, regarding topics that may include:

a. Basic understanding of the prenatal period

i. Physical and emotional changes related to pregnancy including fetal development;

ii. Healthy and appropriate weight gain during pregnancy;

iii. Healthy prenatal diet and food precautions;

iv. Physical activity precautions and appropriate exercise;

v. Substance use and how it can affect maternal and infant health outcomes;

vi. Sexually transmitted diseases/infections and how they can affect maternal and infant health outcomes;

vii. Bonding with the baby before birth;

viii. Importance of oral hygiene;

ix. Warning signs of preterm labor; and

x. Common terminology;

b. Common concerns related to childbirth and breastfeeding

i. Birth planning, hospital packing/preparation, and attending birth classes;

ii. Pain management options during delivery; and

iii. Benefits of breastfeeding, preparing for breastfeeding and breastfeeding basics;

c. The postpartum period and healthy infancy

i. Postpartum mood disorders ("baby blues" and postpartum depression);

ii. Postpartum recovery issues and adjustment including body changes, self-esteem, and relationship stressors;

iii. Managing stress, day-to-day problem-solving, positive communication techniques, building and using support networks;

iv. Family planning and contraception;

v. Comforting and stimulating infants (including education on shaken baby syndrome risk reduction, recognizing an infant's distress cues, and bonding/attachment postpartum);

vi. Appropriate expectations for infant behavior, sleeping patterns, teething and crying;

vii. Infant health including newborn feeding, immunizations, pediatrician visits, and car-seat safety; and

viii. Environmental risk factors including violence in the home, smoke, substance use and how they can affect infant health; and

4. Targeted case management provided by the care coordinator. Targeted case management is a service provided to assist clients in gaining access to needed medical, social, educational, and other services, and includes the following components:

a. Comprehensive assessment and periodic reassessment of the client's needs to determine the necessity for any medical, educational, social, or other services;

b. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that specifies the goals and actions to address the medical, social, educational, and other services needed and identifies a course of action to respond to the assessed needs;

c. Referral and related activities to help the client obtain needed services including activities that help link the client with medical, social, or educational providers, or other programs and services that are capable of providing needed services; and

d. Monitoring and follow-up activities including activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the client's needs, and which may be with the client, family members, providers, or other entities or individuals.

e. Targeted case management provided by the care coordinator may include, but is not limited to, screening for nutrition and psychosocial risk factors.

f. Note: Targeted case management does not include case management activities that are an integral component of another covered Medicaid service; the direct delivery of an underlying medical, educational, social, or other service to which a client has been referred; activities integral to the administration of foster care programs; or activities for which a client may be eligible that are integral to the administration of another non-medical program.

8.748.6 REIMBURSEMENT

8.748.6.A Reimbursement shall be the lower of:

1. Submitted charges; or

2. Fee schedule for Prenatal Plus Program services as determined by the Department.

8.749 NURSE HOME VISITOR PROGRAM

8.749.1 DEFINITIONS

Nurse means a person licensed as a professional nurse pursuant to §12-38-102,C.R.S., et seq., or accredited by another state or voluntary agency that the state board of nursing has identified by rule pursuant to §12-38-108(1)(a),C.R.S., as one whose accreditation may be accepted in lieu of board approval.

Nurse Home Visitors means registered nurses who provide targeted case management services.

Provider Agency means an agency that has met the Nurse Home Visiting Program provider requirements and has been certified by the Department of Public Health and Environment.

Targeted Case Management means services which will assist individuals in gaining access to needed medical, social, education and other services to promote healthy first pregnancies, improve the health and development of a woman's first child and to encourage self-sufficiency.

8.749.2 PROGRAM DESCRIPTION

Nurse Home Visitor Program (NHVP) means a program established pursuant to §25-31-101,C.R.S. et seq., including the provision of targeted case management services to first-time pregnant women or whose first child is less than one month old and who are at or below 200% of the Federal Poverty Level. Services are offered through the child's second birthday plus one month.

8.749.3 CLIENT ELIGIBILITY

First-time (defined as no previous live births), pregnant women or whose first child is less than one month old and who are at or below 200% of the Federal Poverty Level are eligible for the NHVP.

8.749.4 PROVIDER REQUIREMENTS

8.749.4.A. A participating provider shall be:

1. Certified by the Colorado Department of Public Health and Environment; and

2. Allowed to bill as a clinic including, but not limited to Certified Public Health Clinics, Federally Qualified Health Centers and Rural Health Centers.

8.749.5 PROVIDER RESPONSIBILITIES

8.749.5.A. Targeted Case Management Services

1. Providers shall provide Targeted Case Management services including:

   a. Assessment of the first time pregnant woman and her first child's needs for health, mental health, social services, education, housing, childcare and related services.

   b. Development of care plans to obtain the needed services.

   c. Referral to resources to obtain the needed services including medical providers who provide care to a first time pregnant woman and her first child.

   d. Routine monitoring and follow-up visits with the women where progress in obtaining the needed services is monitored, problem-solving assistance is provided and the care plans are revised to reflect the women and children's current needs.

2. Providers shall document and chart Targeted Case Management activities and complete assessment and referral forms.

8.749.6 REIMBURSEMENT

8.749.6.A. Monthly payments for Targeted Case Management shall be made for each child/family visited under the program.

1. Services to the mother shall be limited to 3 units per month with a lifetime maximum limit of 30 units.

2. Services to the child shall be limited to 3 units per month with a lifetime maximum of 75 units.

3. A different rate shall be calculated for each provider agency based on their actual historical cost and their projected budget for the next fiscal year.

4. At the end of the fiscal year, payments will be reconciled with the actual costs for each agency based on agency cost reports, to assure that payment was not more than the actual cost of providing services. Overages shall be recovered.

8.750 COMMUNITY MENTAL HEALTH CENTERS/CLINICS

8.750.1 DEFINITIONS

Community Mental Health Center/Clinic means either a physical plant or health institution planned, organized, operated, and maintained to provide basic community services or a group of services under unified administration or affiliated with one another.

Outpatient means a program of care in which the client receives services in a hospital or other health care facility, but does not remain in the facility twenty four hours a day.

Rehabilitative services means activities and/or services recommended by a physician or other licensed practitioner, for maximum reduction or restoration of a physical or mental disability to the best possible functional level.

8.750.2 REQUIREMENTS FOR PARTICIPATION

8.750.2.A. The center/clinic must be licensed by the Colorado Department of Public Health and Environment (CDPHE).

