DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Special Connections Reimbursement, Section 8.745
Rule Number: MSB 18-03-01-A
Division / Contact / Phone: Delivery System and Payment Innovation / Susanna Snyder / (303) 866-3154

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 18-03-01-A, Revision to the Medical Assistance Rule concerning Special Connections Reimbursement, Section 8.745
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) 8.745, 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 the current text at 8.745 with the proposed text beginning at 8.745.1 through the end of 8.745.4. This rule is effective August 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Special Connections Reimbursement, Section 8.745
Rule Number: MSB 18-03-01-A
Division / Contact / Phone: Delivery System and Payment Innovation / Susanna Snyder / (303) 866-3154

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).

   Currently section 8.745 limits the Department to reimbursing Colorado Department of Human Services, Office of Behavioral Health (OBH) for services rendered by Special Connections providers. We are updating the interChange system to allow for a specialty provider type that we can reimburse directly. We will remove the Office of Behavioral Health as the only provider whom we can reimburse and allow direct provider reimbursement.

   We will also update the names of organizations, the list of supervising providers by referring to section 8.746, and definitions to be more person centered and clinically accurate

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:

   • 42 U.S.C. § 300x-21, Block Grants for Prevention and Treatment of Substance Abuse; and 42 U.S.C. § 300x-27, Treatment services for pregnant women

   • 42 U.S.C. § 1396a(a)(10)(A)(i)(III), State plans for medical assistance with regard to pregnant women; and 42 U.S.C. § 1396(n)(1), Definition of "qualified pregnant woman."

   • 42 U.S.C. § 1396a(e)(5) and (6), Continuous 60-day eligibility for women post-partum

4. State Authority for the Rule:

   • C.R.S. §§ 25.5-1-301 through 303, (2018)
   • C.R.S. §§27-80-112 through 15 (2018)

Initial Review	**06/08/18**	Final Adoption	**07/13/18**
Proposed Effective Date	**08/30/18**	Emergency Adoption	

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Special Connections Reimbursement, Section 8.745
Rule Number: MSB 18-03-01-A
Division / Contact / Phone: Delivery System and Payment Innovation / Susanna Snyder / (303) 866-3154

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.

   Current and future Special Connections providers will be affected. This will reduce their time spent billing since they won't have to submit claims through both OBH and HCPF. By easing the administrative burden of billing for these providers, we hope to recruit more providers who can serve women who are pregnant or parenting and experiencing substance use disorders.

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

   Providers currently submit claims to HCPF and invoices to OBH. Then, HCPF pays OBH, and then OBH staff reconcile the invoices from providers with what HCPF pays OBH. Then, OBH pays the providers. This is an unnecessary and inefficient process. Providers also report that this extra administrative step is a barrier to delivering services. We've lost several providers in the last decade. By reducing this barrier, we can recruit more providers serving women who are pregnant or parenting and experiencing substance use disorders.

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.

   The proposed rule will not result in any change to the net amount paid to Special Connections providers. The rates and claims criteria for the services covered under Special Connections will remain the same. The only difference will be that the providers will be paid directly by HCPF for those services, rather than through OBH.

   Currently, the administrative cost to OBH is .05 of 1.0 FTE and the administrative cost to HCPF is .05 of 1.0 FTE to process the claims between the agencies. The proposed rule will free up that time and allow both FTE to focus more on program policy and administration.

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

   The costs of this change are limited to the time spent building the change to our MMIS. After that, the costs saved will be realized by providers, OBH and HCPF. Inaction will lead to further administrative waste. An MMIS system change is required to enable direct payments to providers.

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

   This is a less intrusive and costly method than the previous system.

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.

   Currently, the Department makes CORE payments to OBH, and OBH pays providers. This is not a sustainable solution.

8.745 SPECIAL CONNECTIONS

8.745.1 DEFINITIONS

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

~~Assessment means an evaluation by a certified drug/alcohol treatment counselor that is designed to determine the level of drug/alcohol abuse or dependence and the comprehensive treatment needs of a drug/alcohol abusing pregnant client.~~

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

~~Case Management means services provided by a certified drug/alcohol treatment counselor to include Medicaid and non-Medicaid service planning, linkage to other service agencies and monitoring, and those actions necessary to obtain both Medicaid and non-Medicaid reimbursable services for the eligible client with multiple treatment needs.~~

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

D. Group Counseling means ~~Drug/Alcohol Individual Therapy means substance abuse counseling services provided by a certified drag/alcohol treatment counselor to a client in a licensed drug and alcohol treatment program.~~

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

~~E. Drug/Alcohol Group Therapy means substance abuse counseling services provided by a certified drug/alcohol treatment counselor to a group of not more than twelve clients in a licensed drug and alcohol treatment program.~~

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

F. Residential Treatment means a ~~Health Maintenance Group means services facilitated by a certified drug/alcohol treatment counselor to help a client develop health and life management skills.~~

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

8.745.2 DETERMINATION OF CLIENT ELIGIBILITY

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

1. Medically verified to be pregnant.

2. Determined either presumptively eligible or eligible for Medicaid.

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

8.745.2.B. To receive ~~drug/alcohol treatment~~substance use disorder services, the client shall meet the following conditions:

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

2. ~~Be prior authorized by~~Received a prior authorization from the ~~Alcohol and Drug Abuse Division~~Office of Behavioral Health of the Colorado Department of Human Services. ~~to receive services.~~

8.745.3 PROVIDER ELIGIBILITY

~~8.745.3.A. The Alcohol and Drug Abuse Division of the Colorado Department of Human Services shall be the only provider to receive reimbursement for Assessments and drug/alcohol treatment services provided to Program enrolled clients.~~

