DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning The Pharmacy Rate Methodology, Section 8.800
Rule Number: MSB 21-04-26-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 303-866-6715

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MS21-04-26-A, Revision to the Medical Assistance Rule Concerning The Pharmacy Rate Methodology

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) 8.800.1 and 8.800.13, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.800 with the proposed text beginning at 8.800.1 through the end of 8.800.1. Replace the current text at 8.800.13 with the proposed text beginning at 8.800.13.A through the end of 8.800.13.O.1. This rule is effective April 14, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning The Pharmacy Rate Methodology, Section 8.800
Rule Number: MSB 21-04-26-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 303-866-6715

STATEMENT OF BASIS AND PURPOSE

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

   The Department is updating the outpatient pharmacy rate methodology for clotting factor drugs by incorporating Average Acquisition Cost (AAC) and Clotting Factor Maximum Allowable Cost (CFMAC) rates, effective April 1, 2022. The incorporation of AAC and CFMAC will result in rates better aligned with acquisition costs. This update will impact pharmacy providers' reimbursement for clotting factor drugs. This change is necessary for the Department to better manage drug expenditures for clotting factor drugs.

   In addition, the Department received guidance from CMS which said state Medicaid programs have full discretion in determining how often a Cost of Dispensing survey must be conducted. Therefore, to allow for more contractor funding flexibilities and to reduce the administrative work related to the Cost of Dispensing survey for pharmacy providers, the Department is modifying the two-year timeframe to "periodically".

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 USC 1396r-8(e)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   Sections 25.5-4-401, 25.5-5-202(1)(a)(I), C.R.S.

Initial Review	**01/14/22**	Final Adoption	**02/14/22**
Proposed Effective Date	**04/14/22**	Emergency Adoption	

DOCUMENT #05

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning The Pharmacy Rate Methodology, Section 8.800
Rule Number: MSB 21-04-26-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 303-866-6715

REGULATORY ANALYSIS

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

   Clotting Factor Methodology: The class of persons who will be affected by this proposed rule is clotting factor pharmacy providers as they may receive lower reimbursement due to the integration of the AAC and CFMAC rates into the lesser-of reimbursement methodology. The class of persons who will benefit from the proposed rule is the Department as it will address a gap in the current AAC rate setting for clotting factor prescription drugs, resulting in rates better aligned with acquisition costs.

   Cost of Dispensing Survey: There are no costs based on the proposed rule. The benefit of the proposed rule is that it gives the Department more flexibility related to the frequency that the cost of dispensing survey must be conducted. In addition, it requires less contractor funding and reduces administrative work for pharmacy providers.

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

   Clotting Factor Methodology: The probable quantitative and qualitative impact is that clotting factor providers may receive lower reimbursement due to the integration of AAC and CFMAC rates into the lesser-of methodology; whereas the Department will utilize rates better aligned with acquisition costs.

   Cost of Dispensing Survey: Quantitatively, the proposed rule will require less contractor funding for the Department. Qualitatively, the proposed rule will reduce the administrative work that the Cost of Dispensing survey creates for pharmacy providers.

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.

Clotting Factor Methodology: There are no probable costs to the Department as the new clotting factor reimbursement methodology can be implemented with existing resources.

Cost of Dispensing Survey: There are no costs based on the implementation of the proposed rule.

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

   Clotting Factor Methodology: The probable cost of action is that clotting factor providers may receive lower reimbursement due to the incorporation of the AAC and CFMAC rates into the lesser-of methodology; whereas the probable benefit of action is that the Department will be able to utilize rates better aligned with acquisition costs. The probable benefit of inaction is that providers may not receive lower reimbursement due to the incorporation of the AAC and CFMAC rates into the lesser-of methodology; whereas the probable cost of inaction is that the Department will reimburse well over acquisition costs for clotting factor drugs.

   Cost of Dispensing Survey: The probable cost of inaction is that the Department must conduct the cost of dispensing survey every two years, which does not allow for contractor funding flexibilities, and the administrative burden for pharmacy providers will remain the same; whereas the probable benefit of action is that it will give the Department more contractor funding flexibilities and will reduce the administrative work for pharmacy providers.

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

8.800.1 DEFINITIONS

A. 340B Pharmacy means any pharmacy that participates in the Federal Public Health Service's 340B Drug Pricing Program as described in Title 42 of the United States Code, Section 256b (2020). Title 42 of the United States Code, Section 256b (2020) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

B. Average Acquisition Cost (AAC) means the average acquisition cost for like drugs grouped by Generic Sequence Number (GSN). For GSNs with both generic and brand drugs, the Department shall determine two separate AAC rates for the GSN. One AAC rate shall be based on the average acquisition cost for all generic drugs while the other shall be based on the average acquisition cost for all brand drugs.

C. Clotting Factor Maximum Allowable Cost (CFMAC) means the rate for a clotting factor drug for which nodoes not possess an Average Acquisition Cost (AAC) rate is established. Theis CFMAC rate is determined based on available acquisition cost data and publicly available data unique to each clotting factor drug.

DC. Conflict of Interest means having competing professional or personal obligations or personal or financial interests that would make it difficult to fulfill duties in an objective manner.

ED. Department means the Colorado Department of Health Care Policy and Financing.

FE. Dispensing Fee means the reimbursement amount for costs associated with filling a prescription. Costs include salary costs, pharmacy department costs, facility costs, and other costs.

GF. Dispensing Prescriber means a health care professional who, as licensed by Colorado state law, prepares, dispenses and instructs members to self-administer medication.

HG. Drug Class means drugs that are grouped together due to a common mechanism of action, or to treat a particular disease, symptom or indication.

IH. Emergency Situation means any condition that is life threatening or requires immediate medical intervention as determined in good faith by the pharmacist.

JI. E-prescription means the transmission of a prescription through an electronic application.

KJ. Fiscal agent means a contractor that supports and operates the pharmacy benefit management system on behalf of the Medical Assistance Program.