8.750.3 COVERED SERVICES

8.750.3.A. Services shall include but are not limited to prevention, diagnosis and treatment of emotional or mental disorders. Such services shall be rendered primarily on an outpatient and consultative basis for clients residing in a particular community in or near the facility so situated.

8.750.3.B. Community Mental Health Centers/Clinics shall provide medically necessary rehabilitation services in an outpatient setting. Covered services shall include:

1. Case management services, including but not limited to:

    a. Service planning and program linkage.

    b. Referral recommendations.

    c. Monitoring and follow up.

    d. Client advocacy.

    e. Crisis management.

2. Group psychotherapy services shall be face-to-face, or interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) in accordance with Section 8.095, services that are insight-oriented, behavior modifying, and that involve emotional interactions of the group members. Group psychotherapy services shall assist in providing relief from distress and behavior issues with other clients who have similar problems and who meet regularly with a practitioner. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care

3. Individual psychotherapy services shall be face-to-face, or interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) in accordance with Section 8.095, services that are tailored to address the individual needs of the client. Services shall be insight-oriented, behavior modifying and/or supportive with the client in an office or outpatient facility setting. Individual psychotherapy services are limited to thirty-five visits per State fiscal year. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care

8.750.4 REIMBURSEMENT

8.750.4.A. For the purpose of reimbursing Community Mental Health Center and Clinic providers, the Department shall establish a price schedule annually with the Department of Human Services in order to reimburse each provider for its actual or reasonable cost of services.

8.754 CLIENT CO-PAYMENT

8.754.1 CLIENT RESPONSIBILITY

Clients shall be responsible for the following co-payments:

8.754.1.A. Hospital outpatient, $0.00 per visit, effective July 1, 2023.

8.754.1.B. Physician (M.D. or D.O) office or home visit, $0.00 per visit, effective July 1, 2023.

8.754.1.C. Rural health clinic, $0.00 per visit, effective July 1, 2023.

8.754.1.D. Brief, individual, group and partial care community mental health center visits except services which fall under Home and Community Based Service programs, $0.00 per visit, effective July 1, 2023.

8.754.1.E. Pharmacy, $0.00 per prescription or refill, effective July 1, 2023.

8.754.1.F. Optometrist, $0.00 per visit, effective July 1, 2023.

8.754.1.G. Podiatrist, $0.00 per visit, effective July 1, 2023.

8.754.1.H. Inpatient hospital, $0.00 per admission, July 1, 2023.

8.754.1.I. Durable medical equipment/disposable supply services, $0.00 per date of service, effective July 1, 2023.

8.754.1.J. Laboratory services, $0.00 per date of service, July 1, 2023.

8.754.1.K. Radiology services, $0.00 per date of service, July 1, 2023.

8.754.1.L. Emergency services, $0.00 co-pay.

1. For services that continue to have a co-pay under Section 8.754.2, it is the provider's responsibility to identify emergency on the claim form so that the fiscal agent can exempt the service from co-payment.

8.754.2 NON-EMERGENCY SERVICES

Effective July 1, 2022, non-emergency services rendered in the hospital outpatient emergency room are subject to a $8.00 co-payment, in compliance with 42 U.S.C. 1396o (2021), per visit.

8.754.2.A. Providers may not assess a $6.00 co-payment for non-emergency services provided in the emergency room unless they have first:

1. Determined that the medical condition does not meet the threshold for emergency care services, as defined at 10 C.C.R. 2505-10, Section 8.300.1.I;

2. Informed the client that the condition does not require emergency care services;

3. Informed the client of the amount of their cost sharing obligation for non-emergency services provided in the emergency room;

4. Provided the client with the name and location of an available and accessible alternative non-emergency services provider; and

5. Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and

6. Provide a referral to coordinate scheduling for treatment by the alternative provider.

8.754.3 EMERGENCY TREATMENT

Prescription drugs administered during emergency treatment shall be considered part of the treatment and are not subject to co-payment.

8.754.4 PRESCRIPTIONS

All prescriptions written in the emergency room or elsewhere are subject to the co-payment set forth in Paragraph 8.754.1.E. above.

8.754.5 EXEMPTIONS

The following clients and services are exempt from co-payment requirements:

8.754.5.A. Children under the age of 19.

8.754.5.B. All services to women in the maternity cycle.

1. The maternity cycle means pregnancy, labor, birth and the immediate postpartum period not to exceed six weeks.

2. The client must inform the provider of her pregnancy or postpartum condition at the time of service, and all providers must indicate pregnancy on the claim form in order to claim this exemption.

3. In the case of prescription drugs, the prescribing physician should note pregnancy or postpartum on the prescription.

4. Providers may request oral or written verification of pregnancy or postpartum condition by contacting the physician.

5. If the provider questions the client's statement that she is pregnant or postpartum and the provider is unable to obtain verification of the pregnancy or postpartum condition, then the provider may collect the co-payment amount imposed by this regulation from the recipient.

6. If the recipient feels that she has been wrongly denied an exemption due to an unverified pregnancy or postpartum condition, she has the right of appeal through the recipient appeal process set forth at 10 C.C.R. 2505-10, Section 8.057.

8.754.5.C. All services to institutionalized clients, including those in skilled nursing facilities, intermediate care facilities (ICF's), ICF's for the mentally retarded, recipients under age 21 in inpatient psychiatric hospitals, and recipients 65 and over in institutions for mental diseases.

8.754.5.D. Family planning services and supplies furnished to clients of child-bearing age. The fiscal agent shall identify the family planning services and supplies exempted on the Medicaid claim form.

8.754.5.E. All emergency care services.

1. Emergency care services is defined in Section 8.300.1.I.

2. Emergency treatment can be given in the emergency room, the outpatient department, or a physician's office.

3. The attending medical personnel shall define the emergent nature of the recipient's condition.

4. For cases where it is not clear if an emergency exists, a triage of the member will be conducted to determine if the member's condition meets the threshold for emergency care services, as defined in Section 8.300.1.I.

5. There shall be no co-payment charge for the triage.

8.754.5.F. All services provided under the Community Mental Health Services program and Managed Care programs.

8.754.5.G All preventive and vaccine services as required by the Affordable Care Act (42 USC § 1396d(a)(13) (2010)) and described in the United States Preventive Services Task Force (USPSTF) A and B recommendations and the Advisory Committee for Immunization Practices (ACIP) recommended vaccines and their administration which are hereby incorporated by reference. The incorporation of the USPSTF A and B recommendations and the ACIP recommended vaccines excludes later amendments to, or editions of, the referenced material.

