THIS PAGE NOT FOR PUBLICATION

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 13-10-22-D, Revision to the Medical Assistance Rule Concerning the Community Mental Health Services Program Section 8.212
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Section 8.212, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Replace current text beginning at §8.212 'COMMUNITY MENTAL HEALTH SERVCIES' through the end of §8.212.5.2 with new text provided. This revision is effective 06/01/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Community Mental Health Services Program Section 8.212
Rule Number:	MSB 13-10-22-D
Division / Contact / Phone:	Health Programs Office / Nikki Lemmon / x4711

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule addresses enrollment, exemptions, rights/protections, required services and emergency services concerning the Community Mental Health Services program. The revision of this rule includes the addition of substance use disorder services, and eliminates benefit limits. Additionally, the Department is changing the name of the Community Mental Health Service program to the Community Behavioral Health Services program.

2. An emergency rule-making is imperatively necessary

☐ to comply with state or federal law or federal regulation and/or

☐ for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

Section 1915(b) of the Social Security Act [42 U.S.C. § 1396]; 42 CFR part 438.

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2013);
C.R.S §§ 25.5-5-402, 25.5-5-411.

Initial Review	**03/14/2014**	Final Adoption	**04/11/2014**
Proposed Effective Date	**06/01/2014**	Emergency Adoption	

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Community Mental Health Services Program Section 8.212
Rule Number:	MSB 13-10-22-D
Division / Contact / Phone:	Health Programs Office / Nikki Lemmon / x4711

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The classes who will benefit from this proposed rule are any of those eligible for Medicaid and for enrollment in the Community Mental Health Services program. For the incorporation of substance use disorder services into the program, the Department anticipates that aligning the delivery system for mental health and substance use disorders will improve health outcomes and recovery success, and will result in a significant increase in care management for these populations which are often dually-diagnosed. Eliminating benefit limits on services means that the Behavioral Health Organizations will be financially responsible for their client's entire inpatient hospital stay and individual psychotherapy sessions, which previously were limited to 45 days and 35 sessions. Finally, changing the name of the program from the Community Mental Health Services program to the Community Behavioral Health Services program will reflect a more inclusive and integrated behavioral health care system.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The populations of persons previously utilizing substance use disorder services were likely receiving them through fee-for-service Medicaid, and were possibly going without behavioral health care management. Clients receiving services in fee-for-service Medicaid may have been responsible for co-payments in accordance with 10 CCR 2505-10 8.700 MEDICAL ASSISTANCE - SECTION 8.754. Behavioral health services provided through the Community Mental Health Services program are provided free of charge to clients.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   In 2013, the Colorado General Assembly approved funds which allocate the changes in this rule amendment. The funds will be used to enhance the existing substance use disorder benefit by administering services through the Behavioral Health Organizations. The Department believes a managed care structure through the Behavioral Health Organizations would result in overall better health outcomes and lower total costs of care for these clients. In addition, the State will receive a Federal match for the services in this program.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

The result of inaction would mean our rules are not aligned with program changes and the Department's contracts with the Behavioral Health Organizations.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly methods for incorporating substance use disorder services in the managed care structure, as the state's goal is to increase integration and care coordination for clients as much as possible, and integrating substance use disorder is one additional step towards that goal.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   As part of the legislative action, the Department considered alternative methods, including substance use disorder service limitations and the option of continuing to offer this benefit only in a fee-for-service environment. However, given other states' experience and recommendations from stakeholders, the Department believes a managed care structure would result in the best health outcomes for clients.

8.212 COMMUNITY BEHAVIORAL ~~MENTAL~~ HEALTH SERVICES

8.212.1 ENROLLMENT

8.212.1.A. The following individuals are not eligible for enrollment in the Community Behavioral~~Mental~~ Health Services program:

1. Qualified Medicare Beneficiary only (QMB-only).

2. Qualified Disabled and Working Individuals (QDWI) ~~Working Disabled Individuals (QWDI).~~

3. Qualified Individuals 1 (QI 1).

4. Special Low Income Medicare Beneficiaries (SLMB).

5. Undocumented aliens, including non-qualified, undocumented and qualified aliens who have not met the five-year bar who are eligible for Federal Medicaid for care and services related to the treatment of an approved medical condition.

6. Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE).

7. Individuals who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan who are:

   a. Found by a criminal court to be Not Guilty by Reason of Insanity (NGRI);

   b. Found by a criminal court to be Incompetent to Proceed (ITP); or

   c. Ordered by a criminal court to ~~the~~ a ~~Institute~~State Institute for Mental Disease (IMD) for evaluation (eg. Competency to proceed, sanity, conditional release revocation, pre-sentencing).

8. Individuals between ages 21 and 64 who receive inpatient treatment who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.

9. Individuals who are NGRI and who are in the community on Temporary Physical Removal (TPR) from the Colorado Mental Health Institute at Pueblo and who are eligible for Medicaid are exempted from the Community Behavioral Health ~~Mental Health~~ Services program while they are on TPR. TPR individuals remain under the control and care of the Institute.

10. Classes of individuals determined by the Department to require exclusion from the Community Behavioral Health ~~Mental Health~~ Services program, defined as individuals residing in State Regional Centers for people with developmental disabilities and associated satellite residences for more than 90 days.

11. Individuals who receive an individual exemption as set forth at Section 8.212.2.

12. Individuals while determined presumptively eligible for Medicaid.

13. Children or youth in the custody of the Colorado Department of Human Services -Division of Child Welfare or Division of Youth Corrections who are placed by those agencies in a Psychiatric Residential Treatment Facility (PRTF) as defined in C.R.S. 25.5-4-103 or a Residential Child Care Facility (RCCF) as defined in C.R.S. 26-6-102.

8.212.1.B. All other Medicaid clients shall be enrolled in the Community Behavioral Health ~~Mental Health~~ Services program, into a behavioral health organization in the client's geographic area.

1. The Department automatically re-enrolls a client into the same behavioral health organization if there is a loss of Medicaid eligibility of two months or less.

8.212.2 INDIVIDUAL EXEMPTIONS

8.212.2.A. A client may request to be exempt from enrollment in the Community Behavioral Health ~~Mental Health~~ Services program if:

1. The client has a clinical relationship with a provider of behavioral health~~mental health~~ services that the client wishes to maintain and that provider is not part of the provider network of the behavioral health organization in the client's geographic area~~,~~; or

2. The client and the behavioral health organization have been unable to develop a healthy working relationship and continued enrollment would not be in the best clinical interest of the client.

8.212.2.B. If the client requests an exemption because the client's existing provider is not in the provider network, based on Section 8.212.2.A.1:

1. The client shall notify the behavioral health organization of his/her request to receive necessary behavioral health ~~mental health~~ services from the provider with whom the client has established a clinical relationship.

2. Within fourteen (14) calendar days of receiving notice from the client, the behavioral health organization shall determine whether it can contract with the client's chosen provider to provide necessary behavioral health ~~mental health~~ services to the client and provide written notice to the client and the client's provider of that determination.

3. If the behavioral health organization is unable to approve the client's request, the notice shall:

   a. Identify one or more providers within the behavioral health organization's network who can appropriately meet the client's behavioral health ~~mental health~~ needs;

   b. Include information on the client's right to request an exemption, the process for requesting an exemption and assistance available to the client.

4. The client may request an exemption with the Department within fourteen (14) calendar days of the date of the notice from the behavioral health organization disapproving the client's request.

5. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.

8.212.2.C. If the client requests an exemption because continued enrollment would not be in the best clinical interest of the client, based on Section 8.212.2.A.2:

1. The client shall request an exemption from the Department.

2. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.

8.212.2.D. A client whose request for exemption has been denied by the Department has the right to appeal the determination pursuant to Section 8.057.

8.212.2.E. A newly Medicaid eligible client who requests an exemption shall be enrolled in the Community Behavioral Health ~~Mental Health~~ Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.

8.212.2.F. A client who is enrolled in the Community Behavioral Health ~~Mental Health~~ Services program and is requesting an exemption shall continue to be enrolled in the Community Behavioral~~Mental~~ Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.

8.212.2.G. A client who wants to re-enroll in the Community Behavioral Health ~~Mental Health~~ Services program shall notify the Department. The client will be re-enrolled within thirty (30) calendar days of receipt of the client's request. The Department shall notify the client and the behavioral health organization of the re-enrollment prior to the effective date of re-enrollment.

8.212.2.H. A client who has been exempted from enrollment in the Community Behavioral Health ~~Mental Health~~ Services program because the program was not in the best clinical interest of the client, as described in Section 8.212.2.A.2, may be re-enrolled by the Department into the Community Behavioral Health ~~Mental Health~~ Services program after a period of exemption, if the client demonstrates a clear need for a behavioral health organization to manage his or her behavioral health ~~mental health~~ care.

1. The Department shall notify the client and the behavioral health organization of the re-enrollment at least ten (10) calendar days prior to the effective date of re-enrollment.

8.212.3 CLIENT RIGHTS AND PROTECTIONS

8.212.3.A. A client enrolled in the Community Behavioral Health ~~Mental Health~~ Services program shall have the following rights and protections:

1. To be treated with respect and with due consideration for his/her dignity and privacy.

2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

3. To participate in decisions regarding his/her health care, including the right to refuse treatment and the right to a second opinion.

4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

5. To request and receive a copy of his/her medical records and to request that they be amended or corrected, as specified in 45 CFR Part 164.

