DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Family Support Services Program Rule, Section 8.613
Rule Number: MSB 20-01-02-A
Division / Contact / Phone: Benefits and Services Management / Courtney Montes / 303-866-5066

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 19-08-21-A, Revision to the Medical Assistance Act Rule concerning OP Pages, Section Form Review. Testing more copy here to see how it wraps.

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) 8.613, 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 8.613 with the proposed text beginning at 8.613.G.2.b through the end of 8.613.2.b. This rule is effective April 15, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Family Support Services Program Rule, Section 8.613
Rule Number: MSB 20-01-02-A
Division / Contact / Phone: Benefits and Services Management / Courtney Montes / 303-866-5066

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 purpose of this rule change is to is make it easier for CCBs to implement the Family Support and Services Program (FSSP) by removing the regulatory requirement of only one Family Support Plan (FSP) per family. This change will benefit the CCBs by allowing them to maintain documentation in a way that best meets their needs.

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. (2018);
   25.210-303

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Family Support Services Program Rule, Section 8.613

Rule Number: MSB 20-01-02-A

Division / Contact / Phone: Benefits and Services Management / Courtney Montes / 303-866-5066

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 proposed rule will affect persons receiving FSSP funding, families of persons receiving FSSP funding, providers and CCBs. The proposed rule amendment will benefit the CCBs implementing the program by allowing them the flexibility to maintain the required documentation in a way that best meets their needs. By removing the requirement stating that only one FSP inclusive of all individuals with IDD or Developmental Delay be maintained per family, the CCB is given more flexibility to capture and maintain FSP documentation for families with more than one eligible individual. There should be no additional costs to the CCBs, the Department or on state revenue. Implementing the proposed rule will not impact the allocation amounts or how the funding is currently being spent.

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, the Department is not currently requesting additional funding. The allocation amount will remain the same. Qualitatively, the proposed rule amendment will benefit the CCBs by allowing them to create and maintain the required documentation in a way that best meets the needs of their 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 should be no additional costs to the Department or on state revenue. Implementing the proposed rule will not impact the allocation amounts or how the funding is currently being spent.

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

   There should be no additional costs to the Department or on state revenue. Implementing the proposed rule will not impact the allocation amounts or how the funding is currently being spent. The proposed rule amendment will benefit the

CCBs implementing the program by allowing them the flexibility to maintain the required documentation in a way that best meets their needs. By removing the requirement stating that only one FSP inclusive of all individuals with IDD or Developmental Delay be maintained per family, the CCB is given more flexibility to capture and maintain FSP documentation for families with more than one eligible individual.

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 intrusive methods, as less intrusive methods have been proven ineffective. The Department initially attempted to provide a standardized FSP template however this tool was found to be ineffective due to the flexible nature of the program and the unique needs of each CCB implementing the program. By removing the requirement stating that only one FSP inclusive of all individuals with IDD or Developmental Delay be maintained per family, the CCB is given more flexibility to capture and maintain FSP documentation for families with more than one eligible individual. There should be no additional costs to the CCBs, the Department or on state revenue. Implementing the proposed rule will not impact the allocation amounts or how the funding is currently being spent.

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 to the proposed rule is to continue requiring CCBs to maintain documentation in a way that interferes with their internal processes and systems.

8.613 FAMILY SUPPORT SERVICES PROGRAM (FSSP)

A. ADMINISTRATION

1. The Community Centered Board (CCB) shall administer the Family Support Services Program (FSSP), subject to available appropriations and according to the rules, regulations, policies and guidelines of the Department, local Family Support Council (FSC) and CCB.

2. The CCB shall ensure that the FSSP is implemented within its designated service area.

3. The CCB shall designate one (1) person as the contact for the overall implementation and coordination of the FSSP.

4. Referrals to the FSSP shall be made through the CCB pursuant to 10 CCR 2505-10, Section 8.607.

5. Nothing in these rules and regulations shall be construed as to prohibit or limit services and supports available to an individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay and their families which are authorized by other state or federal laws.

6. The CCB, in cooperation with the local FSC, shall ensure that the FSSP is publicized within the designated service area.

7. The CCB shall develop written policies and procedures for the implementation and ongoing operation of the FSSP, which must be kept on file and made available to the Department or the public, upon request.

