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Title of Rule: Revision to the Medical Assistance Rule concerning the Primary Care Fund, Section 8.950.2.T
Rule Number: MSB 20-02-04-A
Division / Contact / Phone: Special Finance/Marissa Visscher/6328

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: Revision to the PCF rule concerning the definition of visit/encounter 8.950.2.T.

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) 8.950.2.T, 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 8.950.E with the proposed text beginning at 8.950.E through the end of 8.950.E. Replace the current text at 8.950.T with the proposed text beginning at 8.950.T through the end of 8.950.T. This rule is effective August 30, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning the Primary Care Fund, Section 8.950.2.T
Rule Number: MSB 20-02-04-A
Division / Contact / Phone: Special Finance/Marissa Visscher/6328

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).

   Current rule defines a Visit/Encounter as a *face-to-face* appointment with medical personnel (physicians, physician assistants, dentists, behavioral health workers, etc.) in which the patient received health related services and/or products (e.g., pharmaceuticals or radiology) and the appointment is customarily billable to a Third Party Payer.

   We are purposing to revise this rule to remove the "face-to-face" requirement therefore allowing telemedicine appointments to be acceptable for the Primary Care Fund grant program.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

C.R.S. § 25.5-3-302 (3)(2020) and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020)

Initial Review **6/12/2020** Final Adoption **7/10/2020**
Proposed Effective Date **8/30/2020** Emergency Adoption

DOCUMENT #02

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Primary Care Fund, Section 8.950.2.T
Rule Number: MSB 20-02-04-A
Division / Contact / Phone: Special Finance/Marissa Visscher/6328

REGULATORY ANALYSIS

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

   The Primary Care Fund is a grant program that awards clinics and hospitals for comprehensive primary care services provided to the indigent uninsured population. By lifting the "face-to-face" restriction from patient visit encounters means grantees will be able to count services provided via telemedicine for the Primary Care Fund.

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

   By removing the "face-to-face" restriction from the rule this will allow for visit patient encounters to include those done through telemedicine. The COVID-19 pandemic caused many providers to resort to telemedicine for comprehensive primary care services. By allowing telemedicine patient encounters for the Primary Care Fund would mean that they can include these patient counts towards their award, otherwise, they would have a significant decrease in their patient counts and ultimately their grant award.

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.

   HB 05-1262 declares the Primary Care Fund to be funded by nineteen percent of tobacco tax revenue and awarded based on the number of uninsured or medically indigent patients served by the provider in proportion to the total number of uninsured or medically indigent patients served by all eligible qualified providers in the previous calendar year. Therefore, the allocation of money will remain the same even with the revision of the rule at no extra cost or burden on state revenues.

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

   With the COVID-19 pandemic many providers are resorting to telemedicine visits. If we do not revise the rule by lifting the patient encounter as being face-to-face many grantees will see a significant decrease in their patient count from which the Primary

Care Fund award is based on. That is why the proposed revision to remove the "face-to-face" restriction is paramount for those applying to the grant program.

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

   There are no less costly or less intrusive methods for the revision of this 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.

   Revising the rule to lift the "face-to-face" restriction is the only way to achieve the purpose of allowing telemedicine visits to be included in the Primary Care Fund patient count.

8.950 PRIMARY CARE FUND

8.950.2 DEFINITIONS

8.950.2.A. Arranges For - Demonstrating Established Referral Relationships with health care providers for any of the Comprehensive Primary Care services not directly provided by the provider.

8.950.2.B. Children's Basic Health Plan also known as Child Health Plan Plus (CHP+) - As specified in Article 19 of Title 26, C.R.S.

8.950.2.C. Colorado Indigent Care Program (CICP) - As specified in Article 15 of Title 26, C.R.S.

8.950.2.D. Comprehensive Primary Care - Basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. At a minimum, this includes providing or arranging for the provision of the following services on a Year-Round Basis: primary health care; maternity care, including prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services, diagnostic laboratory and radiology services; emergency care for minor trauma; Pharmaceutical Services; and coordination and follow-up for hospital care. It may also include optional services based on a patient's needs such as dental, behavioral health and eyeglasses.

8.950.2.E. Cost-Effective Care - Provides or Arranges ~~For~~for Comprehensive Primary Care that is appropriate and at a reasonable average cost per patient Visit and/or Encounter.

8.950.2.F. Eligible Qualified Provider - A qualified Provider who is identified by the Department to receive funding from the Primary Care Fund.

8.950.2.G. Established Referral Relationship - A formal, written agreement in the form of a letter, a memorandum of agreement or a contract between two entities which includes:

1. The Comprehensive Primary Care and/or products (e.g., pharmaceuticals, radiology) to be provided by one entity on behalf of the other entity;

2. Any applicable policies, processes or procedures;

3. The guarantee that referred Medically Indigent Patients shall receive services on a Sliding Fee Schedule or at no charge; and

4. Signatures by representatives of both entities.

8.950.2.H. Medical Assistance Program (Medicaid) - As specified in Article 4 of Title 26, C.R.S.

8.950.2.I. Medically Indigent Patient - A patient receiving medical services from a Qualified Provider ~~and~~:

1. Whose yearly family income is below two hundred percent (200%) of the Federal Poverty Level (FPL);

2. Who is not eligible for the Medical Assistance Program, , the Children's Basic Health Plan, Medicare or any other governmental reimbursement for health care costs such as through Social Security, the Veterans Administration, Military Dependency (TRICARE or CHAMPUS), or the United States Public Health Service. (Payments received from the Colorado Indigent Care Program are not considered a governmental reimbursement for health care costs related to a specific patient); and

3. There is no Third Party Payer.

8.950.2.J. Medically Underserved Area - A federal government designation given to a geographical area based on the ratio of medical personnel (physicians, dentists, behavioral health workers, etc.) to the population. These areas have fewer than a generally accepted minimum number of medical personnel per thousand population resulting in insufficient health resources (personnel and/or facilities) to meet the medical needs of the resident population. Such areas are also defined by measuring the health status of the resident population; an area with an unhealthy population being considered underserved.