The USPSTF A and B recommendations is available from the US Preventive Services Task Force web page at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. The ACIP recommended vaccines is available at the Centers for Disease Control and Prevention webpage at http://www.cdc.gov/vaccines/hcp/acip-recs/. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.754.6 PROVIDERS

8.754.6.A. The co-payment amount charged by a provider shall not vary depending on the cost of the specific service being rendered.

8.754.6.B. A provider may not deny services to an individual when such clients are unable to immediately pay the co-payment amount. However, the client remains liable for the co-payment at a later date.

8.754.6.C. Providers shall bill their usual and customary charge. For any service for which a co-payment amount is imposed, the fiscal agent shall deduct the appropriate co-payment amount from the payment to the provider.

8.754.6.D. Physicians providing laboratory or radiology services in their office shall be responsible for collecting co-payments for the office visit and for the laboratory or radiology services provided.

8.760 TARGETED CASE MANAGEMENT SERVICES

8.760.1 DEFINITIONS

.10 "Case Management Agency" (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management service for Home and Community Based waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

.11 "Child with a developmental delay" means: a person less than five years of age with delayed development or who is at risk of having a developmental disability.

.12 Community Centered Board means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

a. Persons receiving targeted case management services may not be restricted from requesting, on a statewide basis, which Community Centered Board or Case Management Agency will provide them with targeted case management services.

.13 "Developmental disability" means a disability that is manifested before the person reaches twenty-two years of age; which constitutes a substantial disability to the affected individual; and is attributable to a developmental delay or intellectual disability or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with intellectual disability Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15002, et seq., shall not apply.

8.761 TARGETED CASE MANAGEMENT (TCM) SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITITES

.14 Targeted Case Management services for Persons with Developmental Disabilities consists of facilitating enrollment; locating, coordinating, and monitoring needed developmental disabilities services; and coordinating with other non-developmental disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources. Targeted case management services includes the following activities:

a. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support. These assessment activities include:

1. Taking Client history; and

2. Identifying the Client's needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers, and educators as necessary, to form a complete assessment of the Client.

b. Development and periodic revision of a specific care plan that:

1. Is based on the information collected through the assessment;

2. Specifies the goals and actions to address the medical, social, educational, and other services needed by the Client;

3. Includes activities such as ensuring the active participation of the Client, and working with the Client (or the Client representative as defined in Section 8.500.1) and others to develop those goals; and

4. Identifies a course of action to respond to the assessed needs of the Client.

c. Referral and related activities to help a Client obtain needed services including activities that help link a Client with:

1. Medical, social, educational providers; or

2. Other programs and services including making referrals to providers for needed services and scheduling appointments, as needed.

d. Monitoring and follow-up includes activities that are necessary to ensure the care plan is implemented and adequately addresses the Client's needs. Monitoring and follow up actions shall:

1. Be performed when necessary to address health and safety and services in the care plan;

2. Include activities to ensure:

A. Services are being furnished in accordance with the Client's care plan;

B. Services in the care plan are adequate; and

C. Necessary adjustments in the care plan and service arrangements with providers are made if the needs of the Client have changed;

3. Include direct contact and observation with the Client in a place where services are delivered to a Client in accordance with the following frequency:

A. Face-to-face monitoring shall be completed for a Client enrolled in HCBS-DD at least once per quarter;

B. Face-to-face monitoring shall be completed for a Client enrolled in HCBS-SLS at least once per quarter;

C. Face-to-face monitoring shall be completed for a Client in HCBS-CES at least once per quarter; and

D. Face-to-face monitoring shall be completed at least once every six months for children in Early Intervention Services.

E. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

.15 All case documentation must be entered into the Department's IMS within five (5) business days from the date of activity.

8.761.2 DETERMINATION OF CLIENT ELIGIBLITY

.21 To receive targeted case management services individuals must meet the following criteria:

a. Be determined eligible for Medicaid by the County Department of Social/Human Services in the county in which the person resides;

b. Be determined by the designated Community Centered Board to have a developmental disability or developmental delay; and

c. Be actively enrolled in one of the following programs:

1. Home and Community Based Services for Persons with Developmental Disabilities waiver (HCBS-DD);

2. Home and Community Based Services - Supported Living Services waiver (HCBS-SLS);

3. Home and Community Based Services- Children's Habilitation Residential Program (HCBS-CHRP)

3. Home and Community Based Services - Children's Extensive Support waiver (HCBS-CES); or

4. Early Intervention Services (EI) .

.22 The specific programs listed in Section 8.761.21.c.1 through 4 are the only programs which are eligible for targeted case management services.

8.761.3 PROVIDER ELIGIBILITY

.31 Only certified Early Intervention Services may be reimbursed for targeted case management services for persons enrolled in Early Intervention Services pursuant to 12 CCR 2509-10, Section 7.913.

.32 Only case management agencies certified by the Department pursuant to Sections 8.519 through 8.519.23 may provide case management for persons enrolled in the Home and Community Based Services outlined in Sections 8.503 Home and Community Based Services for Children's Extensive Support (HCBS-CES) Waiver, 8.508 Home and Community Based Services for Children's Residential Habilitation Program (HCBS-CRHP), 8.500 Home and Community Based Services for the Developmentally Disabled (HCBS-DD) Waiver, and 8.500.90 Home and Community Based Services for Supported Living Services (HCBS-SLS) Waiver *et seq*.

8.761.4 REIMBURSEMENT

.41 Claims are reimbursable only when supported by the following documentation:

a. The name of the Client;

b. The date of the activity;

c. The nature of the activity including whether it is direct or indirect contact with the Client;

d. The content of the activity including the relevant observations, assessments, findings;

e. Outcomes achieved, and as appropriate, follow up action;

f. For EI services, the total number of units associated with the activity; and

g. For HCBS waiver programs, documentation required under Sections 8.519 and 8.760.

.42 TCM providers shall record what documentation exists in the log notes and enter it into the state data system as required by the Department.

.43 Claims related to EI for travel time to and from a TCM activity are reimbursable at the same unit rate as TCM services. The time claimed for travel shall be documented separately from the time claimed for the TCM activity.