8.745.3.A Eligible providers shall meet the following criteria:

1. Be enrolled as a Colorado Medicaid provider

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

~~The Alcohol and Drug Abuse Division of the Colorado Department of Human Services shall contract with certified and approved drug/alcohol treatment programs for the delivery of services.~~

8.745.4 REIMBURSABLE SERVICES

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

1. One Assessment per pregnancy.

2. ~~Drug/alcohol~~ Substance use disorder treatment services including c~~C~~ase m~~M~~anagement, ~~Drug/Alcohol Individual Therapy~~substance use disorder individual and family counseling, ~~Drug/Alcoho~~substance use disorder~~l~~ g~~G~~roup ~~Therapy~~ counseling, residential treatment and/or enhanced prenatal care education~~Health Maintenance Group Services~~.

3. Urine screening and monitoring.

8.745.4.B. ~~All services must be prior approved by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services.~~ Services may be provided as outpatient or residential. Room and board are not covered services.

8.745.5 REIMBURSEMENT

Reimbursement for services provided shall be the lowest of:

1. Submitted charges; or
2. Fee schedule as determined by the Department.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning CICP State Administered Audits, Section 8.902.D
Rule Number: MSB 18-04-04-A
Division / Contact / Phone: Special Financing / Taryn Graf / 303-866-5634

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-04-04-A, Revision to the Medical Assistance Rule concerning CICP State Administered Audits, Section 8.902.D
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) 8.902.D, 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 the current text at 8.902 with the proposed text beginning at 8.902.D through the end of 8.902.D. This rule is effective August 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning CICP State Administered Audits, Section 8.902.D
Rule Number: MSB 18-04-04-A
Division / Contact / Phone: Special Financing / Taryn Graf / 303-866-5634

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).

   The current CICP rule states that all CICP providers must submit an annual provider audit and compliance statement as specified by the Department. The Special Financing Division has been appropriated funds to create a State administered audit of our CICP providers. The proposed changes to this rule is to update language to reflect this State administered audit.

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. (2017);
   25.5-3-101 through 25.5-3-111 C.R.S. (2018)

Initial Review **06/08/18** Final Adoption **07/13/18**
Proposed Effective Date **08/30/18** Emergency Adoption

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning CICP State Administered Audits, Section 8.902.D
Rule Number: MSB 18-04-04-A
Division / Contact / Phone: Special Financing / Taryn Graf / 303-866-5634

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.

   Existing program providers are required to complete an annual provider audit in accordance with guidelines stipulated in the CICP Provider Manual. Providers whose reimbursement is more than $1 million must hire an outside auditor to complete their annual audit. The creation of a State administered audit will remove the financial aspect of the annual audit for these providers. Providers whose reimbursement is less than $1 million are allowed to conduct an internal audit. The creation of a State administered audit will remove the administrative burden for these providers. Also, the State administered audit is intended to audit approximately one third of the current CICP providers, so the burden of the audit will be lessened to about once every three years instead of every year.

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 State administered audit will help ensure the audit is conducted in a more uniform manner than the current provider administered audits. Due to the fact that the majority of providers are conducting their own audits, some of the audits are conducted on a much deeper and thorough level than others. By having a State administered audit, the Department will be better able to control the uniformity of the provider audits.

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.

   The Department of Health Care Policy and Financing sees no fiscal impact of this rule change for the Department. Funding for the audit will come from the appropriated Children's Hospital Colorado Clinic Based Indigent Care line and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE). The total appropriated amount is $150,700, with $110,513 coming from the CHASE fee and $40,187 coming from the Clinic Based Indigent Care line.

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

   Currently, all CICP providers conduct their own audit on their program activities each year. The Special Financing Division has learned in recent years that the providers' self-audits are not as precise and thorough as they are intended to be. By creating a state administered audit, the Department can ensure that audits are conducted more uniformly. This would also remove the requirement for providers to conduct their own audit, reducing the administrative burden for providers that conduct internal audits and the financial burden for providers who hire outside auditors to complete their annual audit.

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

   The Department considered continuing to allow providers to conduct their own annual audits. Since the Department has learned that the current audit procedure does not appear to be working as intended, the creation of a state administered audit will ensure more uniformity and will also lessen the frequency of audits from once a year to about once every three years. Our stakeholders are supportive of the move to state administered audits.

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 Department considered continuing to allow providers to conduct their own annual audits. However, as the Department is aware that the current audit process may not be achieving the intended purpose, the Special Financing Division, with support from our Stakeholders, chose to seek the funding to create the state administered audit.

8.902 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Requirements for Qualified Health Care Providers

1. Agreements will be made annually between the Department and Qualified Health Care Providers through an application process.

2. Agreements may be executed with Hospital Providers throughout Colorado that meet the following requirements:

a. Licensed or certified as a general hospital or birth center by the Department of Public Health and Environment.

b. Hospital Providers shall assure that Emergency Care is available to all Clients throughout the Program year.

c. Hospital Providers shall have at least two obstetricians with staff privileges at the Hospital Provider who agree to provide obstetric services to individuals under Medicaid. In the case where a Hospital Provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term “obstetrician” includes any physician with staff privileges at the Hospital Provider to perform non-emergency obstetric procedures.