8.950.2.K. Medically Underserved Population - A federal government designation given to a human population that does not receive adequate medical attention or have access to health care facilities.

8.950.2.L. Outside Entity - A business or professional that is not classified as an employee of the provider or the Department and does not have a direct or indirect financial interest with the provider. The business or professional shall have auditing experience or experience working directly with the Medical Assistance Program or similar services or grants for Medically Indigent Patients.

8.950.2.M. Pharmaceutical Services - Provides prescription drugs, or coordinates access to or Arranges For client to receive prescription drugs prescribed by the Qualified Provider on a Sliding Fee Schedule or at no charge.

8.950.2.N. Qualified Provider - An entity that provides Comprehensive Primary Care in Colorado and that:

1. Accepts all patients regardless of their ability to pay and uses a Sliding Fee Schedule for payments or does not charge Medically Indigent Patients for services;

2. Serves a designated Medically Underserved Area or Medically Underserved Population as provided in section 330(b) of the federal "Public Health Service Act", 42 U.S.C. sec. 254b, or demonstrates to the Department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;

3. Has a demonstrated Track Record of providing Cost-Effective Care;

4. Provides or Arranges For the provision of Comprehensive Primary Care to persons of all ages. An entity in a rural area may be exempt from this requirement if they can demonstrate that there are no providers in the community to provide one or more of the Comprehensive Primary Care services;

5. Completes a screening that evaluates eligibility for the Medical Assistance Program, the Children's Basic Health Plan, and the Colorado Indigent Care Program and refers patients potentially eligible for one of the programs to the appropriate agency (e.g., county departments of human/social services) for eligibility determination if they are not qualified to make eligibility determinations; and

6. Is a community health center, as defined in Section 330 of the federal "Public Health Services Act", 42 U.S.C. Section 254b; or at least 50% of the patients served by the provider are Medically Indigent Patients or patients who are enrolled in the Medical Assistance Program, the Children's Basic Health Plan, or any combination thereof.

8.950.2.O. Quality Assurance Program - Formalized plan and processes designed to ensure the delivery of quality and appropriate Comprehensive Primary Care in a defined medical setting. This can be demonstrated by obtaining a certification or accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). If such certification or accreditation is not available, then at a minimum, the Quality Assurance Program shall be comprised of elements that meet or exceed the following components:

1. Establishment of credentialing/re-credentialing requirements for medical personnel;

2. Surveying and monitoring of patient satisfaction;

3. Establishment of a grievance process for patients, including documentation of grievances and resolutions;

4. Development of clinic operating policies and scheduled performance monitoring;

5. Review of medical records to check for compliance with established policies and to monitor quality of care;

6. Assessment of state and federal regulations to ensure compliance;

7. Establishment of patient safety procedures; and

8. Establishment of infection control practices.

8.950.2.P. Sliding Fee Schedule - A tiered co-payment system that determines the level of patient's financial participation and guarantees that the patient financial participation is below usual and customary charges. Factors considered in establishing the tiered co-payment system shall only be financial status and the number of members in the patient's family unit.

8.950.2.Q. Third Party Payments or Third Party Payer - Any individual, entity or program with a legal obligation to pay for some or all health-related services rendered to a patient. Examples include the Medical Assistance Program; the Children's Basic Health Plan; Medicare; commercial, individual or employment-related health insurance; court-ordered health insurance (such as that required by non-custodial parents); workers' compensation; automobile insurance; and long-term care insurance. The Colorado Indigent Care Program is not considered a Third Party Payer and payments received from the Colorado Indigent Care Program are not considered Third Party Payments.

8.950.2.R. Track Record - Evidence of providing Comprehensive Primary Care covering at least a consecutive 52-week period prior to the submission of the application.

8.950.2.S. Unduplicated User/Patient Count - The sum of patients who have had at least one Visit/Encounter and received at least one of the services under the Comprehensive Primary Care definition during the applicable calendar year, but does not include the same patient more than once. The sum shall be calculated on a specific point-in-time occurring between the end of the applicable calendar year and prior to the submission of the application. Each patient shall be counted once under only one payment source designation (Third Party Payer or Medically Indigent Patient). The patient's payment source designation shall be the payment source

designation listed for the patient at the specific point-in-time in which the calculation is made. The sum shall not include:

1. Counting a patient more than once if the same patient returns for additional services (e.g., medical or dental) and/or products (e.g., pharmaceuticals) during the applicable calendar year;

2. Counting a patient more than once if the payment source designation changed during the applicable calendar year;

3. Persons who have only received services through an outreach event, community education program, nurse hotline, or other types of community-based events or programs and were not documented on an individual basis;

4. Persons who have only received services from large-scale efforts such as mass immunization programs, screening programs, and health fairs; or

5. Persons whose only contact with the provider is to receive Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) counseling and vouchers are not users and the contact does not generate an encounter.

8.950.2.T. Visit/Encounter - An ~~face-to-face~~ appointment with medical personnel (physicians, physician assistants, dentists, behavioral health workers, etc.) in which the patient received health related services and/or products (e.g., pharmaceuticals or radiology) and the appointment is customarily billable to a Third Party Payer.

8.950.2.U. Year-Round Basis - Comprehensive Primary Care provided in a consecutive 52-week period directly by the provider and/or through an established referral relationship with other providers. If an organization is closed for four consecutive weeks or longer in a calendar year on a regularly scheduled basis, it is not considered to directly provide services on a year-round basis.

Title of Rule: Revision to Medical Assistance Rule concerning School Health Services Program Changes, Section 8.290
Rule Number: MSB 20-03-11-A
Division / Contact / Phone: Special Financing/Shannon Huska/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: Revision to School Health Services Program rule concerning program changes 8.290

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, 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 with the proposed text beginning at 8.290.1 through the end of 8.290.8.E. This rule is effective August 30,2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to Medical Assistance Rule concerning School Health Services Program Changes, Section 8.290
Rule Number: MSB 20-03-11-A
Division / Contact / Phone: Special Financing/Shannon Huska/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).