.44 Reimbursement rates shall be published prior to their effective date in accordance with Federal requirements at 42 C.F.R. § 447.205 and shall be based upon a market-based. EI shall continue to utilize the rate with a unit of service equal to fifteen (15) minutes according to the State's approved fee schedule. EI TCM, which is limited to 240 units per Client per state fiscal year.

.45 TCM services may not be claimed prior to the first day of enrollment into an eligible program nor prior to the actual date of eligibility for Medicaid benefits.

.46 TCM for HCBS-DD, HCBS-CES, HCBS-CHRP and HCBS-SLS are to be reimbursed based on the Departments TCM Fee Schedule.

8.761.5 EXCLUSIONS

.51 Case management services provided to any individuals enrolled in the following programs are not billable as Targeted Case Management services for persons with developmental disabilities as specified in Section 8.760:

a. Persons enrolled in a Home and Community Based Services waiver not included as an eligible HCBS service as described in Section 8.761.21.c.

b. Persons residing in a Class I nursing facility.

c. Persons residing in an Intermediate Care Facility for the Intellectually Disabled (ICF-ID).

8.762 CASE MANAGEMENT - MENTAL HEALTH

.10 Case Management Services - Mental Health are a Medicaid benefit statewide when provided in accordance with the provisions of the following sections.

.20 DEFINITION

Case Management Services are defined as those services which will assist mentally ill individuals eligible under the state plan, in gaining access to needed medical, social educational, and other services. These services are separate from those services defined under the clinic options services in Section 8.750.

.30 DETERMINATION OF CLIENT ELIGIBILITY

In addition to Medicaid eligibility, individuals must be determined by the community mental health centers to be mentally ill (see section 8.400b.) and in need of case management services as defined above.

.40 PROVIDER ELIGIBILITY

Only community mental health centers and clinics designated by the Department of Institutions and licensed by the Department of Health shall be reimbursed for case management services under these provisions.

.50 REIMBURSEMENT

Reimbursement shall be on a prospective fee for services basis in accordance with Federal requirements at 42 CFR 447.321 and Section 8.752.

8.763 TARGETED CASE MANAGEMENT - TRANSITION COORDINATION

8.763.A Definitions

1. Transition coordination means support provided to a member who is transitioning from a congregate setting other than an assisted living facility and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition.

8.763.B Eligibility

1. To be eligible for Transition Coordination, members must be adult Medicaid recipients, who reside in a congregate setting other than an assisted living facility and are willing to participate and have expressed interest in moving to a home and community-based setting. Members may also be Medicaid recipients receiving Home and Community Based Services provided by the State operated Regional Centers who want to transition to a private Home and Community Based Services Provider. Services are expected to begin while an individual is living in a facility and continue through transition and integration into community living, based on the community risk assessment. Excluded are children under the age of 18.

8.763.C Services

1. Transition Coordination is provided pursuant to 10 CCR 2505-10, section 8.519.27.

8.763.D Limitations on Service

1. Transition coordination is limited to 360 units per member per transition. A unit of service is defined as each completed 15-minute increment that meets the description of a Transition Coordination activity. When an individual has a documented need for additional units, the 360-unit cap may be exceeded to ensure the health and welfare of the member. The Transition Coordinator shall submit documentation to the Department including:

    1. A copy of the community risk assessment describing the member’s current needs.

2. The number of additional units requested.

3. A history of transition coordination units provided to date and outcomes of those services

4. An explanation of the additional transition coordination supports to be provided by the transition coordinator using any additional approved units.

8.765 SERVICES FOR CLIENTS IN RESIDENTIAL CHILD CARE FACILITIES AS DEFINED BELOW

8.765.1 DEFINITIONS

Assessment means the process of continuously collecting and evaluating information to develop a client's profile on which to base a Plan of Care, service planning, and referral.

Clinical Staff means medical staff that are at a minimum licensed at the level of registered nurse, performing within the authority of the applicable practice acts.

Colorado Client Assessment Record (CCAR) means a clinical instrument designed to assess the behavior/mental health status of a medically eligible client. The CCAR is used to identify current diagnosis and clinical issues facing the client, to measure progress during treatment and to determine mental health medical necessity. This instrument is used for children in the custody of a county department of human/social services or Division of youth corrections and for those children receiving mental health services in an RCCF through the Child Mental Health Treatment Act.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the Colorado Medicaid program's benefit under Section 8.280 for children and adolescents that provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21.

Emergency Safety Intervention means the use of Restraint and Seclusion as an immediate response to an Emergency Safety Situation.

Emergency Safety Situation means unanticipated behavior of the client that places the client or others at serious threat of violence or injury if no intervention occurs and that calls for Emergency Safety Intervention.

Emergency Services means emergency medical and crisis management services.

Independent Assessment means a process to assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool. The assessment determines whether treatment in a Qualified Residential Treatment Program (QRTP) provides the most effective and appropriate level of care for the child in the least restrictive environment, in accordance with Colorado Department of Human Services regulations.

Independent Team means a team certifying the need for Psychiatric Residential Treatment Facility (PRTF) services that is independent of the Referral Agency and includes a physician who has competence in the diagnosis and treatment of mental illness and knowledge of the client's condition.

Interdisciplinary Team means staff in a PRTF comprised of a physician, and a Licensed Mental Health Professional, registered nurse or occupational therapist responsible for the treatment of the client.

Licensed Mental Health Professional means a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a psychiatrist licensed pursuant to part 1 of article 36 of title 12, C.R.S., a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S., or a social worker licensed pursuant to part 4 of article 43 or title 12, C.R.S., that is supervised by a licensed clinical social worker. Sections 12-43-301, et seq, 12-36-101, et seq, 12-43-401, et seq, 12-43-501, et seq and 12-43-601, et seq, C.R.S. (2005) are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

Medication Management Services means review of medication by a physician at intervals consistent with generally accepted medical practice and documentation of informed consent for treatment.

Multidisciplinary Team means staff in a Residential Child Care Facility (RCCF) providing mental health services comprised of at least one Licensed Mental Health Professional and other staff responsible for the treatment of the client and may include a staff member from the Referral Agency.

Plan of Care means a treatment plan designed for each client and family, developed by an Interdisciplinary or Multidisciplinary Team.

Prone Position means a client lying in a face down or front down position.

Psychiatric Residential Treatment Facility (PRTF) means a facility that is not a hospital and provides inpatient psychiatric services for individuals under age 21 under the direction of a physician, licensed pursuant to part 1 of article 36 of title 12, C.R.S.