6. To exercise his/her rights without any adverse effect on the way he/she is treated.

7. To enforce, pursuant to Section 8.209, the provisions of the community behavioral health ~~mental health~~ services contracting regarding rights or duties owed to the client under the contract.

8.212.4 ~~MENTAL~~ BEHAVIORAL HEALTH SERVICES

8.212.4.A. The following are required services of the Community Behavioral Health ~~Mental Health~~ Services program:

1. Inpatient Psychiatric Hospital Services:

a. Under age 21 -- A program of psychiatric care in which the client remains 24 hours a day in a psychiatric hospital, State Institute for Mental Disease (IMD), or other facility licensed as a hospital by the State. ~~This service is limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.~~

b. Adults ages 21-64 -- A program of psychiatric care in which the client remains 24 hours a day in a psychiatric hospital, or other facility licensed as a hospital by the State, excluding State Institutes of Mental Disease (IMD).

c. Adults ages 65 and over -- A program of care in which the client remains 24 hours a day in a psychiatric hospital, State Institute for Mental Disease (IMD), or other facility licensed as a hospital by the State.

~~2. Under 21 Psychiatric -- A program of care for clients under age 21 in which the client remains 24 hours a day in a psychiatric hospital, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.~~

~~3. 65 and Over Psychiatric -- A program of care for clients age 65 and over in which the client remains 24 hours a day in an institution for mental diseases, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year.~~

2. ~~4.~~ Outpatient Services -- 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 24 hours a day, including:

~~5.~~ a. Physician S~~s~~ervices, including psychiatric care – Behavioral health s~~S~~ervices provided within the scope of practice of medicine as defined by State law.

~~6.~~ b. Rehabilitative Services – Any remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under S~~s~~tate law, for maximum reduction of behavioral~~mental~~/emotional disability and restoration of a client to his/her best possible functional level, including:

~~a.~~ i. Individual Behavioral Health Therapy ~~Psychotherapy~~ - Therapeutic contact with one client of more than ~~-~~30 minutes, but no more than two (2) hours. ~~This service, in conjunction with Individual Brief services, is limited to 35 visits per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.~~

~~b.~~ ii. Individual Brief Behavioral Health Therapy~~Psychotherapy~~ - Therapeutic contact with one client of up to and including 30 minutes. ~~This service, in conjunction with Individual services, is limited to thirty-five (35) visits per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.~~

~~c.~~ iii. Group Behavioral Health Therapy~~Psychotherapy~~ - Therapeutic contact with more than one client, of up to and including two (2) hours.

~~d~~iv. Family Behavioral Health Therapy~~Psychotherapy~~ – Face to face therapeutic contact with a client and family member(s), or other persons significant to the client, for improving client-family functioning. Family behavioral health ~~psychotherapy is~~therapy is appropriate when intervention in the family interactions is expected to improve the client's emotional/~~behavioral~~ behavioral health~~disturbance~~. The primary purpose

of family behavioral health ~~psychotherapy is~~therapy is treatment of the client.

~~e.~~ v. Behavioral~~Mental~~ Health Assessment – Face to face clinical assessment of a client by a behavioral ~~mental~~ health professional that determines the nature of the client's problem(s), factors contributing to the problem(s), a client's strengths, abilities and resources to help solve the problem(s), and any existing diagnoses.

~~f.~~ vi. Pharmacologic Management – Monitoring of medications prescribed and consultation provided to clients by a physician or other medical practitioner authorized to prescribe medications as defined by State law, including associated laboratory services, as indicated.

~~g.~~ vii. Outpatient Day Treatment – Therapeutic contact with a client in a structured, non-residential program of therapeutic activities lasting more than four (4) hours but less than twenty-four (24) hours per day. Services include assessment and monitoring; individual/group/family therapy; psychological testing; medical/nursing support; psychosocial education; skill development and socialization training focused on improving functional and behavioral deficits; medication management; expressive and activity therapies; and coordination of needed services with other agencies. When provided in an outpatient hospital program, may be called "partial hospitalization."

~~h.~~ viii. Emergency/Crisis Services - Services provided during a behavioral ~~mental~~ health emergency which involve unscheduled, immediate, or special interventions in response to crisis situation with a client, including associated laboratory services, as indicated.

3. ~~7.~~ Pharmacy Services – Prescribed drugs when used in accordance with 10 CCR 2505-10 Section 8.800, Pharmaceuticals.

4.~~8.~~ Targeted Case Management ~~- -~~ Case management services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. ~~Medically necessary case management services provided in a licensed community mental health center or clinic by a licensed/qualified non-physician practitioner or physician~~.

5. ~~9.~~ School-Based Behavioral ~~Mental~~ Health Services - Behavioral~~Mental~~ health services provided to school~~-~~aged children and adolescents on~~-~~site in their schools, with the cooperation of the schools.

6. Drug Screening and Monitoring – Substance use disorder counseling services provided along with screening results to be discussed with client.

7. Detoxification Services – Services relating to detoxification including all of the following: Physical assessment of detox progression including vital signs monitoring; level of motivation assessment for treatment evaluation; provision of daily living needs (includes hydration, nutrition, cleanliness and toiletry); safety assessment, including suicidal ideation and other behavioral health issues.

8. Medication-Assisted Treatment – Administration of Methadone or another approved controlled substance to an opiate-dependent person for the purpose of decreasing or eliminating dependence on opiate substances.

8.212.4.B. Alternative services of the Community Behavioral~~Mental~~ Health Services program are:

1. Vocational -- Services designed to help adult and adolescent clients who are ineligible for state vocational rehabilitation services to gain employment skills and employment. Services are skill and support development interventions, educational services, vocational assessment, and job coaching.

2. Assertive Community Treatment (ACT) – Comprehensive, locally-based, individualized treatment for adults with serious ~~-~~behavioral health disorders~~mental illness~~, that is available 24 hours a day, 365 days a year. Services include case management, initial and ongoing behavioral~~mental~~ health assessment, psychiatric services, employment and housing assistance, family support and education, and substance ~~ab~~use disorders services~~. for individuals with co-occurring diagnoses of substance abuse and mental illness.~~

3. Intensive Case Management -- Community-based services averaging more than one hour per week, provided to adults with serious behavioral health disorders ~~mental illness~~ who are at risk of a more intensive 24 hour placement and who need extra support to live in the community. Services are assessment, care plan development, multi-system referrals, assistance with wraparound and supportive living services, monitoring and follow-up. Intensive case management may be provided to children/youth under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. ~~EPSDT~~.

4. Clubhouse and drop-in center services – Peer support services for people who have behavioral health disorders ~~mental illness~~, provided in a Clubhouse or Drop-In Center setting. Clubhouse participants may use their skills for clerical work, data input, meal preparation, providing resource information and outreach to clients. Drop-in Centers offer planned activities and opportunities for individuals to interact socially, promoting and supporting recovery.

5. Recovery Services – Community-based services that promote self-management of behavioral health~~psychiatric~~ symptoms, relapse prevention, treatment choices, mutual support, enrichment, rights protection, social supports. Services are peer counseling and support services, peer-run drop-in centers, peer-run employment services, peer mentoring, consumer and family support groups, warm lines, and advocacy services.

6. Residential Services – Twenty-four (24) hour care, excluding room and board, provided in a non-hospital, non-nursing home setting, appropriate for adults whose mental health issues and symptoms are severe enough to require a 24-hour structured program but do not require hospitalization. Services are provided in the setting where the client is living, in real-time, with immediate interventions available as needed. Clinical interventions are assessment and monitoring of mental and physical health status; assessment and monitoring of safety; assessment of/support for motivation for treatment; assessment of ability to provide for daily living needs; observation and assessment of group interactions; individual , group and family therapy; medication management; and behavioral interventions. Residential services may be provided to children/youth under EPSDT.

7. Prevention/Early Intervention Services – Proactive efforts to educate and empower individuals to choose and maintain healthy life behaviors and lifestyles that promote positive behavioral ~~mental~~ health. Services include behavioral ~~mental~~ health screenings; educational programs promoting safe and stable families; senior workshops related to ~~common~~ aging disorders; and parenting skills classes.

8. Respite Care – Temporary or short-term care of a child, youth or adult client provided by adults other than the birth parents, foster/adoptive parents, family members or caregivers that the client normally resides with. Respite is designed to give the caregivers some time away from the client to allow them to emotionally recharge and become better prepared to handle normal day-to-day challenges. Respite care providers are specially trained to serve individuals with ~~mental~~ behavioral health issues.

8.212.5 EMERGENCY SERVICES

8.212.5.A. A client enrolled in the Community Behavioral ~~Mental~~ Health Services program shall seek all behavioral ~~mental~~ health services from the behavioral health organization with which he/she is enrolled except as specified in 8.212.5.B.

8.212.5.B. Clients with an emergency medical condition may seek emergency services outside of the network of the behavioral health organization in which they are enrolled.