LK. Federal Upper Limit (FUL) means the upper limit for multiple source drugs as set by the Centers for Medicare and Medicaid Services pursuant to Title 42 of the Code of Federal Regulations, Part 447.512-447.516 (2020). Title 42 of the Code of Federal Regulations, Part 447.512-447.516 (2020) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver,

CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

ML. Generic Sequence Number (GSN) means a standard number to group together drugs that have the same ingredients, route of administration, drug strength, and dosage form.

NM. Good Cause means failing to disclose a Conflict of Interest; participating in wrongdoing or misconduct in the case of serving as a member of a committee or other advisory body for the Department; failing to perform required duties; or missing two scheduled meetings per calendar year.

ON. Government Pharmacy means any pharmacy whose primary function is to provide drugs and services to members of a facility whose operating funds are appropriated directly from the State of Colorado or the federal government excluding pharmacies funded through Indian Health Services.

PO. Institutional Pharmacy means any pharmacy whose primary function is to provide drugs and services to hospitalized patients and others receiving health care provided by the facility with which the pharmacy is associated.

QP. Mail Order Pharmacy means any pharmacy that delivers drugs primarily by mail.

RQ. Maintenance Medication means any drug, as determined by the Department, which is used to treat a chronic illness or symptoms of a chronic illness.

SR. Maximum Allowable Cost (MAC) means the rate for a covered drug which does not possess Average Acquisition Cost (AAC) nor National Average Drug Acquisition Cost (NADAC) rates. This rate is calculated using an adjustment of the national pricing benchmark Wholesale Acquisition Cost (WAC).

TS. Medical Assistance Program shall have the meaning defined in Section 25.5-1-103(5), C.R.S. (2020).

UT. Medical Assistance Program Allowable Charge means the allowed ingredient cost plus a dispensing fee or the provider's Usual and Customary Charge, whichever is less, minus the member's copayment as determined according to Section 8.754.

VU. Medical Director means the physician or physicians who advise the Department.

WV. Medicare Part D means the prescription drug benefit provided to Part D eligible individuals pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

XW. Medicare Part D Drugs means drugs defined at Title 42 of the United States Code, Section 1395w-102(e) (2020) and Title 42 of the Code of Federal Regulations, Section 423.100 (2020). Title 42 of the United States Code, Section 1395w-102(e) (2020) and Title 42 of the Code of Federal Regulations, Section 423.100 (2020) are hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall

provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

~~X~~. ~~Non-preferred Drug means a drug that is designated as non-preferred by the Medical Director pursuant to Section 8.800.16, and requires prior authorization before being payable by the Medical Assistance Program.~~

Y. National Average Drug Acquisition Cost (NADAC) is a Centers for Medicare and Medicaid Services published rate which represents the national average of the drug acquisition costs submitted by retail community pharmacies.

Z. Non-preferred Drug means a drug that is designated as non-preferred by the Medical Director pursuant to Section ~~8.800.16, and~~8.800.16 and which requires prior-authorization ~~before being~~to be payable by the Medical Assistance Program.

AA~~Z~~. Old Age Pension Health Care Program and Old Age Pension Health Care Supplemental Program (OAP State Only) means the program established to provide necessary medical care for clients that qualify for Old Age Pension but do not qualify for the Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes.

BB~~AA~~. Over-the-Counter (OTC) means a drug that is appropriate for use without the supervision of a health care professional such as a physician, and which can be purchased by a consumer without a prescription.

CC~~BB~~. Part D eligible individual has the same meaning as defined in Section 8.1000.1.

DD~~CC~~. Pharmacy and Therapeutics Committee (P&T Committee) means an advisory board that shall perform reviews and make recommendations which facilitate the development and maintenance of the Preferred Drug List as described in Section 8.800.17.

EE~~DD~~. Preferred Drug means a drug that is designated preferred by the Medical Director pursuant to Section 8.800.16.A, that is payable by the Medical Assistance Program without first obtaining a prior authorization unless otherwise required to protect the health and safety of specific members.

FF~~EE~~. Preferred Drug List (PDL) means a list, applicable only to fee-for-service and primary care physician Medical Assistance Program members, which identifies the Preferred Drugs and Non-preferred Drugs within a drug class.

GG~~FF~~. Prescriber means a healthcare professional who, as licensed by Colorado state law, may prescribe and authorize the use of medicine or treatment to a member. Prescribers must be enrolled in the Medical Assistance Program to receive reimbursement.

HH~~GG~~. Provider Bulletin means a document published and distributed by program and policy staff to communicate information to providers related to the Department.

II~~HH~~. Retail Pharmacy means any pharmacy that is not a 340B Pharmacy, Government Pharmacy, Institutional Pharmacy, Mail Order Pharmacy, or Rural Pharmacy.

JJ~~II~~. Rural Pharmacy means any pharmacy that is the only pharmacy within a twenty-mile radius.

KK~~JJ~~. Submitted Ingredient Cost means a pharmacy's calculated ingredient cost. For drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program, the Submitted Ingredient Cost means the 340B purchase price.

LL~~KK~~. Total Prescription Volume means all new and refill prescriptions dispensed for all payer types. Payer types include but are not limited to Medicaid, Medicare, commercial, third-party, and uninsured.

MM~~LL~~. Usual and Customary Charge means the reimbursement amount the provider charges the general public to pay for a drug.

NN~~MM~~. Wholesale Acquisition Cost (WAC) means with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

8.800.13.A. Covered drugs for all members except for OAP State Only clients shall be reimbursed the lesser of:

1. The Usual and Customary Charge minus the member's copayment, as determined according to Section 8.754; or

2. The allowed ingredient cost plus a Dispensing Fee minus the member's copayment, as determined according to Section 8.754.