Qualified Residential Treatment Programs (QRTP) means a facility that provides residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

Referral Agency means the Division of Youth Corrections, County Departments of Human/Social Services who have legal custody of a client, Behavioral Healthcare Organization or Community Mental Health Center that refers the client to a PRTF or RCCF for the purpose of placement through the Child Mental Health Treatment Act.

Restraint includes Drug Used as a Restraint, Mechanical Restraint and Personal Restraint.

Drug Used as a Restraint means any drug that is administered to manage a client's behavior in a way that reduces the safety risk to the client or to others; has the temporary affect of restricting the client's freedom of movement and is not a standard treatment for the client's medical or psychiatric condition.

Mechanical Restraint means any device attached or adjacent to the client's body that the client cannot easily remove that restricts freedom of movement or normal access to the client's body.

Personal Restraint means personal application of physical force without the use of any device, for the purpose of restraining the free movement of the client's body. This does not include briefly holding a client without undue force in order to calm or comfort, or holding a client's hand to safely escort the client from one area to another. This does not include the act of getting the client under control and into the required position for Restraint.

Residential Child Care Facility (RCCF) means any facility that provides out-of-home, 24-hour care, protection and supervision for children in accordance with 12 C.C.R. 2509-8, Section 7.705.91.A.

Seclusion means the involuntary confinement of a client alone in a room or an area from which the client is physically prohibited from leaving.

8.765.2 PRTF BENEFIT

8.765.2.A. PRTF benefit shall include services as identified in the Plan of Care as well as other services necessary for the care of the client in the facility. These services include, but are not limited to:

1. Individual therapy.

2. Group therapy.

3. Family, or conjoint, therapy conducted with the client present, unless client contact with family members is contraindicated.

4. Emergency services.

5. Medication Management Services.

6. Room and Board.

8.765.3 PRTF NON-BENEFIT

8.765.3.A. The following are not a benefit in a PRTF:

1. The day of discharge.

2. Leave days.

3. Days when the client is in detention.

8.765.4 PRTF CLIENT ELIGIBILITY

8.765.4.A. To receive benefits in a PRTF, the client shall:

1. Be between the ages of three and twenty-one.

2. Be certified to need PRTF level of care by an Independent Team. The Team shall certify that:

   a. Ambulatory care resources available in the community do not meet the treatment needs of the client.

   b. Proper treatment of the client's mental illness condition requires services on an inpatient basis under the direction of a physician.

   c. The services can reasonably be expected to improve the client's mental health or prevent further regression so that the services shall no longer be needed.

3. Be certified to have a diagnosis of a psychiatric disorder classified as a Diagnostic Statistical Manual (DSM) IV Text Revision, Fourth Edition, diagnosis that is the primary reason for placement from one of the following diagnostic categories:

   295 Schizophrenic disorders

296 Affective psychoses

297 Paranoid states

298 Other nonorganic psychoses

300 Neurotic disorders

301 Personality disorders

307 Eating Disorders, Tic Disorders and Sleep Disorders

308 Acute reaction to stress

309 Adjustment reaction

311 Depressive disorder, not elsewhere classified

312 Disturbance of conduct, not elsewhere classified

313 Disturbance of emotions specific to childhood and adolescence

314 Hyperkinetic syndrome of childhood

4. Be certified to have a DSM Axis 5 GAF score of 40 or less.

5. Be assessed using a current valid Colorado Client Assessment Record (CCAR) that supports medical necessity.

8.765.4.B. The client shall be not be eligible to receive services when:

1. The client is no longer able to benefit from the service or is no longer progressing towards goals.

2. The client is absent without leave in excess of 24 consecutive hours or has been removed from the facility and placed in non-PRTF services.

3. The Interdisciplinary Team determines that the client has attained treatment goals.

4. Admission of minors not in the custody of a County Department of Human/Social Services or DHS as a result of commitment to the Division of Youth Corrections shall be subject to the requirements set forth at Section 27-10-103, C.R.S (2005), which is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

8.765.5 PRTF PROVIDER ELIGIBILITY

8.765.5.A. All PRTF Providers shall have an Interdisciplinary Team.

1. The Interdisciplinary Team shall include either a board-certified psychiatrist, or a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy, and one of the following:

a. A licensed clinical social worker, licensed marriage and family therapist or licensed professional counselor.

b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

c. A certified occupational therapist with specialized training or one year's experience in treating mentally ill individuals; or

d. A licensed psychologist.

2. The Interdisciplinary team shall:

a. Assess the client's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities.

b. Assess the potential resources of the client and client's family.

c. Develop and implement a comprehensive, individualized written Plan of Care.

d. Set treatment objectives.

e. Prescribe therapeutic modalities to achieve the objectives of the Plan of Care.

8.765.5.B. All PRTF providers shall implement a Plan of Care.

8.765.5.C. An initial Plan of Care shall be developed within 72 hours of the client's admission and shall address the immediate and emergency needs of the client.

8.765.5.D. A comprehensive Plan of Care shall:

1. Be completed within 14 days of admission.

2. Be signed and dated by the client, the Referral Agency and the Licensed Mental Health Professional.

3. Address clinical and other needs including the client's presenting problems, physical health, emotional status, behavior, support system in the community, available resources and discharge plan.

4. Include specific goals and measurable objectives, expected dates of achievement and specific discharge criteria to be met for termination of treatment. Criteria for discharge shall include provisions for follow-up services.

5. Specify the type, frequency and duration of all PRTF services necessary to meet the needs of the client and to treat the client's current diagnosis.

6. Identify the provision of or the referral for services other than PRTF Services.

7. Be readily identifiable and be maintained in the client's record.

8. Document any court-ordered treatment including identifying the agency responsible for providing the court-ordered treatment.

9. Include revisions to the Plan of Care at least monthly, or sooner if appropriate.

8.765.5.E. The PRTF shall designate a Licensed Mental Health Professional to act as a case manager for each client to oversee the formulation, implementation, review and revision to the Plan of Care.

8.765.5.F. The Licensed Mental Health Professional shall sign and date the Plan of Care.

8.765.5.G. The PRTF shall ensure the client and/or legal guardian participate in the formulation, review and revision of the Plan of Care. If the client or legal guardian is unable to participate or when his or her participation is clinically contraindicated, the PRTF shall document the reasons in the client's record. Any decision to not involve the family or guardian shall be approved by the Referral Agency. In addition, other persons selected by the client, the family or guardian, the Referral Agency or the Licensed Mental Health Professional may be included in the formulation, review and revision of the Plan of Care.

