DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Speech Language Pathology, Section 8.200.3
Rule Number: MSB 18-06-01-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 18-06-01-A, Revision to the Medical Assistance Rule concerning Speech Language Pathology, Section 8.200.3
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) 8.200.3.D.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 the current text at 8.200.3. with the proposed text beginning at 8.200.3 through the end of 8.200.3.D.2. This rule is effective March 1, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Speech Language Pathology, Section 8.200.3
Rule Number: MSB 18-06-01-A
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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).

   Certain Speech Language Pathology (SLP) benefit documentation requirements are being revised to improve program fidelity by replacing permissive language with mandatory language. This revision is necessary to ensure provider documentation of a client's initial evaluation includes (1) an assessment of the factors which influence the treatment diagnosis and prognosis, and (2) a discussion of the inter-relationship between the diagnoses and disabilities for which the referral was made. In addition, care plans must cover a period no longer than 90 days or the time frame documented in the Individual Family Service Plan. Documentation must follow the Subjective, Objective, Assessment and Plan (SOAP) format for each visit and include a subjective element, an objective element, an assessment component, and a plan component. Mandatory documentation requirements are necessary for program integrity and compliance oversight. Revision also clarifies that payment for therapies provided as part of a client's school requirement are not separately billable to Medicaid. The Department reimburses school districts for SLP services rendered to clients. Providers rendering SLP services to clients as part of the school requirement are reimbursed by the school district and may not submit additional claims to the Department for reimbursement. Finally, the revision includes miscellaneous citation updates, terminology updates, and removal of obsolete language.

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 USC 1396d(a)(11) / 42 CFR 440.110

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   Section 25.5-4-410, C.R.S. (2018)

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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.

   Speech Language Pathology providers (SLP providers) and clients utilizing SLP services will be affected by the proposed rule. SLP providers will bear the cost of the mandatory documentation requirements. Clients will benefit from more robust documentation of services rendered. Moreover, the Department's compliance and oversight of the SLP benefit will improve as a result of mandatory documentation.

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

   SLP providers must invest time and resources into mandatory documentation requirements. Robust documentation of SLP services will qualitatively improve the recordkeeping of SLP services and the Department's ability to oversee program integrity. Moreover, clarifying reimbursement for SLP services rendered through the School Health Services Program (SHSP) will prohibit double-billing for such services.

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 to the Department or to any other agency to implement and enforce the proposed rule. No anticipated impact on state revenues.

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

   Cost of the proposed rule is increased documentation requirements for SLP providers. Benefits of the proposed rule include (1) robust SLP benefit utilization documentation, (2) improved SLP benefit compliance and enforcement oversight, and (3) prohibition of double-billing for SLP services rendered through the SHSP. Costs of inaction include (1) inability to enforce permissive SLP service documentation provisions and (2) potential double-billing of SLP services rendered through SHSP. There are no benefits to inaction.

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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 to require SLP service documentation or prohibit double-billing of SLP services rendered through SHSP.

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 codifying the SLP service documentation requirements or prohibiting double-billing of SLP services rendered through SHSP.

8.200.3.D Physician Services ~~Benefit Coverage Standards~~

Note: 8.200.3.D.1 Podiatry Services ~~Benefit Coverage Standard~~ was moved to §8.810 01/2015.

2. Speech – Language and Hearing Services ~~Benefit Coverage Standard~~

a. ELIGIBLE PROVIDERS

i. Eligible providers include individual practitioners and those employed by home care agencies, children's developmental service agencies, health departments, federally qualified health centers (FQHC), clinics, or hospital outpatient services.

ii. Otolaryngologists, speech-language pathologists (speech therapists), and audiologists shall have a current and active license or registration and be current, active and unrestricted to practice.

iii. Providers shall be enrolled as a ~~Colorado Medicaid~~Health First Colorado provider in order to be eligible to bill for procedures, products and services in treating a ~~Colorado Medicaid~~Health First Colorado client.

iv. Rendering Providers include:

1. Otolaryngologist

2. Speech-language pathologist

3. Speech-language pathology assistant

4. Clinical fellows

5. Audiologist

b. PROVIDER AGENCY REQUIREMENTS

i. Providers of in-home health who employ therapists or audiologists shall apply for licensing through the Colorado Department of Public Health and Environment (CDPHE). (§25-27.5-103(1), C.R.S. and 6 CCR 1011-1, Chapter XXVI, Section 5.1) as a home care agency.

1~~ii~~. This rule does not apply to providers delivering Early Intervention Services under an Individual Family Service Plan (IFSP) and billing through contracts with the Community Centered Boards.

c. ELIGIBLE PLACES OF SERVICE

i. Eligible Places of Service shall include:

1. Office

2. Home

3. School

A. Therapies provided as part of a member's school requirement are not separately reimbursable. These services are paid for by the school district which is reimbursed by the Department. Providers may not submit claims for therapy services performed as part of a member's school requirement.

4. FQHC

5. Outpatient Hospital

6. Community Based Organization

d. ELIGIBLE CLIENTS

i. Eligible Clients include enrolled clients ages twenty (20) and under and adult clients who qualify under medically necessary services. Qualifying adult clients may receive services for non-chronic conditions and acute illness and injuries.

e. COVERED SERVICES

i. Newborn Screening

1. Screening shall include a comprehensive health assessment performed soon after birth or as early as possible in a child's life and repeated at periodic intervals of time as recommended by the Colorado Early & Periodic Screening & Diagnostic and Treatment (EPSDT) periodicity schedules.

ii. Early Language Intervention

1. Early language intervention for children 0 through three with a hearing loss may be provided by audiologists, speech therapists, or Colorado Home Intervention Program (CHIP) providers.

iii. Audiology Services

1. Audiological benefits include identification, diagnostic evaluation and treatment for children with hearing loss, neurologic, dizziness/vertigo, or balance disorders. Conditions treated may be either congenital or acquired.

2. Assessment – Service may include testing or clinical observation or both, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report.

a. Auditory sensitivity (including pure tone air and bone conduction, speech detection and speech reception thresholds).

b. Auditory discrimination in quiet and noise.

c. Impedance audiometry (tympanometry and acoustic reflex testing).

d. Hearing aid evaluation (amplification selection and verification).

e. Central auditory function.

f. Evoked otoacoustic emissions.

g. Brainstem auditory evoked response.

h. Assessment of functional communicative skills to enhance the activities of daily living.

i. Assessment for cochlear implants (for clients ages 20 and under).

j. Hearing screening.

k. Assessment of facial nerve function.

l. Assessment of balance function.

m. Evaluation of dizziness/vertigo.

3. Treatment – Service may include one or more of the following, as appropriate:

a. Auditory training.

b. Speech reading.

c. Augmentative and alternative communication training including training on how to use cochlear implants for clients ages 20 and under. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living.

d. Purchase, maintenance, repairs and accessories for approved devises.

e. Selection, testing and fitting of hearing aids for children with bilateral or unilateral hearing loss; and auditory training in the use of hearing aids.

f. Purchase and training on Department approved assistive technologies.

g. Balance or vestibular therapy.

iv. Cochlear Implants

1. Cochlear implants may be indicated for clients aged 12 months through 20 years under the following pre-authorization criteria:

    a. Six months of age or older.

    b. Limited benefit from appropriately fitted binaural hearing aids (with different definitions of “limited benefit” for children 4 years of age or younger and those older than 4 years) and a 3-6 month hearing aid trial.

    c. Bilateral hearing loss with unaided pure tone average thresholds of 70 dB or greater.

    d. Minimal speech perception measured using recorded standardized stimuli-speech discrimination scores of 50-60% or below with optimal amplification at 1000, 2000 and 4000 Hz.

    e. Family support and motivation to participate in a post-cochlear aural, auditory and speech language rehabilitation program.

    f. Assessment by an audiologist and otolaryngologist experienced in cochlear implants.

    g. Bi lateral and hybrid/Electric Acoustic Stimulation cochlear implantation considered on a case by case basis.

    h. No medical contraindications.

    i. Up-to-date-immunization status as determined by the Advisory Committee on Immunization Practices (ACIP).

    j. Replacement of an existing cochlear implant for all ages is a benefit when the currently used component is no longer functional and cannot be repaired.

v. Speech-language Services

    1. Assessment **–** Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report:

        a. Expressive language.

        b. Receptive language.

        c. Cognition.

        d. Augmentative and alternative communication.

        e. Voice disorder.

f. Resonance patterns.

g. Articulation/phonological development.

h. Pragmatic language.

i. Fluency.

j. Feeding and swallowing.

k. Hearing status based on pass/fail criteria.

l. Motor speech.

m. Aural rehabilitation (defined by provider's scope of practice.

2. Treatment – Service may include one or more of the following, as appropriate:

a. Articulation/phonological therapy

b. Language therapy including expressive, receptive, and pragmatic language.

c. Augmentative and alternative communication therapy. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living

d. Auditory processing/discrimination therapy

e. Fluency therapy.

f. Voice therapy.

g. Oral motor therapy.

h. Swallowing therapy.

i. Speech reading.

j. Cognitive treatment.

k. Necessary supplies and equipment.

l. Aural rehabilitation (defined by provider's scope of practice)

f. DOCUMENTATION

i. General Requirements for Client's Record of Service:

1. Rendering providers shall document all evaluations, re-evaluations, services provided, client progress, attendance records, and discharge plans. All documentation must be kept in the client's records along with a copy of the referral or prescribing provider's order.