3. Covered drugs for the OAP State Only Program shall be reimbursed according to Section 8.941.9.

8.800.13.B. The allowed ingredient cost for Retail Pharmacies, Rural Pharmacies, 340B Pharmacies, Institutional Pharmacies, Government Pharmacies and Mail Order Pharmacies shall be the lesser of AAC, NADAC or Submitted Ingredient Cost. If AAC and NADAC are not available, the allowed ingredient cost shall be the lesser of MAC or Submitted Ingredient Cost.

1. The Department shall grant an exception to the allowed ingredient cost for clotting factor which shall be the lesser of AAC or Submitted Ingredient Cost. If AAC is not available, the allowed ingredient cost shall be the lesser of Clotting Factor Maximum Allowable Cost (CFMAC) or Submitted Ingredient Cost. ~~or WAC.~~

8.800.13.C. MAC rates shall be calculated as follows:

1. The generic drug MAC rate shall be WAC minus 10 percent.

2. The brand name drug MAC rate shall be WAC minus 3 percent.

8.800.13.D. AAC rates shall be rebased monthly using invoices and/or purchase records provided to the Department through a representative group of pharmacies. If the Department cannot establish a process to obtain invoices and/or purchase records on a monthly basis, the Department shall survey one-fourth (1/4) of all Medicaid enrolled pharmacies every quarter to rebase AAC rates.

1. Notwithstanding Section 8.800.13.D, AAC rates for clotting factor drugs shall be rebased at least biannually.

8.800.13.E. A pharmacy wanting to inquire about a listed AAC rate shall complete the Average Acquisition Cost Inquiry Worksheet posted on the Department's website. The pharmacy shall email the completed worksheet with a copy of the receipt invoice to the Department or designated vendor as indicated on the Average Acquisition Cost Inquiry Worksheet. The Department shall have five (5) days to provide an inquiry response to the pharmacy. If the AAC rate requires revision, the Department shall then have 5 additional days to update the AAC rate.

8.800.13.F. To address weekly fluctuations in drug prices, the Department shall apply a percent adjustment to existing AAC rates for drugs experiencing significant changes in price. The percent adjustment shall be determined using weekly changes in price based on national pricing benchmarks. Every week, the Department shall post an updated AAC price list, with the adjusted AAC rates, on the Department's website (www.colorado.gov/hcpf). A percent adjustment shall only be applied to an AAC rate until the Department can rebase the rate through the process discussed in Section 8.800.13.D.

8.800.13.G. Any pharmacy, except a Mail Order Pharmacy, that is the only pharmacy within a twenty-mile radius may submit a letter to the Department requesting the designation as a Rural Pharmacy.

8.800.13.H. Dispensing Fees shall be determined based upon reported dispensing costs provided through a Cost of Dispensing (COD) survey~~. completed every two fiscal years.~~ The Dispensing Fees for Retail Pharmacies, 340B Pharmacies, Institutional Pharmacies and Mail Order Pharmacies shall be tiered based upon annual Total Prescription Volume. The Dispensing Fees shall be tiered at:

1. Less than 60,000 total prescriptions filled per year = $13.40

2. Between 60,000 and 90,000 total prescriptions filled per year = $11.49

3. Between 90,000 and 110,000 total prescriptions filled per year = $10.25

4. Greater than 110,000 total prescriptions filled per year = $9.31

8.800.13.I. The designation of a pharmacy's Dispensing Fee shall be updated annually. Every October, the Department shall contact a pharmacy requesting the completion of an attestation letter stating the pharmacy's Total Prescription Volume for the period September 1 to August 31. A pharmacy shall have until October 31 to provide the completed attestation letter to the Department. Using the attestation letter, the Department shall update a pharmacy's Dispensing Fee effective January 1. A pharmacy failing to provide the Department an attestation letter on or before October 31, regardless of their previous Dispensing Fee, shall be reimbursed the $9.31 Dispensing Fee.

8.800.13.J. The Department shall determine the Dispensing Fee for a pharmacy enrolling as a Medicaid provider based on the pharmacy's Total Prescription Volume. During the enrollment process, a pharmacy shall provide the Department an attestation letter stating their Total Prescription Volume for the previous twelve (12) months. Using the attestation letter, the Department shall determine the pharmacy's Dispensing Fee effective upon approval of enrollment. A pharmacy failing to provide the Department an attestation letter during the enrollment process shall be reimbursed the $9.31 Dispensing Fee. The Dispensing Fee shall be used until it can be updated the following year in accordance with ~~10 C.C.R. 2505-10,~~Section 8.800.13.I.

1. If a pharmacy has been open for less than 12 months, the Department shall annualize the Total Prescription Volume to determine the pharmacy's Dispensing Fee.

2. If a pharmacy is new and possesses no Total Prescription Volume history to annualize, then the pharmacy shall provide a good faith estimate of their expected Total Prescription Volume.

8.800.13.K. In November of each year, the Department shall compare a pharmacy's Total Prescription Volume and Medicaid percent provided with the attestation letter to their Medicaid claims data. If the Department identifies any inconsistencies, the Department shall request a pharmacy to provide documentation that substantiates their Total Prescription Volume for the period September 1 to August 31 within thirty (30) days. If the Department determines that the pharmacy incorrectly reported their Total Prescription Volume, the pharmacy shall be reimbursed at the correct tier based on their actual Total Prescription Volume. If a pharmacy does not provide the documentation to the Department within the 30 days, the pharmacy shall be reimbursed the $9.31 Dispensing Fee.

8.800.13.L. The tiered Dispensing Fee shall not apply to Government Pharmacies which shall instead be reimbursed a $0.00 Dispensing Fee.

8.800.13.M. The tiered Dispensing Fee shall not apply to Rural Pharmacies which shall instead be reimbursed a $14.14 Dispensing Fee.

8.800.13.N. Dispensing Prescribers who dispense medications that are reimbursed as a pharmacy benefit pursuant to 8.800 shall be reimbursed a $1.89 Dispensing Fee.