8.212.5.C. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention or behavioral ~~mental~~ health services to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

8.212.5.D. Emergency services means covered inpatient and outpatient services that are as follows:

1. Furnished by a provider that is qualified to furnish these services.

2. Needed to evaluate or stabilize an emergency medical condition.

THIS PAGE NOT FOR PUBLICATION

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-01-09-A, Revision to the Medical Assistance Nursing Facility Rule Concerning Services and Items Not Included in the Per Diem Payment, Section 8.440.2
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.440.2, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at §8.440.2.A.3 with the new text provided. All text indicated in blue is for context and clarification only and should not be revised. This revision is effective May 30, 2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Nursing Facility Rule Concerning Services and Items Not Included in the Per Diem Payment, Section 8.440.2
Rule Number:	MSB 14-01-09-A
Division / Contact / Phone:	Long Term Services and Supports / John Estes / 303-866-5453

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule lists items and services that are not included in a facility's per diem reimbursement rate. The first portion of this rule lists items and services that are not reimbursed in the per diem, but that may be charged to clients' personal needs funds. The second portion lists items and services that are not included in the per diem reimbursement, and may not be charged to the clients' personal needs funds.

   The current rule lists a service that is not covered, but the language currently used is unclear and has caused some confusion on the part of long term care facilities and the department. The revision will clarify this item, reducing the frustration of providers and the number of appeals.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   25.5-6-201 et seq.

Initial Review	**03/14/2014**	Final Adoption	**04/11/2014**
Proposed Effective Date	**06/01/2014**	Emergency Adoption	

DOCUMENT #01

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Nursing Facility Rule Concerning Services and Items Not Included in the Per Diem Payment, Section 8.440.2
Rule Number:	MSB 14-01-09-A
Division / Contact / Phone:	Long Term Services and Supports / John Estes / 303-866-5453

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This rule amendment will affect Nursing Facility Providers.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   This rule amendment will clarify an issue that was causing confusion in the per diem rate calculation.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   This will clarify an issue that is currently causing confusion, likely reducing the number of costly appeals filed.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rule.

8.440.2 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT

8.440.2.A. The following general categories and examples of items and services are not included in the facility's per diem rate. Items 1 – 11 may be charged to the resident's personal needs funds if requested, in writing by a resident and/or the resident's family:

1. Cosmetic and grooming items and services in excess of those for which payment is allowed under the per diem rate, i.e., beauty permanents, hair relaxing, hair coloring, hair styling, hair curling, shaving lotion and cosmetics such as lipstick, perfume, eye shadow, rouge/blush, haircuts, beyond simple trimming, normally performed by licensed barbers or beauticians;

2. Gifts purchased on behalf of a resident;

3. Non-covered special care services, i.e., a private duty nurse not employed by the nursing facility., ~~prescribed by the resident's physician;~~

4. Items or services requested by the resident, including but not limited to, over the counter drugs/related items not prescribed by a physician, not included in the nursing care plan and not ordinarily furnished for effective patient care. In these instances, it is required that:

   a. The resident has made an informed decision supported by a statement in the Personal Needs Funds file that he/she/family is willing to use personal funds.

   b. The balance in the Personal Needs Funds in the resident's ledger is sufficient to cover the charge.

5. Personal clothing and dry cleaning;

6. Personal comfort items, including smoking materials, notions, novelties and confections/candies;

7. Personal reading material, subscriptions;

8. Private room;

9. Social events and entertainment offered off premises and outside the scope of the regular facility activities program;

10. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. If the resident refuses the prepared food the facility shall offer substitutes. Residents may be charged only for specially prepared food if they are informed that there will be a charge, and the charge may be only the difference in price between the requested item and the covered item pursuant to 42 C.F.R. 483.35.

11. Telephone, television/radio for personal use, if not equally available to all residents.

12. Provider fee.

13. Prescription drugs, with certain specific exemptions.

14. Ambulance and medical transport, including emergent and non-emergent.

15. Oxygen

16. Physician fees

17. Non-nursing costs, including but not limited to direct and indirect outpatient therapy, assisted living, independent living, adult day care and meals-on-wheels.

8.440.2.B. The Department's approval shall be required in order for a resident or his/her relatives to be billed for the following:

1. The physician orders that a full-time R.N. or L.P.N. is needed. The R.N. or L.P.N. is not employed by the nursing facility and has duties limited to the care of a particular resident, or two such residents in the same room.

2. The physician orders a private room.

3. The attending physician shall indicate the medical necessity on the resident's chart for either service above and shall submit to the Department a completed copy of Form 10013 (Physician's Request for Additional Benefits).

4. Upon approval of the Form 10013, payment for such services may be received from the resident's personal needs fund, relatives or others.

8.440.2.C The following items are allowable costs for class II and class IV facilities only:

1. Eye/Hearing examinations

2. Eyeglasses and repairs

3. Hearing aids and batteries

4. Provider fees

THIS PAGE NOT FOR PUBLICATION

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-01-09-B, Revision to the Medical Assistance Long Term Service and Supports Rule Concerning Provider Appeals, Section 8.050
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.050, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at §8.050.3 through §8.050.3.A with new text provided. All text indicated in blue is for context and clarity only and should not be changed. Replace current text from §8.050.4 through §8.050.4.A.5 with the new text provided. This revision is effective 05/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long Term Service and Supports Rule Concerning Provider Appeals, Section 8.050
Rule Number:	MSB MSB 14-01-09-B
Division / Contact / Phone:	Long Term Services and Supports / John Estes / 303-866-5453

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule lists the steps that nursing facilities must take to initiate the informal reconsideration process.

The current rule only addresses the process if a nursing facility receives a physical copy of notifications. With the department's recent efforts to increase the use of technology and electronic copies, there is a need to codify a new process for nursing facilities that addresses receipt of electronic copies as opposed to physical copies. This revision provides the legal support for delivering rate determinations to nursing facilities by electronic copy, and details the steps nursing facilities may take to challenge these determinations. This will provide the department insulation from legal liability when the department does issue notifications electronically. It will also enable the department to make full use of electronic notification, which will make both the department and nursing facilities more efficient.

Section 8.050.3 is being amended to remove an incorrect address.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);

Initial Review	**03/14/2014**	Final Adoption	**04/11/2014**
Proposed Effective Date	**06/01/2014**	Emergency Adoption	

DOCUMENT #02

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This rule change will affect Nursing Facility Providers. The removal of the incorrect address will affect other long term care providers as well.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   This rule change enables the Department to communicate electronically with Providers. This will enable Providers to more effectively and efficiently receive their rate determinations, and will clarify the dates for submitting a request for an informal reconsideration.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department or other agencies.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   By passing this rule, the Department will be able to submit rate determinations electronically to providers. This will save the Department costs associated with submitting print copies. Not changing the rule will cost the Department money and create confusion regarding deadlines for appealing rate determinations.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rule.

8.050.3 PROVIDER APPEALS ~~[Eff. 12/30/2008]~~

8.050.3.A. A Provider, other than a nursing facility whose notice of Adverse Action is regarding a rate determination, may appeal a notice of Adverse Action by filing a written appeal within thirty (30) calendar days from the date on the Notice of Adverse Action. The appeal shall be filed with the Office of Administrative Courts, Department of Personnel and Administration 1525 Sherman Street, Fourth Floor, Denver, CO 80203.~~., 633 Seventeenth Street, Suite 1300, Denver, Colorado 80202.~~

8.050.3.B. The appeal shall specify the basis upon which the Provider appeals the Adverse Action.

8.050.3.C. The date of filing the appeal shall be the date the Office of Administrative Courts receives the appeal. Failure to file a timely appeal shall result in dismissal of the appeal.

8.050.3.D. No recovery of an overpayment shall be implemented until the appeal process has been completed.

8.050.4 NURSING FACILITY RATE DETERMINATION APPEALS ~~[Eff. 12/30/2008]~~

8.050.4.A. Mandatory Informal Reconsiderations

1. A nursing facility, whose notice of Adverse Action results from its rate determination, may file a written request for informal reconsideration with the Department within 30 days of the date the rate determination letter is mailed or the date that the nursing facility is notified that an electronic copy of the rate determination letter is available for review, whichever is later. The request shall state, with specificity, the adjustments to the cost report the nursing facility wants reconsidered and the nursing facility's position as to each adjustment.

2. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.

3. When the first rate letter that incorporates a nursing facility's new appraised value is issued or made available electronically to the facility, the nursing facility may file a written request with the Department for informal reconsideration of the appraisal within thirty (30) days of the date on the rate letter or the date that the facility was notified that an electronic copy of the rate letter is available for review, whichever is later. Failure to file an informal reconsideration as set forth in this section shall cause any subsequent reconsideration or appeal of the appraisal at issue to be untimely and the reconsideration or appeal shall be dismissed.

4. Failure to file a written request for reconsideration as set forth in this section shall result in a waiver of the right to appeal the Adverse Action. Any issue not presented for informal reconsideration shall not be considered and shall not be appealable to the Office of Administrative Courts.

5. At informal reconsideration, the Provider shall not be allowed to present any information that was not submitted during the audit process prior to the issuance of the rate determination. The end of the audit process is defined as the expiration of the proposed adjustment review period as specified in section 10 CCR 2505-10 §§8.442.3.B and 8.442.3.C.

THIS PAGE NOT FOR PUBLICATION

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-01-09-C, Revision to the Medical Assistance Long Term Supports and Services Rule Concerning Health Care Reimbursement Rate Calculation, Section 8.443.7.A
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.443.7, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at the unnumbered paragraph following §8.443.7.A.1 with new text provided; replace the current text at the second unnumbered paragraph following §8.443.7.A.2 with new text provided; Replace current text at §8.443.7.A.5, 7, 9 and 11 with new text provided; add new text provided at §8.443.7.A.11.a and b; replace current text at the unnumbered paragraph following §8.443.7.A.11.b with new text provided. All text indicated in blue is for clarity and context only and should not be changed. This revision is effective 05/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long Term Supports and Services Rule Concerning Health Care Reimbursement Rate Calculation, Section 8.443.7.A
Rule Number:	MSB 14-01-09-C
Division / Contact / Phone:	Long Term Services and Supports / John Estes / 303-866-5453

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule lists the costs that may be considered health care costs for the purpose of calculating the per diem reimbursement rate.