2. Documentation shall support both the medical necessity of services and the need for the level of skill provided.

3. Rendering providers shall copy the client's prescribing provider and medical home/primary care provider on all relevant records.

ii. Documentation shall include all of the following:

1. The client's name and date of birth.

2. The date and type of service provided to the client.

3. A description of each service provided during the encounter including procedure codes and time spent on each.

4. The total duration of the encounter.

5. The name or names and titles of the persons providing each service and the name and title of the therapist supervising or directing the services.

iii. Documentation categories

1. Provider shall keep documentation for the following episodes of care: Initial Evaluation, Re-evaluation, Visit/Encounter Notes, and Discharge Summary.

2. Written documentation of the Initial Evaluation shall include the following:

a. The reason for the referral and reference source.

b. Diagnoses pertinent to the reason for referral, including:

i. Date of onset;

ii. Any cognitive, emotional, or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses;

iii. Current functional limitation or disability as a result of the above loss, and the onset of the disability;

iv. Pre-morbid functional status, including any pre-existing loss or disabilities;

v. Review of available test results;

vi. Review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.

c. Assessment: Include a summary of the client's impairments, and functional limitations and disabilities, based on a synthesis of all findings gathered from the evaluation. Highlight pertinent factors which influence the treatment diagnosis and prognosis, and discuss the inter-relationship between the diagnoses and disabilities for which the referral was made ~~should~~ must be discussed.

d. Plan of Care: A detailed Plan of Care must include the following

i. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured.

e. Proposed interventions/treatments to be provided during the episode of care.

f. Proposed duration and frequency of each service to be provided.

g. Estimated duration of episode of care.

7. The therapist's Plan of Care must be reviewed, revised if necessary, and signed, as medically necessary by the client's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days. The care plan ~~should~~ must not cover more than a 90-day period or the time frame documented in the Individual Family Service Plan (IFSP). (~~Senate bill 07-004~~ 27-10.5-702(7), C.R.S. (2017) states the IFSP "shall qualify as meeting the standard for medically necessary services." Therefore no physician is required to sign a work order for the IFSP.)

8. A plan of care must be certified. Certification is the physician's, physician's assistant or nurse practitioner's approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. If the service is a Medicare covered service and is provided to a recipient who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

9. Re-evaluation. A re-evaluation must be done whenever there is an unanticipated change in the client's status, a failure to respond to interventions as expected or there is a need for a new Plan of Care based on new problems and goals that require

significant changes to the Plan of Care. The documentation for a re-evaluation need not be as comprehensive as the initial evaluation, but must include at least the following: Reason for re-evaluation; Client's health and functional status reflecting any changes; findings from any repeated or new examination elements; and, Changes to plan of care.

iv. Visit/Encounter Notes

1. Written documentation of each encounter must be in the client's record of service. These visit notes document the implementation of the plan of care established by the therapist at the initial evaluation. Each visit note must include the following:

   a. The total duration of the encounter.

   b. The type and scope of treatment provided, including procedure codes and modifiers used.

   c. The time spent providing each service. The number of units billed/requested must match the documentation.

   d. Identification of the short or long term goals being addressed during the encounter.

2. Documentation must ~~Colorado Medicaid recommends but does not require that documentation~~ follow the Subjective, Objective, Assessment and Plan (SOAP) format. In addition to the above required information, the visit note ~~should~~ must include:

   a. A *subjective* element which includes the reason for the visit, the client or caregiver's report of current status relative to treatment goals, and any changes in client's status since the last visit;

   b. An *objective* element which includes the practitioner's findings, including abnormal and pertinent normal findings from any procedures or tests performed;

   c. An *assessment* component which includes the practitioner's assessment of the client's response to interventions provided, specific progress made toward treatment goals, and any factors affecting the intervention or progression of goals; and

   d. A *plan* component which states the plan for next visit(s).

v. Discharge Summary

1. At the conclusion of therapy services, a discharge summary must be included in the documentation of the final visit in an episode of care. This may include the following:

a. Highlights of a client's progress or lack of progress towards treatment goals.

b. Summary of the outcome of services provided during the episode of care.

g. NON-COVERED SERVICES AND GENERAL LIMITATIONS

i. Health First Colorado~~Colorado Medicaid~~ does not cover items and services which generally enhance the personal comfort of the eligible person but are not necessary in the diagnosis of, do not contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member.

ii. Maintenance programs beginning when the therapeutic goals of a treatment plan have been achieved and no further functional progress is apparent or expected to occur, are **not** covered for adult clients.

iii. Services provided without a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law are not covered, unless they are covered by an ~~Individual Family Service Plan (~~IFSP~~)~~.

iv. Treatment of speech and language delays not associated with an acquired or chronic medical condition, neurological disorder, acute illness, injury, or congenital defect are not covered, unless they are covered by an ~~Individual Family Service Plan (~~IFSP~~)~~.

v. Any service that is not determined by the provider to be medically necessary according to the definition of medical necessity ~~in the Speech Language Hearing Services Benefit Coverage Standard is not covered~~in Section 8.076.1.8.

vi. Hearing aids for adults are not a covered service.

vii. Hearing exams and evaluations are a benefit for adults only when a concurrent medical condition exists.

viii. Initial placement of cochlear implants for adults **is not covered.**

ix. The upgrading of a cochlear implant system or component (e.g., upgrading processor from body worn to behind the ear, upgrading from single to multi-channel electrodes) of an existing properly functioning cochlear implant is not covered.

x. Services not documented in the client's Plan of Care are not covered.

xi. Services specified in a plan of care that is not reviewed and revised as medically necessary by the client's attending physician or by an IFSP are not covered.

xii. Services that are not designed to improve or maintain the functional status of a recipient with a physical loss or a cognitive or psychological deficit are not covered.

xiii. A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements is not covered.

xiv. Vocational or educational services, including functional evaluations, except as provided under IEP-related services are not covered.

xv. Services provided by unsupervised therapy assistants as defined by the American Speech-Language Hearing Association (ASHA) are not covered.

xvi. Treatment for dysfunction that is self-correcting (for example, natural dysfluency or developmental articulation errors) is not covered.

xvii. Psychosocial services are not covered.

xviii. Costs associated with record keeping documentation and travel time are not covered.

xix. Training or consultation provided by an audiologist to an agency, facility, or other institution is not covered.

xx. Therapy that replicates services that are provided concurrently by another type of therapy is not covered. Particularly, occupational therapy which should provide different treatment goals, plans, and therapeutic modalities from speech therapy.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Drug Benefits, Section 8.800.4
Rule Number: MSB 18-06-20-A
Division / Contact / Phone: Client and Clinical Care / Kristina Gould / 303-866-6715

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 18-06-20-A, Revision to the Medical Assistance Rule concerning Drug Benefits, Section 8.800.4
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) 8.800.4.B, 8.800.4.C and 8.800.4.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 8.800.4 with the proposed text beginning at 8.800.4.B through the end of 8.800.4.D. This rule is effective March 1, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Drug Benefits, Section 8.800.4
Rule Number: MSB 18-06-20-A
Division / Contact / Phone: Client and Clinical Care / 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).

   First, the Department is moving "agents when used for cosmetics purposes or hair growth" in section 8.800.4.B to section 8.800.4.C, to comply with Title XIX of the Social Security Act, Section 1903 (i) (21). CMS required the Department to remove this language from our State Plan and now the Department must move it to 8.800.4.C (drugs that are never a pharmacy benefit). Second, stakeholders requested that the Department make clarifications at 8.800.4.B because it was not clear which drug categories the Department covers; therefore, language was rearranged to clarify. Lastly, the Department is expanding coverage of select non-prescription drugs (Bisacodyl, Docusate Sodium and Ferrous Sulfate) to Medicaid members and clarifying the specific non-prescription drug categories that are currently covered by the Department.

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:

   Title XIX of the Social Security Act, Sections 1903(i)(21), 1927(d)(2) and 1935(d)(1) and (2)

   42 CFR 441.25

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);

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Title of Rule: Revision to the Medical Assistance Rule concerning Drug Benefits, Section 8.800.4
Rule Number: MSB 18-06-20-A
Division / Contact / Phone: Client and Clinical Care / 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.

   Members will have increased access to specific over-the-counter (OTC) medications, stakeholders and providers will have a clearer understanding of the drug(s) that the Department covers, and the Department will likely see a decrease in appeals. There are no adverse costs related to this rule change.

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 estimated economic impact associated with this rule revision is $0 based on the assumptions that there will be a reduction in Emergency Department use and a reduction in prescriptions that are currently being written for higher cost drugs.

   These rule revisions will have a positive impact because: agents when used for cosmetic purposes or hair growth were never a covered benefit; therefore, moving this language to 8.800.4.C will have no impact, members will have increased access to select non-prescription medications, providers will better understand the drug categories that are covered, the Department will not incur additional costs, and the Department is confident that these clarifications will decrease 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.

   The Department's estimated economic impact associated with this rule revision is $0 and there are no costs to other agencies in the implementation and enforcement of this rule change.

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

   Expanding access of lower cost therapeutically equivalent drugs to members, while also paying close attention to government resources, is achieved through this rule change. Members will have increased access to medications, the Department will not

bear additional costs and stakeholders/providers will have more clarity regarding drugs that are covered and drugs that are not covered.