8.800.13.O. Reimbursement for ~~C~~clotting factor drugs that are reimbursed at AAC or Submitted Ingredient Cost shall include~~receive~~ an enhanced ~~per drug unit~~ professional dispensing fee, in addition to the usual professional dispensing fee as defined in Section 8.800.13.H.

1. The enhanced professional dispensing fee for clotting factor drugs shall be $0.03 per drug unit.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2021-22 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 3.8000
Rule Number: MSB 21-10-19-A
Division / Contact / Phone: Special Financing / Riley DeValois / 303-866-6621

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 21-10-19-A, Revision to the Medical Assistance Rule concerning FFY 2021-22 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 8.3000

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) 8.3000, 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 8.3000 with the proposed text beginning at 8.3000.1 through the end of 8.3000.1. Replace the current text at 8.3003 with the proposed text beginning at 8.3003 through the end of 8.3004.F. This rule is effective April 14, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2021-22 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 3.8000
Rule Number: MSB 21-10-19-A
Division / Contact / Phone: Special Financing / Riley DeValois / 303-866-6621

STATEMENT OF BASIS AND PURPOSE

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

   This rule is being amended to reflect the changes necessary for the federal fiscal year (FFY) 2021-22 Hospital Affordability and Sustainability (HAS) provider fees and supplemental payments. Inpatient per-diem fees and outpatient percentage fees have been updated to account for changes to estimated Medicaid expansion costs, estimated administration costs, and HAS supplemental payments. The rule also includes revisions to the disproportionate share hospital (DSH) supplemental payment for the FFY 2022 DSH allotment increase from the Centers for Medicare and Medicaid Services (CMS) and revisions to the hospital quality incentive payment (HQIP) supplemental payment for changes recommended by the HQIP subcommittee and the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board. Lastly, there are some minor revisions to further clarify the scope of the CHASE and how it operates.

   The Department submitted a state plan amendment (SPA) on 12/8/2021 to the CMS and expects approval in the next several months. In addition, the Department presented FFY 2021-22 HAS provider fees and supplemental payments to the CHASE Board on 12/14/2021, which approved the fees and payments. FFY 2021-22 provider fees and supplemental payments will be implemented only after the CMS and the MSB approval.

   For FFY 2021-22, hospitals will pay $1.14 billion in fees, which will generate $3.54 billion in federal funds for Colorado. Hospitals will receive $1.59 billion in supplemental and quality incentive payments. Currently, more than 610,000 Coloradans are enrolled in Medicaid and CHP+ coverage financed with hospital provider fees. As the HAS provider fee funds the Department's administrative costs, there is no impact on state General Fund.

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:

Initial Review	**01/14/22**	Final Adoption	**02/14/22**
Proposed Effective Date	**04/14/22**	Emergency Adoption	

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

3. Federal authority for the Rule, if any:

   42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   Sections 25.5-4-402.4(4)(b), (g), C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2021-22 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 3.8000
Rule Number: MSB 21-10-19-A
Division / Contact / Phone: Special Financing / Riley DeValois / 303-866-6621

REGULATORY ANALYSIS

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

   Colorado hospitals benefit from increased Medicaid reimbursement made possible through HAS supplemental payments and the reduced number of uninsured Coloradans from expanded Medicaid and CHP+ eligibility. Low-income persons benefit from having healthcare coverage through the expanded Medicaid and CHP+ eligibility.

   Colorado hospitals bear the costs of the proposed rule due to paying the HAS fee to fund HAS supplemental payments and expanded Medicaid and CHP+ eligibility expenditures before federal matching funds.

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

   The HAS fee, with federal matching funds, will result in approximately $2.97 billion in annual health care expenditures for more than 610,000 Coloradans and will provide more than $456 million new funds to Colorado hospitals.

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

   While there are administrative costs, such costs are funded with HAS fees and federal matching funds. No state General Fund is used.

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

   The benefits of the proposed rule are the funding of approximately $2.97 billion in annual health care expenditures for more than 610,000 Coloradoans and more than $456 million in new funds to Colorado hospitals. The cost of the proposed rule is the HAS fee paid by Colorado hospitals to fund the expanded Medicaid and CHP+ eligibility and HAS supplemental payments.

If no action is taken, there will not be enough HAS fee to fund Colorado Medicaid and CHP+ expansions, affecting over 610,000 currently enrolled persons or the ability to fund the HAS supplemental payments.

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

   No other methods are available 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.

   No other alternatives to rule making are available.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017 (Act), C.R.S. § 25.5-4-402.4, authorizes the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) to assess a healthcare affordability and sustainability fee, pursuant to rules adopted by the State Medical Services Board, to provide ~~a~~ business services to hospitals as described in C.R.S. § 25.5-4-402.4(4)(a). These business services include, but are not limited to, obtaining federal financial participation to increase reimbursement to hospitals for care provided under the state medical assistance program (Medicaid) and the Colorado Indigent Care Program (CICP); expanding health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan Plus (CHP+), and for low-income adults without dependent children; providing a Medicaid buy-in program for people with disabilities; implementing twelve month continuous eligibility for Medicaid eligible children; paying CHASE's administrative costs of implementing and administering the Act; consulting with hospitals to help them improve cost efficiency, patient safety, and clinical effectiveness; advising hospitals regarding potential changes to federal and state laws and regulations governing Medicaid; providing coordinating services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the Medicaid program; and providing funding for a health care delivery system reform incentive payments program.

8.3001: DEFINITIONS

"Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-402.4, C.R.S.

"CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability Enterprise described in C.R.S. § 25.5-4-402.4(3).

"CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

"CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.

"CMS" means the federal Centers for Medicare and Medicaid Services.

"Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

"Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to qualified hospitals that serve a disproportionate share of Medicaid and uninsured individuals as required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that limits federal financial participation for total statewide DSH payments made to hospitals.

"Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described in C.R.S. § 25.5-4-402.4(7).

"Essential Access Hospital" means a Critical Access Hospital or General Hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget and having 25 or fewer licensed beds.