B. FAMILY SUPPORT COUNCIL (FSC)

1. The CCB shall assist its designated service area to establish and maintain an FSC pursuant to Section 25.5-10-304 C.R.S.

2. The CCB shall establish an FSC roster that includes the names of members, type of membership and identifies the chairperson. The roster shall be available to the Department or the public, upon request.

3. Composition of the FSC:

   a. The majority of the members and the chairperson of each FSC shall be family members of an individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay.

   b. New members of the FSC shall be recruited from the service area. New members shall be approved by the current FSC and the board of directors of the CCB.

   c. The members of the FSC shall receive written notice of their appointment.

   d. The CCB shall ensure an orientation and necessary training regarding the duties and responsibilities of the FSC is available for all council members. The training and orientation shall be documented with a record of the date of the training, who provided the training, training topic, and names of attendees.

e. The size of the FSC shall be sufficient to meet the intent and functions of the council, but no fewer than five (5) persons, unless approved by the Department.

f. Each FSC shall establish the criteria for tenure of members, selection of new members, the structure of the council and, in conjunction with the CCB, a process for addressing disputes or disagreements between the FSC and the CCB. Such processes shall be documented in writing. Processes may include a request for mediation assistance from the Department.

4. The FSC duties include providing guidance and assistance to the CCB on the following:

a. Overall implementation of the FSSP;

b. Development of the written annual FSSP report for the designated service area, as defined at Section 8.613.M;

c. Development of written procedures describing how families are prioritized for FSSP funding;

d. Development of written policy defining how an emergency fund is established, funded and implemented. The policy must include a definition of a short-term crisis or emergency and the maximum amount of funds a family may receive per event and/or year;

e. Provide recommendations on defining the “other” service category within the parameters as defined in this part;

f. Monitor the implementation of the overall services provided in the designated service area; and

g. Provide recommendations on how to assist families who are transitioning out of the FSSP.

C. ELIGIBILITY

1. Any individual with an Intellectual and Developmental Disability (IDD) or Developmental Delay, as determined pursuant to Section 25.5-10-211, C.R.S., living with their family is eligible for the FSSP. Living with a family means that the individual's place of residence is with that family.

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

b. The CCB, in cooperation with the local FSC, shall determine what constitutes a transition.

2. The family and eligible individual shall reside in the State of Colorado.

3. All eligible individuals 18 and older must provide proof of lawful presence in the United States to receive FSSP funding.

4. Eligibility for the FSSP does not guarantee the availability of services or supports under this program.

D. WAITING LIST

1. The CCB shall maintain an accurate and up-to-date waiting list of eligible individuals for whom Department funding is unavailable in the current fiscal year.

2. In cooperation with the local FSC, the CCB shall develop written procedures for determining how and which individuals on the waiting list will be enrolled into the FSSP.

3. Individuals receiving ongoing FSSP funding shall not be listed on the waiting list for the program.

4. Individuals determined to be prioritized for FSSP funding shall be served prior to individuals determined at a lower level of prioritization.

5. The CCB must inform eligible families of the program and waiting list procedures and offer assessment and enrollment onto either the waiting list or the program, based on the assessment and available appropriations.

6. Any individual on the waiting list for FSSP may receive emergency funding through the CCB through the FSSP, if the needs meet the parameters set by the FSC and the CCB.

7. Waiting lists shall not exist for any CCB that does not expend all FSSP direct service funds.

E. PRIORITIZATION FOR FAMILY SUPPORT SERVICES PROGRAM (FSSP) FUNDING

1. CCBs must ensure that families with the highest assessed needs shall be prioritized for FSSP state funding.

2. CCBs, in conjunction with the FSC, will develop written procedures that describe how families shall be prioritized and notified of the prioritization process.

3. The assessment process shall be applied equally and consistently to all families who are assessed.

4. CCBs must distribute the prioritization process to families in their designated service area at the time the family requests FSSP funding, when the individual is placed on the waiting list, or upon request.

5. The CCB must notify families in writing of the results of the assessment.

6. All families, both on the waiting list and receiving FSSP services, shall be assessed for level of need on an annual basis or earlier if the family’s circumstances change.