This requirement does not apply to a Hospital Provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

d. Using the information submitted by an Applicant, the Qualified Health Care Provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. If the Applicant is eligible to receive discounted health care services under the Program, the Qualified Health Care Provider shall determine an appropriate copayment for the Client. Hospital Providers shall determine if the Applicant is eligible to receive discounted services under the Program at the time of application, unless required documentation is not available, in which case a determination should be made within 15 working days of the date the Applicant provides a signed application and such other information, written or otherwise, as is necessary to process the application. Hospital Providers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age eighteen (18) and older;

II. Household size, where all non-spouse or civil union partner, non-student adults ages eighteen (18) to sixty-four (64) included on the application must have financial support demonstrated or attested to; and

III. Liquid Resources. Including Liquid Resources in the financial eligibility determination is optional for Hospital Providers. If a Hospital Provider chooses to include Liquid Resources in the financial eligibility determination, at least $2,500 must be protected for each family member counted in household size, and the Hospital Provider must include a Spend Down opportunity.

e. Hospital Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories divided into at least three income tiers covering 0 to 250% of the federal poverty level. Copayments shall be expressed in dollar amounts and shall not exceed the copayments in the Standard Client Copayment Table found in Appendix A.

f. Hospital Providers shall submit Program utilization and charge data in a format and timeline determined by the Department.

3. Agreements may be executed with Clinic Providers throughout Colorado that meet the following minimum criteria:

a. Licensed or certified as a community health clinic by the Department of Public Health and Environment, or certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.

b. Using the information submitted by an Applicant, the provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. If the Applicant is eligible to receive discounted health care services under the Program, the Qualified Health Care Provider shall determine an appropriate copayment for the Client. Clinic Providers should determine if the Applicant is eligible to receive discounted services under the Program at the time of application, unless required documentation is not available, in which case a determination should be made within 15 days of the date the Applicant provides a signed application and such other information, written or otherwise, as is necessary to process the application. Clinic Providers who are federally qualified health centers shall determine Client financial eligibility as required under federal regulations and guidelines. Clinic Providers who are not federally qualified health centers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age eighteen (18) and older, and

II. Household size.

c. Clinic Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories. Copayments for Clients between 0 and 100% of the federal poverty level shall be nominal or $0. Sliding Fee Scales shall have at least three tiers between 101 and 250% of the federal poverty level.

I. Sliding fee scales used by federally qualified health centers approved by the federal government meet all requirements of the Program.

II. Copayments for Clients between 101 and 250% of the federal poverty level may not be less than the copayments for Clients between 0 and 100% of the federal poverty level.

III. The same sliding fee scale shall be used for all Clients eligible for the Program.

IV. Sliding fee scales shall be reviewed by the Qualified Health Care Provider on a regular basis to ensure there are no barriers to care.

d. Clinic Providers shall submit Program data and quality metrics with their annual application. Specific quality metrics are listed in Section 8.905.B. The data and quality metrics shall be submitted in a format determined by the Department and provided as part of the annual application.

4. Determination of Lawful Presence

a. Qualified Health Care Providers shall develop procedures for handling original lawful presence documents to ensure that the documents are not lost, damaged or destroyed. Qualified Health Care Providers shall develop and follow procedures for returning or mailing original documents to Applicants within five business days of receipt.

b. Qualified Health Care Providers shall accept copies of an Applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter, provided that the verification identifies that the copy is from an original and that the individual who reviewed the document(s) signifies such by including their name, organization, address, telephone number and signature on the copy.

c. Qualified Health Care Providers shall retain photocopies of the Applicant's affidavit and lawful presence documentation.

d. Qualified Health Care Providers shall not discriminate against Applicants on the basis of race, national origin, gender, religion, age or disability. If an Applicant has a disability that limits the Applicant's ability to provide the required evidence of citizenship or lawful presence, the provider shall assist the individual to obtain the required evidence.

I. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the Applicant may provide the required documentation; or referring the Applicant to other agencies or organizations which may be able to provide assistance.

II. Examples of additional assistance that shall be provided to Applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the Applicant.

III. The Qualified Health Care Provider shall not be required to pay for the cost of obtaining required documentation.

IV. The Qualified Health Care Provider shall document its efforts of providing additional assistance to the Applicant and retain such documentation.

5. Qualified Health Care Providers shall provide the Applicant and/or representative a written notice of the provider's determination as to the Applicant's eligibility to receive discounted services under the Program. If eligibility to receive discounted health care services is granted by the Qualified Health Care Provider, the notice shall include the date when eligibility began. If eligibility to receive discounted health care services is denied, the notice shall include a brief, understandable explanation of the reason(s) for the denial. Every notice of the Qualified Health Care Provider's decision, whether an approval or a denial, shall include an explanation of the Applicant's appeal rights found at Section 8.902.B in these regulations.

6. Qualified Health Care Providers shall screen all Applicants for eligibility for Medicaid and the Children's Basic Health Plan and refer Applicants to those programs if they appear eligible. The Qualified Health Care Provider shall refer Applicants to Colorado's health insurance marketplace for information about private health insurance.

B. Client Appeals

1. If an Applicant or Client feels that a financial determination or denial is in error, he or she shall only challenge the financial determination or denial by filing an appeal with the Qualified Health Care Provider who determined eligibility to receive discounted health care services under the CICP pursuant to this Section 8.902. There is no appeal process available through the Office of Administrative Courts.

2. Instructions for Filing an Appeal

The Qualified Health Care Provider shall inform the Applicant or Client that he or she has the right to appeal the financial determination or denial if he or she is not satisfied with the Qualified Health Care Provider's decision.

If the Applicant or Client wishes to appeal the financial determination or denial of the application, the Applicant or Client shall submit a written request for appeal to the Qualified Health Care Provider, which includes any documentation supporting the reasons for the request.