The current rule requires owners and owner related parties to keep contemporaneous time logs in order to allocate the cost of their services to separate facilities. This is administratively burdensome on both the facility and department auditors. The proposed revision removes the burden by replacing this requirement with a simple formula intended to accurately reflect the cost, without the burden of contemporaneous time keeping. This may make both facilities and the department more efficient.

In Section A.2, admissions personnel was too broad a category for inclusion in the health care cost allocation. The change to admissions coordinator narrows this category to align with policy objectives.

In Section A.5, vaccinations are being explicitly included as health care services that may be reimbursed so that the rule is consistent with current practices.

In Section A.7, changes are being made to reflect the changing delivery of health care and the ubiquitous use of computers in direct and indirect delivery of healthcare. This change will allow Facilities to be reimbursed as a healthcare cost for the cost of computers and software used in the delivery of healthcare.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);

Initial Review	**03/14/2014**	Final Adoption	**04/11/2014**
Proposed Effective Date	**06/01/2014**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long Term Supports and Services Rule Concerning Health Care Reimbursement Rate Calculation, Section 8.443.7.A
Rule Number:	MSB 14-01-09-C
Division / Contact / Phone:	Long Term Services and Supports / John Estes / 303-866-5453

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This rule change will impact Nursing Facility Providers.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   There will be no costs to providers, but the rule will simplify and clarify the allocation of costs into the appropriate cost center for the purpose of reimbursement.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The rule change will simplify and clarify the allocation of costs, reducing the administrative burden, auditing burden, and likely resulting in fewer appeals of reimbursement rates.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods for achieving the rule's purpose.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the rule's purpose.

8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION

8.443.7.A Health Care Services Defined: Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides, feeding assistants, registered dietician, MDS coordinators, nursing staff development personnel, nursing administration (not clerical) case manager, patient care coordinator, quality improvement, clinical director. These personnel shall be appropriately licensed and/or certified, although nurse aides may work in any facility for up to four months before becoming certified.

   If a~~n~~ facility employee or a management company/home office employee or owner has dual health care and administrative duties ~~(i.e. Admissions and Marketing)~~, the provider must keep contemporaneous time records or perform time studies to verify hours worked performing health care related duties. If no contemporaneous time records are kept or time studies performed, total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will be classified as administrative and general. Licenses are not required unless otherwise specified. Periodic time studies in lieu of contemporaneous time records may be used for the allocation. Time studies used must meet the following criteria:

   a. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

   b. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

   c. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

   d. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

   e. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

   f. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.

   Health Information Managers (Medical Records Librarians): Must work directly with the maintenance and organization of medical records.

   Social Workers: Includes social workers, life enhancement specialists and admissions ~~personnel~~coordinators.

Central or Medical Supply personnel: Includes duties associated with stocking and ordering medical and/or central supplies.

Activity personnel: Personnel classified as "activities" must have a direct relationship (i.e., providing entertainment, games, and social opportunities) to residents. For instance, security guards and hall monitors do not qualify as activities personnel. Costs associated with security guards and hall monitors are classified as administrative and general.

3. If the provider's chart of accounts directly identifies payroll taxes and benefits associated with health care versus administrative and general cost centers, the amounts directly identified will be appropriately allowed as either health care or administrative and general. If these costs are comingled in the chart of accounts, payroll taxes and benefits shall be allocated to the cost centers (health care and administrative and general) based on total employee wages reported in those cost centers. The reporting method for payroll taxes and benefits by cost center is required to be consistent from year to year. When a provider wishes to change its reporting method because it believes the change will result in more appropriate and a more accurate allocation, the provider must make a written request to the Department for approval of the change ninety (90) days prior to the end of that cost reporting period. The Department has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. If the Department approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods. The approval will be for a minimum three year period. The provider can not change methods until the three year period has expired.

4. Personnel licensed to perform patient care duties shall be reported in the administrative and general cost center if the duties performed by these personnel are administrative in nature.

5. Non-prescription drugs ordered by a physician that are included in the per diem rate, including costs associated with vaccinations.~~.~~

6. Consultant fees for nursing, medical records, registered dieticians, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.

7. Purchases, rental, depreciation, interest and repair expenses of health care equipment and medical supplies used for health care services such as nursing care, medical records, social services, therapies and activities. Purchases, lease expenses or fees associated with computers and software (including the associated training and upgrades) used in departments within the facility that provide direct or indirect health care services to residents. Dual purpose software that includes both a health care and administrative and general component will be considered a health care service.

8. Purchase or rental of motor vehicles and related expenses, including salary and benefits associated with the van driver(s), for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs if there is dual purpose. An example of the dual purpose vehicle is one used for both resident transport and maintenance activities.

9. Copier lease expense.~~, computers and software used in the departments classified as health care, as documented by appropriate logs or other auditable documentation.~~

10. Salaries, fees, or other expenses related to health care duties performed by a facility owner or manager who has a medical or nursing credential. Note that costs associated with the Nursing Home Administrator are an administrative and general cost.

11. Related Party Management Fees and Home Office Costs

Related party management fees and home office costs shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the related party which are listed in this section, may be included in the health care cost center equal to the actual costs incurred by the related party. ~~To be included in the health care cost center, the provider must show a direct relationship between the health care costs incurred and the facility receiving the services. Allocations, time studies or estimates will not be allowed. For example, home office or management company nurses must keep contemporaneous time logs in 15 minute increments supporting the number of hours worked at each facility. In addition, d~~Documentation supporting the ~~nurse's~~ cost and health care licenses must be maintained. Only salaries, payroll taxes and employee benefits associated with health care personnel will be considered as allowable in the health care cost center. No overhead expenses will be included. ~~The provider will report health care costs either by:~~ The amount allowable in the health care cost category will be calculated in one of two ways:

a. Keeping contemporaneous time logs in 15 minute increments supporting the number of hours worked at each facility.

b. Distributing the cost evenly across all facilities as follows: the amount allowable in each health care facility's health care costs shall be equal to the total salary, payroll taxes and benefits of the health care personnel divided by the number of facilities where the health care personnel worked during the year. For example, if a nurse's total salary, payroll taxes, and benefits total $80,000, and the nurse worked ~~at~~on five facilities during the year, $16,000 is allowable in each of the facility's health care costs.

Auditable documentation supporting the number of facilities worked on during the year must be maintained. Even if a related party exception is granted in accordance with CCR 8.441.5.I.4, no mark-up or profit will be allowed in the health care cost center, only supported actual costs.

Non-Related Party Management Fees

Non-related party management fees shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the management company which are listed in this section, may be included in the health care cost center. Management contracts which specify percentages related to health care services will not be considered a direct charge from the management company.

12. Professional liability insurance, whether self-insurance or purchased, loss settlements, claims paid and insurance deductibles.

13. Medical director fees.

14. Therapies and services provided by an individual qualified to provide these services under Federal Medicare/Medicaid regulations including:

Utilization review

Dental care, when required by federal law

Audiology

Psychology and mental health services

Physical therapy

Recreational therapy

Occupational therapy

Speech therapy

15. Nursing licenses and permits, disposal costs associated with infectious material (medical or hazardous waste), background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

16. Food Costs. Food costs means the cost of raw food, and shall not include the costs of property, staff, preparation or other items related to the food program.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long Term Supports and Services Rule Concerning Reimbursement for Administrative and General Costs, Section 8.443.8.A
Rule Number:	MSB 14-01-10-B
Division / Contact / Phone:	Long Term Services and Supports / John Estes / 303-866-5453

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-01-10-B, Revision to the Medical Assistance Long Term Supports and Services Rule Concerning Reimbursement for Administrative and General Costs, Section 8.443.8.A
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.443.8, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at §8.443.8.A.7 with new text provided. All text indicated in blue is for clarity and context only and should not be changed. This revision is effective 05/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long Term Supports and Services Rule Concerning Reimbursement for Administrative and General Costs, Section 8.443.8.A
Rule Number:	MSB 14-01-10-B
Division / Contact / Phone:	Long Term Services and Supports / John Estes / 303-866-5453

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule defines which costs must be considered administrative and general for the purpose of calculating the per diem reimbursement rate.

   The current rule is ambiguous with how it allocates computer service fees and software costs. This revision will clarify how these costs are to be allocated. Clarifying how we treat these costs may reduce the number of appeals, and will make it easier for nursing facilities to comply with the regulations. It will also simplify the task of auditors.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   C.R.S. §25.5-6-201 et seq

Initial Review	**03/14/2014**	Final Adoption	**04/11/2014**
Proposed Effective Date	**06/01/2014**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long Term Supports and Services Rule Concerning Reimbursement for Administrative and General Costs, Section 8.443.8.A
Rule Number:	MSB 14-01-10-B
Division / Contact / Phone:	Long Term Services and Supports / John Estes / 303-866-5453

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Nursing Facility providers will be affected by the proposed rule. This rule will simplify the allocation of costs to the appropriate cost center for the purpose of reimbursement.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The proposed rule will minimally impact provider's economic interests, but it will simplify and clarify their allocation of costs. This will reduce uncertainty and costly appeals.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   This will have no cost to the Department.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   There are no costs associated, but both the Department and providers will benefit from increased clarity and fewer appeals of reimbursement rates.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly methods for achieving the rule's purpose.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose for the proposed rule.