7. The assessment must contain the following components:

    a. The qualifying individual’s disability and overall care need, which includes:

        i. The type of disability or condition and the need and complexity of medical or personal care for the individual;

        ii. The need for, frequency of, and amount of direct assistance required to care for the individual; and

iii. The types of services needed that are above and beyond what is typically needed for any individual.

b. The qualifying individual's behavioral concerns including how behaviors disrupt or impact the family's daily life, the level of supervision required to keep the individual and others safe, and the services and frequency required to help with the behaviors.

c. The family composition, which considers obligations and limitations of the parent(s), the number of siblings, disabilities of other family members living in the home, and the level of stability of the family, such as pending divorce or age and disability of parents.

d. The family's access to support networks, which includes the level of isolation or lack of support networks for the family, such as not having extended family nearby, living in rural areas or availability of providers.

e. The family's access to resources such as family income, insurance coverage, HCBS waivers, and/or other private or public benefits.

F. DIRECT SERVICES

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

2. All services must be needed as a result of the individual's Intellectual and Developmental Disability (IDD) or Developmental Delay and shall not be approved if the need is a typical age-related need. Correlation between the need and the disability must be documented in the Family Support Plan (FSP).

3. All services must be provided in the most cost-effective manner, meaning the least expensive manner to meet the need.

4. All services shall be authorized pursuant to the FSP.

5. Services provided to the family through the FSSP shall not supplant third party funding sources available to the family including, but not limited to, public funding, insurance, or trust funds.

6. CCBs shall not charge a separate fee for assisting individuals to access services identified on the FSP.

7. FSSP funds shall not be used for any donation; religious-, political-, or otherwise or activities prohibited by law.

8. Direct Services

a. Assistive technology is equipment or upgrades to equipment, which are necessary for the individual with an IDD or Developmental Delay to communicate through expressive and receptive communication, move through or manipulate his or her environment, control his or her environment, or remain safe in the family home.

b. Environmental engineering is home or vehicle modification needed due to the individual's disability and is not a regular maintenance or modification needed by

all owners. Modifications to the home or vehicle must be necessary due to the individual's IDD or Developmental Delay; or needed due to health and safety; or to allow the individual to attain more independence; and completed in a cost-effective manner. Cost-effective manner means the least expensive manner to meet the identified need. Home modifications are to be limited to the common areas of the home the individual with an IDD frequents, the individual's bedroom, and one bathroom. Other bedrooms and bathrooms shall not be modified. All devices and adaptations must be provided in accordance with applicable state or local building codes and/or applicable standards of manufacturing, design, and installation. Only homes or vehicles occupied and owned by the family where the eligible individual resides may be modified. Minor modifications may be made to rental units with the permission of the landlord. Rental modifications must be made in a way that the modification can be moved with the eligible individual during a change in residence.

c. Medical and dental items prescribed by a licensed medical professional qualified to prescribe such items and are needed to maintain or attain physical health. Medical, dental, and vision services, exams and procedures are available when not covered by another source.

    i. Over the counter medications and vitamins are excluded, except as indicated at Section 8.800.4.D, when prescribed by a licensed medical professional qualified to write such prescriptions.

d. Other: Services in this category must be identified in the FSP, are specific to the family, and are limited to:

    i. A consultant and/or advocate to assist a family with accessing services outside of the CCB.

    ii. Recreational needs of the individual with an IDD or Developmental Delay when the need of recreation is above and beyond the typical need due to the disability or delay. The cost of family recreation passes shall be limited to $650 or one family pass, whichever is less, per fiscal year and shall be limited to use only at community recreation centers. The following items are specifically excluded under the FSSP and shall not be eligible for coverage:

        1) Entrance fees for zoos;

        2) Museums;

        3) Butterfly pavilion;

        4) Movie, theater, concerts;

        5) Professional and minor league sporting events;

        6) Outdoor play structures;

        7) Batteries for recreational items; and,

        8) Memberships to non-community gyms.

iii. Specialized services as identified by the FSC and CCB, included in their written policy and are available to any family receiving ongoing Family Support Services Program assistance in the service area.

e. Parent and sibling support, which may include special resource materials or publications, cost of care for siblings, or behavioral services or counseling.

f. Professional services are services which require licensure or certification to treat a human condition other than medical, dental or vision, and is provided to the individual with an IDD or Developmental Delay. Professional services must be provided by qualified, certified and/or licensed personnel in accordance with the standards and practices of the industry. Professional services may include related support items or activities which are recommended as part of the therapy with supporting documentation from the treating professional. Insurance expenses directly incurred by the individual with an IDD or Developmental Delay are included.