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

   None.

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.

   None.

8.800.4 DRUG BENEFITS

8.800.4.A. Only those drugs designated by companies participating in the federally approved Medical Assistance Program drug rebate program and not otherwise excluded according to these rules are regular drug benefits. Notwithstanding the foregoing, drugs not covered by rebate agreements may be reimbursed if the Department has made a determination that the availability of the drug is essential, such drug has been given an "A" rating by the U. S. Food and Drug Administration (FDA), and a prior authorization has been approved. Reimbursement of any drugs that are regular drug benefits may be restricted as set forth in these rules.

8.800.4.B. ~~The following~~ Pursuant to 42 U.S.C. 1396r-8 (d)(2), certain drugs or classes of drugs ~~categories~~ may be excluded from ~~being a drug benefit~~ coverage or may be subject to restrictions. ~~:~~

1. The following are covered with restrictions:

   a. Agents when used for ~~anorexia, weight loss or~~ weight gain;

   b. Agents when used for the symptomatic relief of cough and colds;

   c. Prescription vitamin and mineral products, except prenatal vitamins and fluoride, for documented deficiency; and

   d. Non-prescription Drugs.

2. The following are excluded from coverage:

   a. Agents when used for anorexia or weight loss;

   b Agents when used to promote fertility;

   c. Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; and

   d. Agents used for the treatment of sexual or erectile dysfunction unless such agents are used to treat a condition, other than a sexual or erectile dysfunction, for which the agents have been approved by the FDA.

~~Agents when used to promote fertility;~~

~~3. Agents when used for cosmetic purposes or hair growth;~~

~~4. Agents when used for symptomatic relief of cough and colds;~~

~~5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;~~

~~6. Non-prescription Drugs;~~

~~7. Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; and~~

~~8. Agents used for the treatment of sexual or erectile dysfunction unless such agents are used to treat a condition, other than a sexual or erectile dysfunction, for which the agents have been approved by the FDA.~~

8.800.4.C. The following are not pharmacy benefits of the Medical Assistance Program:

1. Spirituous liquors of any kind;

2. Dietary needs or food supplements;

3. Personal care items such as mouth wash, deodorants, talcum powder, bath powder, soap of any kind, dentifrices, etc.;

4. Medical supplies;

5. Drugs classified by the FDA as "investigational" or "experimental"; except for the following:

   a. Stiripentol may be covered if the coverage has been ordered by the member's physician, has been deemed medically necessary by the Department and has been authorized for the specific member's use by the U.S. Food & Drug Administration.

6. Less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program; ~~and~~

7. Medicare Part D Drugs for Part D eligible individuals; and~~.~~

8. Agents when used for cosmetic purposes or hair growth.~~;~~

8.800.4.D. Aspirin, OTC insulin and medications that are available OTC and that have been designated as Preferred Drugs on the PDL are the only OTC drugs that are regular benefits without restrictions. Nonprescription drugs prescribed for a medically accepted indication in the following classes may be covered: aspirin; cough and cold or allergy preparations consisting of antihistamines, analgesics/antipyretics, cough suppressants, decongestants, and expectorants or combinations thereof; doxylamine; emergency contraceptives; fluoride preparations; intranasal corticosteroids; iron supplements; laxatives; l-methylfolate; pain relievers; proton pump inhibitors; pyridoxine; smoking cessation preparations.

8.800.4.E. Restrictions may be placed on drugs in accordance with Title 42 of the United States Code, Section 1396r-8(d)(2014). Title 42 of the United States Code, Section 1396r-8(d)(2014) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

1. Without limiting the foregoing, restrictions may be placed on drugs for which it has been deemed necessary to address instances of fraud or abuse, potential for, and history of, drug diversion and other illegal utilization, overutilization, other inappropriate utilization or the availability of more cost-effective comparable alternatives.

8.800.4.F. To the extent the drug categories listed in Section 8.800.4.B are not Medicare Part D Drugs, they shall be covered for Part D eligible individuals in the same manner as they are covered for all other eligible Medical Assistance Program members.

8.800.4.G. Generic drugs shall be dispensed to members in fee-for-service programs unless:

1. Only a brand name drug is manufactured.

2. A generic drug is not therapeutically equivalent to the brand name drug.

3. The final cost of the brand name drug is less expensive to the Department.

4. The drug is in one of the following exempted classes for the treatment of:

    a. Mental Illness;

    b. Cancer;

    c. Epilepsy; or

    d. Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.

5. The Department shall grant an exception to this requirement if:

    a. The member has been stabilized on a medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand name drug would be unacceptably disruptive; or

    b. The member is started on a generic drug but is unable to continue treatment on the generic drug.

Such exceptions shall be granted in accordance with procedures established by the Department.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning School Health Services Program Claims Submission and Interim Payment, Section 8.290.6.D
Rule Number: MSB 18-06-25-B
Division / Contact / Phone: Special Financing / Shannon Huska / 303.866.3131

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 18-06-25-B, Revision to the Medical Assistance Rule concerning School Health Services Program Claims Submission and Interim Payment, Section 8.290.6.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) 8.290.6.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 8.290.6.D with the proposed text beginning at 8.290.6.D through the end of 8.290.6.D. This rule is effective March 1, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning School Health Services Program Claims Submission and Interim Payment, Section 8.290.6.D
Rule Number: MSB 18-06-25-B
Division / Contact / Phone: Special Financing / Shannon Huska / 303.866.3131

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 changes to the SHS rules are to maintain the 120 days for timely filing and not have the SHS Program go with the new update to 365 days to submit claims. Changing to 365 days would have a negative impact on the school districts because it would delay payments to the school districts. In addition, if we do not update the SHS rules the SHS state plan amendment would have to be updated as the two would be contradict each other.

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);
   Section 25.5-5-318

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning School Health Services Program Claims Submission and Interim Payment, Section 8.290.6.D
Rule Number: MSB 18-06-25-B
Division / Contact / Phone: Special Financing / Shannon Huska / 303.866.3131

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.

   Public School Districts, Boards of Cooperative Education Services and state educational institutions that serve student in Kindergarten through twelfth grade that participate in the School Health Services Program will benefit by the proposed rule by continuing operations as they are accustomed with no impact to cash flow. These participants will would be negatively impacted if the proposed rule is not adopted.

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 allow the participating districts to continue in the program as they are used to. Not adopting the rule changes would create a delay in payments to school districts and be a financial burden for districts to continue in the program.

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 associated with implementing the rule changes.

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

   Implementing the rule will allow participating districts in the School Health Services Program to continue in the program as they are accustomed. Not implementing would delay payments and negatively impact cash flow to participating districts. In addition, not implementing would mean that the program's Medicaid State Plan and rules are in contradiction to each other.

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

This is the least intrusive option for the school districts and is supported by the school districts. If the rule is not changed, the Department will have to request an amendment to program's Medicaid State Plan to adjust for the current rule. Seeking an amendment to the State Plan is the more intrusive and riskier option as amending the Medicaid State Plan would likely result in the federal government requiring additional changes to program operations that could increase the districts' administrative costs in running the program.

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 not changing the rule, which would mean the program would follow the Medicaid rule for timely submission of claims. If the School Health Services Rule is not changed, however, cash flow for school districts would be negatively impacted due to a delay in final cost settlement which cannot occur until all claims have been adjudicated. In addition, not amending the rule would mean that the rules and Medicaid State Plan contradict each other. Amending the Medicaid State Plan would likely result in the federal government requiring additional changes to program operations that could increase the districts' administrative costs in running the program.

8.290.6 REIMBURSEMENT

8.290.6.D. Claims Submission and Interim Payment

1. The Participating District shall submit a procedure code specific fee-for-service claim for each School Health Service provided for each client.

2. Interim payment for School Health Services provided shall be reimbursed on a monthly rate. The monthly rate shall be based on the Participating Districts actual, certified costs identified in the Participating Districts most recently filed annual cost report. For a new Participating District, the monthly rate shall be calculated based on historical data.

3. Interim payment shall be tied to claims submission by the Participating District. Claims shall be monitored by the Department and if claim volume decreases significantly or drops to zero in any two consecutive months while school is in session, interim payment shall be withheld until the issue has been resolved.

4. The Participating District shall be notified of the monthly rate each state fiscal year no later than 30 days prior to July 1 of that state fiscal year.

5. The Participating District shall receive the federal share of the rate, not to exceed 100% of the federal match rate, as interim payment.

6. School Health Services provided shall be billed as an encounter or in 15-minute unit increments, in accordance with proper billing practices as defined by the Health Insurance Portability and Accountability Act or by the Healthcare Common Procedure Coding System.

7. Specialized Transportation services shall be billed as one-way trips to and from the destination.

8. Each Participating District submitting claims for reimbursement shall follow proper billing instructions as outlined in the Department's School Health Services Program Manual and in accordance with 10 C.C.R. 2505-10, Section 8.040.2. ~~and 8.043~~.