3. Appeals

An Applicant or Client may file an appeal if he or she wishes to challenge the accuracy of his or her initial financial determination.

A Client or Applicant shall have 15 calendar days to request an appeal from the date of the Qualified Health Care Provider's decision.

If the Qualified Health Care Provider receives the Applicant's or Client's appeal after the 15 working day deadline, the Qualified Health Care Provider shall notify the Applicant or Client in writing that the appeal was denied because it was not submitted timely. At the discretion of the Qualified Health Care Provider and for good cause shown, including a death in the Applicant's or Client's immediate family member, the Qualified Health Care Provider may review an appeal received after 15 working days.

An Applicant or Client can request an appeal for the following reasons:

a. The initial financial determination or denial was based on inaccurate information because the family member or representative was uninformed;

b. The Applicant or Client believes that the calculation is inaccurate for some other reason; or

c. Miscommunication between the Applicant or Client and the financial determination technician cause incomplete or inaccurate data to be recorded on the application.

Each Qualified Health Care Provider shall designate a manager to review appeals. An appeal involves receiving a written request from the Applicant or Client, and reviewing the application completed by the financial determination technician, including all back-up documentation, to determine if the application to receive discounted health care services under the CICP is accurate.

If the manager finds that the initial financial determination or denial is not accurate, the designated manager shall correct the financial determination to receive discounted health care services under the CICP and assign the correct financial determination to the Applicant or Client. The correct financial determination is effective retroactive to the initial date of application, and charges incurred 90 days prior to the initial date of application must be discounted. The Qualified Health Care Provider shall notify the Applicant or Client in writing of the results of an appeal within 15 working days following receipt of the appeal request from the Applicant or Client.

4. Provider Management Exception

Each Qualified Health Care Provider shall designate a manager to review provider management exceptions. At the discretion of the Qualified Health Care Provider and for good cause shown, the designated manager may grant the Applicant or Client a provider management exception to the Client's financial determination. This process can be used during the initial financial determination, simultaneously with an appeal, or within 15 working days of the Qualified Health Care Provider's decision regarding an appeal.

A Client may request and a Qualified Health Care Provider may grant a provider management exception if the Client can demonstrate that there are circumstances that should be taken into consideration when establishing his or her initial financial determination. Provider Management Exceptions shall always result in a lower Client financial determination.

A Client may request a provider management exception simultaneously with an appeal, or within 15 working days of the Qualified Health Care Provider's decision regarding an appeal.

The facility shall notify the Client in writing of the Qualified Health Care Provider's findings within 15 working days of receipt of the written request.

The Qualified Health Care Provider must note provider management exceptions on the application. Qualified Health Care Providers shall treat Clients equitably in the provider management exception process.

A financial determination from a provider management exception is effective as of the initial date of application. Charges incurred 90 days prior to the initial date of application must be discounted. Qualified Health Care Providers are not required to honor provider management exceptions granted by other Qualified Health Care Providers.

C. Financial Eligibility

General Rule: An Applicant shall be financially eligible for discounted health care services under the CICP if his or her household income is no more than 250% of the most recently published federal poverty level (FPL) for a household of that size.

1. Qualified Health Care Providers determine eligibility for the CICP and shall maintain auditable files of applications for discounted health care services under the CICP.

2. The determination of financial eligibility process looks at the financial circumstances of a household as of the date that a signed application is completed.

3. All Qualified Health Care Providers must accept each other's CICP financial determinations unless the Qualified Health Care Provider believes that the financial determination was determined incorrectly, the Qualified Health Care Provider's financial determination process is materially different from the process used by the issuing Qualified Health Care Provider, or that the financial determination was a result of a provider management exception.

4. CICP eligibility is retroactive for services received from a Qualified Health Care Provider up to 90 days prior to application.

5. Documentation concerning the Applicant's financial status shall be maintained by the provider.

6. Beyond the distribution of available funds made by the CICP, allowable Client copayments, and other third-party sources, a provider shall not seek payment from a Client for the provider's CICP discounted health care services to the Client.

7. Emergency Application for Providers

   a. In emergency circumstances, an Applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the Qualified Health Care Provider shall follow these steps in processing the application:

      I. Use the regular application to receive discounted health care services under the CICP, but indicate emergency application on the application.

      II. Ask the Applicant to give spoken answers to all questions and to sign the application to receive discounted health care services under the CICP.

      III. Determine a federal poverty level based on the spoken information provided.

   b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room episode. If the Client receives any care other than the emergency room visit, the Hospital Provider must request the Client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the Client does not support the earlier, spoken information, the Hospital Provider must obtain a new application from the Client. If the Client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the emergency application.

c. In emergency circumstances, an Applicant is not required to provide identification or execute an affidavit as specified at 10 C.C.R. 2505-10, Section 8.904.D.

D. Audit Requirements

~~The Qualified Health Care Provider shall provide the Department with an annual audit compliance statement in a format as specified by the Department. The purpose of the audit requirement is to furnish the Department with a separate audit report, which attests to the Qualified Health Care Provider's compliance with the use of CICP funding and other requirements for participation.~~The Department will conduct audits of Qualified Health Care Providers. Qualified Health Care Providers shall comply with requests for data and other information from the Department. Qualified Health Care Providers shall complete corrective actions when required by the Department. The Department's intention is to audit at minimum one-sixth of the participating Qualified Health Care Providers in state fiscal year 2018-19 and at minimum one-third of the participating Qualified Health Care Providers each year beginning in state fiscal year 2019-20.