g. Program expenses are services related to serving multiple families and are funded through the direct service line.

i. This service is not identified in the individual's FSP. This service is provided by the CCB for the benefit of multiple families.

ii. Program expense is the maintenance, operation, or enhancement of a resource library that consists of an inventory of goods and equipment used to meet the needs of individuals with an IDD or Developmental Delay on a temporary basis.

iii. Program expense is the cost associated with participation with other community agencies in the development, maintenance, and operation of projects, supports or services that benefit individuals with an IDD or Developmental Delay.

iv. Program expense is the development or coordination of a training event for families.

v. Program expense is the cost of an event sponsored by the CCB for all eligible individuals and their families to meet other families to provide socialization and an opportunity to build a network of support.

vi. Program expense is the development and coordination of group respite.

vii. The FSC in conjunction with the CCB shall determine the maximum amount of direct services to be used for program expenses.

h. Respite is the temporary care of an individual with an IDD that provides relief to the family.

i. Transportation is the direct cost to the family that is higher than costs typically incurred by other families because of specialty medical appointments or therapies. Specialty medical appointments or therapies are defined as appointments needed due to the individual's IDD or Developmental Delay. The direct cost is the cost of transportation, lodging, food expense, and long-distance telephone calls to arrange for or coordinate medical services which are not covered by other sources.

G. CASE MANAGEMENT

Case management is the coordination of services provided for individuals with an IDD or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, such as medical, social, education, and other services to ensure non-duplication of services, and monitor the effective and efficient provision of services across multiple funding sources.

1. At minimum, the case manager is responsible for:

    a. Determining initial and ongoing eligibility for the FSSP;

    b. Development, application assistance, and annual re-evaluation of the Family Support Plan (FSP); and

    c. Ensuring service delivery in accordance with the FSP.

2. Family Support Plan Requirements

    a. Families enrolled into the FSSP shall have an individualized FSP which meets the requirements of an Individualized Plan, as defined in Section 25.5-10-202 and 25.5-10-211 C.R.S., and includes the following information:

        i. The name of the eligible individual;

        ii. The names of family members living in the household;

        iii.. The date the FSP was developed or revised;

        iv. The prioritized needs requiring support as identified by the family;

        v. The specific type of service or support, how it relates to the family need and the individual's disability or developmental delay, and period which is being committed to in the FSP, including, when applicable, the maximum amount of funds which can be spent for each service or support without amending the FSP;

        vi. Documentation regarding cost-effectiveness of a service or support, which can include quotes, bids, or product comparisons but must include the reason for selecting a less cost-effective service or support, when applicable.

        vii. A description of the desired results, including who is responsible for completion;

        viii. The projected timelines for obtaining the service or support and, as appropriate, the frequency;

        ix. A statement of agreement with the plan;

        x. Signatures of a family representative and an authorized CCB representative;

        xi. The level of need;

xii. The length of time the funds are available; and

xiii. A description of how payment for the services or supports will be made.

b. The FSP shall integrate with other Service Plans affecting the family and avoid, where possible, any unnecessary duplication of services and supports. ~~One FSP, inclusive of all eligible individuals with IDD or Developmental Delay shall be maintained per family.~~

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

i. Any changes to the provision of services and supports identified in the FSP are subject to available funds within the designated service area.

ii. Any decision to modify, reduce or deny services or supports set forth in the FSP, without the family's agreement, are subject to the requirements in Section 8.605.

H. MANAGEMENT AND GENERAL ACTIVITIES

Management and general activities are the financial and corporate administration of the CCB specific to FSSP requirements by the Department.

I. EMERGENCY FUND

1. Each CCB shall establish an emergency fund that may be accessed by any individual eligible for the FSSP when needed due to an unexpected event that has a significant impact on the individual or family's health or safety and impacts the family's daily activities.

2. Any individual with an IDD or Developmental Delay determined by the CCB and living with family shall be eligible to receive emergency funds regardless of the enrollment status of the family.