9. Each Participating District shall submit claims for School Health Services Program eligible services provided to eligible Medicaid recipients. To comply with the School Health Services Program cost reconciliation requirements, all claims must be received by the fiscal agent within 120 days from the date of service. Claims submitted more than 120 days after the end of the state fiscal year (June 30th) will not be included in the cost reconciliation calculation and final payment as specified under 8.290.6.E.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision of Reimbursement for Non-DRG Hospital's Inpatient Services provided by Freestanding Long Term Acute Care Hospitals and Freestanding Rehabilitation Hospitals, Sections 8.300.1 8.300.5.A, 8.300.5.C, 8.300.5.D
Rule Number: MSB 18-07-23-A
Division / Contact / Phone: Finance / Kevin Martin / 303-866-2842/Elizabeth Quaife / 303-866-2083

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 18-07-23-A, Revision of Reimbursement for Non-DRG Hospital's Inpatient Services provided by Freestanding Long Term Acute Care Hospitals and Freestanding Rehabilitation Hospitals, Sections 8.300.1 8.300.5.A, 8.300.5.C, 8.300.5.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) 8.300.1, 8.300.5.A, 8.300.5.C, 8.300.5.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 8.300.1 with the proposed text beginning at 8.300.1 through the end of 8.300.1. Replace the current text at 8.300.5.A with the proposed text beginning at 8.300.5.A.1 through the end of 8.300.5.A.1. Replace the current text at 8.300.5.C with the proposed text beginning at 8.300.5.C through the end of 8.300.5.C. Replace the current text at 8.300.5.D with the proposed text beginning at 8.300.5.D through the end of 8.300.5.D. This rule is effective March 1, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision of Reimbursement for Non-DRG Hospital's Inpatient Services provided by Freestanding Long Term Acute Care Hospitals and Freestanding Rehabilitation Hospitals, Sections 8.300.1 8.300.5.A, 8.300.5.C, 8.300.5.D
Rule Number: MSB 18-07-23-A
Division / Contact / Phone: Finance / Kevin Martin / 303-866-2842/Elizabeth Quaife / 303-866-2083

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, Freestanding Long Term Acute Care Hospitals and Freestanding Rehabilitation Hospitals, impact to Inpatient claims only, are being reimbursed under APR-DRG and included in section 8.300.A. Changing the Inpatient reimbursement to a step-down per diem methodology would better align with national practices and provide a more accurate reimbursement for long-term and short-term stays inpatient stays. Per diem rules will be added to the existing section 8.300.5.D.

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);
   Section 25.5-4-402(1), C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision of Reimbursement for Non-DRG Hospital's Inpatient Services provided by Freestanding Long Term Acute Care Hospitals and Freestanding Rehabilitation Hospitals, Sections 8.300.1 8.300.5.A, 8.300.5.C, 8.300.5.D
Rule Number: MSB 18-07-23-A
Division / Contact / Phone: Finance / Kevin Martin / 303-866-2842/Elizabeth Quaife / 303-866-2083

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.

   Only Medicaid Clients who meet a list of admission requirements for a Long-Term Acute Care Hospitals OR Rehabilitation Hospitals will be impacted by this change. Hospitals licensed as General Hospital with Certification of Long-Term Acute Care OR Rehabilitation Hospital will see a decrease in reimbursement for short stays while receiving a higher reimbursement for longer stays. Ease of calculating reimbursement will see quicker admissions for Medicaid Clients instead of being held in Short Term Acute Care Hospitals. Case load impact: may see a reduction in mild/holding cases (where a client is being held for additional procedures but not necessarily ready for recovery) and increase in servicing higher acuity patients who truly need these services. This impacts Inpatient claims only and is Budget Neutral.

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

   Per extensive research and outreach to the Provider community, this change will provide an easier and more accurate method of calculating reimbursement which will lead to quicker approval or denials for admissions. Currently Clients are being held in Short Term Acute Care Hospitals awaiting these decisions. Case load impact: may see a reduction in mild/holding cases (where a client is being held for additional procedures but not necessarily ready for recovery) and increase in servicing higher acuity patients whom truly need these services. This impacts Inpatient claims only and is Budget Neutral.

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 per diem is designed to be Budget Neutral for the Department's annual budget. For the hospitals they will be reimbursed by the days the client is in their care. Shorter stays (holding/lower acuity patients) may see a decrease compared to the APR-DRG methodology while the longer stays (higher acuity patients) will see an

increase in reimbursement compared to APR-DRG. The savings on the shorter stays are being allocated to the longer stays allowing this change to be budget neutral.

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

   While the design is meant to be Budget Neutral to the fiscal budget, by not doing anything we are allowing some hospitals with higher base rates (base rate is multiplied by the weight component of APR-DRG which results in the reimbursement amount) to take in more patients then their counterparts. This allows an equal opportunity for all hospitals in the same peer groups to take a Medicaid patient. Thus allowing quicker admissions for our clients to these Hospitals offering special rehabilitation and long-term acute care services instead of waiting for placement at the hospital or in a Short-Term Acute Care Hospital.

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

   This action is Budget Neutral no financial impact to the fiscal state - while the change is drastic to completely change the reimbursement methodology, it has been very successful in other state Medicaid programs and is strongly supported by the Provider community. This methodology also allows a good base methodology for additional components and improvements for future rate building.

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.

   Different types of per diem structures and reimbursement methodologies were considered. Including updating the APR-DRG methodology, different DRG methodologies and a per diem in different formats. The different per diem methods included a severity component, universal stepdown tiers and different peer groupings. Many were eliminated due to not enough data available to accurately build all components, APR-DRG software is licensed by 3M and a heavy lift such as adding new codes is not possible, had difficulty finding a grouping software that would accurately capture costs for this small subset of hospitals.

8.300 HOSPITAL SERVICES

8.300.1 Definitions

Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.

Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.

Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.

Department means the Department of Health Care Policy and Financing.

Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.

DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals.

Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury or other health condition in a client.

Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.

Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably be expected to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

Enhanced Ambulatory Patient Group (EAPG) means a cluster of similar procedures within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of services performed during Outpatient visits that utilize similar amounts of Hospital resources.

Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide

Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical services and/or obstetrical services including a delivery room and nursery.

A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.

A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.

A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital which primarily serves an inpatient population requiring long-term care services including but not limited to respiratory therapy, head trauma treatment, complex wound care, IV aAntibiotic tTreatment and pain management.

A Spine/Brain Injury Treatment Specialtyist Hospital licensed as a General Hospital withand CMS-certified as a Long-Term Care Hospital OR CMS-certified as a Rehabilitation Hospital. iAdditionally, Hospital isIs a Not-for Profit Hospital as determined by the CM a CMS Waiver for a Not-For-Profit HospitalS's Cost Report for the most recent fiscal year. A Spine/Brain Injury Treatment Specialty Hospital The Hospital pPprimarily serves an inpatient population requiring long term acute care and extensive rehabilitation for recent spine/brain injuries. To qualify as a Spine/Brain Injury Treatment Specialty Hospital, for at least 50% of Medicaid members discharged in the preceding calendar year the hospital must have submitted Medicaid claims including spine/brain injury treatment codes (previously grouped to APR-DRG 40, 44, 55, 56, and 57). The Department shall revoke the designation if the percentage of Medicaid members discharged falls below the 50% requirement for a calendar year. Designation is removed the calendar year following the disqualifying year.Hospital must maintain a minimum fifty (50) percent Medicaid case load of spine/brain injury treatment cases consists of at least of fifty (50) percent of all Medicaid cases for previous fiscal year and continue with each fiscal year for designation.

A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.

Inpatient means a person who is receiving professional services at a Hospital; the services include a room and are provided on a continuous 24-hour-a-day basis. Generally, a person is considered an Inpatient by a physician's order if formally admitted as an Inpatient with the expectation that the client will remain at least overnight and occupy a bed even though it later develops that the client can be discharged or transferred to another Hospital and does not actually use a bed overnight.

Inpatient Hospital Services means preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by a Hospital for the care and treatment of Inpatients and are provided in the Hospital by or under the direction of a physician.

Medical Necessity is defined at Section 8.076.1..

Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals, Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital are considered Non-DRG Hospitals since their reimbursement is based on a per diem rate.

Observation Stay means a stay in the Hospital for no more than forty-eight hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed twenty-four hours in length.

Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.

Outpatient means a client who is receiving professional services at a Hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-a-day basis.

Outpatient Hospital Services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist.

Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service prior to treatment.

Rehabilitative Services means any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his/her best possible functional level.

Relative Weight (DRG weight or EAPG weight) means a numerical value which reflects the relative resource consumption for the DRG or EAPG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost for each DRG or EAPG. Relative Weights are intended to be cost effective, and based upon Colorado data as available.

Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.

Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by the United States Office of Management & Budget.

State University Teaching Hospital means a Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education; and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called “swing beds.”

Trim Point Day (Outlier Threshold Day) means the day which would occur 2.58 standard deviations above the mean (average) length of stay (ALOS) for each DRG.

Urban Hospital means a Hospital located within a MSA as designated by the United States Office of Management & Budget.

Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

8.300.2 Requirements for Participation

8.300.2.A In-Network Hospitals

1. In order to qualify as an in-network Hospital, a Hospital must:

    a. be located in Colorado

    b. be certified for participation as a Hospital in the Medicare Program;

    c. have an approved Application for Participation with the Department; and

    d. have a fully executed contract with the Department.

2. A border-state Hospital (located outside of Colorado) which is more accessible to clients who require Hospital services than a Hospital located within the state may be an in-network Hospital by meeting the requirements of 10 CCR 2505-10 Section 8.300.2.A.1.b – c. The Department shall make the proximity determination for Hospitals to enroll as a border-state Hospital.