"Exclusive Provider Organization" or "EPO" means a type of managed care health plan where members are not required to select a primary care provider or receive a referral to receive services from a specialist. EPOs will not cover care provided out-of-network except in an emergency.

“Fund” means the healthcare affordability and sustainability fee cash fund described in C.R.S. § 25.5-4-402.4(5).

“General Hospital” means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

“High Volume Medicaid and CICP Hospital” means a hospital with at least 27,500 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients.

“Health Maintenance Organization” or “HMO” means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency.

“Hospital-Specific Disproportionate Share Hospital Limit” or “Hospital-Specific DSH Limit” means a hospital’s maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.

“Hospital Transformation Program Supplemental Medicaid Payments” or “HTP Supplemental Medicaid Payments” means the:

1. Outpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.B.,

2. Inpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.C., and

3. Essential Access Hospital Supplemental Medicaid Payment described in Section 8.3004.E.

The HTP Supplemental Medicaid Payments ~~does~~ do not include the Hospital Quality Incentive Payment described in Section 8.3004.F. or Rural Support Program Hospital Supplemental Medicaid Payment described in Section 8.3004.G.

“Inpatient Services Fee” means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

“Inpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

“Long Term Care Hospital” means a General Hospital that is certified as a long-~~-~~term care hospital by the Colorado Department of Public Health and Environment.

“Managed Care Day” means an inpatient hospital day for which the primary payer is a managed care health plan, including ~~a~~ HMO, PPO, POS, and EPO days.

“Medicaid Day” means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

“Medicaid Managed Care Day” means a Managed Care Day for which the primary payer is Medicaid.

“Medicare Cost Report” means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.

“MMIS” means the Medicaid Management Information System, the Department’s Medicaid claims payment system.

“MIUR” means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospital days.

“Non-Managed Care Day” means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.

“Non-State-Owned Government Hospital” means a hospital that is either owned or operated by a local government.

“Outpatient Services Fee” means an assessment on hospitals based on outpatient hospital charges.

“Outpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

“Pediatric Specialty Hospital” means a hospital that provides care exclusively to pediatric populations.

“POS” or “Point of Service” means a type of managed care health plan that charges patients less to receive services from providers in the plan’s network and requires a referral from a primary care provider to receive services from a specialist.

“PPO” or “Preferred Provider Organization” means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost.

“Privately-Owned Hospital” means a hospital that is privately owned and operated.

“Psychiatric Hospital” means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

“Rehabilitation Hospital” means an inpatient rehabilitation facility.

“Respiratory Hospital” means a hospital that primarily specializes in respiratory related diseases.

“Rural Hospital” means a hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget.

“State-Owned Government Hospital” means a hospital that is either owned or operated by the State.

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

“Supplemental Medicaid Payments” means the:

1. Outpatient Hospital Supplemental Medicaid Payment described in ~~Sections~~ 8.3004.B.,
2. Inpatient Hospital Supplemental Medicaid Payment described in 8.3004.C.,
3. Essential Access Hospital Supplemental Medicaid Payment described in 8.3004.E.,
4. Hospital Quality Incentive Payment described in 8.3004.F., and
5. Rural Support Program Hospital Supplemental Medicaid Payment described in 8.3004.G.

“Uninsured Cost” means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.

“Urban Center Safety Net Specialty Hospital” means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total inpatient hospital days, rounded to the nearest percent, equals, or exceeds, 65%.

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

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

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.~~7592~~6365% of total hospital outpatient charges with the following exception.

   a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to 1.~~7444~~6228% of total hospital outpatient charges.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

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

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $105.53~~96.42~~ per day for Managed Care Days and $471.76~~31.01~~ per day for all Non-Managed Care Days with the following exceptions:

   a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $55.10~~0.34~~ per day for Managed Care Days and $246.31~~25.03~~ per day for all Non-Managed Care Days, and.

   b. Essential Access Hospitals' Inpatient Services Fee is discounted to $42.21~~38.56~~ per day for Managed Care Days and $188.70~~172.41~~ per day for Non-Managed Care Days.

8.3003.C. ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

1. The Enterprise shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be assessed. ~~and the fee assessment be retroactively distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-Specific DSH Limit.~~

2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the data confirmation report. The Enterprise will prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

3. In order to receive a Supplemental Medicaid Payment or DSH Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. Outpatient billed costs equal outpatient billed charges multiplied by the Medicare cost-to-charge ratio. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, ~~and~~ Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for ~~Major~~ Pediatric ~~Teaching~~ Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to qualified hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.C. INPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients are qualified to receive this payment, except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal Medicaid Days multiplied by an adjustment factor. The adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, ~~and~~ Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Pediatric Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to qualified hospitals shall not exceed the Inpatient Upper Payment Limit. The adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

c. Critical Access Hospitals with at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment.

a. Total funds for the payment shall equal $~~219,367,288~~226,610,302.

b. A qualified hospital with CICP write-off costs greater than 1,000.00% of the state-wide average shall receive a payment equal to ~~88~~96.00% of their Hospital-Specific DSH Limit. A qualified Critical Access Hospital shall receive a payment equal to 96% of their Hospital Specific DSH Limit. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than 2,000 Medicaid Days shall receive a payment equal to ~~88~~50.00% of their Hospital-Specific DSH Limit.

c. All remaining qualified hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining funds.

d. No remaining qualified hospital shall receive a payment exceeding 96.00% of their Hospital-Specific DSH Limit as specified in federal regulation. If a qualified hospital's payment exceeds 96.00% of their Hospital-Specific DSH Limit, the payment shall be reduced to 96.00% of the Hospital-Specific DSH Limit. The amount of the reduction shall then be redistributed to other qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit.

e. A new CICP hospital shall have their Hospital-Specific DSH Limit equal to 10.00%. A Low MIUR hospital shall have their Hospital-Specific DSH Limit equal 10.00%.

i. A new CICP hospital is a hospital approved as a CICP provider after October 1, ~~2019~~2021.

ii. A low MIUR hospital is a hospital with a MIUR less than or equal to 15.00%.