3. The CCB in conjunction with the Family Support Council shall develop written policies and procedures regarding the Emergency Fund. At a minimum the policies and procedures must:

a. Define the purpose of the emergency fund;

b. Define an unexpected event and significant impact;

c. Describe the process for accessing emergency funds;

d. Describe how funding determination is made;

e. Give a timeline of the determination of the request;

f. Define the maximum funding amount per family or per event; and

g. Describe how families will be notified of the decision in writing.

J. BILLING AND PAYMENT PROCEDURES

1. The CCB shall develop and implement policies, procedures, and practices for maintaining documentation for the FSSP and reporting information in the format and timeframe established by the Department.

2. Families shall maintain and provide either receipts or invoices to the CCB documenting how funds provided to the family through the FSSP were expended. The CCB shall maintain supporting documentation capable of substantiating all expenditures and reimbursements made to providers and/or families, which shall be made available to the Department upon request.

    a. When the CCB purchases services or items directly for families, the CCB shall maintain receipts or invoices from the service provider and documentation demonstrating that the provider was paid by the CCB. Receipts or invoices must contain, at a minimum, client and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount due or paid.

    b. When the CCB reimburses families for services or items, the CCB shall ensure the family provides the CCB with receipts or invoices prior to reimbursement. The CCB shall maintain receipts or invoices from the families, and documentation demonstrating that the family was reimbursed by the CCB. The CCB must ensure all receipts or invoices provided by the families contain, at a minimum, client and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

    c. When the CCB provides funding to the families for the purchase of services or items in advance, the CCB shall notify the families that they are required to submit invoices or receipts to the CCB of all purchases made prior to the close of the State Fiscal Year. The CCB must ensure that all receipts or invoices are collected and maintained from the family, as well as documentation demonstrating that the family received funding from the CCB. The CCB must ensure all receipts or invoices provided by the families contain, at a minimum, client and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost, amount paid.

3. The CCB shall submit to the Department, on a form and frequency prescribed by the Department, information which outlines individual family use of the FSSP.

4. The CCB shall report only FSSP expenditure data in the format and timeframe as designated by the Department.

K. PROGRAM EVALUATION

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

2. The evaluation may be based upon a family satisfaction survey and shall address the following areas:

    a. Effectiveness of outreach/public awareness including:

        i. The demographics of participants in comparison to demographics of the service area; and

ii. How well the program integrates with other community resources.

b. Satisfaction and program responsiveness to include:

i. Ease of access to the program;

ii. Timeliness of services;

iii. Effectiveness of services;

iv. Availability of services;

v. Responsiveness to family concerns;

vi. Overall family satisfaction with services; and

vii. Recommendations.

c. Effective coordination and utilization of funds to include:

i. Other local services and supports utilized in conjunction with the FSSP; and

ii. Efficiency of required documentation for receipt of the FSSP.

3. The CCB, and participating families as requested, shall cooperate with the Department regarding statewide evaluation and quality assurance activities, which includes, but is not limited to providing the following information:

a. The maximum amount any one family may receive through the FSSP during the fiscal year; and

b. The total number of families to be served during the year.

L. PERFORMANCE AND QUALITY REVIEW

1. The Department shall conduct a Performance and Quality Review of the FSSP to ensure that it complies with the requirements set forth in these rules.

2. A CCB found to be out of compliance with these rules through the results of the Performance and Quality Review, shall be required to develop a corrective action plan, upon written notification from the Department. A corrective action plan must be submitted to the Department within ten (10) business days of the receipt of the written request from the Department. A corrective action plan shall include, but not limited to:

a. A detailed description of the action to be taken, including any supporting documentation;

b. A detailed time frame specifying the actions to be taken;

c. Employee(s) responsible for implementing the actions; and

d. The implementation timeframes and a date for completion.

3. The CCB shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The agency shall explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the agency's compliance.

    a. Upon receipt of the corrective action plan, the Department will accept, modify or reject the proposed corrective action plan. Modifications and rejections shall be accompanied by a written explanation.

    b. In the event that the corrective action plan is rejected, the agency shall re-write the corrective action plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

    c. The agency shall implement the corrective action plan upon acceptance by the Department.

    d. If corrections are not made within the requested timeline and quality specified by the Department, funds may be withheld or suspended.