3. In-network and out-of-network Hospitals located in Colorado shall be surveyed by the CDPHE. Failure to satisfy the requirements of CDPHE may cause the Department to institute corrective action as it deems necessary.

8.300.2.B Out-of-Network Hospitals

An out-of-network Hospital, including out-of-state Hospitals, may receive payment for emergency Hospital services if:

1. the services meet the definition of Emergency Care;

2. the services are covered benefits;

3. the Hospital agrees on an individual case basis not to charge the client, or the client's relatives, for items and services which are covered Medicaid benefits, and to return any monies improperly collected for such covered items and services; and

4. the Hospital has an approved Application for Participation with the Department.

8.300.2.C Out-of-State Hospitals

Out-of-state Hospitals may receive reimbursement for non-emergent Hospital services if they meet the conditions specified in 10 CCR 2505-10 Section 8.300.2.B.2 – 4, and the Department has issued a written prior authorization.

8.300.2.D Hospitals with Swing-Bed Designation

1. Hospitals which intend to designate beds as swing beds shall apply to CDPHE for certification of swing beds and to the Department for participation as a Medicaid provider of nursing facility services. The criteria in 10 CCR 2505-10 Section 8.430 must be met in order to become a Medicaid provider.

2. Hospitals providing nursing facility services in swing beds shall furnish within the per diem rate the same services, supplies and equipment which nursing facilities are required to provide.

3. Clients and/or their responsible parties shall not be charged for any of these required items or services as specified in 10 CCR 2505-10 Sections 8.440 and 8.482.

4. Hospitals providing nursing facility services to swing-bed clients shall be in compliance with the following nursing facility requirements.

    a. Client rights: 42 C.F.R. Section 483.10(b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (l), and (m).

    b. Client Admission, transfer and discharge rights: 42 C.F.R. Section 483.12 (a)(1) through (a)(7).

    c. Client behavior and facility practices: 42 C.F.R. Section 483.13.

    d. Client activities: 42 C.F.R. Section 483.15(f).

    e. Social Services: 42. C.F.R. Section 483.15(g).

    f. Discharge planning: 42 C.F.R. Section 483.20(e)

    g. Specialized rehabilitative services: 42 C.F.R. Section 483.45.

    h. Dental services: 42 C.F.R. Section 483.55.

5. Personal Needs Funds and Patient Payments

    Swing-bed Hospitals shall maintain personal needs accounts, submit AP-5615 forms, and be responsible for collecting patient payment amounts in accordance with the requirements established for nursing facilities in 10 CCR 2505-10 Section 8.482.

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

Inpatient Hospital Services are a Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. Inpatient Hospital services include:

    a. bed and board, including special dietary service, in a semi-private room to the extent available;

    b. professional services of hospital staff;

    c. laboratory services, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;

d. emergency room services;

e. drugs, blood products;

f. medical supplies, equipment and appliances as related to care and treatment; and

g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.

2. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.

3. Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

4. Psychiatric Hospital Services

Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-network Hospital.

a. Inpatient care in a Psychiatric Hospital is limited to forty-five (45) days per state fiscal year, unless additional services are prior-authorized as medically necessary by the Department's utilization review vendor or other Department representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.

b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:

i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and

ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.

c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

5. Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-network DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

a. an acute medical condition for which dialysis treatments are required; or

b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or

c. placement or repair of the dialysis route ("shunt", "cannula").

8.300.3.B Covered Hospital Services – Outpatient

Outpatient Hospital Services are a Medicaid benefit when determined Medically Necessary and provided by or under the direction of a physician. Outpatient Hospital Services are limited to the scope of Outpatient Hospital Services as defined in 42 C.F.R. Section 440.20.

1. Observation Stays

Observation stays are a covered benefit as follows:

a. Clients may be admitted as Outpatients to Observation Stay status.

b. With appropriate documentation, clients may stay in observation more than 24 hours, but an Observation Stay shall not exceed forty-eight hours in length.

c. A physician's order must be written prior to initiation of the Observation Stay.

d. Observation Stays end when the physician orders either Inpatient admission or discharge from observation.

e. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged.

2. Outpatient Hospital Psychiatric Services

Outpatient psychiatric services, including prevention, diagnosis and treatment of emotional or mental disorders, are Medicaid benefits at DRG Hospitals.

a. Psychiatric outpatient services are not a Medicaid benefit in free-standing psychiatric hospitals.

3. Emergency Care

a. Emergency Care Services are a Medicaid benefit, and are exempt from primary care provider referral.

b. An appropriate medical screening examination and ancillary services such as laboratory and radiology shall be available to any individual who comes to the emergency treatment facility for examination or treatment of an emergent or apparently emergent medical condition and on whose behalf the examination or treatment is requested.

8.300.3.C. Bariatric Surgery

1. Eligible Clients

    a. All currently enrolled Medicaid clients over the age of sixteen when:

        i) The client has clinical obesity; and

        ii) It is Medically Necessary.

2. Eligible Providers

    a. Providers must enroll in Colorado Medicaid.

    b. Surgeons must be trained and credentialed in bariatric surgery procedures.

    c. Preoperative evaluations and treatment may be performed by:

        i) Primary care physician,

        ii) Nurse Practitioner,

        iii) Physician Assistant,

        iv) Registered dietician,

        v) Mental health providers available through the Client's Behavioral Health Organization.

3. Eligible Places of Service

    a. All surgeries shall be performed at a Hospital, as defined at 8.300.1.

        i) Facilities must have safety protocols in place specific to the care and treatment of bariatric clients.

    b. Pre- and Post- operative care may be performed at a physician's office, clinic, or other medically appropriate setting.

4. Covered Services and Limitations

    a. Colorado Medicaid covers participating providers for one bariatric procedure per client lifetime unless a revision is appropriate based one of the identified complications.

        i) Appropriate revision procedures are identified at section 8.300.3.C.4.d.

    b. Covered primary procedures Include:

        i) Roux-en-Y Gastric Bypass;

        ii) Adjustable Gastric Banding;

        iii) Biliopancreatic Diversion with or without Duodenal Switch;

        iv) Vertical-Banded Gastroplasty;

v) Vertical Sleeve Gastroplasty.

c. Criteria for Primary Procedures

All Clients must meet the first four following criteria, clients under age 18 must meet criteria five:

i) The client is clinically obese with one of the following:

1) BMI of 40 or higher, or

2) BMI of 35-40 with objective measurements documenting one or more of the following co-morbid conditions:

a) Severe cardiac disease;

b) Type 2 diabetes mellitus;

c) Obstructive sleep apnea or other respiratory disease;

d) Pseudo-tumor cerebri;

e) Hypertension;

f) Hyperlipidemia;

g) Severe joint or disc disease that interferes with daily functioning;

h) Intertriginous soft-tissue infections, nonalcoholic steatohepatitis, stress urinary incontinence, recurrent or persistent venous stasis disease, or significant impairment in Activities of Daily Living (ADL).

ii) The BMI level qualifying the client for surgery (>40 or >35 with one of the above co-morbidities) must be of at least two years' duration. A client's BMI may fluctuate around the required levels during this period around the required levels, and will be reviewed on a case-by-case basis.

iii) The client must have made at least one clinically supervised attempt to lose weight lasting at least six consecutive months or longer within the past eighteen months of the prior authorization request, monitored by a registered dietician that is supervised by a physician, nurse practitioner, or physician's assistant.

iv) Medical and psychiatric contraindications to the surgical procedure must have been ruled out through:

1) A complete history and physical conducted by or in consultation with the requesting surgeon; and

2) A psychiatric or psychological assessment, conducted by a licensed mental health professional, no more than three months prior to the requested authorization. The assessment must

address both potential psychiatric contraindications and client's ability to comply with the long-term postoperative care plan.

v) For clients under the age of eighteen, the following must be documented:

1) The exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome;

2) Whether female clients have attained Tanner stage IV breast development; and

3) Whether bone age studies estimate the attainment of 95% of projected adult height.

4) Mental health evaluations for clients age 17 must address issues specific to these clients' maturity as it relates to compliance with postoperative instructions.

d. Revision Procedures

i) Colorado Medicaid covers Revisions of a surgery for clinical obesity if it is used to correct complications such as slippage of an adjustable gastric band, intestinal obstruction, or stricture, following a primary procedure.

ii) Indications for surgical revision:

1) Weight loss to 20% below the ideal body weight;

2) Esophagitis, unresponsive to nonsurgical treatment;

3) Hemorrhage or hematoma complicating a procedure;

4) Excessive bilious vomiting following gastrointestinal surgery;

5) Complications of the intestinal anastamosis and bypass;

6) Stomal dilation, documented by endoscopy;

7) Documented slippage of the adjustable gastric band;

8) Pouch dilation documented by upper gastrointestinal examination or endoscopy producing weight gain of 20% of more, provided that:

a) The primary procedure was successful in inducing weight loss prior to the pouch dilation; and

b) The client has been compliant with a prescribed nutrition and exercise program following the procedure (weight and BMI prior to surgery, at lowest stable point, and at current time must be submitted along with surgeon's statement to document compliance with diet and exercise);

9) Other and unspecified post-surgical non-absorption complications.

e. Non-Covered Services:

i) For Clients with clinically diagnosed COPD (Chronic Obstructive Pulmonary Disease), including Chronic Bronchitis or Emphysema.

ii) Repeat procedures not associated with surgical complications.

iii) Cosmetic Follow-up: Weight loss following surgery for clinical obesity can result in skin and fat folds in locations such as the medial upper arms, lower abdominal area, and medial thighs. Surgical removal of this skin and fat for solely cosmetic purposes is not a covered benefit.

iv) During pregnancy.