   In December 2014 CMS reversed their decision of not allowing Free Care to be reimbursed. This reversal means Medicaid eligible services provided to enrolled students are available for reimbursement if all other Medicaid requirements are met. Effective October 1, 2020, SPA CO-19-0021, was approved by CMS for the SHS Program expansion to include program covered services to be reimbursable to districts and BOCES for Medicaid enrolled students that have other medical plans of care (outside of IEPs/IFSPs) and where medical necessity has been established. Additionally, three additional job categories were added: Applied Behavior Analyst, Speech Language Pathologist Assistant, and School Psychologist. This expansion will allow an estimated $12 million of extra reimbursement to SHS Program participants.

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:

   SPA CO-19-0021

4. State Authority for the Rule:

   C.R.S. § 25.5-5-318(9) (2019) and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020)

Initial Review **6/12/2020** Final Adoption **07/10/2020**
Proposed Effective Date **08/30/2020** Emergency Adoption

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Rule concerning School Health Services Program Changes, Section 8.290
Rule Number: MSB 20-03-11-A
Division / Contact / Phone: Special Financing/Shannon Huska/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.

   The SHS Program expansion will benefit participating public school districts, Boards of Cooperative Educational Services (BOCES), and K-12 educational institutions such as, Colorado School for the Deaf and Blind, by allowing for new qualified providers and claimable direct health services prescribed in other standalone plans of care. The SHS Program is a cost-based program and therefore by allowing for more qualified providers and claimable services SHS Program participants will see an increase in their reimbursement. Moreover, according to C.R.S 25.5-5-318, this reimbursement must go back to the health needs of all students in the school district. Thus, the classes affected will be public school districts, BOCES, and K-12 educational institutions such as, Colorado School for the Deaf and Blind, their students, and the school district community. There is no class that will have a negative impact of the SHS Program expansion.

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

   An in-depth analysis was conducted to determine the cost-benefit of expanding the program. Our analysis determined an estimated $12 million dollars of additional federal reimbursement for SHS Program participating public school districts, BOCES, and K-12 educational institutions such as, Colorado School for the Deaf and Blind. This would result in additional providers and services for all students in the school district.

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 SHS Program expansion is state general fund neutral. The impact on public school districts, BOCES, and K-12 educational institutions such as, Colorado School for the Deaf and Blind, is positive with additional estimated reimbursement of $12 million in federal funds.

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

   The probable costs and benefits of the rule change means an additional $12 million of federal reimbursement for SHS Program participating public school districts, BOCES and K-12 educational institutions such as, Colorado School for the Deaf and Blind, benefiting more students under the expansion of free care.

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

   The SHS Program had to open our State Plan Amendment (SPA), in order to include additional qualified providers and expand to other plans of care beyond IEP/IFSP. The SPA has been approved by CMS and is the most cost-effective way we are able to expand to other plans of care and additional providers given state and federal requirements.

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 alternative would be to keep with status quo and not expand the SHS Program. After an in-depth analysis, which included a pilot time study, we determined an additional estimated amount of $12 million in federal reimbursement to participating public school districts, BOCES and K-12 educational institutions such as, Colorado School for the Deaf and Blind, and received the approval for our SPA from CMS to do that.

8.290 SCHOOL HEALTH SERVICES

8.290.1 DEFINITIONS

Administrative aActivities means service coordination, outreach, referral, enrollment and administrative functions that directly support the Medicaid program and are provided by qQualified pPersonnel or qQualified hHealth c Care PpProfessionals employed by or subcontracting with a PpParticipating dDistrict.

Board of Cooperative Education Services (BOCES) means a regional organization that is created when two or more school districts decide they have similar needs that can be met by a shared program. BOCES help school districts save money by providing opportunities to pool resources and share costs.

Care cCoordination PpPlan means a document written by the DdDistrict that describes how the dDDistrict coordinates client services across multiple providers to assure effective and efficient access to service delivery and prevent duplication of services.

Case mMManagement SsServices mean activities that assist the target population in gaining access to needed medical, social, educational and other services.

Disability means a physical or mental impairment that substantially limits one or more major life activities.

District means any BOCES established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado School for the Deaf and the Blind, created in article 80 of title 22, C.R.S., and any public school district organized under the laws of Colorado, except a junior college.

Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services as defined pursuant to 10 C.C.R. 2505-10, Section 8.280.1~~are state mandated services required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. One example is the diagnosis and treatment for defects in vision or hearing.~~

Free Care Services (services provided to Medicaid enrolled students at no charge, and/or provided to the community at large free of charge) to be reimbursed where medical necessity has been established. This means Medicaid eligible services provided to enrolled students are available for reimbursement if all other Medicaid requirements are met.

Individualized Education Program (IEP) means a document developed pursuant to the federal Individuals with Disabilities Education Act (IDEA). The IEP guides the delivery of special education supports and services for the student with a disability.

Individualized Family Services Plan (IFSP) means a document developed pursuant to the IDEA. The IFSP guides the delivery of early intervention services provided to infants and toddlers (birth to age 3) who have disabilities, including developmental delays. The IFSP also includes family support services, nutrition services, and case management.

Local Services Plan (LSP) means a document written by the DddDistrict that describes the types and the costs of services to be provided with the federal funds received as reimbursement for providing School Health Services.

Medicaid Administrative Claiming (MAC) means a method for a PpParticipating DddDistrict to claim federal reimbursement for the cost of performing allowable AaAdministrative AaActivities.

Medically at ~~R~~risk means a client who has a diagnosable physical or mental condition having a high probability of impairing cognitive, emotional, neurological, social, or physical development.

Medically ~~N~~necessary service means a benefit service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

Participating ~~D~~district means a ~~D~~district that is contracted with the Department of Health Care Policy and Financing (the Department) to provide~~,~~ and receive funding for School Health Services.