M. FAMILY SUPPORT SERVICES PROGRAM (FSSP) ANNUAL REPORT

1. Each CCB shall submit an annual FSSP report to the Department by October 1 of each year. The report will contain two sections.

    a. The first section must describe how the CCB plans to spend the FSSP funds in the current fiscal year and will include:

        i. Description of the outreach/public awareness efforts for the coming year;

        ii. Description of anticipated special projects or activities under the Program Expense service category; and

        iii. Goals with measurable outcomes for any changes to the FSSP.

    b. The second section of the annual report will describe how the FSSP funds were spent in the previous year and must contain:

        i. The program evaluation outcomes for the previous year as described in this section;

        ii. The total amount of funds expended by service category;

        iii. The total number of families served and the total number of families placed on the waiting list;

        iv. Detailed information for the Program Expense service category to include:

            1) The total number of families that utilized services under the Program Expense category;

            2) The specific services provided; resource library, special projects, training events, social events, or group respite;

3) How these services enhanced the lives of families in the community and the total number of families who participated in each project; and

4) The report shall include the total number of staff, total of staff cost, and other costs associated with the Program Expense service category.

iv. A description of how the annual FSSP report was distributed to eligible families; and

v. The signature of Family Support Council (FSC) members, the FSSP Coordinator, and the CCB Executive Director.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adult Dental Annual Limit Decrease, Section 8.201
Rule Number: MSB 20-08-27-A
Division / Contact / Phone: Health Programs / 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 20-08-27-A, A Revision to the Medical Assistance Rule concerning Adult Dental Annual Limit Decrease, Section 8.201

3. This action is an adoption of: an amendment

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

   Sections(s) 8.201.6, 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 8.201.6 with the proposed text beginning at 8.201.6.2 through the end of 8.201.6.3. This rule is effective April 15, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adult Dental Annual Limit Decrease, Section 8.201
Rule Number: MSB 20-08-27-A
Division / Contact / Phone: Health Programs / Russ Zigler / 303-866-5927

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 2020 Long Bill (HB20-1360) passed by the Colorado General Assembly decreases the Colorado Medicaid annual adult dental limit from $1,500 to $1,000, effective April 1, 2021. This rule decreases the adult dental annual limit from $1,500 to $1,000, effective April 1, 2021, to comply with HB20-1360. This bill impacts adult clients and reduces the maximum reimbursable dental services per year by $500.

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 CFR § 440.100 (2020)

4. State Authority for the Rule:

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

   C.R.S. § 25.5-5-202(1)(w) (2020)

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**
			DOCUMENT #

Title of Rule: Revision to the Medical Assistance Rule concerning Adult Dental Annual Limit Decrease, Section 8.201
Rule Number: MSB 20-08-27-A
Division / Contact / Phone: Health Programs / Russ Zigler / 303-866-5927

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.

   Adult members will be affected by this rule and will bear the cost of the reduction in the adult dental annual limit.

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

   Adult members will have $500 less dental coverage per year.

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 estimates that this rule change will impact 22,260 clients. This is based on the number of clients who utilized the full $1500 maximum benefit in FY 2018-19. The Department spent approximately $174 million on dental services for adult clients (about $255 per capita) in FY 2017-18. The Budget Division calculates that this decrease will result in a decrease of $11.1 million total funds, including $2.9 million cash funds and $8.2 million federal funds, in FY 2021-2022. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

4. 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 bringing Department rule in alignment with HB20-1360.

5. 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 bringing Department rule in alignment with HB20-1360.

8.201 ADULT DENTAL SERVICES

8.201.6 ANNUAL LIMITS

1. Beginning July 1, 2019, dental services for Adult Clients age 21 years and older shall be limited to a total of $1,500 per Medicaid Adult Client per state fiscal year. An Adult Client may make personal expenditures for any dental services that exceed the $1,500 annual limit.

2. Effective April 1, 2021, or beginning when the higher federal match afforded through the federal "Families First Coronavirus Response Act", Pub.L. 116-127, or any amendment thereto, expires, whichever is later, and continuing through June 30, 2022, the dental services for Adult Clients age 21 years and older shall be limited to a total of $1,000 per Medicaid Adult Client per state fiscal year. An Adult Client may make personal expenditures for any dental services that exceed the $1,000 annual limit.