E. HIPAA

The CICP does not meet the definition of a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 at 45 CFR 160.103. The CICP is not a part of the Colorado Medical Assistance Program, nor of Health First Colorado, Colorado's Medicaid program. CICP's principal activity is the making of grants to providers who serve eligible persons who are medically indigent. The state personnel administering the CICP will provide oversight in the form of procedures and conditions to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a Qualified Health Care Provider or Client.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Family Services Loan Fund - Rescind, Section 8.613.1
Rule Number: MSB 18-04-05-B
Division / Contact / Phone: Benefits and Services Management / Candace Bailey / 5156

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 18-04-05-B, Revision to the Medical Assistance Rule concerning the Family Services Loan Fund - Rescind, Section 8.613.1
3. This action is an adoption of:	a repeal of existing rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 10 CCR 2505-8.613.1, 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 the current text beginning at 8.613.1 with the proposed text beginning at 8.613.1 through the end of 8.613.1. This section of the rule is repealed. The effective date of this rule is August 30, 2018.

Title of Rule: Revision to the Medical Assistance Rule concerning the Family Services Loan Fund - Rescind, Section 8.613.1
Rule Number: MSB 18-04-05-B
Division / Contact / Phone: Benefits and Services Management / Candace Bailey / 5156

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).

   The statute authorizing the Family Support (FS) Loan Fund, Section 25.5-10-401 - 403,
   C.R.S. was repealed pursuant to HB17-1078. Therefore, the rule implementing the FS Loan Fund, 10 C.C.R. 2505-10, Section 8.613.1, is rescinded.

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:

   House Bill 17-1078 and 25.5-1-301 through 25.5-1-303, C.R.S. (2017).

Initial Review	**06/08/18**	Final Adoption	**07/13/18**
Proposed Effective Date	**08/30/18**	Emergency Adoption	

DOCUMENT #05

Title of Rule: Revision to the Medical Assistance Rule concerning the Family Services Loan Fund - Rescind, Section 8.613.1
Rule Number: MSB 18-04-05-B
Division / Contact / Phone: Benefits and Services Management / Candace Bailey / 5156

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 eligibility group for this loan was families who have a family member with a developmental delay or disability living in the family home, regardless of Medicaid eligibility. The rescission of this rule will impact those families. The family will no longer be able to secure a low interest loan to assist with paying for services or supports for their family member. The potential cost to families may be that they would need to secure a loan from a private lender at a higher interest rate to provide services or supports to their family member that are not covered by third party insurances. There will be no benefit to any class with the rescission of this rule.

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 FS Loan fund was available to assist families to acquire a low interest loan to purchase supports and services for their family member. An average of 30 families annually took this opportunity to secure a loan to provide mainly vehicle modifications or home modifications that could not be accessed through third party insurances or waivers. The qualitative impact to the individual within the family is that the individual would not have the option of obtaining a Family Support Loan to access the modifications he or she needs, thus making it more difficult to achieve independence in the community.

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 anticipated effects on state revenues.

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

   The cost to rescind the FS Loan fund rules is zero and will prohibit families from accessing low interest loans in the future. The benefit will be that the Department is compliant with HB 17-1078 and the cost of administering the FS Loan fund will reduce to zero once all outstanding loans have been repaid.

   If the Department does not rescind the rule, the cost will be that the Department is not compliant with statute and will continue to have ongoing administration costs. The FS Loan fund received no state general funds for loans and was replenished through

principle and interest paid on loans. HB 17-1078 authorized C.R.S. 25.5-10-303 which transfers all payments made to the FS Loan fund into the Family Support Services Fund. This depletes the FS Loan fund and leaves no revenue to make future loans. In order to retain the FS Loan fund, additional revenue would have to be available for future loans. The benefit of retaining rules would allow families to access low interest loans.

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

   The Department does not have any less costly or intrusive method of rescinding the FS Loan 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.

   Because the General Assembly has acted to remove some measure of the Department's authority by repealing the statutes authorizing the Family Support Loan Fund, the Department must repeal, through the rule-making process, the regulations it promulgated pursuant to, and in furtherance of, that defunct statute. The rule-making process is the only statutorily authorized process for rescinding a rule promulgated under the APA.

8.613 FAMILY SUPPORT SERVICES (FSS) PROGRAM

A. The community centered board shall administer the Family Support Services program according to the rules, regulations, policies and guidelines of the Department, local Family Support Council and community centered board.

1. The community centered board shall ensure that the Family Support Services (FSS) program is implemented within its designated service area.

2. The community centered board shall designate one (1) person to serve as the contact for the overall implementation and coordination of the Family Support Services program.

3. The community centered board shall assist its designated service area to establish and maintain a Family Support Council pursuant to section 25.5-10-304 C.R.S.

4. The Family Support Council shall meet the responsibilities specified in section 25.5-10-304, C.R.S., and make recommendations to the community centered board regarding budget parameters for the Family Support Services program, including, but not limited to, the maximum amount any one family may receive through the Family Support Services program during any given fiscal year.

5. The majority of the members and the chairperson of each local Family Support Council shall be members of families with a person with a developmental disability living in the home.

6. New members of the local Family Support Council shall be recruited from the service area, and approved by the current Council and the board of directors of the community centered board.

   a. The members of the Family Support Council shall receive written notice of their appointment.

   b. The community centered board shall ensure an orientation and necessary training regarding the duties and responsibilities of the Family Support Council is available for all council members.

7. The size of the local Family Support Council shall be sufficient to meet the intent and functions of the council, but no less than five (5) persons.