Qualified ~~H~~health ~~C~~care ~~P~~professional means an individual who is registered, certified or licensed by the Department of Regulatory Agencies (DORA) as a health care professional and who acts within the profession's scope of practice. In the absence of state regulations, a qualified health care professional means an individual who is registered or certified by the relevant national professional health organization.

Qualified ~~P~~personnel means an individual who meets Colorado Department of Education-recognized certification, licensing, registration, or other comparable requirements of the profession in which they practice.

School ~~H~~health ~~S~~service means medical or health-related assistance provided to a client, by ~~Q~~qualified ~~P~~personnel or ~~Q~~qualified ~~H~~health ~~C~~care ~~P~~professionals; which is required for the diagnosis, treatment, or care of a physical or mental disorder and is recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

Specialized t~~T~~ransportation means transportation service necessary to provide a client with access to Medicaid services performed in the school or at another site in the community.

8.290.2 CLIENT ELIGIBILITY

8.290.2.A. Clients shall be eligible to receive services from ~~P~~participating d~~D~~istricts if they are:

1. Enrolled in Medicaid,

2. Enrolled with a p~~P~~articipating ~~D~~district;

3. Under the age of 21;

4. Have~~s~~ a d~~D~~isability or are~~is~~ m~~M~~edically at r~~R~~isk; and

5. Receive~~s~~ a referral for School Health Services according to an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established.

8.290.3 PARTICIPATING DISTRICTS

8.290.3.A. Contracts may be executed with d~~D~~istricts throughout Colorado that meet the following minimum criteria:

1. Approval of a Local Service Plan (LSP) by the Colorado Department of Education and the Department;

2. An assessment, documented in the LSP, of the health needs of students enrolled in the District; and

3. Evidence, documented in the LSP, of community input on the health services to be delivered to public school students.

8.290.3.B. The pPparticipating dDistrict may employ or subcontract with qQualified Ppersonnel or qQualified hHealth cCare pProfessionals to provide sSchool hHealth sServices or aAdministrative aActivities.

8.290.4 SCHOOL HEALTH SERVICES, BENEFITS AND LIMITATIONS

8.290.4.A. School hHealth sServices provided by pParticipating Ddistricts to clients shall be mMedically Nnecessary and prescribed under an IEP, or IFSP or other medical plans of care.

8.290.4.B. School Hhealth sServices shall be provided in accordance with the client's individual need and shall not be subject to any arbitrary limitations as to scope, amount or duration.

8.290.4.C. School Hhealth Sservices shall be delivered in the least restrictive environment consistent with the nature of the specific service(s) and the physical and mental condition of the client.

8.290.4.D. School Hhealth sServices shall not be for academic assessment.

8.290.4.E. Except for sSchool hHealth sServices delivered pursuant to the federal Individuals with Disabilities Education Act (IDEA), the Participating District shall not claim reimbursement for School Health Services to clients enrolled in health maintenancemanaged care organizations that would normally be provided for clients by their health maintenancemanaged care organization.

8.290.4.F. School Hhealth Sservices shall be performed in a school setting, at the client's home or at another site in the community and may include the following:may be performed in the school, at the client's home or at another site in the community by qualified personnel or a qualified health care professional. A qualified provider is defined as an individual who is registered, certified or licensed in accordance with 42 CFR 440 and authorized to provide services by Colorado state law or federal regulations. In the absence of state regulations, a qualified provider must be registered or certified by the relevant national professional health organization and must be allowed to practice if the provider is qualified per Colorado state law. The following service categories are eligible for reimbursement in the School Health Services Program as further defined in the Department's School Health Services Program Manual.

1. Physician Services

a. Physician services shall be provided by a Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.50(a) or a psychiatrist who meets the requirements of , and in accordance with 42 CFR § 440.60(a) and other applicable state and federal law or regulation.

b. Physician services shall be provided with the intent to diagnose, identify or determine the nature and extent of a student's medical or other health related condition.

c. Physician services shall be provided only in an individual setting.

2. Nursing Services

~~a. Nursing services shall be provided by a Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.60(a) and other applicable state and federal law or regulation.~~

~~b. Nursing services shall be medically based services that are within the scope of the professional practice of a Registered Nurse or Licensed Practical Nurse, provided during a face-to-face encounter and provided on a one-to-one basis.~~

~~c. Nursing services shall be provided or delegated in accordance with 42 CFR § 440.130(d) and according to the delegation clause in Section 12-38-132, C.R.S. of the Colorado Nurse Practice Act.~~

~~d. The delegating nurse shall provide all training to the delegate for delegated activities and is solely responsible for determining the required degree of supervision the delegate will need.~~

3. Personal Care Services

~~a. Personal Care services shall be provided by Qualified Personnel or a Qualified Health Care Professional in accordance with 42 CFR § 440.167, who is 18 years or older and has been trained to provide the personal care services required by the client.~~

~~b. Personal Care services may be a range of human assistance services provided to persons with disabilities and chronic conditions, which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him or herself.~~

4. Psychological, Counseling and Social Work Services

~~a. Psychological, Counseling and Social Work services shall be performed by:~~

~~i) A Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.50 or 42 CFR § 440.60(a) and other applicable state and federal law and regulation;~~

~~b. Psychological, Counseling and Social Work services may be provided as health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical and mental health problems.~~

~~c. Psychological, Counseling and Social Work services may be provided in an individual or group setting.~~

5. Audiology Services ~~Orientation, Mobility and Vision Services~~

~~a. Orientation, Mobility and Vision services shall be provided by a Qualified Health Care Professional in accordance with 42 CFR § 440.130(d) and other applicable state or federal law.~~

b. Orientation, Mobility and Vision services shall be evaluations and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision.

6. Speech, Language and Hearing Services

a. Speech, Language and Hearing services shall be provided by a Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.110(c).

b. Speech, Language and Hearing services shall require a referral from a physician or licensed practitioner of the healing arts within the scope of his or her practice under state law.

c. Speech, Language and Hearing services may include any necessary supplies and equipment.

d. Speech, Language and Hearing services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD).

e. Speech, Language and Hearing services may be provided in an individual or group setting.