~~2~~-3. The complete and partial dentures benefit shall be subject to prior authorization and shall not be subject to the ~~$1,500~~ annual maximum for dental services for Adult Clients age 21 years and older. Although the complete and partial dentures benefit is not subject to the ~~$1,500~~ annual maximum for the adult dental services, it shall be subject to a set Medicaid allowable rate.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers, Section 8.700.
Rule Number: MSB 20-12-18-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

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 20-12-18-A, Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers.

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

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/11/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700 with the proposed text beginning at 8.700.6.D.4.c through the end of 8.700.6.D.4.c. This rule is effective April 15, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers, Section 8.700.
Rule Number: MSB 20-12-18-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

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 purpose of this rule revision is to adjust the FQHC rate setting process to consider the changes to utilization and cost due to COVID-19. The pandemic has caused utilization to drop at FQHCs and costs have changed as well. To avoid setting unreasonable rates, this rule revision will set rates for FQHC cost reports with fiscal year ends between May 31, 2020 and May 31, 2021 using the previous year's rates multiplied by the Medicare Economic Index (MEI).

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:

   Without the emergency adoption of this rule revision, FQHC rates could skyrocket causing a serious budget on the Department's budget. This could create issues with our programs and prompt service delivery for our members.

3. Federal authority for the Rule, if any:

   1902(bb) SSA

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers, Section 8.700.
Rule Number: MSB 20-12-18-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

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.

   Federally Qualified Health Centers will be impacted by this rule. This rule revision will set reasonable FQHC rates for time periods where costs and visits were dramatically impacted by the COVID-19 pandemic. FQHCs will benefit from this rule because their rates will neither skyrocket nor drop due to the extreme changes caused by the pandemic.

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

   FQHC rates will increase by 1.9%. FQHC rates usually increase annually by overall average of 4.0% per year. However, the rate change varies by year and is sometimes negative. Therefore, the Department believes the MEI is a good estimate of how FQHC rates should increase. The MEI is currently used to inflate FQHC's annual cost per visit rate, base rate, and Prospective Payment System (PPS) rate.

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 rule revision will impact the Department and state revenues. Instead of having unpredictable and potentially very high FQHC rates, we will have predictable and reasonable FQHC rates for the near future. The Department will be better able to budget FQHC payments and not see an alarming increase in FQHC payments.

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

   If the Department does not adopt this rule change FQHC rates will be more unstable and less predictable. It is likely FQHC rates will increase greatly, causing the Department to spend more on FQHCs than expected.

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

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There are no other methods that are less costly or less intrusive to achieve 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.
   The Department has considered other ways of setting FQHC rates such as using estimates for pandemic months or another inflationary factor. The MEI was chosen due to its familiarity with FQHCs and by the ease of use.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

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

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

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

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

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

8.700.2 CLIENT CARE POLICIES

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

8.700.2.B The policies shall include:

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

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

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

8.700.3 SERVICES

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

1. General services

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

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

b. Part-time or intermittent visiting nurse care.

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

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

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

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

8.700.4 PHYSICIAN RESPONSIBILITIES

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

practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.700.5 ALLOWABLE COST

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

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

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

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

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

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

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

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

1. Offsite Laboratory/X-Ray;

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

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

8.700.6 REIMBURSEMENT

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

rendered services are covered and paid by either the Regional Accountable Entity (RAE) or through the short-term behavioral health services in the primary care setting policy.

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

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

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

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

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

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

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

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

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

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

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

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

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

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

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

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

8.700.6.D Encounter rates calculations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or

medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

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

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

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

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

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

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

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

vii. The addition or removal of administrative staff;

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

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

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

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

xii. A change in ownership.

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

e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.D.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. An FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually

or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Pending federal approval, the Department will offer a second Alternative Payment Methodology (APM 2) that will reimburse FQHCs a Per Member Per Month (PMPM) rate. FQHCs may opt into APM 2 annually. This reimbursement methodology will convert the FQHC's current Physical Health cost per visit rate into an equivalent PMPM rate using historical patient utilization, member designated attribution, and the Physical Health cost per visit rate for the specific FQHC. Physical health services rendered to patients not attributed to the FQHC, or attributed based on geographic location, will pay at the appropriate encounter rate. Dental and specialty behavioral health services for all patients will be paid at the appropriate encounter rate. Year 2 rates for FQHCs participating in APM 2 will be set using trended data. Year 3 rates will be set using actual data.

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

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

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

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

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

8.700.8.B

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

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

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