8.3004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal adjusted discharge points multiplied by dollars per-adjusted discharge point.

   a. Adjusted discharge points equal normalized points awarded multiplied by adjusted Medicaid discharges. Normalized points awarded equals the sum of points awarded, normalized to a ~~100 point~~100-point scale for measures a hospital is not eligible to complete. There are ~~eleven~~ fifteen measures separated into three measure groups.

~~b. Due to the COVID-19 pandemic, not all measures were implemented resulting in only 65 available awarded points. Every qualified hospital's points awarded shall be normalized to the 100-point scale.~~

The measures and measure groups are:

Maternal Health and Perinatal Care Measure Group

1. Exclusive Breast Feeding
2. Cesarean Section
3. Perinatal Depression and Anxiety
4. Maternal Emergencies and Preparedness
5. ~~Reproductive Life/Family Planning~~Reduction of Peripartum Racial and Ethnic Disparities
6. ~~Incidence of Episiotomy~~Reproductive Life/Family Planning

Patient Safety Measure Group

7. ~~Clostridium Difficile~~Zero Suicide
8. Clostridium Difficile~~Adverse Event~~
9. Sepsis~~Culture of Safety Survey~~
10. Antibiotics Stewardship
11. Adverse Event
12. Culture of Safety Survey
13. Handoffs and Sign-Outs

Patient Experience Measure Group

14~~0~~. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

15~~1~~. Advance Care Plan

Adjusted Medicaid Discharges equal inpatient Medicaid discharges multiplied by a discharge adjustment factor.

i. The discharge adjustment factor equals total Medicaid charges divided by inpatient Medicaid charges. The discharge adjustment factor is limited to 5.

ii. For qualified hospitals with less than 200 inpatient Medicaid discharges, inpatient Medicaid discharges shall be multiplied by 125%.

b. Dollars per-adjusted discharge point are determined using a qualified hospital's normalized points awarded. Dollars per-adjusted discharge point are tiered so that qualified hospitals with more normalized points awarded receive more dollars per-adjusted discharge point. There are five tiers delineating the dollars per-adjusted discharge point with each tier assigned a certain normalized points awarded range. For each tier the dollars per-adjusted discharge point increase by a multiplier.

The multiplier and normalized points awarded for each tier are:

Tier	Normalized Points Awarded	Dollars Per-Adjusted Discharge Point
1	1-19	0(x)
2	20-39	1(x)
3	40-59	2(x)
4	60-79	3(x)
5	80-100	4(x)

The dollars per discharge point shall equal an amount such that the total quality incentive payments made to all qualified hospitals shall equal seven percent (7.00%) of total hospital payments in the previous state fiscal year.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Health Programs Office Rule Concerning Medicaid Statewide Managed Care System, Section 205, 209, 212 and 215.
Rule Number: MSB 21-10-19-B
Division / Contact / Phone: Health Programs Office / Mark Queirolo / 303-866-5449

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 21-10-19-21-B, Revision to the Medical Assistance Health Programs Office Rule Concerning Medicaid Statewide Managed Care System, Section 8.205, 8.209, 8.212 and 8.215

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) 205, 209, 212 and 215, 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 8.205 through the end of 8.205.11.D. Replace the current text at 8.209 with the proposed text beginning at 8.209.1 through the end of 8.209.7.K. Remove the text at 8.212. Replace the current text at 8.215 with the proposed text beginning at 8.215 through the end of 8.215.6.D. This rule is effective April 14, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Health Programs Office Rule Concerning Medicaid Statewide Managed Care System, Section 205, 209, 212 and 215.
Rule Number: MSB 21-10-19-B
Division / Contact / Phone: Health Programs Office / Mark Queirolo / 303-866-5449

STATEMENT OF BASIS AND PURPOSE

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

   The rule establishes an operational component of managed care for Colorado Medicaid, including eligibility, enrollment/disenrollment, covered services, grievances and appeals, and rate setting. Multiple rule sections related to managed care have been revised to align with current statute for the statewide managed care system defined in C.R.S. 25.5-5 Part 4. The changes also reflect the federally authorized waivers for the Accountable Care Collaborative Phase II and the new inpatient substance use disorder benefit.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR Part 438

   Section 1915(b) waiver for the Colorado Medicaid Accountable Care Collaborative

   Substance Use Disorder Continuum 1115(a) Waiver

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   C.R.S. § 25.5-5-402(1)

Initial Review **01/14/22** Final Adoption **02/14/22**
Proposed Effective Date **04/14/22** Emergency Adoption

DOCUMENT #07

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Health Programs Office Rule Concerning Medicaid Statewide Managed Care System, Section 205, 209, 212 and 215.
Rule Number: MSB 21-10-19-B
Division / Contact / Phone: Health Programs Office / Mark Queirolo / 303-866-5449

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.

   There are no classes of persons that will bear the costs of the proposed rule. Classes of persons affected by the proposed rule include: full-benefit Medicaid members not enrolled in the Program of All-Inclusive Care for the Elderly, primary care providers, and behavioral health providers. All these affected are expected to benefit from the proposed rule.

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

   There are no expected quantitative or qualitative impacts to the proposed rule as the proposed rule reflect federally authorized policies and procedures that have been in operation since 2018.

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

   There are no probable costs to the Department and any other agency. All of the conversations related to costs were had as part of the budgeting process in 2017. The Department is currently operating the program accordingly to the proposed rule.

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

   There are no probable costs and benefits of the proposed rule. The cost for inaction is that the Department would be out of compliance with C.R.S. 25.5-5-402 (1) and 25.5-5-402(15).

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

As mentioned above, there are no probable costs.

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

   No alternative methods were considered as the Department is currently operating the program accordingly to the proposed rule.