5. Prior Authorization Requirements

All bariatric surgical procedures require prior authorization, which must include:

a) The Client's height, weight, BMI with duration.

b) A list and description of each co-morbid condition, with attention to any contraindication which might affect the surgery including all objective measurements.

c) A detailed account of the Client's clinically supervised weight loss attempt(s), including duration, medical records of attempts, identification of the supervising clinician, and evidence of successful completion and compliance.

d) A current psychiatric or psychological assessment regarding contraindications for bariatric surgery, as described in 8.300.3.C.4.c(iv)(2).

e) A statement written or agreed to by the client, detailing for the interdisciplinary team the client's:

i) Commitment to lose weight;

ii) Expectations of the surgical outcome;

iii) Willingness to make permanent life-style changes;

iv) Be willing to participate in the long-term postoperative care plan offered by the surgery program, including education and support, diet therapy, behavior modification, and activity/exercise components; and

v) If female, client's statement that she is not pregnant or breast-feeding and does not plan to become pregnant within two years of surgery.

f) A description of the post-surgical follow-up program.

g) For clients under the age of eighteen, documentation of the physical criteria requirements at 8.300.3.C.4.c(v).

8.300.4 Non-Covered Services

The following services are not covered benefits:

1. Inpatient Hospital Services defined as experimental by the United States Food and Drug Administration.

2. Inpatient Hospital Services which are not a covered Medicare benefit.

3. Court-ordered psychiatric Inpatient care which does not meet the Medical Necessity criteria established for such care by the Department's utilization review vendor or other Department representative.

4. Days awaiting placement or appropriate transfer to a lower level of care are not a covered benefit unless otherwise Medically Necessary.

5. Substance abuse rehabilitation treatment is not covered unless individuals are aged 20 and under. Services must be provided by facilities which attest to having in place rehabilitation components required by the Department. These facilities must be approved by the Department to receive reimbursement.

8.300.5 Payment for Inpatient Hospital Services

8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services

1. Peer Groups

   For the purposes of Inpatient reimbursement, DRG Hospitals are assigned to one of the following peer groups. Hospitals which do not fall into the peer groups described in a and b shall default to the peer groups described in c and d based on geographic location.:

   a. Pediatric Hospitals

   b. Urban Safety Net Hospitals

   c. Rural Hospitals

   d. Urban Hospitals

   ~~e. Hospitals which do not fall into the peer groups described in a through c above shall default to the peer groups described in d and e based on geographic location.~~

2. Base Payment and Outlier Payment

   DRG Hospitals shall be reimbursed for Inpatient Hospital Services based on a system of DRGs and a hospital-specific Medicaid Inpatient base rate. The reimbursement for Inpatient Hospital Services shall be referred to as the DRG base payment.

   a. The DRG base payment shall be equal to the DRG Relative Weight multiplied by the Medicaid Inpatient base rate as calculated in 10 CCR 2505-10 Section 8.300.5.A.3 – 6.

b. Outlier days shall be reimbursed at 80% of the DRG per diem rate. The DRG per diem rate shall be the DRG base payment divided by the DRG average length of stay.

c. The DRG base payment plus any corresponding outlier payment is considered the full reimbursement for an Inpatient Hospital stay where the client was Medicaid-eligible for the entire stay.

d. When a client was not Medicaid-eligible for an entire Inpatient Hospital stay, reimbursement shall be equal to the DRG per diem rate for every eligible day, with payment up to the full DRG base payment. If applicable, the Hospital shall receive outlier reimbursement.

3. Medicaid Inpatient Base Rate for In-network Colorado DRG Hospitals

a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate

i For in-network Colorado DRG Hospitals, excluding Rehabilitation Hospitals, Long-Term Care Hospitals, CAHs, Pediatric Hospitals, and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the hospital-specific Medicare Federal base rate minus any DSH factors. For the purpose of rate setting effective on July 1 of each fiscal year, the Medicare base rate used shall be the Medicare base rate effective on October 1 of the previous fiscal year.

ii For Pediatric Hospitals, the starting point shall be equal to the cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 for rates effective July 1 of the same calendar year.

iv For CAHs and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the average Medicare base rate minus DSH factors for their respective peer group. The average calculation shall exclude CAHs and those Hospitals with less than twenty Medicaid discharges in the previous fiscal year.

b. Application of Adjustment Based on General Assembly Funding

For all in-network, Colorado DRG Hospitals, excluding Urban Safety Net Hospitals, the starting point for the Medicaid Inpatient base rate, as determined in 10 CCR 2505-10 Section 8.300.5.A.3.a, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Urban Safety Net Hospitals' starting point shall be adjusted by the percentage applied to all other Hospitals plus 10 percent. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent.

c. Application of Cost Add-ons to Determine Medicaid Inpatient Base Rate

i The Medicaid Inpatient base rate shall be equal to the rate as calculated in 10 CCR 2505-10 Sections 8.300.5.A.3.a and 8.300.5.A.3.b, plus any Medicaid hospital-specific cost add-ons. The Medicaid hospital-specific cost add-ons are calculated from the most recently audited

Medicare/Medicaid cost report (CMS 2552) available as of March 1. Partial year cost reports shall not be used to calculate the cost add-ons.

ii The Medicaid hospital-specific cost add-ons shall be an estimate of the cost per discharge for nursery, neo-natal intensive care units, and Graduate Medical Education (GME). The GME cost add-on information shall be obtained from the audited Medicare/Medicaid cost report, worksheet B, part I; discharges from worksheet S-3, part I, nursery and neo-natal costs, shall be obtained from the audited Medicare/Medicaid cost report, Title XIX in worksheet D-1, part II. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals. State University Teaching Hospitals shall receive reimbursement for GME costs as described in 10 CCR 2505-10 Section 8.300.9.2.

iii Ten percent of the Medicaid hospital-specific cost add-ons shall be applied.

d. Application of Adjustments for Certain Hospitals

For Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals, the Medicaid Inpatient base rate shall receive an additional adjustment factor for the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process.

e. Annual Adjustments

The Medicaid Inpatient base rates are adjusted annually (rebased) and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department.

4. Medicaid Inpatient Base Rate for New In-Network Colorado DRG Hospitals

The Medicaid Inpatient base rate for new in-network Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered “new” until the next Inpatient rate rebasing period after the Hospital’s contract effective date. For the next Inpatient rate rebasing period, the Hospital’s Medicaid Inpatient base rate shall be equal to the rate as determined in 10 CCR 2505-10 Section 8.300.5.A.3. If the Hospital does not have a Medicare Inpatient base rate or an audited Medicare/Medicaid cost report to compute a starting point as described in 10 CCR 2505-10 Section 8.300.5.A.3.a, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals

The Medicaid Inpatient base rate for border-state Hospitals shall be equal to the average Medicaid Inpatient base rate for the corresponding peer group.

6. Medicaid Inpatient Base Rate for Out-of-network Hospitals

a. The Medicaid Inpatient base rate for out of network Hospitals, including out-of-state Hospitals, shall be equal to 90% of the average Medicaid Inpatient base rate for the corresponding peer group.

b. The Department may reimburse an out-of-state Hospital for non-emergent services at an amount higher than the DRG base payment when the needed services are not available in a Colorado Hospital. Reimbursement to the out-of-state Hospital shall be made at a rate mutually agreed upon by the parties involved.

7. Reimbursement for Inpatient Hospital claims that (a) include serious reportable events identified by the Department in the Provider Bulletin with (b) discharge dates on or after October 1, 2009, may be adjusted by the Department.

8.300.5.B Abbreviated Client Stays

1. DRG Hospitals shall receive the DRG base payment and any corresponding outlier payment for Abbreviated Client Stays. The DRG base payment and outlier payment shall be subject to any necessary reduction for ineligible days.

8.300.5.C Transfer Pricing

1. Reimbursement for a client who is transferred from one DRG Hospital to another DRG Hospital is calculated at a DRG per diem rate for each Hospital with payment up to the DRG base payment to each DRG Hospital. If applicable, both Hospitals may receive outlier reimbursement.

2. Reimbursement for a client who is transferred from one DRG Hospital to a Non-DRG Hospital, or the reverse, is calculated at the DRG per diem rate for the DRG Hospital with payment up to the DRG base payment. Reimbursement for the Non-DRG Hospital shall be calculated based on the assigned per diem rate. If applicable, the DRG Hospital may receive outlier reimbursement.

3. For transfers within the DRG Hospital, the Hospital is required to submit one claim for the entire stay, regardless of whether or not the client has been transferred to different parts of the Hospital. Since the Colorado Medicaid program does not recognize distinct part units, Hospitals may not submit two claims for a client who is admitted to the Hospital and then transferred to the distinct part unit or vice versa.

~~4. Rehabilitation Hospitals and Long -Term Care Hospitals shall not be subject to DRG transfer pricing. (removed)~~

8.300.5.D Payments to Non-DRG Hospitals for Inpatient Services

1. Payments to Psychiatric Hospitals

a. Inpatient services provided to Medicaid clients in Psychiatric Hospitals shall be reimbursed on a per diem basis. The per diem rates shall follow a step-down methodology. Each step has a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. Criteria for each step are described below:

i Step 1: day 1 through day 7

ii Step 2: day 8 through remainder of care at acute level

b. Hospital rates may be adjusted annually on July 1 to account for changes in funding by the General Assembly and inflationary adjustments as determined by the Medicare Economic Index.