8.765.5.H Except in cases of emergency, all PRTF services in the Plan of Care shall be provided.

8.765.5.I. The PRTF shall ensure that physician prescribed information is used for the component of the Plan of Care requiring Medication Management Services.

8.765.5.J. The PRTF shall ensure all clients and/or guardians are aware of the complaint and grievance procedures.

8.765.5.K. The PRTF shall ensure all clients and/or guardians are aware of the PRTFs policies regarding Restraint and Seclusion as required in 42 C.F.R. 483.350-376, which is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

8.765.5.L. The PRTF shall facilitate access to necessary medical care and shall be responsible for coordinating mental health treatment with medical treatment.

8.765.5.M. Client Transfers:

1. A client shall be transferred only to the care of another PRTF or placement facility when adequate arrangements for care have been made by the Referral Agency.

2. The client and the legal guardian shall be given a minimum of 24 hours notice before the client is transferred unless this notice is waived by the Referral Agency or legal guardian in writing or if an emergency condition exists.

3. Transfers shall be documented in the clinical record.

8.765.5.N. PRTF Licensure and Certification Requirements.

1. The PRTF shall:

   a. Be certified by the Department of Human Services (DHS), to provide mental health services as a PRTF.

   b. Be licensed by DHS, Division of Child Care Licensing, as a Residential Child Care Facility and a PRTF.

c. Be certified as a qualified residential provider by the Department of Public Health and Environment.

d. Be accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children.

e. Provide an attestation to the Department that the PRTF is in compliance with the condition of participation for Restraint and Seclusion as described in Section 8.765.6.F and in federal law.

2. A PRTF located in another state shall meet the requirements as set forth in Section 8.765.5.N.1.d. and e. and shall meet all other license and certification requirements for a PRTF in the state in which it is located.

3. A PRTF that has more than one physical address shall have a separate Medicaid provider number for each facility.

8.765.6 PRTF PROVIDER RESPONSIBILITIES

8.765.6.A. A PRTF shall complete a CCAR and maintain an organized, legible, chronological, current treatment record for each client. Treatment records shall include:

1. Admission information such as the client's personal information and demographic data, source of referral, most current Diagnostic Statistical Manual diagnosis and substance abuse history.

2. Documentation of the client's legal status, including but not limited to guardianship, conservatorship, court orders, custody, certifications, advisement and consent.

3. Copies of all CCARs.

4. All Plans of Care and revisions.

5. Documentation of client's attendance at, participation in and outcomes of PRTF Services.

6. Documentation that the client and/or the legal guardian was provided with a copy of the Plan of Care.

7. Correspondence to and from agencies and individuals involved in the client's treatment.

8. An explanation whenever any member of the Interdisciplinary Team, client, parent or guardian, when appropriate, does not sign a Plan of Care.

9. The name of the Licensed Mental Health Professional responsible for the formulation, implementation, review and revision of the client's Plan of Care.

10. A discharge report, within 30 consecutive days of the discharge from the PRTF, summarizing treatment received and outcomes.

11. For transfers between facilities, documentation of appropriate clinical information and coordination of services between the two facilities.

12. Documentation of any unplanned discharges without advance notice and any discharges against the Licensed Mental Health Professional's advice.

13. Information regarding any serious injury sustained while in the PRTF to the client or by the client and details describing the circumstances by which the injury occurred.

14. Information regarding a client's death and details of the circumstances by which the death occurred.

15. Dates, times and circumstances of unauthorized leave.

16. Documentation of detention dates.

17. Treatment entries that are signed and dated by the person providing treatment, including title or position of the person providing treatment.

8.765.6.B. All members of the Clinical Staff shall be trained annually in the development and review of Plans of Care and the details of this training shall be documented.

8.765.6.C. Records shall be kept in a secure location at the PRTF.

8.765.6.D. Data, including claims data, shall be retained for six years unless there is a written statutory requirement or regulation available from a county, state or federal agency requiring a longer retention period.

8.765.6.E. Clinical records shall be retained for six years after the client's 21st birthday.

8.765.6.F. The PRTF shall comply with the following requirements for the use of Restraint and Seclusion:

1. Personal, Mechanical and Drugs Used as Restraint shall be ordered only by a physician, physician's assistant or nurse practitioner.

2. An order for Restraint or Seclusion shall not be written as a standing order or on an as-needed basis.

3. Restraint and Seclusion shall not result in harm or injury to the client and shall be used only to ensure the safety of the client or others during an Emergency Safety Situation and only until the Emergency Safety Situation has ceased.

4. Restraint and Seclusion shall not be used simultaneously.

5. A Personal Restraint when a client is in a Prone Position is prohibited.

6. If the order for Restraint or Seclusion is verbal, it shall be received by a registered nurse, licensed practical nurse or physician's assistant.

7. The Restraint or Seclusion shall be carried out by Clinical Staff who are trained in the use of emergency safety intervention.

8. Only a physician, registered nurse, licensed practical nurse or physician's assistant shall administer a Drug Used as a Restraint.

9. Clinical Staff trained in the use of emergency safety interventions that are physically present during the Restraint or Seclusion shall monitor the client during the Restraint or Seclusion period.

10. Each order for Restraint or Seclusion shall never:

a. Exceed the duration of the emergency safety situation; and

b. Exceed four hours in length for youth ages 18 to 21; two hours in length for clients ages nine to 17; or one hour in length for clients under age of nine.

11. Within one hour of the initiation of the Emergency Safety Intervention a physician, registered nurse or physician's assistant shall conduct a face-to-face assessment of the physical and psychological well being of the client. A psychologist may conduct the face-to-face assessment if done in conjunction with a physician, registered nurse or physician's assistant.

12. The PRTF shall report each serious occurrence to both the Department and the federally-designated Protection and Advocacy agency no later than close of business the next business day. Serious occurrences to be reported include a client's death, a serious injury to a client, or a client's suicide attempt.

13. The PRTF shall notify the parent(s) or legal guardian(s) of a client who has been restrained or secluded as soon as possible, but not to exceed 24 hours, after the initiation of each emergency safety intervention and shall document the date and time of this notification in the client's record.