8.205 MEDICAID STATEWIDE MANAGED CARE SYSTEM~~MANAGED CARE PROGRAM~~

8.205.1 DEFINITIONS

8.205.1.A. Attribution means the process by which the Department enrolls a Member with a Primary Care Medical Provider or Managed Care Organization.

8.205.1.B. Covered Services means the health care services defined in the contract between the Department and a Managed Care Organization or Prepaid Inpatient Health Plan that are paid through a Monthly Capitation Payment.

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

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

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

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

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

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

8.205.2.E. Managed Care Organization (MCO) shall mean an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR 438.2, and that is:

1. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR 489; or

2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary of the U.S. Department of Health and Human Services to also make the services it provides to its Medicaid members as accessible (in terms of timelines, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and meets the solvency standards of 42 CFR 438.116.

8.205.1.F. Medicaid Statewide Managed Care System, also known as the Accountable Care Collaborative, means any Managed Care Organization, Primary Care Case Management Entity, or Prepaid Inpatient Health Plan established under the State authorities established in Title 25.5, Article 5, Part 4, C.R.S. and under the federal authority established in 42 C.F.R. Part 438 and approved by the Centers for Medicare and Medicaid Services (CMS).

8.205.1.G. Member means any person enrolled in the Medicaid Statewide Managed Care System.

8.205.1.H. Prepaid Inpatient Health Plan (PIHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides,

arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.205.1.I. Primary Care Case Management Entity (PCCM Entity) means an entity contracted with the state department to furnish case management services, including the coordination and monitoring of primary health care services, as defined in 42 CFR § 438.2.

8.205.1.J. Primary Care Medical Provider (PCMP) means a primary care provider contracted with PCCM Entity to serve as a medical home for members.

8.205.1.K. Utilization Management means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.

8.205.2~~1~~ CLIENT ELIGIBILITY

~~8.205.1.A. A Medicaid client may choose to enroll in any Medicaid Managed Care Program for which the client meets the eligibility criteria.~~

~~1. For the purposes of this rule, Medicaid Managed Care Programs include any Managed Care Organization (MCO), Primary Care Case Management program (PCCM), or any Prepaid Inpatient Health Plan (PIHP) that is not a part of the Community Mental Health Services Program.~~

~~2. Rules for the Community Mental Health Services program PIHPs are located in Section 8.212 of these rules, "Community Mental Health Services."~~

~~8.205.1.B. A Medicaid client who receives limited benefits and is not otherwise eligible for Medicaid, is not eligible to receive services through a Medicaid Managed Care Program.~~

8.205.2.A. A Medicaid Client with full Medicaid benefits must be enrolled into the Medicaid Statewide Managed Care System, with the exception of the individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE) as defined in Section 8.497.

8.205.2.B.~~8.212.1.A.~~ The following individuals are not eligible for enrollment in the Medicaid Statewide Managed Care System~~Community Behavioral Health Services program~~:

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

2. Qualified Disabled and Working Individuals (QDWI)

3. Qualified Individuals 1 (QI 1).

4. Special Low Income Medicare Beneficiaries (SLMB).

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

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

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

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

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

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

7~~8~~. Individuals between ages 21 and 64 who ~~receive inpatient treatment who~~ are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.

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

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

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

8. Individuals who are incarcerated.

~~12~~9. Individuals while determined presumptively eligible for Medicaid.

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

~~8.205.2 CLIENT RESPONSIBILITIES~~

~~8.205.2.A. A client in a PCCM program agrees to comply with the following responsibilities:~~

~~1. Select a primary care provider from those participating in the PCCM program.~~

~~2. Obtain a referral from his/her primary care provider for care that requires a referral according to the program guidance, when the care is provided by anyone other than his/her primary care provider.~~

~~3. Request any change of primary care provider from the Department or its designee.~~

~~4. Pay for any services received which are not Medicaid covered services.~~

~~5. Notify the primary care provider of any third party insurance, including Medicare.~~

~~8.205.2.B. A client in an MCO or PIHP agrees to comply with the following responsibilities:~~

~~1. Select a primary care provider from those providers available in the MCO or PIHP.~~

~~2. Follow all requirements of the Medicaid managed care program as described in the Member Handbook for the MCO or PIHP.~~

~~3. Obtain a referral from his/her primary care provider for specialty care as required by the MCO or PIHP.~~

~~4. Follow MCO's or PIHP's procedures for complaints and grievances.~~

~~5. Request any change of primary care provider from the MCO or PIHP.~~

~~6. Pay for any services received which are not Medicaid covered services.~~

~~7. Notify the Managed Care Organization of any third party insurance, including Medicare.~~

8.205.3 ~~CLIENT~~ MEMBER RIGHTS AND PROTECTIONS

8.205.3.A. A ~~client~~ Member enrolled in a PCCM Entity, MCO, or PIHP has the following rights and protections:

1. To be treated with respect and with due consideration for ~~his/her~~the Member's dignity and privacy.

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

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

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

5. To obtain family planning services and family planning-related services directly from any provider duly licensed or certified to provide such services without regard to enrollment in a PCCM Entity, MCO, or PIHP, without referral.

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

7. To select a PCMP from those available in the PCCM Entity or MCO network.

8. To request any change of PCMP in a PCCM Entity network from the Department or its designee.

9. To select or request a change of a provider from those providers available in the MCO or PIHP provider network.

10. To have access to written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages. All materials shall be written in English and Spanish, or any other prevalent language, as directed by the Department or as required by 42 CFR 438.10.

11. To have oral interpretation available in all languages and written translation available in each prevalent non-English language at no cost to any Member.

12~~7~~. To exercise ~~his/her~~the Member's rights without any adverse effect on the way ~~he/she~~the Member is treated.

8.205.4 ~~CLIENT~~ MEMBER ENROLLMENT AND DISENROLLMENT

8.205.4.A. Enrollment in the Medicaid Statewide Managed Care System is mandatory for eligible Members~~a PCCM, MCO, or PIHP is voluntary~~.