2. Payment to State-Owned Psychiatric Hospitals

State-owned Psychiatric Hospitals shall receive reimbursement on an interim basis according to a per diem rate. The per diem rate shall be determined based on an estimate of 100% of Medicaid costs from the Hospital's Medicare cost report. A periodic cost audit is conducted and any necessary cost settlement is done to bring reimbursement to 100% of actual audited Medicaid costs.

3. Payments to Freestanding Long-Term Care and Freestanding Rehabilitation Hospitals shall be divided into three (3) subgroups: Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital.

Inpatient services provided to Medicaid clients in Freestanding Long-Term Care Hospital, Freestanding Rehabilitation Hospital or Spine/Brain Injury Treatment Specialist Hospital shall be reimbursed on a per diem basis. The per diem rates shall follow a step-down methodology based on length of stay, with a decrease of five (5) percent with each step. Each step shall be assigned a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. The Department may adjust hospital rates annually on July 1 to account for changes in funding by the General Assembly. The criteria for each of the steps are described below:

a. Payments to Freestanding Long-Term Care Hospital as defined in 8.300.1:

i. Step 1: Day 1 through Day 21

ii. Step 2: Day 22 through Day 35

iii. Step 3: Day 36 through Day 56

iv. Step 4: Day 57 through remainder of stay

b. Payments to Freestanding Rehabilitation Hospital as defined in 8.300.1:

i. Step 1: Day 1 through Day 6

ii. Step 2: Day 7 through Day 10

iii. Step 3: Day 11 through Day 14

iv. Step 4: Day 14 through remainder of stay

c. Payments to Spine/Brain Injury Treatment Specialty Hospital as defined in 8.300.1:

i. Step 1: Day 1 through Day 28

ii. Step 2: Day 29 through Day 49

iii. Step 3: Day 50 through Day 77

iv. Step 4: Day 78 through remainder of stay

d. The Classification-specific base per diem for the year of methodology implementation shall be calculated using the following method:

i. The Department shall assign the claims submitted by each hospital for fiscal year 2017 to one of the following peer groups based on definitions from 8.300.1

1) Freestanding Long-Term Care Hospital

2) Freestanding Rehabilitation Hospital

3) Spine/Brain Injury Treatment Specialty Hospital

ii. The Department shall process Medicaid Inpatient hospital claims from state fiscal year 2017, known as the Base Year, though the methodology described in 8.300.5.D.3 a-c. The base per diems shall be budget neutral to fiscal year 2017.

Additionally the base per diem shall be increased by 1.4% to reflect budget increases for state fiscal year 2018, increased by 1% to reflect budget increases for state fiscal year 2019, and adjusted by the percentage change in the budget for fiscal year 2020 as appropriated by the General Assembly. ~~Payments to Freestanding Long-Term Care and Freestanding Rehabilitation Hospitals~~ shall be ~~divided into three (3) subgroups: Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital.~~

DO NOT PUBLSIH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning the Children's Extensive Supports (CES) waiver to remove: Behavioral Services at Section 8.503.40.3, Personal Care at Section 8.503.40.8, and Vision Service at Section 8.503.40.13.
Rule Number: MSB 18-08-24-A
Division / Contact / Phone: Benefits and Services Management / Lindsay Westlund / 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 18-08-24-A, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning the Children's Extensive Supports (CES) waiver to remove: Behavioral Services at Section 8.503.40.3, Personal Care at Section 8.503.40.8, and Vision Service at Section 8.503.40.13.

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) 8.503.40.3; 8.503.40.8 and 8.503.40.13, 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 8.503.40 with the proposed text beginning at 8.503.40.A through the end of 8.503.40.A. This rule is effective March 1, 2019.

*to be completed by MSB Board Coordinator

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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 rule change is necessary to remove services no longer approved in the waiver application CO.4180.R04.03 for the Children's Extensive Supports (CES) waiver. Per guidance from the Centers for Medicare and Medicaid Services (CMS), the CES waiver services including: Behavioral Services, Personal Care and Vision Services are duplicative to services available in State Plan pursuant to the Early and Periodic Screening, Diagnostic Treatment (EPSDT) benefit. Those 20 years of age and younger can access the above services through EPSDT and so the removal of these services from this waiver rule is necessary to have aligned waiver applications and rules.

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:

   The Home and Community Based Services Children's Extensive Supports program (HCBS-CES) in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   C.R.S. 25.5-6-409

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Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning the Children's Extensive Supports (CES) waiver to remove: Behavioral Services at Section 8.503.40.3, Personal Care at Section 8.503.40.8, and Vision Service at Section 8.503.40.13.
Rule Number: MSB 18-08-24-A
Division / Contact / Phone: Benefits and Services Management / Lindsay Westlund / 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.

   Children on the Children's Extensive Supports (CES) waiver will be affected by this proposed rule in that they will access behavioral services, personal care and vision services through state plan and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The availability of these services to waiver recipients will not change. These services are available to all children receiving state plan services. The removal of these services from rule will add clarity to services covered as the rule will match the waiver.

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 quantitative impact by this rule revision. There is a potential qualitative impact to members who may have had to change providers. There will be no impact on the availability of services to members. Members will have to choose to receive services from an enrolled state plan provider as opposed to those enrolled to provide services through the CES wavier.

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 removal of these services from the waiver will increase the service utilization under EPSDT for behavioral services, and utilization under state plan for personal care, and vision services. The cost to the Department to provide these services under state plan or EPSDT will remain consistent with current costs under the waiver. By removing the proposed services from rule and therefore, CES members' annual spending limits, there will be a potential increase in utilization for other available CES waiver services. The Department will be in compliance with CMS by the enforcement of accessing these services through state plan.

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

   Should the Department not remove the following services: Behavioral Services, Personal Care and Vision Services from the CES waiver rule, the Department will lack operational alignment between the CES waiver application with CMS and state rule. The Department may not operationalize the provision of services not approved in our waiver application with CMS. There is not an option of inaction in regards to aligning our waiver applications with waiver rules.

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

   No other less costly or less intrusive methods are available 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 and ensuring compliance with CMS for accessing these services.

~~d~~8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (HCBS-CES)

8.503.40 HCBS-CES WAIVER SERVICES

8.503.40.A The following services are available through the HCBS-CES waiver within the specific limitations as set forth in the federally approved HCBS-CES waiver:

1. Adaptive ~~T~~therapeutic ~~R~~recreational e~~E~~quipment and f~~F~~ees are services which assist a client to recreate within the client's community. These services include recreational equipment that is adapted specific to the client's disability and not those items that a typical age peer would commonly need as a recreation item.

   a. The cost of item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.

   b. Adaptive therapeutic recreational equipment may include adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a client with a developmental disability.

   c. A pass for admission to recreation centers for the client only when the pass is needed to access a professional service or to achieve or maintain a specific therapy goal as recommended and supervised by a doctor or therapist. Recreation passes shall be purchased as day passes or monthly passes, whichever is the most cost effective.

   d. Adaptive therapeutic recreation fees include those for water safety training.

   e. The following items are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

      i. Entrance fees for zoos,

      ii.~~)~~ Museums,

      iii.~~)~~ Butterfly pavilion,

      iv~~ii.)~~ Movie, theater, concerts,

      ~~i~~v.~~)~~ Professional and minor league sporting events,

      vi.~~)~~ Outdoors play structures,

      vii. Batteries for recreational items; and,

      viii. Passes for family admission to recreation centers.

   f. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (1,000.00) dollars per service plan year.

2. Assistive ~~T~~technology includes services, supports or devices that assist a client to increase maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes:

a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client,

b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,

c. Training or technical assistance for the client, or where appropriate, the family members, guardians, care-givers, advocates, or authorized representatives of the client,

d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-CES waiver, and

e. Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency's procedures.

f. Assistive t~~T~~echnology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid State Plan or ~~third party~~third-party resource.

g. Assistive t~~T~~echnology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

h. When the expected cost is to exceed two thousand five hundred (2,500) dollars per device three estimates shall be obtained and maintained in the case record.

i. Training and technical assistance shall be time limited, goal specific and outcome focused.

j. The following items and services are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

i. Purchase, training or maintenance of service animals,

ii. Computers,

iii. In home installed video monitoring equipment,

iv. Medication reminders,

v. Hearing aids,

vi Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of games,

vii. Ttraining, or adaptation directly related to a school or home educational goal or curriculum; or

viii. Iitems considered as typical toys for children.

k. The total cost of hHome aAccessibility aAdaptations, vVehicle mModifications, and aAssistive tTechnology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the DepartmentOperating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client or that enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Department'sOperating Agency's procedures and the Department shall respond to exception requests within thirty (30) days of receipt.:

i. The Operating Agency shall respond to exception requests within thirty (30) days of receipt.

3. Behavioral Services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.

a. Behavioral Services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.

b. A client with a co-occurring diagnosis of developmental disabilities and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.

c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

d. Behavioral Services include:

i. Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.

a) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service must be established.

ii. Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

1) Behavioral plan assessment services are limited to forty (40) units and one assessment per service plan year. One unit is equal to fifteen (15) minutes of service.