14. Within 24 hours of the use of Restraint or Seclusion, staff involved in an Emergency Safety Intervention and the client shall have a face-to-face discussion. This discussion shall include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the client. Other staff and the client's parent or guardian may participate in the discussion, if appropriate.

15. Within 24 hours after the use of Restraint or Seclusion, all staff involved in the Emergency Safety Intervention, and appropriate supervisory and administrative staff, shall conduct a debriefing session that includes, at a minimum, a review and discussion of:

a. The situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention.

b. Alternative techniques that may have prevented the use of the Restraint or Seclusion.

c. New procedures implemented to mitigate any recurrence of the use of Restraint or Seclusion.

d. The outcome of the intervention, including any injuries that may have resulted from the use of Restraint or Seclusion.

8.765.7 REIMBURSEMENT FOR PRTFs

8.765.7.A. A PRTF shall be reimbursed a per diem rate as determined by DHS and approved by the Department.

8.765.7.B. The Department shall recover the per diem reimbursement when:

1. Each service is not documented in the treatment record at the frequency specified in the Plan of Care.

2. There is no Plan of Care in the record, for the period of time claims were paid.

3. Records are requested but not provided with 21 calendar days.

8.765.C. A PRTF may appeal the Department's recovery actions within 30 calendar days from the date of notice. The appeal shall be submitted in accordance with 10 C.C.R. 2505-10, Section 8.050.

8.765.8 MENTAL HEALTH BENEFITS FOR CLIENTS IN AN RCCF

8.765.98.A. Family therapy shall not exceed maximum of one service unit per day.

1. Family therapy without the client present may be provided at a maximum of one service unit per week if treatment is documented in the Plan of Care that client contact with family members is contraindicated. Family Therapy without the client present shall be for the specific benefit of the client.

8.765.8.B. Individual therapy shall not exceed two service units per day.

8.765.8.C. Group therapy shall not exceed eight service units per day.

8.765.8.D. A Licensed Mental Health Professional may authorize family, individual and group therapy in excess of maximum service units per day if the following is documented in the Plan of Care:

1. The reason for the additional therapy.

2. How many additional units are necessary.

3. How long the additional therapy is necessary.

8.765.8.E. The Licensed Mental Health Professional shall re-authorize therapy in excess of the maximum service units per day in the Plan of Care at least every 30 days.

8.765.8.F. Beginning July 1, 2022, only services rendered under Early and Periodic Screening, Diagnosis and Treatment in accordance with Section 8.280 are a covered RCCF benefit.

8.765.9 NON-COVERED BENEFITS FOR CLIENTS IN AN RCCF

8.765.9.A. The following benefits are not covered for clients in an RCCF:

1. Court-ordered treatment that is not otherwise medically indicated;

2. Room and board services;

3. Educational, vocation and job training services;

4. Recreational or social activities;

5. Habilitative care for children who are developmentally disabled or mentally retarded; and

6. Services provided by public institutions or institutions for mental diseases.

8.765.10 CLIENT ELIGIBILITY FOR MENTAL HEALTH SERVICES IN AN TRCCF

8.765.10.A. To be eligible for mental health services delivered in an RCCF the client shall:

1. Be between the ages of three and 21 years of age.

2. Have a diagnosis of a psychiatric disorder classified by a Diagnostic and Statistical Manual of Mental Disorders (DSM).

3. Have a current, and valid CCAR assessment completed by a Licensed Mental Health Professional that supports medical necessity for mental health services, and demonstrates which services the client would benefit from.

8.765.11 ELIGIBILITY FOR PROVIDERS DELIVERING SERVICES IN AN RCCF

8.765.11.A Individual, group and family therapy provided in an RCCF shall be provided by a Licensed Mental Health Professional or a provisionally-licensed Mental Health Professional supervised by a Licensed Mental Health Professional, employed by or contracted with an RCCF that is licensed by the Colorado Department of Human Services.

8.765.11.B. Licensed Mental Health Professionals providing mental health services to clients in an TRCCF are exempt from the direct physician supervision requirement in 10 C.C.R. 2505-10, Section 8.200.2.A through E.

8.765.11.C. Licensed Mental Health Professionals providing mental health services to clients in the RCCF enroll as Medicaid rendering providers.

8.765.12 RCCF RESPONSIBLITIES

8.765.12.A. The RCCF shall include the following in the client's record:

1. Results from the Multidisciplinary Team's Assessment;

2. Client's Medicaid Eligibility Determination Form; and

3. Client's diagnoses, characteristics and presenting problem.

8.765.12.B. The RCCF shall transmit the items listed in 8.765.12.A. to the Referral Agency.

8.765.12.C. The RCCF shall designate a Licensed Mental Health Professional to act as a case manager for mental health services for each client.

8.765.12.D. The Licensed Mental Health Professional shall maintain an organized, legible, chronological, current record on each client.

8.765.12.E. The client's Plan of Treatment for mental health services shall be integrated into the agency's comprehensive Plan of Care reviewed by the Multidisciplinary Team. The Plan of Care shall:

1. Be signed and dated by the client, the Referral Agency and the Licensed Mental Health Professional and the parent/guardian.

2. Include an initial plan developed prior to the onset of mental health services that needs of the client.

3. Address mental health and other needs including the client's presenting problems, physical health, emotional status, behavior, support system in the community, available resources and discharge plan.

4. Include specific goals and measurable objectives, expected dates of achievement and specific discharge criteria to be met for termination of treatment. Criteria for discharge shall include provisions for follow-up services.

5. Specify all mental health services necessary to meet the needs of the client and to treat the client's current diagnosis while the client is in the RCCF.

6. Identify the provision of or the referral for services other than mental health services.

7. Be readily identifiable and be maintained in the client's record.

8. Document any court-ordered mental health services including identifying the agency responsible for providing the court-ordered treatment.

9. Be reviewed by the Multidisciplinary Team monthly and revised as needed.

8.765.12.F. Except in cases of emergency, all mental health services indicated in the Plan of Care shall be provided.

8.765.13 REIMBURSEMENT FOR MENTAL HEALTH SERVICES IN A TRCCF

8.765.13.A. Reimbursement for Mental Health Services in a RCCF shall be the lower of billed charges or the maximum unit rate of reimbursement. Beginning July 1, 2022, RCCF services will be not reimbursable unless provided under Early and Periodic Screening, Diagnosis and Treatment in accordance with Section 8.280.