8.443.8 REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL COSTS

8.443.8.A. Administration Costs means the following categories of reasonable, necessary and patient-related costs:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other clerical help, hall monitors, security guards, janitorial and plant staff and food service staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records or perform a time study in order to properly allocate their salaries between cost centers. Time studies used must meet the criteria described in 8.443.7.A.1.

2. Any portion of other staff costs directly attributable to administration.

3. Advertising and public relations.

4. Recruitment costs and staff want ads for all personnel.

5. Office supplies.

6. Telephone costs.

7. Purchased services: accounting fees, legal fees; computer network infrastructure fees. Computers and software used in administrative and general departments. ~~services. A computer service refers to any costs associated with the information technology system such as repair, maintenance and upgrades.~~

8. Management fees and home office costs, except as described in 8.443.7.A.13.

9. Licenses and permits (except health care licenses and permits) and training for administrative personnel, dues for professional associations and organizations.

10. All business related travel of facility staff and consultants, except that required for transporting residents to activities or for medical purposes.

11. Insurance, including insurance on vehicles used for resident transport, is an administrative cost. The only exception is professional liability insurance, which is a health care cost.

12. Facility membership fees and dues in trade groups or professional organizations.

13. Miscellaneous general and administrative costs.

14. Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.

15. Purchases (including depreciation and interest), rentals, repairs, betterments and improvements of equipment utilized in administrative departments, including but not limited to the following:

    Resident room furniture and decor, excluding beds and mattresses

    Office furniture and decor

Dining room and common area furniture and decor

Lighting fixtures

Artwork

Computers and related software used in administrative departments

16. Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below.

17. All other reasonable, necessary and patient-related costs which are not specifically set forth in the description of "health care services" above, and which are not property, room and board, food or capital-related assets.

18. Background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

19. Provider fees for Class II and Class IV facilities.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Service and Supports Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201
Rule Number:	MSB 14-01-22-A
Division / Contact / Phone:	Medicaid Programs & Services / Max Salazar / 3289

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-01-22-A, Revision to the Medical Assistance Health Programs Service and Supports Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.201, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Replace current text beginning at §8.201 ‘DENTAL SERVICES’ through the end of §8.201.4.A.2 with new text provided beginning at §8.201 ‘DENTAL SERVICES’ through the end of the unnumbered paragraph following §8.201.6. This revision is effective 07/01/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Service and Supports Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201
Rule Number:	MSB 14-01-22-A
Division / Contact / Phone:	Medicaid Programs & Services / Max Salazar / 3289

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Colorado Senate Bill 13-242 requires that the Department create a limited adult dental benefit. The Department engaged in a Benefits Collaborative Process to define the amount, scope and duration of this new benefit. This rule therefore implements the full dental benefit.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   §§ 25.5-1-301-303, C.R.S. (2013);
   § 25.5-5-201(1)(w), C.R.S. (2013).

Initial Review	**03/14/2014**	Final Adoption	**04/10/2011**
Proposed Effective Date	**07/01/2014**	Emergency Adoption	

DOCUMENT #06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Service and Supports Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201
Rule Number:	MSB 14-01-22-A
Division / Contact / Phone:	Medicaid Programs & Services / Max Salazar / 3289

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Colorado currently provides a dental benefit to children 21 years of age and younger in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

This rule will enable the Department to provide adult Medicaid clients 21 and older the full dental services (such as x-rays, cleanings and fillings) that were defined in the Benefits Collaborative.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Research has shown that untreated oral health conditions negatively affect a person's overall health and that gum disease has been linked to diabetes, heart disease, strokes, kidney disease, Alzheimer's disease, and even mental illness.

Regular dental care and prevention are the most cost-effective methods available to prevent minor oral conditions from developing into more complex oral and physical health conditions that would eventually require emergency and palliative care.

A 2012 report from the Pew Center on the States found that preventable dental conditions were the primary diagnosis in 830,590 visits to emergency departments nationwide in 2009.

For FY 2013-14, the Department anticipates emergency dental services costs will be $12.7 million. The introduction of a limited adult dental benefit should reduce emergency dental service costs by 15 percent, or $1.9 million, in FY 2013-14 and 30 percent, or $4.0 million, in FY 2014-15. Additional medical savings can be expected.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

SB 13-242 created the Adult Dental Fund. The transfer of funds from the Unclaimed Property Trust Fund to the Adult Dental Fund is authorized to pay state costs associated with the provision and administration of the adult dental benefit. It is expected to cover the projected cost of the benefit. The Adult Dental Fund may retain interest earnings and unexpended moneys at the end of each fiscal year.

Dental benefits will be capped at $1,000 per client. The fiscal note that accompanied SB 13-242 assumes that clients will use an average of $627 in dental benefits per year. Of the eligible population, The Department estimates approximately 27 percent of eligible clients will use dental benefits, which is prorated in the first year. As a result, caseload is estimated at 43,043 in FY 2013-14 and 82,072 in FY 2014-15.

Total adult dental benefit costs are $28.8 million in FY 2013-14 and $58.8 million in FY 2014-15. However, a portion of the adult dental benefit costs are assumed to be offset by reduced emergency dental services. The fiscal note assumes savings of 15 percent, or $1.9 million, in FY 2013-14 and 30 percent, or $4.0 million, in FY 2014-15.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

See items #2 and #3.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

This rule is legislatively mandated and the state share is fully funded by monies collected as part of the Unclaimed Property Tax Fund - now the Adult Dental Fund.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There were no alternative methods for achieving the purpose of this proposed rule as it was legislatively mandated.

8.201 DENTAL SERVICES

8.201.1 DEFINITIONS

Adult Client means an individual who is 21 years or older and eligible for medical assistance benefits.

Comprehensive Oral Evaluation means a thorough evaluation and documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

~~Concurrent Medical Condition means a pre-existing medically-diagnosed state that can be exacerbated by a condition present in the oral cavity.~~

Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation, as defined by the Current Dental Terminology (CDT) (2014).

Endodontic services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues.

Emergency Services means the need for immediate intervention by a physician, osteopath or ~~dentist~~ dental professional to stabilize an oral cavity condition. Immediate Intervention or Treatment means services rendered within twelve (12) hours.

Evaluation means a patient assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions, as defined by the CDT (2014).

Fiscal Year refers to the State Fiscal Year (SFY) July 1 to June 30.

Oral Cavity means the jaw, mouth or any structure contiguous to the jaw.

Palliative Treatment for Dental Pain means emergency treatment to relieve the client of pain; not a mechanism for addressing chronic pain.

Preventive services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries, as defined by the CDT (2014).

Restorative means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic requirements of the client, as defined by the CDT (2014).

~~Fiscal Year refers to the State Fiscal Year (SFY) July 1 to June 30.~~

8.201.2 BENEFITS

~~8.201.2.A Treatment of a Condition of the Oral Cavity for Adult Clients with a Concurrent Medical Condition is a benefit.~~ Covered Services

~~1. Allowable Concurrent Medical Conditions include:~~

~~a. Neoplastic disease requiring chemotherapy and/or radiation.~~

~~b. Pre and post organ transplant.~~

~~c. Pregnancy.~~

~~d. Chronic medical condition in which there is documentation that the medical condition is exacerbated by a Condition of the Oral Cavity.~~

~~8.201.2.B. Covered Services~~

~~Subject to 8.201.2.B, evaluations, diagnostic imaging, preventive, and restorative services shall be available for all adult clients. Emergency Treatment as defined in 8.201.1 is a covered service. The dental benefit for children age 20 and under are defined at 8.280 (EPSDT).~~

1. Covered Evaluation Procedures:

a. Periodic Oral Evaluation, two (2) per fiscal year.

b. Limited Oral Evaluations are available to clients presenting with a specific oral health condition or problem.

i. If rendered by the same dental provider or the same dental practice, ~~s~~shall be deemed as one of two (2) periodic oral evaluations allowed ~~-~~per fiscal year.

ii. Dental hygienists may only provide limited oral evaluations for a client of record.

c. Comprehensive Oral Evaluation, new clients only, one (1) every three (3) fiscal years.

d. Comprehensive Periodontal Oral Evaluation, one (1) every three (3) fiscal years.