8. Each Family Support Council shall establish the criteria for tenure of members, selection of new members, the structure of the council and, in conjunction with the community centered board, a process for addressing disputes or disagreements between the Family Support Council and the community centered board. Such process may include requesting mediation assistance from the Department.

9. Nothing in these rules and regulations shall be construed as to prohibit or limit services and supports available to persons with developmental disabilities and their families which are authorized by other state or federal laws.

10. The community centered board, in cooperation with the local Family Support Council, shall ensure that the Family Support Services program is publicized within the designated service area.

B. Accessing the Program

1. Referrals to the Family Support Services program shall be made through the community centered board pursuant to rules and regulations enumerated in section 8.607.

2. Any family who has a member with a developmental disability, as determined pursuant to section 25.5-10-211, C.R.S., living in the household is eligible for the Family Support Services program. Living in the household with a family means that the person's place of residence is with that family.

a. Living in the household with a family may include periods of time from one (1) day up to six (6) months during which time the person is not in his or her primary residence because of transition into or out of the home.

b. The community centered board, in cooperation with the local Family Support Council, shall determine the general circumstances under which a family is considered to be in transition. The community centered board is responsible for making the determination on a case-by-case basis as to whether the specific family circumstances qualify as a legitimate period of transition.

3. Once one family member meets the Family Support Services program eligibility criteria, the entire family living in the household becomes eligible to receive services and supports as specified in the Family Support Plan which are necessary to maintain the family member with a developmental disability in the home.

4. The community centered board shall, subject to available appropriations, continue funding for the remainder of the fiscal year for the services and supports committed to by the community centered board in the Family Support Plan for eligible families who move to another designated service area during the fiscal year.

5. The community centered board shall not utilize state funds to support families who do not reside in the State of Colorado.

6. Eligibility for the Family Support Services program does not guarantee the availability of services or supports under this program.

7. The community centered board shall maintain a waiting list of eligible individuals for whom Department funding is unavailable.

8. In cooperation with the local Family Support Council, the community centered board shall develop procedures for determining how and which individuals on the waiting list will be enrolled into the Family Support Services program.

C. Services and Supports

Services and supports available under the Family Support Services program may be purchased from a variety of providers who are able to meet the individual needs of the family.

D. Family Support Plan

1. Families enrolled into the Family Support Services program shall have a Family Support Plan (FSP) which meets the requirements of an Individualized Plan and also provides the following information:

a. The length of time the funds are available;

b. A description of how payment for the services or supports will be made; and,

c. When applicable, the maximum amount of funds which can be spent for each service or support without amending the Family Support Plan.

2. The Family Support Plan shall integrate with other Individual Service Plans affecting the family and avoid, where possible, any unnecessary duplication or multiple Family Support Plan or service plans for families.

3. The Family Support Plan shall be reviewed at least annually or on a more frequent basis if the plan is no longer reflective of the family's needs.

a. Any changes to the provision of services and supports identified in the Family Support Plan are subject to available funds within the designated service area.

b. Any decision to modify, reduce or deny services or supports set forth in the Family Support Plan, without the family's agreement, are subject to the requirements of section 8.605.1.

E. Billing and Payment Procedures

1. Families shall provide either receipts or a signed statement to the community centered board documenting how funds provided to the family through the Family Support Services program were expended.

2. The community centered board shall submit to the Department, on a form and frequency prescribed by the Department, information which outlines individual family use of the Family Support Services program.

F. Program Evaluation

1. The community centered board, in cooperation with the local Family Support Council, shall be responsible for evaluating the effectiveness of Family Support Services program within its designated service area on an annual basis.

2. The community centered board, and participating families as requested, shall cooperate with the Department regarding statewide evaluation and quality assurance activities.

~~**8.613.1 COLORADO FAMILY SUPPORT LOAN FUND**~~

~~A. Administration of the Loan Fund~~

~~1. The Loan Fund shall be administered by the Department in accordance with the requirements of the Colorado State fiscal rules, and Department rules.~~

~~2. Loans from the Loan Fund shall bear an annual interest rate at the annual earnings rate calculated by the Colorado State Treasurer for the preceding fiscal year.~~

~~3. The maximum outstanding loan to any family shall be $ 8,000.00.~~

~~4. Loans from the Loan Fund will only be made to eligible families to enable families to obtain short-term support services or equipment for the purpose of supporting the family member with a developmental disability at home. Loans may be for a maximum period of sixty (60) months from the date of the loan.~~

~~B. Eligibility Requirements~~

~~A family is eligible to apply for a loan from the Loan Fund if the family meets the eligibility requirement of having a family member with a developmental disability living at home.~~

~~C. Loan Application Process~~

~~1. The Department shall designate an open application period each fiscal year in which sufficient funds are available for new loans. The Department shall notify the community centered boards of the dates.~~

~~2. Community centered boards shall provide information and make Loan Fund applications available to families.~~

~~3. Families can access the Loan Fund by submitting a loan application, using forms specified by the Department.~~

~~4. The community centered board shall determine if a family has an eligible family member living at home and thus is eligible for the Loan Fund. The community centered board shall provide the family with certification of eligibility, which the family can use for verification for the Loan Fund when they submit a Loan application.~~

5. The Department will review the loan application and make a determination to grant or deny the loan within thirty days from the close of the open application period.

6. Any loan applications which are determined by the Department to be incomplete or have reported false information will be denied.

D. Available Funds

1. Each fiscal year, after the Department is notified of the previous fiscal year's annual earnings rate, the Department shall notify the community centered boards of the annual interest rate, the total amount of funds available for new loans, and the date applications will be accepted.