7. Occupational Therapy Services

a. Occupational Therapy services shall be provided by a Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.110(b).

b. Occupational Therapy services shall require the skills, knowledge and education of an Occupational Therapist Registered (OTR) or Certified Occupational Therapist Assistant (COTA) to provide services.

c. Occupational Therapy services shall be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

d. Occupational Therapy services may include any necessary supplies and equipment.

e. Occupational Therapy services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD).

f. Occupational Therapy services may be provided in an individual or group setting.

8. Physical Therapy Services

a. Physical Therapy services shall be provided by a Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.110(a).

b. Physical Therapy services shall require the skills, knowledge and education of a Colorado Licensed Physical Therapist (PT) as defined in 12-41-103(5) C.R.S. or an appropriately supervised Physical Therapist Assistant (PTA) as defined in 12-41-113(1) C.R.S, to provide services.

c. Physical Therapy services shall be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

d. Physical Therapy services may include any necessary supplies and equipment.

e. Physical Therapy services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD) or orthotic/prosthetic devices.

f. Physical Therapy services may be provided in an individual or group setting.

9. Specialized Transportation Services

a. Specialized Transportation services shall be required on the client's IEP or IFSP.

b. Specialized Transportation services shall be provided on the same date of service that a School Health Service, required by the student's IEP or IFSP, is received.

c. Specialized Transportation shall be on a specially adapted school bus to and from a client's place of residence and the school or the site of a School Health Service, if the School Health Service is not provided in the school setting.

d. Specialized Transportation services shall not be covered on a regular school bus unless an aide for the transported student(s) is present and is required by the student's IEP or IFSP.

e. All Specialized Transportation services provided shall be documented in a transportation log.

f. Specialized Transportation services shall include services provided by direct service personnel, such as bus drivers and aides, employed or contracted by the school district.

10. Targeted Case Management (TCM) Services

a. TCM services shall be provided by case managers who shall be Qualified Health Care Professionals or shall meet the qualifications established by the Colorado Department of Education to develop and or implement an IEP, IFSP or services under the IDEA.

b. The case manager shall provide TCM services on a one-to-one basis to eligible clients. The case manager shall be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the client's assessed needs.

c. A client with a Disability or one who is Medically at Risk is eligible for TCM services when he or she receives or is referred for School Health Services according to, an IEP or IFSP.

d. TCM services shall identify special health problems and needs that affect the client's ability to learn and assist the client to gain and coordinate access to necessary medical, social, educational, and other services.

e. TCM services shall be performed with or on behalf of the client, his or her parent(s) or legal guardian.

f. Except as specified in CFR Section 441.18(b), clients eligible for TCM services shall be free to choose their case management providers from among those qualified to participate in Medicaid.

g. Clients eligible to receive TCM services shall be given the option to decline Case Management Services.

h. A Participating District shall not require that an individual receive TCM services as a condition to receive other Medicaid School Health Services.

i. Providers of TCM services shall not serve as gatekeepers under Medicaid. Case managers may not authorize or deny the provision of other School Health Services under the plan for the client.

j. TCM services shall include:

i) A comprehensive strengths and needs assessment and annual face-to-face reassessment;

ii) Service planning that provides an individualized written, comprehensive care plan based on needs identified in the assessment;

iii) Referrals and related activities to help the client obtain needed services;

iv) Monitoring and follow-up activities necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the client;

v) At a minimum, an annual review of the care plan; and

vi) The maintenance of case records that document specific information on the TCM services provided to each client, progress of service goals and coordination activities.

k. TCM services may also include:

i) Service coordination and advocacy;

ii) Crisis assistance planning; and

iii) Contact with individuals who are not eligible for Medicaid when necessary to manage the care of the client who is receiving TCM services.

l. TCM services shall not include:

i) Activities related to the development, annual review and triennial review of IEP or IFSP documents that are the inherent responsibility of the Colorado Department of Education;

ii) Activities or interventions specifically designed to only meet the client's educational goals;

iii) Transporting or escorting the client to a service to which he or she is referred;

~~iv) The direct delivery of a medical, social, educational or other service to which the client is referred;~~

~~v) Program activities of the Participating District itself that do not meet the definition of Targeted Case Management;~~

~~vi) Administrative activities necessary for the operation of the Participating District providing Case Management Services other than the overhead costs directly attributable to Targeted Case Management;~~

~~vii) Diagnostic, treatment or instructional services, including academic testing;~~

~~viii) The provision of case management when it is solely part of a client's plan under Section 504 of the Rehabilitation Act;~~

~~ix) Preparing, scheduling, conducting or attending IEP or IFSP meetings, or any duplicative activities that are components of the administration of the Individuals with Disabilities Education Act;~~

~~x) Services that are an integral part of another service already reimbursed by Medicaid; or~~

~~xi) Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing.~~

8.290.5 COORDINATION OF CARE

8.290.5.A. The ~~P~~participating ~~D~~district shall coordinate the provision of care with the client's primary health care provider for routine and preventive health care.

8.290.5.B. The ~~P~~participating ~~D~~district shall refer clients to their primary care provider, health maintenance organization or managed care provider for further diagnosis and treatment that may be identified as the result of ~~an Early Periodic Screening, Diagnostic and Treatment (~~EPSDT ~~)~~ services~~screen or service~~.

8.290.5.C. When the client is receiving Medicaid services from other health care providers and the ~~P~~participating ~~D~~district, the ~~P~~participating ~~D~~district shall coordinate medical care with the providers to ensure that service goals are complementary and mutually beneficial to the client or shall show cause as to why coordination did not occur.

~~8.290.5.D. When the client of the targeted population is receiving Ccase Mmanagement sServices from another provider agency as the result of being members of other covered targeted groups, the pParticipating Ddistrict shall ensure that case management activities are coordinated to avoid unnecessary duplication of Medicaid services.~~

8.290.5.~~E~~D. The ~~P~~participating d~~D~~istrict shall inform a family receiving ~~C~~case m~~M~~anagement s~~S~~ervices from more than one provider that the family may choose one lead case manager to facilitate coordination.