2. Covered Diagnostic Imaging Procedures:

a. Intra-oral; complete series, one per five (5) fiscal years; minimum of ten (10) (periapical or bitewing) films. Counts as one set of bitewings per fiscal year.

b. Intra-oral first periapical x-ray, six (6) per five (5) fiscal years. Providers may not bill the same day as full mouth series.

c. Each additional periapical x-ray. Providers may not bill the same day as a full mouth series. Working and final treatment films for endodontics are not covered.

d. Bitewing; single image, one set per fiscal year; one set is equal to two (2) to four (4) films.

e. Bitewing; two images, one set per fiscal year; one set is equal to two (2) to four (4) films.

f. Bitewing; three images, one set per fiscal year; one set is equal to two (2) to four (4) films.

g. Bitewing; four images, one set per fiscal year; one set is equal to two (2) to four (4) films.

h. Vertical bitewings; seven (7) to eight (8) images, as one (1) every five (5) fiscal years. Counts as a full mouth series.

i. Panoramic image; with or without bitewing, one (1) per five (5) fiscal years. Counts as full mouth series

3. Covered Preventive Services

Clients determined to fit into a high ~~-~~risk category, as described below, are eligible for any combination of the following periodontal maintenance and cleanings, but are limited to a maximum of ~~up to~~ four (4) per fiscal year:

a. Adult Cleaning, two (2) per fiscal year; unless client falls into a high risk category.

i. Clients at high risk for periodontal disease or for caries may receive up to four (4) cleanings per fiscal year. High risk is indicated by:

1. active and untreated caries (decay) at the time of examination;

2. history of periodontal scaling and root pla~~n~~ning;

3. history or periodontal surgery;

4. diabetic diagnosis; or

5. pregnancy.

b. Fluoride varnish, two (2) per fiscal year for clients with:

i. dry mouth; and/or

ii. history of head or neck radiation; or

iii. high caries risk. High risk is indicated by active and untreated caries (decay) at the time of examination. If, at the end of the fiscal year they no longer have active decay, they are no longer considered high risk.

c. Topical fluoride, two (2) per fiscal year for clients with:

i. dry mouth; and/or

ii. history of head or neck radiation; or

iii. high caries risk. High risk is indicated by active and untreated caries (decay) at the time of examination. If, at the end of the fiscal year they no longer have active decay, they are no longer considered high risk.

4. Minor Restorative Services.

The occlusal surface is exempt from the three (3) fiscal year frequency limitations listed below when a multi-surface restoration is required or following endodontic therapy.

a. One surface amalgam (silver filling), one (1) time per surface per tooth every three (3) fiscal years.

b. Two (2) surface amalgam (silver filling), one (1) time per surface per tooth every three (3) fiscal years.

c. Three (3) surface amalgam (silver filling), one (1) time per surface per tooth every three (3) fiscal years.

d. Four (4) surface amalgam (silver filling), one (1) time per surface per tooth every three (3) fiscal years.

e. One (1) surface anterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.

f. Two (2) surface anterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.

g. Three (3) surface anterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.

h. Four (4) surface anterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.

i. Resin based composite crown (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.

j. One (1) surface posterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.

k. Two (2) surface posterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.

l. Three (3) surface posterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.

m. Four (4) surface posterior composite (tooth-colored filling), one (1) time per surface per tooth every three (3) fiscal years.

5. Major Rrestorative Ssservices

a. The following crowns are covered:

i. Single crowns, one (1) per tooth every seven (7) fiscal years.

ii. Core build-up; building, one per tooth every seven (7) fiscal years.

iii. Pre-fabricated post and core, one per tooth every seven (7) fiscal years.

b. Crowns are covered services only when:

i. The tooth is in occlusion; and

ii. The cause of the problem is either decay or fracture; and

iii. The tooth is not a second or a third molar.

1. The second molar is covered if it meets all of the above criteria and it is necessary to support a partial denture or to maintain eight (8) posterior teeth or more -(artificial or natural) in occlusion; and

iv. The client's record reflects evidence of good and consistent oral hygiene; and either one of the following is also true:

v. The tooth in question requires a multi-surface restoration and ~~when~~ it cannot be restored with other restorative materials; or

vi. A crown is requested for cracked tooth syndrome and the tooth is symptomatic and appropriate testing and documentation is provided.~~;~~ ~~and/or~~

c. Crown materials are limited to porcelain and noble metal on anterior teeth and premolars.

6. Endodontic Services

a. The following endodontic procedures are covered:

i. Root canal; anterior tooth, one (1) per tooth per lifetime.

ii. Root canal; premolar, one (1) per tooth per lifetime.

iii. Root canal; molar, one (1) per tooth per lifetime.

iv. Pulpal debridement, one (1) per tooth per lifetime:

1. Covered in emergency situations only;

2. Is exempt from prior authorization process but may be subject to post-treatment and pre-payment review.

v. Retreatment of previous root canal therapy; anterior tooth, one (1) per lifetime; only if original treatment not paid by Colorado Medicaid.

vi. Retreatment of previous root canal therapy; premolar tooth, one (1) per lifetime; only if original treatment not paid by Colorado Medicaid.

vii. Retreatment of previous root canal therapy; molar tooth, one (1) per lifetime; only if original treatment not paid by Colorado Medicaid.

b. Endodontic procedures are covered services when:

i. The tooth is not a second or third molar. Root canals for third molars are not covered; root canals for second molars are coversed only when the second molar is essential to keep eight posterior teeth or more in occlusions or when it is necessary to support a partial denture; and/or

ii. The tooth is in occlusion; and/or

iii. A root canal is requested for cracked tooth syndrome and the tooth is symptomatic and appropriate testing and documentation is provided; and

iv. The client's record reflects evidence of good and consistent oral hygiene; and

v. the cause of the problem is either decay or fracture.

c. In all instances in which the client is in acute pain, the dentist should take the necessary steps to relieve the pain and complete the necessary emergency treatment. In these instances, there may not be time for prior authorization. Such emergency procedures may be subject to post-treatment and pre-payment review.

d. Working films (including the final treatment film) for endodontic procedures are considered a part of the procedure and will not be paid for separately. ~~are not paid separately~~.

7. Periodontal Treatment

a. Periodontal scaling and root pla~~n~~ning; four (4) or more teeth per quadrant, once per quadrant every three (3) fiscal years.

i. Prophylaxis is not paid on the same day.

ii. No more than two (2) quadrants per day.

b. Periodontal scaling and root plan~~n~~ing/ one (1) to three (3) teeth per quadrant, once per quadrant every three (3) fiscal years.

i. Prophylaxis is not paid on the same day.

ii. No more than two (2) quadrants per day.

c. Periodontal maintenance, two (2) times per fiscal year; counts as a cleaning.

i. Can only be approved when history of periodontal disease as evidenced by a history of scaling and root pla~~n~~ning and/or osseous surgery.

ii. Clients with diabetes and pregnant women with histories of periodontal disease are entitled to four (4) per fiscal year.

d. Clients who are determined to fit into the high risk category, are eligible for any combination of periodontal maintenance and cleanings, up to four (4) per fiscal year.

8. Removable Prosthetics

Removable ~~prostehtics~~prosthetics are not covered if eight posterior teeth or more (natural or artificial) are in occlusion. Anterior teeth are covered, irrespective of the number of teeth in occlusion. ~~Removable~~Removable prosthetics covered include:

a. Removable partial upper denture; resin based, one (1) time every seven (7) fiscal years.

b. Removable partial lower denture; resin based, one (1) time every seven (7) fiscal years.

c. Removable partial upper denture; cast metal framework, one (1) time seven (7) fiscal years.

d. Removable partial lower denture; cast metal framework, one (1) time every seven (7) fiscal years.

e. Removable partial upper denture; flexible base, one (1) time every seven (7) fiscal years

f. Removable partial lower denture; flexible base, one (1) time every seven (7) fiscal years.

9. Oral surgery, palliative treatment and anesthesia

a. The following surgical and palliative ~~treatements~~treatments are covered:

i. Simple extraction, one (1) time per tooth.

ii. Surgical extraction, one (1) time per tooth.

iii. Incision and drainage, as needed

iv. Minor surgical procedures to prepare the mouth for removable prostheses, one (1) time per lifetime per quadrant.

v. Palliative treatment of dental pain.

1. Not payable on the same visit as any definitive treatment codes; except for covered service necessary for diagnosis.

vi. Deep sedation; general anesthesia.

1. Only covered when there is sufficient evidence to support medical necessity.

2. General anesthesia and/or deep sedation is not covered when it is for the preference of the client or the provider and there are no other medical considerations.

b. In all instances in which the client is in acute pain, the dentist should take the necessary steps to relieve the pain and complete the necessary emergency treatment. In these instances, there may not be time for prior authorization. Such emergency procedures may be subject to post-treatment and pre-payment review.

c. Biopsies are covered only in instances where there is a suspicious lesion.

d. Removal of third molars is only covered in instances of acute pain and overt symptomatology.

8.201.2.B. Exclusions.

1. The following services/treatments are not a benefit for Adult Clients under any circumstances:

a. ~~c.~~ Cosmetic Procedures.

b~~a~~. Inlay and onlay restorations.

c~~b~~. ~~Crowns.~~Crowns in the following categories:

i. Cosmetic Crowns;

ii. Multiple units of crown and bridge;

iii. To restore vertical dimension;

iv. When client has active and advanced periodontal disease;

v. When the tooth is not in occlusion; or

vi. When there is evidence of periapical pathology

dc. Treatment of the Oral Cavity in preparation for ~~partial or~~ full mouth dentures.

ed. Assessment for~~,~~ delivery of dentures or subsequent adjustments to dentures and bridges.

fe. Implants.

g. Screening and assessment.

h. Periodontal surgery.

i. Protective restorations.

j. Full mouth debridement.

k. Graft procedures.

l. Endodontic surgery.

m. Treatment for temporomandibular joint disorders.

n. General Biopsies.

o. Orthodontic treatment.

p. Tobacco cessation counseling.

q. Oral hygiene instruction.

r. Dentures

s. Any service that is not listed as covered.

8.201.3 PRIOR AUTHORIZATION REQUEST

1. Emergency Services do not require a prior authorization before services can be rendered.

2. The following services require prior authorization:

a. Single crowns; core build-ups; post and cores

b. Partial dentures

c. Scaling and root planing

d. Root canals; prior authorization is not required for pulpal debridement in instances of acute pain

e. Non-emergency surgical extractions

f. Minor surgical procedures

g. General anesthesia and deep sedation except in instances of acute pain or medical necessity.