~~iii. Individual and group counseling services include psychotherapeutic or psychoeducational intervention that:~~

~~1.) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and~~

~~2.) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.~~

~~iv. Behavioral Line Services include direct implementation of the behavioral plan under the supervision and oversight of a behavioral consultant, for intervention to address social or emotional issues or with an identified challenging behavior that puts the individual's health and safety or the safety of others at risk.~~

3.~~4.~~ C~~C~~ommunity c~~C~~onnector s~~S~~ervices are intended to provide assistance to the client to enable the client to integrate into the client's residential community and access naturally occurring resources. Community connector services shall:

a. Support the abilities and skills necessary to enable the client to access typical activities and functions of community life such as those chosen by the general population.

b. Utilize the community as a learning environment to assist the client to build relationships and natural supports in the client's residential community.

c. Be provided to a single client in a variety of settings in which clients interact with individuals without disabilities, and

d. The cost of admission to professional or minor league sporting events, movies, theater, concert tickets or any activity that is entertainment in nature or any food or drink items are specifically excluded under the HCBS-CES waiver and shall not be reimbursed.

4.~~5.~~ H~~H~~ome a~~A~~ccessibility a~~A~~daptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most ~~cost effective~~cost-effective means to meet the identified need. Such adaptations include:

a. The installation of ramps,

b. Widening or modification of doorways,

c. Modification of bathroom facilities to allow accessibility, and assist with needs in activities of daily living.

d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment or supplies that are necessary for the health and safety of the client, and

e. Safety enhancing supports such as basic fences or basic door and window alarms;

f. The following items are specifically excluded from hHome aAccessibility aAdaptations and shall not be reimbursed:

i. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability,

ii.) Carpeting,

iii.) Roof repair,

iv.) Central air conditioning,

v.) Air duct cleaning,

vi.) Whole house humidifiers,

vii.) Whole house air purifiers,

viii.) Installation and repair of driveways and sidewalks,

viiiix.) Monthly or ongoing home security monitoring fees,

ix.) Home furnishings of any type,

xi.) Adaptations to rental units when the adaptation is not portable and cannot move with the renter, and

xii.) Luxury upgrades.

g. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i. Improve entrance or egress to a residence; or,

ii. Configure a bathroom to accommodate a wheelchair.

h. Any request to add square footage to the home shall be prior authorized in accordance with Operating Agencythe Department's procedures.

i. All devices and adaptations shall be provided in accordance with applicable state or local building codes and applicable standards of manufacturing, design and installation. Medicaid State Plan, EPSDT or third partythird-party resources shall be utilized prior to authorization of HCBS-CES waiver services.

j. The total cost of hHome aAccessibility aAdaptations, vVehicle mModifications, and aAssistive tTechnology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating AgencyDepartment. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with Operating Agencythe Department's procedure.

56. Homemaker sServices are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of Homemaker Services:

a. Basic hHomemaker sServices includes cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents.

i This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task.

ii. Lawn care, snow removal, air duct cleaning and animal care are specifically excluded under HCBS-CES waiver and shall not be reimbursed.

b. Enhanced hHomemaker sServices include bBasic hHomemaker sServices with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning.

i. Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing.

ii. The provider shall be physically present to provide step by step verbal or physical instructions throughout the entire task:

1.) When such support is incidental to the habilitative services being provided,

2.) To increase independence of the client,

c. Incidental bBasic hHomemaker sService may be provided in combination with eEnhanced hHomemaker sServices; however, the primary intent must be to provide habilitative services to increase independence of the client.

d. Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.

67. Parent eEducation provides unique opportunities for parents or other care givers to learn how to support the child's strengths within the context of the child's disability and enhances the parent's ability to meet the special needs of the child. Parent Education includes:

a. Consultation and direct service costs for training parents and other care givers in techniques to assist in caring for the client's needs, including sign language training,

b. Special resource materials,

c. Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the client's disability,

d. Cost of membership to parent support or information organizations and publications designed for parents of children with disabilities.

e. The maximum service limit for parent education is one thousand (1,000) units per service plan year.

f. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

i.) Transportation,

ii.) Lodging,

iii). Food, or

iv). Membership to any political organizations or any organization involved in lobby activities.

~~8. Personal Care is assistance to enable a client to accomplish tasks that the client may complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task.~~

~~a. Personal care services include assistance with basic self-care tasks that include performing hygiene activities, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.~~

~~b. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required it shall be provided by the HCBS-CES waiver only to the extent the Medicaid State Plan or third party resource does not cover the service.~~

~~c. If the annual Functional Needs Assessment identifies a possible need for skilled care then the client shall obtain a home health assessment.~~

79. Professional sServices are provided by a licensed, certified, registered or accredited professional and the intervention is related to an ~~indentified~~identified medical or behavioral need. Professional services include:

a. Hippotherapy: includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.

b. Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.

c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes WATSU.

d. Professional services can be reimbursed only when:

i~~)~~. The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession,

ii~~)~~. The intervention is related to an identified medical or behavioral need; and

iii~~)~~. The Medicaid state plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

iv). The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

1~~)~~. Acupuncture,

2.~~)~~ Chiropractic care,

3.~~)~~ Fitness training (personal trainer),

4.~~)~~ Equine therapy,

5.~~)~~ Art therapy,

6.~~)~~ Warm water therapy,

7.~~)~~ Therapeutic riding,

8.~~)~~ Experimental treatments or therapies, and

9.~~)~~ Yoga.

8~~10~~. Respite is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client.

a. Respite may be provided:

i.~~)~~ In the client's home, private residence,

ii.~~)~~ The private residence of a respite care provider, or

iii.~~)~~ In the community.

b. Respite is to be provided in an age appropriate manner.

i.~~)~~ The eligible client age twelve (12) or older may receive respite during the time the care-giver works because same age typical peers do not need ongoing supervision at that age and the need for the respite is based on the client's disability.

ii.~~)~~ A client eleven (11) years of age and younger, will not receive respite during the time the parent works, pursues continuing education or volunteers, because this is a typical expense for all parents of young children.

c. When the cost of care during the time the parents works is more for an eligible client, eleven (11) years of age or younger, than it is for same age peers, then respite may be used to pay the additional cost. Parents shall be responsible for the basic and typical cost of child care.

d. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of an eligible client when supervision is needed so the primary caretaker can take the client to receive a state plan benefit or a HCBS-CES waiver service.

e. Respite shall be provided according to an individual or group rates as defined below:

i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a ~~twenty four~~twenty-four (24)-hour period.

ii) Individual day: the client receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a ~~twenty four~~twenty-four (24)-hour period. A full day is ten (10) hours or greater within a ~~twenty four~~twenty-four (24)- hour period.

iii) Overnight group: the client receives respite in a setting which is defined as a facility that offers ~~twenty four~~twenty-four (24)-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a ~~twenty four~~twenty-four (24)-hour period shall not exceed the respite daily rate.

iv) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a ~~twenty four~~twenty-four (24)-hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:

1) Sibling care is not allowed for care needed due to parent's work, volunteer, or education schedule or for parental relief from care of the sibling.

f. Federal financial participation shall not to be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR 503-1 Section 16.221 by the state that is not a private residence.

g. The total amount of respite provided in one service plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units. The Operating Agency may approve a higher amount based on a need due to the client's age, disability or unique family circumstances.

h. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or other services not covered by the HCBS-CES waiver.

i. Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate.

j. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a client. Therefore, additional respite units beyond the service limit will not be approved for clients who receive skilled nursing, certified nurse aid services, or home care allowance from the primary caregiver.

911. Specialized mMedical eEquipment and sSupplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized Medical Equipment and Supplies include:

a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

b. Specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing;

c. Maintenance and upkeep of specialized medical equipment purchased through the HCBS-CES waiver.

d. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

i.) Items that are not of direct medical or remedial benefit to the client vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

102. Vehicle mModifications are adaptations or alterations to an automobile or van that is the client's primary means of transportation, to accommodate the special needs of the client, are necessary to enable the client to integrate more fully into the community and to ensure the health, and safety of the client.

a. Upkeep and maintenance of the modifications are allowable services.

b. Items and services specifically excluded from reimbursement under the HCBS-CES waiver include:

i.) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client,

ii.) Purchase or lease of a vehicle, and

iii.) Typical and regularly scheduled upkeep and maintenance of a vehicle

c. The total cost of Home aAccessibility aAdaptations, vVehicle mModifications, and aAssistive tTechnology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the DepartmentOperating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the

need for paid assistance in another HCBS-CES waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no unnecessary duplication.

~~13. Vision service~~

~~a. Vision therapy is a sequence of activities individually prescribed and monitored by a Doctor of Optometry or Ophthalmology to develop efficient visual skills and processing. It is based on the results of standardized tests, the needs of the client and the client's signs and symptoms. It is used to treat eye movement disorders, inefficient eye teaming, misalignment of the eyes, poorly developed vision, focusing problems and visual information processing disorders to enhance visual skills and performing visual tasks.~~

~~b. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:~~

~~i) Eye glasses as a benefit under Medicaid State Plan,~~

~~ii) Contacts, or~~

~~iii) General vision checks~~

~~c. Vision therapy is provided only when the services are not available through the Medicaid State Plan or EPSDT and due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10,Section 8.208.1 or available through a third party resource.~~