~~8.290.5.F. The Participating District shall complete and submit to the Department, for approval, a Care Coordination Plan for the delivery of TCM services. The Participating District shall have a representative group of parents and community-based providers, including the local public health department, EPSDT case managers and any existing school-based health centers to assist in developing the Care Coordination Plan.~~

~~Included in the Care Coordination Plan shall be the provision for coordination of benefits and case management across multiple providers to:~~

~~1. Achieve service integration, monitoring, and advocacy;~~

~~2. Provide needed medical, social, educational, and other services;~~

~~3. Ensure that services effectively compliment one another; and~~

~~4. Prevent duplication of Medicaid services.~~

8.290.6 REIMBURSEMENT

8.290.6.A. The ~~P~~participating ~~D~~district shall obtain from the client or the client's guardian a written informed consent to submit Medicaid claims on behalf of the client.

8.290.6.B. The ~~P~~participating ~~D~~district shall abide by the Third Party Liability rule at 10 C.C.R. 2505-10, Section 8.061.2.23.

8.290.6.C. The ~~P~~participating ~~D~~district shall participate in a periodic time study based on instructions documented in the Department's School Health Services Program Manual, to determine the percentage of allowable time spent providing Medicaid-claimable ~~S~~school ~~H~~health ~~S~~services.

8.290.6.D. Claims Submission and Interim Payment

1. The ~~P~~participating ~~D~~district shall submit a procedure code specific fee-for-service claim for each ~~S~~school ~~H~~health ~~S~~service provided for each client.

2. Interim payment for ~~S~~school ~~H~~health ~~S~~services provided shall be reimbursed on a monthly rate. The monthly rate shall be based on the ~~P~~participating ~~D~~districts actual, certified costs identified in the ~~P~~participating ~~D~~districts most recently filed annual cost report. For a new ~~P~~participating ~~D~~district, the monthly rate shall be calculated based on historical data.

3. Interim payment shall be tied to claims submission by the ~~P~~participating ~~D~~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 ~~P~~participating ~~D~~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 ~~P~~participating ~~D~~district shall receive the federal share of the rate, not to exceed 100% of the federal match rate, as interim payment.

6. School ~~H~~health ~~S~~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 ~~T~~transportation services shall be billed as one-way trips to and from the destination.

8. Each pPparticipating Ddistrict 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.

9. Each pPparticipating Ddistrict shall submit claims for School Health Services pProgram eligible services provided to eligible Medicaid recipients. To comply with the School Health Services pProgram 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 Section 8.290.6.E.

8.290.6.E. Cost Reconciliation and Final Payment

1. Each pPparticipating Ddistrict shall complete an annual cost report for Sschool Hhealth Sservices delivered during the previous state fiscal year covering July 1 through June 30. The Ccost Rreport shall:

   a. Document the pPparticipating Ddistrict's total Medicaid allowable ~~scope of~~ costs for delivering Sschool Hhealth Sservices, based on an approved cost allocation methodology; and

   b. Reconcile the interim payments made to the pPparticipating Ddistrict to the Medicaid allowable ~~scope of~~ costs, based on an approved cost allocation methodology.

2. Each pPparticipating Ddistrict shall complete ~~and submit to the Department~~ an annual cost report for all school health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due no later than 120 days after the close of the quarter ending June 30th as detailed in the Department's School Health Services Program Manual. ~~on or before October 1 of the fiscal year following the end of the reporting period.~~

3. All annual cost reports shall be subject to an audit by the Department or its designee.

4. If a pPparticipating Ddistrict's interim payments exceed the actual, certified costs of providing Sschool Hhealth Sservices, the pPparticipating Ddistrict shall return an amount equal to the overpayment.

5. If a pPparticipating Ddistrict's actual, certified cost of providing Sschool Hhealth Sservices exceeds the interim payments, the Department will pay the federal share of the difference to the PPparticipating Ddistrict.

6. Each pPparticipating Ddistrict shall follow cost-reporting procedures detailed in the Department's School Health Services Program Manual.

8.290.6.F. Certification of Funds

1. The pPparticipating Ddistrict shall complete a certification of funds statement, included in the cost report, certifying the pPparticipating Ddistrict's actual, incurred costs and expenditures for providing Sschool Hhealth Sservices.

8.290.7 MEDICAID ADMINISTRATIVE CLAIMING, BENEFITS AND LIMITATIONS

8.290.7.A. Medicaid Administrative Claiming (MAC) services shall be performed in a school setting or at another site in the community.

8.290.7.B. MAC services include ~~A~~administrative ~~A~~activities and the activities listed in this ~~S~~section 8.290.7.B. Additionally, MAC may include related paperwork, clerical functions or travel by employees or subcontractors which is solely related to and required to perform MAC services:

1. Medicaid Outreach

   a. Medicaid ~~O~~outreach shall be activities that inform Medicaid eligible or potentially eligible individuals about Medicaid and how to access the program.

   b. Medicaid ~~O~~outreach may only be conducted for populations served by the ~~P~~participating ~~D~~districts such as students and their parents or guardians.

2. Facilitating Medicaid ~~Eligibility~~ Enrollment Determination

   a. Facilitating Medicaid ~~E~~e~~ligibility~~nrollment ~~D~~determination shall be activities that assist individuals in the Medicaid ~~eligibility~~ enrollment process.

   b. Facilitating Medicaid ~~E~~enrollment~~ligibility~~ ~~D~~determination may include making referrals for Medicaid ~~eligibility~~ enrollment determinations, explaining the ~~eligibility~~ enrollment process to prospective applicants, and providing assistance to individuals or families in completing or collecting documents for the Medicaid application.