8.201.4. PROVIDER REQUIREMENTS/REIMBURSEMENT

8.201.4.A. Dental services shall only be provided by a licensed dentist or dental hygienist who ~~are~~is enrolled with Colorado Medicaid. Providers shall only provide covered services that are within the scope of their practice. ~~To submit claims for treatment of oral medical conditions for Adult Clients, the provider shall meet one of the following requirements:~~

~~1. Enroll as a physician and bill according to all medical billing requirements including using Current Procedural Terminology (CPT) codes.~~

~~2. Enroll as a dental provider and bill according to all dental billing requirements including using Current Dental Terminology (CDT) codes.~~

8.201.5 Eligible Clients

Dental services described in 8.201.2 shall be available to Adult Clients age 21 years and older.

8.201.6 Annual Limits

Dental services for adults 21 years of age and older are limited to a total of $1,000 per adult Medicaid recipient per state fiscal year. A client may make personal expenditures for services beyond the $1,000 annual limit and shall be charged the lower of the Medicaid Fee Schedule or submitted charges.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Special Financing Division Rule Concerning the Old Age Pension Health Care Program Dental Benefit, Section 8.940
Rule Number:	MSB 14-01-24-A
Division / Contact / Phone:	Special Financing Division / Karen Talley / 303-866-3170

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-01-24-A, Revision to the Medical Assistance Special Financing Division Rule Concerning the Old Age Pension Health Care Program Dental Benefit, Section 8.940
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Section 8.941, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text beginning at §8.940 'OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM' through the end of the third unnumbered paragraph following §8.941.10 with new text provided beginning at 8.940 'OLD AGE PENSION HEALTH CARE PROGRAM through the end of the third unnumbered paragraph following §8.941.10. This revision is effective 05/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Special Financing Division Rule Concerning the Old Age Pension Health Care Program Dental Benefit, Section 8.940
Rule Number:	MSB 14-01-24-A
Division / Contact / Phone:	Special Financing Division / Karen Talley / 303-866-3170

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Under the Old Age Pension State Only Program, the following State funded benefits are provided: physician and practitioner services, inpatient hospital, outpatient services, lab and x-ray, emergency transportation, emergency dental, pharmacy, home health services and supplies, and Medicare cost sharing. Currently, Old Age Pensioners receive an emergency dental benefit. The proposed rule change will provide a dental benefit that mirrors the new adult Medicaid benefit.

The proposed rule will also delete obsolete language referencing the Old Age Pension Health Care Supplemental Program. Funding for the Supplemental Program was abolished through SB 11-210 in July 2012. The proposed rule also deletes language that references reimbursement rates. This language will be replaced with language added that states information pertaining to reimbursement rates is published in the Provider Bulletin.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   §§25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   § 25.5-2-101, C.R.S. (2013); Colo. Const. Art. XXIV

Initial Review	**03/14/2014**	Final Adoption	**04/10/2014**
Proposed Effective Date	**07/01/2014**	Emergency Adoption	

DOCUMENT #07

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Special Financing Division Rule Concerning the Old Age Pension Health Care Program Dental Benefit, Section 8.940
Rule Number:	MSB 14-01-24-A
Division / Contact / Phone:	Special Financing Division / Karen Talley / 303-866-3170

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The classes of persons that will be affected by and benefit from the proposed rule change would be individuals receiving Old Age Pension grants who do not qualify for Medicaid.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Under existing appropriations, the proposed rule will facilitate access to needed dental benefits to Old Age Pensioners.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   Current budget projections reflect that this benefit can be covered under existing appropriation. Funding for the Old Age Pension Health Care Program is established in the Colorado State Constitution and other legislative appropriation bills. There is no impact on state revenues.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The proposed rule will facilitate greater access for Old Age Pensioners to needed dental benefits, while costing the state nothing extra. It is projected that the dental benefits proposed can be covered under existing appropriations. By contrast, inaction will mean continued reliance on emergency dental care versus comprehensive dental care; which over a period of time will prove to be less costly for the State, but will adversely affect clients.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There is not a less costly method for achieving the purpose of the proposed rule. Offering a dental benefit that mirrors the Adult Medicaid benefit is the most efficient method.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   No alternatives were considered. The proposed rule change will provide a dental benefit that mirrors the new adult Medicaid benefit.

8.940 OLD AGE PENSION HEALTH CARE PROGRAM ~~AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM~~

8.941 EXTENT AND LIMITATIONS OF MEDICAL CARE

8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM ~~AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM [Eff. 06/30/2009]~~

In accordance with the Constitution of Colorado, ~~Title~~ Article XXIV, Section 7, and the Colorado Social Services Act, an Old Age Pension Health Care Program is established to provide necessary medical care for the Old Age Pension recipients who do not qualify for Medicaid under Title XIX of the Social Security Act and Colorado statutes. The State Department is designated as the single State agency to administer the program.

~~The Old Age Pension Health Care Supplemental Program is authorized by Colorado Revised Statues, Section 26-2-117, C.R.S. The funding for this program cannot be accessed until all funds in the Old Age Pension Health Care Program are exhausted.~~

A. The Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~ provides optional benefits to clients who qualify for (State only) OAP-A and (State only) OAP-B pensions who do not qualify for Federal Financial Participation in the Colorado Medicaid Program. These cases are coded with Supplemental Income Status Code (SISC) C.

B. Under the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~, only the following State funded benefits are provided: physician and practitioner services, inpatient hospital, outpatient services, lab and x-ray, emergency transportation, emergency dental, dental, pharmacy, home health services and supplies, and Medicare cost sharing.

   Effective January 1, 2006, Medicare Part D prescription drugs provided pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (defined at 42 U.S.C. Sections 1395w-102 and 141 and 42 C.F.R. Section 423, et seq.) shall not be a benefit for those individuals who are eligible for both Medicare and the Old Age Pension Health Care Program ~~or the Old Age Pension Health Care Supplemental Program~~. The pharmacy drug benefit under the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~ shall follow Medicaid regulations, as specified under ~~8.830~~10 CCR 2505-10, Section 8.800.

   For the benefits listed above, the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~ shall only be used to provide clients with health care services determined to be medically necessary by the health care provider.

C. All other medical benefits not listed in paragraph B are excluded under the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~. Inpatient care in an institution for tuberculosis or mental diseases, skilled and intermediate nursing facility services, and home and community based services are also excluded.

D. The Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~ eligibility shall not be retroactive. Eligibility shall begin with the date of application or date eligibility is established, whichever is later.

E. The Executive Director of the Department of Health Care Policy and Financing, under the direction of the State Medical Services Board, shall manage the Old Age Pension Health and Medical Care fund ~~and the supplemental Old Age Pension Health and Medical Care fund~~ to assure that utilization controls and other mechanisms are in place in order to hold expenditures within the constitutional and statutory limits.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will exceed the available funds, he/she shall take action to reduce expenditures as needed by reducing, suspending, or eliminating payments for covered benefits.

The Executive Director shall consider reducing, suspending or eliminating benefits, individually or in any combination, based upon the shortest duration of time and considering the least impact on the client. The Executive Director shall report to the Board whenever such action is required, specifying the dollar impact, length of time for the reduction, and the number of clients and providers affected. In addition, the Executive Director shall report to the Board on the feasibility of other cost reduction options.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will be less than the available funds, he/she may take action to increase expenditures up to constitutional and statutory limits by modifying the reimbursement methodology for covered benefits. In addition, the Executive Director shall report to the Board whenever such action is taken.

F. Counties shall provide information to Old Age Pension Health Care Program clients regarding the disposal of excess resources in order to qualify for the Medicaid program. Such information shall include advisements concerning the prohibition of transfer of assets without fair consideration.

G. If Medicare pays for a medical service that is a non-benefit for this group, the co-insurance and deductible will not be paid by the Old Age Pension Health Care Program ~~or the Old Age Pension Health Care Supplemental Program~~.

8.941.2 DEFINITION

Throughout this section of the rules, all references to "medical" shall mean the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~. Exceptions will be noted in the specific rule. All forms of communication to providers, counties and recipients (Provider bulletins, claim forms, authorization forms, Medicaid Authorization Card (MAC etc.), ~~and all forms of communication to providers, counties and recipients~~ shall include Colorado Medical Assistance Program, and Old Age Pension Health Care Program~~, and the Old Age Pension Health Care Supplemental Program~~.

8.941.3 GROUPS ASSISTED UNDER THE OLD AGE PENSION HEALTH CARE PROGRAM ~~AND THE OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM~~

Old Age Pension Health Care Program ~~and the Old Age Pension Health Supplemental Program~~ benefits are provided to persons receiving OAP A, OAP-B, and OAP refugees who do not meet SSI eligibility criteria, but do meet the State eligibility criteria for the Old Age Pension Health Care Program. These persons qualify for a SISC Code C.

A. SISC Code C – this code is for persons eligible to receive financial assistance under OAP-A, OAP-B, or OAP Refugee Assistance, who do not receive an SSI payment, and do not otherwise qualify for the Colorado Medicaid Program. Code C signifies that no FFP is available in medical assistance program expenditures.

B. Recipients of financial assistance under State AND, State AB or OAP "C" are not eligible for assistance under the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~.