2. Once a sufficient number of loans have been approved and the available funds have been exhausted, the Department shall notify the community centered boards that no further applications will be accepted. The Department will notify the community centered boards when funds are once again available.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Durable Medical Equipment Reimbursement, Section 8.590.7
Rule Number: MSB 18-05-15-A
Division / Contact / Phone: Client and Clinical Care Office, Pharmacy Unit / Kristina Gould / 303-866-6715

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-05-15-A, Revision to the Medical Assistance Rule concerning Durable Medical Equipment Reimbursement, Section 8.590.7
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) 8.590.7.K. AND 8.590.7.A., 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: 7/01/2018
6. Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS

Replace the current text at 8.590.7 with the proposed text beginning at 8.590.7 through the end of 8.590.7. This rule is effective August 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Durable Medical Equipment Reimbursement, Section 8.590.7
Rule Number: MSB 18-05-15-A
Division / Contact / Phone: Client and Clinical Care Office, Pharmacy Unit / Kristina Gould / 303-866-6715

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).

   The proposed rule will increase the Durable Medical Equipment (DME) rate by 1.0% to account for General Assembly funding appropriation, pursuant to HB 18-1322.In addition, the Attorney General's office requested the Department amends 8.590.7.A. to include the year 2017 in the incorporation by federal statute reference so that it complies with the APA.

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 annual rate increases, pursuant to HB 18-1322, will become effective July 1, 2018 and the proposed rule change will bring the Department into compliance with General Assembly Appropriations. A federal statute in 8.590.7.A is deficient and does not comply with the APA because it fails to include the year of the statute that is incorporated.

3. Federal authority for the Rule, if any:

   42 CFR 440.70, 440.120

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   House Bill 18-1322

Initial Review — Final Adoption **07/13/18**
Proposed Effective Date **08/30/18** — Emergency Adoption

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Durable Medical Equipment Reimbursement, Section 8.590.7
Rule Number: MSB 18-05-15-A
Division / Contact / Phone: Client and Clinical Care Office, Pharmacy Unit / Kristina Gould / 303-866-6715

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.

   DME providers will receive increased reimbursement for equipment and supplies provided, pursuant to HB 18-1322.

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

   In CY2016, the DMEPOS rules at Section 8.590 impacted 127,823 members and the Department's reimbursements for the DMEPOS benefit totaled $180,436,866, with a per utilizer cost of $1,411.62. Reimbursement to DMEPOS providers is estimated to be increased by $1,413,615 for FY 2018-19 which will help ensure that Medicaid members have continued access to DME.

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.

   No costs beyond the estimated expenditures due to the rate increase are anticipated.

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

   The rate increase will give providers the ability to continue supplying DME items to clients at their incremental threshold margin. Inaction can result in decreased client services and access to benefits, as well as noncompliance with HB 18-1322. Additionally, inaction would result in an invalidated rule due to a deficient citation that does not comply with the APA.

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 which is to comply with HB 18-1322.

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.

   An alternative method for achieving a rate increase for the proposed rule was not considered.

8.590.7 REIMBURSEMENT

8.590.7.A. A provider, as defined at Section 25.5-4-414, C.R.S., is prohibited from making a referral to an entity providing DME and Supplies under the Medical Assistance Program if the provider or an Immediate Family member of the provider has a Financial Relationship with the entity unless the Financial Relationship meets the requirements of an exception to the prohibitions established by 42 U.S.C. Section 1395nn (2017), as amended or any regulations promulgated thereunder, as amended. 42 U.S.C. §1395nn (2017) is hereby incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado.

8.590.7.B. If a provider refers a Medicaid member for DME and Supplies services in violation of Section 25.5-4-414, C.R.S., or this rule, then the Department may

1. Deny any claims for payment from the provider;

2. Require the provider to refund payments for services or items;

3. Refer the matter to the appropriate agency for investigation for fraud; or

4. Terminate the provider's Colorado Medicaid provider participation agreement.

8.590.7.C. Invoices received from Related Owners or Related Parties shall not be accepted. Only invoices received from unrelated manufacturers or wholesale distributors shall be recognized as allowable invoices.

8.590.7.D. The provider shall not bill the Department for authorized accessory items included by the manufacturer as part of a standard package for an item.

8.590.7.E. The provider shall credit the cost of any accessory or part removed from a standard package to the Department.

8.590.7.F. Members and providers may negotiate in good faith a trade-in amount for DME items no longer suitable for a member because of growth, development or a change in anatomical and or medical condition. Such trade-in allowances shall be used to reduce the cost incurred by the Department for a replacement item.

8.590.7.G. The refund amount due the Department on a returned Wheelchair or Facilitative Device shall be agreed upon by the dealer or manufacturer; wherever the item was returned, and the Department.

8.590.7.H. Reimbursement for allowable modifications, service, and repairs on DME is as follows:

1. Labor for modifications, service, and repairs on DME shall be reimbursed at the lesser of submitted charges or the rate specified on the Department's fee schedule.

2. Parts that are listed on the Department's fee schedule, with a HCPCS code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

3. Manually priced parts are reimbursed according to the same methodology used for purchased equipment, as described in 8.590.7.K.

4. The provider shall not be reimbursed for labor or parts in excess of unit limitations.

5. Reimbursement for a modification that requires the original equipment provider to supply a part from their own inventory or stock is contingent upon the provider submitting supporting documentation that demonstrates the need and actual cost of the parts to be used in the modification.