3. Translation Related to Medicaid Services

   a. Translation ~~R~~related to Medicaid ~~S~~services are translation services provided solely to assist individuals with access to Medicaid covered services, which services are not included in or paid for as part of a ~~S~~school ~~H~~health ~~S~~service. ~~T~~translation services may be provided by employees of, or subcontractors with ~~P~~participating ~~D~~districts.

   b. Translation ~~R~~related to Medicaid ~~S~~services may include arranging for or providing oral or signing translation services that assist individuals with accessing and understanding necessary care or treatment covered by Medicaid or developing associated translation materials.

4. Medical Program Planning, Policy Development and Interagency Coordination

   a. Medical ~~P~~program ~~P~~planning, ~~P~~policy ~~D~~development and ~~i~~interagency ~~C~~coordination shall be activities associated with the development of strategies to improve the coordination and delivery of Medicaid covered medical, dental or mental health services to school age children.

   b. Medicaid ~~P~~program ~~P~~planning, ~~P~~policy ~~D~~development and ~~i~~interagency ~~C~~coordination may include performing collaborative activities with other agencies or providers.

5. Medical/Medicaid Related Training and Professional Development

   a. Medical/Medicaid ~~R~~related ~~T~~training and ~~P~~professional ~~D~~development shall be activities for outreach staff of ~~P~~participating ~~D~~districts that include coordinating,

conducting or participating in training events or seminars regarding the benefits of medical or Medicaid related services.

b. Medical/Medicaid ~~R~~related ~~T~~training and p~~P~~rofessional ~~D~~development may include how to assist individuals or families with accessing medical or Medicaid related services and how to effectively refer students for those services.

6. Referral, Coordination and Monitoring of Medicaid Services

a. Referral, ~~C~~coordination and ~~M~~monitoring of Medicaid ~~S~~services shall be activities that include making referrals for, coordinating or monitoring the delivery of Medicaid covered services. Activities that function as part of a ~~S~~school ~~H~~health ~~S~~service may not be included in this category.

7. Transportation Related to Medicaid Services

a. Transportation related to Medicaid services shall be activities when assisting an individual to obtain transportation to services covered by Medicaid (does not include the provision of the actual transportation service).

8.290.8 MEDICAID ADMINISTRATIVE CLAIMING REIMBURSEMENT

8.290.8.A. The p~~P~~articipating ~~D~~district shall participate in a periodic CMS approved time study to determine the percentage of allowable time spent on providing Medicaid ~~A~~administrative ~~A~~activities.

8.290.8.B. The p~~P~~articipating ~~D~~district shall complete a cost report for MAC for each time study quarter the district participated in based on a reporting schedule established by the Department.

1. The cost report shall document the p~~P~~articipating ~~D~~district's total Medicaid allowable ~~scope of~~ costs for providing Medicaid ~~A~~administrative ~~A~~activities, based on a CMS approved cost allocation methodology.

2. If a p~~P~~articipating ~~D~~district's cost report for MAC is not submitted within the Department established reporting schedule the p~~P~~articipating ~~D~~district shall not be able to seek reimbursement for the associated period.

3. By July 30th of each fiscal year, the p~~P~~articipating ~~D~~district shall receive a notification letter from the Department identifying the MAC cost reporting schedule.

8.290.8.C. Each p~~P~~articipating ~~D~~district shall follow cost reporting procedures for MAC detailed in the Department's School Health Services Program Manual.

8.290.8.D. Payment

1. Each p~~P~~articipating ~~D~~districts cost report for MAC shall be developed into a claim by the Department and submitted to CMS for reimbursement if appropriate.

2. Reimbursement to p~~P~~articipating ~~D~~districts that have properly submitted valid claims for MAC shall be made on a quarterly basis.

8.290.8.E. Certification of Funds

1. Each pParticipating Ddistrict shall complete a certification of funds statement, included in the cost report for MAC, certifying the pParticipating Ddistrict's actual, incurred costs and expenditures for providing Medicaid Aadministrative Aactivities.

2. All cost reports and claims for MAC shall be subject to an audit by the Department or its designee.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rx Review Program, Section 8.800.18
Rule Number: MSB 20-04-21-B
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 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 20-04-21-B, Revision to the Medical Assistance Rx Review Program, Section 8.800.18

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)8.800.18, 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 8.800.18 with the proposed text beginning at 8.800.18.A through the end of 8.800.18.E. This rule is effective August 30,2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rx Review Program, Section 8.800.18
Rule Number: MSB 20-04-21-B
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 6715

STATEMENT OF BASIS AND PURPOSE

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

   The Department is proposing to modify the Rx Review program requirements. Through this program the Department currently contracts with individual pharmacists to conduct medication review sessions with members with the intent to optimize therapeutic outcomes related to medication regimens.

   This proposed rule will allow the Department to utilize pharmacists, in addition to licensed pharmacy interns under the supervision of licensed pharmacists, to conduct the medication review sessions. The proposed rule will also give the Department the option to contract with an entity to administer the Rx Review program and remove barriers that inhibit pharmacist participation in the program.

   Overall, this rule change is necessary to potentially increase the number of members who receive Rx Review consultations. It is anticipated that removing barriers for pharmacists and/or contracting the program out to an entity could provide a greater number of consultations with existing funding thereby maximizing the benefits of the program's intended goals.

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:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   CO Rev Stat § 25.5-5-507 (2018)

Initial Review **6/12/2020** Final Adoption **7/10/2020**
Proposed Effective Date **8/30/2020** Emergency Adoption

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Initial Review **6/12/2020** Final Adoption **7/10/2020**

Proposed Effective Date **8/30/2020** Emergency Adoption

DOCUMENT #04

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Title of Rule: Revision to the Medical Assistance Rx Review Program, Section 8.800.18
Rule Number: MSB 20-04-21-B
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 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.

   The classes of persons that will bear the costs of the proposed rule, if the Department contracts it out, are licensed pharmacists who currently participate as individual contractors with the Department. Members will benefit from the proposed rule as Rx Review consultations will likely increase by eliminating current barriers that pharmacists face which has inhibited participation in the program. Ultimately, these medication review sessions give members information on the prudent use of the prescription drugs they are taking, as well as how to avoid dangerous drug interactions, which in turn increases member outcomes.