8.765.13.B. The RCCF shall enroll as a Medicaid provider for the purposes of acting as a billing entity for Licensed Mental Health Professionals providing mental health services in the RCCF.

8.765.14 QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP)

8.765.14.A CLIENT ELIGIBILITY

1. Children up to age eighteen (18) years old and for those persons up to twenty-one (21) years old who consent to the placement or are placed by court order, for whom an Independent Assessment determines that the child's needs cannot be met in a less restrictive, family- based setting because of their serious emotional or behavioral disorders or disturbances.

2. Managed Care Entities must use the Independent Assessment to inform medical necessity determinations.

3. For children in the custody of a county department of human/social services or Division of Youth Services and for those children receiving mental health services in a Qualified Residential Treatment Program (QRTP) through the Child and Youth Mental Health Treatment Act, the Independent Assessment will determine mental health medical necessity.

8.765.14.B QRTP AND PROVIDER ELIGIBILITY

1. Beginning October 1, 2021, to be eligible for Colorado Medicaid reimbursement, a QRTP must:

   a. Be enrolled with Colorado Medicaid;

b. Be licensed by the Colorado Department of Human Services (CDHS), Provider Services Unit (PSU), as a Child Care Facility with QRTP indicated as the Service Type in accordance with CDHS regulations;

c. Be accredited by:

i. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO),

ii. The Commission on Accreditation of Rehabilitation Facilities (CARF),

iii. The Council on Accreditation of Services for Families and Children, or

iv. Any other independent, not-for-profit accrediting organization approved by the Secretary of Health and Human Services.

d. Submit an attestation form to the Department with the facility's Colorado Medicaid enrollment application with Colorado Medicaid that attests:

i. The facility has no more than sixteen (16) beds, including all beds at a single address or on adjoining properties regardless of program or facility type;

ii. The facility does not share a campus with a Psychiatric Residential Treatment Facility (PRTF);

iii. For facilities more than one (1) mile but less than ten (10) miles apart by road from another overnight facility controlled by the same ownership or governing body, the other overnight facility meets the following criteria:

1. The facility maintains its own license;

2. The facility has dedicated staff that ensures a stable treatment environment;

3. Residents do not move between the facility and another during the episode of care

iv. For facilities less than one (1) mile apart, but not on the same campus or adjoining properties, the QRTP is in a home-like structure (cottage, house, apartment) located farther than 750 feet from another overnight facility within a community setting that includes publicly used infrastructure (roads, parks, shared spaces, etc.).

2. Provider Qualifications.

a. The rendering provider for the following services must be an enrolled Licensed Mental Health Professional in a QRTP:

i. Individual therapy,

ii. Group therapy, and

iii. Family therapy.

8.765.14.C COVERED SERVICES

1. Medically necessary services pursuant to Section 8.076.1.8 that are not excluded in Section 8.765.14.D and are:

   a. Included in the member's stabilization plan created by the QRTP in accordance Colorado Department of Human Services (CDHS) regulations.

   b. Included in the member's individual child and family plan created by the QRTP in accordance with CDHS regulations.

   c. Included in the member's discharge and aftercare plan created by the QRTP in accordance with CDHS regulations.

2. All EPSDT services not specified in Sections 8.765.14.C.1-3 are covered under Section 8.280.

8.765.14.D NON-COVERED SERVICES

1. The following services are not covered for members in a QRTP:

   a. Room and board;

   b. Educational, vocational, and job training services;

   c. Recreational or social activities; and

   d. Services provided to inmates of public institutions or residents of Institutions of Mental Disease (IMD).

8.765.14.E PRIOR AUTHORIZATION REQUIREMENTS

1. Prior authorization may be required for this benefit.

8.765.14.F REIMBURSEMENT.

1. QRTPs are reimbursed a per diem rate, as determined by the Department, if the following conditions are fulfilled:

   a. Rendered services are documented in the treatment record at the frequencies specified in the member's care plan(s);

   b. A care plan(s) is on record for the time period reported in the reimbursement claim; and

   c. The care meets professionally recognized standards for care in a QRTP.

2. QRTPs must enroll as a Colorado Medicaid provider to act as a billing entity for Licensed Mental Health Professionals rendering mental health services in the QRTP.

8.770 ABORTION SERVICES

8.770.1. Definitions

Life-Endangering Circumstance means:

1. The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term; or

2. The presence of a psychiatric condition, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. In such cases, unless the pregnant woman has been receiving prolonged psychiatric care, the attending physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition.

8.770.2. Client Eligibility

8.770.2.A. All Colorado Medicaid-enrolled clients are eligible.

8.770.3. Provider Eligibility

8.770.3.A. All Colorado Medicaid enrolled providers in compliance with CRS § 25.5-3-106 are eligible to perform abortion services.

8.770.4. Covered Services

8.770.4.A. Abortion services are only covered when the life of the mother would be endangered if the fetus were carried to term; or when the pregnancy is the result of an act of rape or incest.

8.770.4.B. In cases of a life-endangering circumstance, the physician must make every reasonable effort to preserve the lives of the pregnant woman and the fetus.

8.770.4.C. A provider who is licensed by the state and acting within the scope of the provider's license and in accordance with applicable federal regulations shall perform the procedure.

8.770.4.D. Any claim for payment must be accompanied by a case summary that includes the following information:

1. Name, address, and age of the pregnant woman;

2. Gestational age of the fetus;

3. Description of the medical condition which necessitated the abortion;

4. Services performed;

5. Facility in which the abortion was performed; and

6. Date of service.

8.770.4.E. A claim for payment for an abortion that is the result of life-endangering circumstances must also be accompanied by a Department-approved certification statement confirming the life-endangering circumstance of the abortion and at least one of the following forms with additional supporting documentation that confirms the life-endangering circumstances:

1. Hospital admission summary

2. The findings and reports from consultants that provide opinions regarding the health of the client

3. Laboratory results and findings

4. Office visit notes

5. Hospital progress notes

8.770.4.F. A claim for payment for an abortion that is the result of rape or incest must be accompanied by a Department-approved certification statement confirming the circumstances of the abortion.

8.770.4.G. An evaluation by a licensed physician specializing in psychiatry must accompany the claim for reimbursement for the abortion if a psychiatric condition represents a serious and substantial threat to the pregnant woman's life if the pregnancy continues to term.

8.770.5. Prior Authorization Requirements (PAR)

8.770.5.A. Prior authorization is not required for this service.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 03/04/2007, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 03/04/2007, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]