8.590.7.I. Reimbursement for used equipment shall include:

1. A written, signed and dated agreement from the member accepting the equipment.

2. Billing the Department, the lesser of 60% of the maximum allowable reimbursement indicated in the most recent Medicaid Bulletin or 60% of the provider's usual submitted charges.

   a. For used equipment subject to the upper payment limit provisions of section 1903(i)(27) of the Social Security Act, the maximum allowable reimbursement will be the lower of 100% of the applicable Medicare used reimbursement rate effective as of January 1 and posted by July 1 of each year, or the provider's submitted charges.

8.590.7.J. Reimbursement for purchased or rented equipment shall include, but is not limited to:

1. All elements of the manufacturer's warranties or express warranties.

2. All adjustments and modification needed by the member to make the item useful and functional.

3. If item is delivered, set-up and installation of equipment in an appropriate room in the home, if applicable.

4. Training and instruction to the member or caregiver in the safe, sanitary, effective and appropriate use of the item and necessary servicing and maintenance to be done by the member or caregiver.

5. Training and instruction on the manufacturer's instructions, servicing manuals and operating guides.

8.590.7.K. Reimbursement rate for a purchased item shall be as follows:

1. Fee schedule items, with a HCPCS code, that have a maximum allowable reimbursement rate, shall be reimbursed at the lesser of submitted charges or the Department fee schedule rate.

2. Manually priced items that do not have an assigned fee schedule rate shall be reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP) less a percentage set forth below:

   a. July 1, 2017 to June 30, 2018, the percentage is 18.33 ~~percent~~.

b. Pending federal approval, effective July 1, 2018, the percentage is 17.51.

3. Manually priced items that do not have an assigned fee schedule rate and have no MSRP shall be reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus a percentage set forth below:

c. July 1, 2017 to June 30, 2018, the percentage is 19.50. ~~percent.~~

d. Pending federal approval, effective July 1, 2018, the percentage is 20.70.

8.590.7.L. Reimbursement for rental items shall be billed and paid in monthly increments unless otherwise indicated in the Billing Manual.

8.590.7.M. Reimbursement for members eligible for both Medicare and Medicaid shall be made in the following manner:

1. The provider shall bill Medicare first unless otherwise authorized by the Department.

2. If Medicare makes payment, Medicaid reimbursement will be based on appropriate deductibles and co-payments.

3. If Medicare denies payment, the provider shall be responsible for billing the Department. Reimbursement is dependent upon the following conditions:

a. A copy of the Explanation of Medicare Benefits shall be maintained in the provider's files when billing electronically or attached to the claim if it is billed manually; or

b. Medicaid reimbursement shall not be made if the Medicare denial is based upon provider submission error.

8.590.7.N. Face-to-Face Encounters

1. For DME specified in the Billing Manual, a face-to-face encounter must be performed related to the primary reason a member requires the DME.

2. The face-to-face encounter must occur no more than six months before the DME is first provided to a member.

3. The face-to-face encounter must be conducted by one of the following practitioners:

a. The physician responsible for prescribing the DME;

b. A nurse practitioner or clinical nurse specialist, working in collaboration with the prescribing physician; or

c. A physician assistant under the supervision of the prescribing physician.

4. A practitioner may conduct a face-to-face encounter via telehealth or telemedicine if those services are covered by the Medical Assistance Program.

5. If a non-physician practitioner performs a face-to-face encounter they must communicate the clinical findings of the face-to-face encounter to the physician responsible for prescribing the related DME. Those clinical findings must be incorporated into a written or electronic document included in the member's medical record.

6. A physician who prescribes DME requiring face-to-face encounters must document the following:

   a. The face-to-face encounter was related to the primary reason the member required the prescribed DME;

   b. The practitioner who performed the face-to-face encounter;

   c. The date of the face-to-face encounter; and

   d. The face-to-face encounter occurred within the required timeframe.

7. Compliance with this section is required as a condition of payment for DME requiring face-to-face encounters.

8.590.7.O. Reimbursement for Complex Rehabilitation Technology provided to members is subject to the following conditions:

1. The billing provider is a Complex Rehabilitation Technology Supplier;

2. The member has been evaluated or assessed, for selected Complex Rehabilitation Technology identified in the Billing Manual, by:

   a. A Qualified Health Care Professional; and

   b. A Complex Rehabilitation Technology Professional employed by the billing provider.

3. The Complex Rehabilitation Technology is provided in compliance with all applicable federal and state laws, rules, and regulations, including those rules governing the Medical Assistance Program.

8.590.7.P. Reimbursement for Speech Generating Devices (SGD), accessories, and software provided to members is subject to the following conditions:

1. The member has a medical condition resulting in a severe expressive communication impairment; and

2. The SGD, accessories and software is used primarily as a communication device; and

3. The SGD, accessories or software are recommended by a Speech Language Pathologist after a communication assessment as described at 10 CCR 2505-10, Section 8.590.3.E.1; and

   a. The recommended device, software or application should be capable of modifications to meet the needs for supportive functional communication when

possible. The recommended software or application must be compatible with the prescribed SGD.

b. Accessories and supplies that do not have a primary medical use will not be covered, which includes any items that are unnecessary for operation of the SGD, or are unrelated to the SGD.

i. Covered accessories include but are not limited to:

1. Replacement lithium ion batteries;

2. Non-electric SGD communication board;

3. Mounting systems designated for securing the SGD within reach of the client;

4. Safety and protection accessories designated to maintain the life expectancy of the device,

5. Accessories not otherwise classified may be approved to enhance the use of the SGD system as the member's condition changes; and

6. Orthotic and prosthetic supplies and accessories, and/or service components of another HCPCS L code.

4. Other forms of treatment have been considered or ruled out; and

5. The member's communication impairment will benefit from the SGD, accessories, or software.