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

   Quantitatively, licensed pharmacists who currently participate, voluntarily, as individual contractors with the Department may not receive reimbursement ($90 for a telephonic consult, and $150 for a face-to-face consult which comes from the program allotment of $16,500) that they have received for performing these consultations if the Department contracts with an entity. The entity would be paid the program allotment of $16,500 instead.

   Qualitatively, if the Department pays a contractor to abide by specific contract provisions, the number of consultations performed will likely increase which in turn will increase members' health outcomes associated with their therapeutic medication regimens. In addition, program barriers that have inhibited pharmacist participation will be removed, which will maximize the benefits of the program's intended goals.

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.

   N/A

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

The probable cost of action is that current licensed pharmacists who participate in this program may not be able to if the Department shifts administration to a contracted entity; whereas the benefits of the proposed rule are that the number of Rx Review consultations performed may increase, thereby increasing members' health outcomes associated with their therapeutic regimens. The probable cost of inaction will result in less Rx Review consultations performed due to barriers that currently inhibit pharmacist participation; whereas the benefit is that current licensed pharmacists who voluntarily participate in the program may still participate.

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

   N/A

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.

   N/A

8.800 PHARMACEUTICALS

8.800.18 PRESCRIPTION DRUG CONSUMER INFORMATION AND TECHNICAL ASSISTANCE PROGRAM

8.800.18.A The Prescription Drug Consumer Information and Technical Assistance Program provides Medical Assistance Program members the opportunity to speak ~~meet~~ with a licensed pharmacist, or a licensed pharmacy intern~~s~~ under the supervision of a licensed pharmacist,~~s~~ to review the member's medications, receive information on the prudent use of prescription drugs, ~~and, with the approval of the appropriate prescribing health care provider,~~ explore how to avoid dangerous drug interactions, and improve member outcomes., ~~and save the state money for the drugs prescribed.~~

8.800.18.B. REQUIREMENTS FOR PARTICIPATION IN THE PROGRAM

~~1. The Department shall refer members to pharmacists based on location.~~

1~~2~~. Licensed p~~P~~harmacists must have ~~shall:~~ graduated from an accredited college of pharmacy on or after ~~May 1996, or~~May 1996, or completed a structured and comprehensive education program by the Accreditation Council for Pharmacy Education, and must maintain an unrestricted license in good standing to practice pharmacy in Colorado to participate.

~~a. Have and maintain an unrestricted license in good standing to practice pharmacy in Colorado; and~~

2. Licensed p~~P~~harmacy i~~I~~nterns must have and maintain an unrestricted license~~d~~ in good standing in Colorado.

~~b. Maintain liability insurance; and~~

~~c. Complete an application; and~~

~~d. Enter into a contract with the Department; and~~

~~e. Meet one of the following qualifications:~~

~~i) Provide proof of completion of a pharmacy practice residency accredited by the American Society of Health Systems Pharmacists or the American Pharmaceutical Association; or~~

~~ii) Earned a bachelor of pharmacy degree and completed a certificate program accredited by the Accreditation Council for Pharmacy Education (ACPE) in each area of practice, and 40 hours of on-site supervised clinical practice and training in each area in which the pharmacist is choosing to practice; or~~

~~iii) Earned a Doctor of Pharmacy degree and completed at least 40 hours of ACPE-approved continuing education regarding clinical practice and 40 hours of on-site supervised clinical practice and training in the area in which the pharmacist is choosing to practice; or~~

~~iv) Possess current board specialty certification from the Board of Pharmaceutical Specialties, current certification from the National Institute for Standards in Pharmacist Credentialing, or current certification from the Commission for Certification in Geriatric Pharmacy. Such credentials must be in the area of pharmacy practice undertaken in the drug therapy management~~

3. Members may participate in the program if they are a fee-for-service member who receives prescription drug benefits ~~,~~ and is at high risk of complications from drug interactions. ~~and who otherwise lacks access to informational consultation with a pharmacist.~~

8.800.18.C. SERVICES

1. Medication therapy counseling services may be conducted face-to-face, over the telephone, or through a virtual meeting and the pharmacist or licensed intern ~~Pharmacists participating in the program~~ shall:

a. Review the member's profile with the member for accuracy and inquire as to any additional medications, providers or disease states;~~Schedule a face-to-face meeting with the member within ten days of the referral. If the member is unable or refuses to participate in a face-to-face meeting or lives outside of a reasonable travel distance from the consulting pharmacist, then the pharmacist may conduct the consultation by telephone.~~

b. Perform a medication review to identify, resolve and prevent medication related problems; ~~Collect and review member drug histories.~~

c. Provide education and training designed to enhance the ~~client's~~ member's understanding and appropriate use of ~~the client's~~ medications, and encourage member compliance with their therapeutic regimen; ~~Hold face-to-face or telephonic consultations with members.~~

d. Draft and submit a report which documents the counseling session and includes recommended changes to the member's medication therapy and any other information providers may find relevant to the appropriate treatment of the member's health. ~~; and~~ ~~Notify members that they will provide clinical recommendations to the member, the prescribing health care provider and the Department.~~

~~e. Provide the member with information regarding:~~

~~i) The prudent use of prescription drugs.~~

~~ii) How to avoid dangerous drug interactions.~~

~~iii) The appropriate use of medication to optimize therapeutic outcomes.~~

~~iv) How to reduce the risk of adverse events, including adverse drug interactions.~~

~~2. The Department shall notify members participating in the program in writing that a pharmacist has been assigned to review the member's records and that the pharmacist will contact the member within ten days from the date of notification.~~

~~8.800.18.D. REPORTING Within ten days following the consultation, the pharmacist shall provide a letter to the member, all appropriate health-care providers and the Department outlining the face-to-face meeting. The letter shall include the pharmacist's recommendations for possible alternatives available for the member.~~

~~8.800.18.E. REIMBURSEMENT The Department shall pay each pharmacist participating in the program a predetermined amount.~~