8.941.4 FINANCIAL ASSISTANCE

All rules applicable to Old Age Pension financial assistance program payments (as set forth in the Department of Human Services rules at 9 CCR 2503-~~1~~3 shall apply to the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~.

8.941.5 CERTIFICATION OF PAYMENT FOR PROVIDERS

All providers of medical services in their submission of claim to the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~ certify that, "I will accept as payment in full, payment made under the Old Age Pension Health Care Program, and certify that no supplemental charges have been, or will be, billed to the patient, except for those non-covered items, or services, if any, which are not reimbursable under the Old Age Pension Health Care Program ~~or the Old Age Pension Health Care Supplemental Program~~."

8.941.6 GENERAL EXCLUSIONS

In addition to any specific exclusion defined in this manual, the general exclusions from coverage of the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~ defined by the rules of the Department of Human Services (9 CCR 2503-1) are also excluded. *[Eff 03/04/2007]*

8.941.7 OUT-OF-STATE MEDICAL CARE

All requirements for out~~-~~ of~~-~~ state medical care as defined by 10 CCR 2505-10, Section 8.013 ~~the rules in this manual~~ apply to the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~ for covered services with the exception that any reduction, suspension or elimination of benefits must be applied. *[Eff 03/04/2007]*

8.941.8 SUBMISSION OF CLAIMS

Rules governing the submission or payment of claims, provider or recipient appeals, third party liability, overpayment, fraud and abuse, and State identification numbers as defined in ~~this manua~~10 CCR 2505-10, Section 8.000, et seq.~~l~~ apply to the Old Age Pension Health Care Program ~~and the Old Age Pension Health Care Supplemental Program~~ for covered services with the exception that any reduction, suspension or elimination of benefits provided must also be applied. *[Eff 03/04/2007]*

8.941.9 REIMBURSEMENT TO PROVIDERS [Eff. 06/30/2009]

~~As of July 1, 2007, the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program will reimburse inpatient hospital services at 10% of the appropriate Medicaid reimbursement.~~

~~As of April 15, 2009, providers of physician and practitioner services; outpatient services (including outpatient hospitals, federal qualified health centers, rural health centers and dialysis centers); emergency dental services, independent laboratory and x-ray services; medical supply services; hospice and home health services; and emergency transportation services will be reimbursed at 65% of the appropriate Medicaid reimbursement. As of April 15, 2009, pharmacy claims are reimbursed at 75% of the appropriate Medicaid reimbursement.~~

In accordance with 8.941.1(E), the Executive Director may alter the reimbursement for any service with the condition that expenditures remain within the constitutional and statutory limits. Reimbursement rates shall be published on the Department's website. When reimbursement rates are modified, notification will be published in the Provider Bulletin.

8.941.10 CLIENT CO-PAYMENT

Recipients of benefits under the OAP Health Care Program ~~or Old Age Pension Health Care Supplemental Program~~ shall be responsible for paying directly to providers a set portion of the cost of services according to the regulations and fee schedule as defined for the Medical Assistance and described in ~~section 8.754 of this manual~~10 CCR 2505-10, Section 8.754.1. –This ~~charge~~ charge to the recipient will be called co-payment. *[Eff 08/30/2006]*

Those recipients whose co-payments reach a limit of $300.00 within a January 1 through December 31 calendar year will be exempted from further co-payments during that year. The exemption will begin on the date of payment for the claim, which indicates that the cumulative maximum has been reached. *[Eff 08/30/2006]*

It will be a recipient responsibility to present the Medical ID Card to the provider at the time a service is rendered in order to claim exemption from copayment for that service. *[Eff 08/30/2006]*

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Special Financing Division Rule Concerning Hospital Provider Fee Collection and Disbursement, Sections 8.2003.A., 8.2004.D., and 8.2004.E.
Rule Number:	MSB 14-02-06-A
Division / Contact / Phone:	Special Financing / Nancy Dolson / 303-866-3698

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-02-06-A, Revision to the Medical Assistance Special Financing Division Rule Concerning Hospital Provider Fee Collection and Disbursement, Sections 8.2003.A., 8.2004.D., and 8.2004.E.
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.2003.A., 8.004.D., 8.2004.E., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 3/14/14
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at §8.2003.A.3. with new text provided. Replace current text at §8.2004.D.3 with new text provided. Replace current text at §8.2004.E.3.a.i, ii and iii with new text provided. All text indicated in blue is for reference and clarification only and should not be revised. This revision is effective 05/30/2014.

Return to: Office of State Planning and Budgeting (OSPB)
State Capitol, Room 111

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Special Financing Division Rule Concerning Hospital Provider Fee Collection and Disbursement, Sections 8.2003.A., 8.2004.D., and 8.2004.E.
Rule Number:	MSB 14-02-06-A
Division / Contact / Phone:	Special Financing / Nancy Dolson / 303-866-3698

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Under recommendation from the Hospital Provider Fee Oversight and Advisory Board, the proposed rule increases hospital provider fees and Disproportionate Share Hospital (DSH) reimbursement to qualified hospitals due to the increase in Colorado's Federal Fiscal Year (FFY) 2013-14 federal DSH allotment under the Bipartisan Budget Act of 2013 (Public Law number 113-67).

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

   The Bipartisan Budget Act of 2013 (Public Law number 113-67), signed into law by President Obama on December 26, 2013, eliminated the reduction in the FFY 2013-14 DSH allotment, which increased Colorado's DSH allotment from $91,612,207 to $98,648,517. Hospital provider fees serve as the state share to draw the DSH allotment. In order to draw the full DSH allotment as recommended by the Hospital Provider Fee Oversight and Advisory Board, the Department must increase the outpatient services fee rate and increase payment rates for the Colorado Indigent Care Program (CICP) in rule. The federal Centers for Medicare and Medicaid Services (CMS) is currently reviewing an amendment to the Department's Medicaid State Plan and approval is expected before the rules are presented to the Medical Services Board in March 2014.

3. Federal authority for the Rule, if any:

   42 CFR 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   25.5-4-402.3, C.R.S. (2013)

Initial Review		Final Adoption	**04/11/2014**
Proposed Effective Date	**06/01/2014**	Emergency Adoption	

DOCUMENT #08

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Special Financing Division Rule Concerning Hospital Provider Fee Collection and Disbursement, Sections 8.2003.A., 8.2004.D., and 8.2004.E.
Rule Number:	MSB 14-02-06-A
Division / Contact / Phone:	Special Financing / Nancy Dolson / 303-866-3698

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Colorado hospitals will realize an increase in their FFY 2013-14 outpatient services fee rate and will also benefit from increased DSH reimbursement under the CICP and uninsured DSH payments.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Colorado hospital provider fees will increase $7,035,310 and DSH funding to hospitals will increase $14,070,620, resulting in $7,035,310 in net new federal funds to hospitals. DSH funds are a component of CICP payments, and hospitals that serve the greatest number of CICP clients realize greater increases in funding compared to other hospitals.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department or other agencies to implement the proposed rule. All associated administrative costs are covered by hospital provider fees; no state General Fund is used.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The benefit of the proposed rule is $7 million more federal funds for hospital providers for services provided to low income uninsured persons. Inaction would mean not drawing down Colorado's full DSH allotment as appropriated by Congress and would result in less federal funds for hospitals.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   Under the Colorado Health Care Affordability Act, the state share for funding hospital CICP payments, including DSH, is the hospital provider fee. The state does not have other resources available to fund DSH reimbursement for hospitals that participate in the CICP.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

The purpose of the proposed rule is to draw the full DSH allotment. The Department could lower non-DSH payment rates to draw the full DSH allotment without increasing fees. The Hospital Provider Fee Oversight and Advisory Board rejected this option because doing so would mean no net new federal funds for Colorado hospitals to offset the cost of care to low-income uninsured persons as Congress intended when it eliminated the DSH reduction in FFY 2013-14 through passage of the Bipartisan Budget Act of 2013.

8.2003.A. Outpatient Services Fee

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.~~5473~~5939% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.2004.D. Uninsured Disproportionate Share Hospital Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and that report charges for services provided to low-income uninsured persons to the Department in a manner as prescribed by the Department shall receive this payment.

2. Excluded hospitals. Hospitals that participate in the CICP, Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. Three million two hundred thirty thousand three hundred ninety five dollars ($3,~~000,000~~230,395) of the State's annual Disproportionate Share Hospital allotment shall be allocated to the Uninsured Disproportionate Share Hospital Payment. A qualified hospital's annual payment shall equal its share of the percent of Uncompensated Charity Care Costs of all qualified providers divided by the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital Payment, except that no hospital shall receive a payment which exceeds its estimated Hospital-Specific Disproportionate Share Hospital Limit.

8.2004.E. CICP Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals and hospitals that do not participate in the CICP shall not receive this payment.

3. Calculation methodology for payment.

    a. Qualified hospitals shall receive an annual payment, such that, when combined with the CICP Disproportionate Share Hospital Payment, shall total to a percentage of Weighted Uncompensated CICP Costs. The percentage applied to Weighted Uncompensated CICP Costs shall be:

        i. Fifty two point forty-five percent (5~~0~~2.~~0~~45%) for High Volume Medicaid and CICP Hospitals,

        ii. Seventy-~~five~~ seven point forty-five percent (7~~5~~7.~~0~~45%) for Rural Hospitals, or

        iii. Fifty-two point forty-five percent (5~~0~~2.45%) for all other qualified hospitals.