8.205.4.B. Members enrolled into the Medicaid Statewide Managed Care System are attributed to a PCMP or MCO.

1. Members may be attributed to an MCO in accordance with the Department's member enrollment policy that takes into consideration the following:
   a. County of residence.
      i. Members residing in Garfied, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco counties may be attributed to the MCO operated by or under the control of Rocky Mountain Health Plans.
      ii. Members residing in Adams, Arapahoe, Denver, and Jefferson Counties may be attributed to the MCO operated by or under the control of Denver Health and Hospital Authority.
   b. Member's age.
   c. Member's Medicaid aid category.
2. Members will be attributed to a PCMP based on factors that include Member choice, Member utilization history, provider capacity, and geographic location in accordance with the Department's member enrollment policy in the following instances:
   a. The Member resides in a county that is not covered by an MCO.
   b. The Member opts out of enrollment in an MCO.
3. Members may change their attribution to a PCMP by contacting the Department or its designee. Any change in attribution to a PCMP is effective the first day of the month following the member's formal submission of the change request to the Department or its designee.
4. Members may change their attribution to an MCO as specified in 8.205.5. H, I, J, and K.

8.205.4.C. Members attributed to a PCMP are assigned to a PCCM Entity/PIHP based on the PCMP's contract with a PCCM Entity/PIHP.

8.205.4.D. Members attributed to an MCO are assigned to the PIHP contracted with the MCO.

8.205.4.E Child and youth Members determined eligible for Medicaid as a result of a dependency and neglect action resulting in out-of-home placement pursuant to article 2 of title 19 C.R.S. must be assigned to the PCCM Entity and PIHP that cover the county with jurisdiction over the action.

1. The Department or its designee may change the child or youth Member's PCCM Entity and PIHP assignment only at the request of the county with jurisdiction over the action or by the child's or youth's legal guardian.

8.205.4.F~~B~~. Members who are disenrolled from a PCCM Entity, MCO, or PIHP for a period of two (2) months or less due to loss of eligibility shall be reenrolled into the same program upon regaining eligibility within the two (2) month period.

8.205.4.G~~C~~. A ~~client~~ Member who is enrolled with an ~~PCCM,~~ MCO~~, or PIHP~~ remains assigned to that ~~PCCM,~~ MCO~~, or PIHP~~ for a period of twelve (12) months except as otherwise provided in these rules.

8.205.4.H~~D~~. A ~~client who is not subject to mandatory enrollment~~Member may request disenrollment from their ~~PCCM,~~ MCO~~, or PIHP~~ without cause during the ninety (90) days following the date of their initial enrollment or the date the Department or its designee sends the notice of enrollment, whichever is later.

8.205.4.I~~E~~. A ~~client who is not subject to mandatory enrollment~~Member may request disenrollment without cause at least every twelve (12) months after the date of initial enrollment with an ~~PCCM,~~ MCO~~, or PIHP~~.

~~1. A client who is not subject to mandatory enrollment may request disenrollment within 30 days of automatic enrollment into a PCC, MCO, or PIHP if the client was ineligible during the annual disenrollment opportunity and was automatically enrolled after becoming eligible for Medicaid again.~~

8.205.4.J~~F~~. A ~~client~~ Member may request disenrollment when the Department imposes intermediate sanctions as set forth in the Department's contract with the ~~PCCM,~~ MCO~~, or PIHP~~.

8.205.4.KG. A client Member who is not subject to mandatory enrollment may request disenrollment from an MCO for cause at any time. Cause shall be defined as any of the following:

1. The client Member moves out of the PCCM, MCO, or PIHP service area.

2. The plan or programMCO does not, because of moral or religious objections, cover the service the client Member needs.

3. The client Member needs related services to be performed at the same time and not all related services are available within the plan or programMCO network, and the client's Member's provider determines that receiving the services separately would subject the client Member to unnecessary risk.

4. The Department or its designee unintentionally enrolls a client Member into the wrong plan.

5. Poor quality of care, as documented by the Department.

6. Lack of access to covered services, as documented by the Department.

7. Lack of access to providers experienced in dealing with the client's Member's health care needs, as documented by the Department.

8. The client's Member's primary care provider leaves the PCCM, MCO, or PIHP.

9. Other reasons satisfactory to the Department.

8.205.4.H A client who is subject to mandatory enrollment may request to be exempt from enrollment, or request to be disenrolled from the program if:

1. The client does not have access to a primary care provider contracted with the program.

2. There is poor quality of care, as documented by the Department, and there is no access to another primary care provider contracted with the program.

3. The client and the program have been unable to develop a healthy working relationship and continued best clinical interest of the client.

4. The Department, at its discretion, decides that it would meet the considerations of equity to do so.

8.205.4.LI. For clients Members who are unable to make decisions for themselves, a family member, legal guardian or designated advocate shall be included in all decision-making concerning enrollment and disenrollment of the clientMember.

8.205.5 DISMISSAL OF MEMBER BY A PROVIDER

8.205.5.A4.J. Primary care pProviders, excluding safety net providers, participating in a PCCM Entity, MCO, or PIHP may dismiss an enrolled client Member from their practice for cause at any time. The primary care provider shall give no less than 45 days notice to both the Department and the client Cause shall be defined as any of the following:

1. A documented, ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet any other Member responsibilities.The client misses multiple scheduled appointments.

2. ~~The client fails~~A documented ongoing pattern of failure to follow the recommended treatment plan or medical instructions.

3. The ~~primary care~~ provider cannot provide the level of care necessary to meet the ~~client's~~ Member's needs.

4. The ~~client~~ Member and /or ~~client's~~ Member's family is abusive to provider and/or staff ~~in compliance with 42 CFR 438.56(a)(2)~~.

5. The provider moves out of the service area.

6. Other reasons ~~satisfactory to~~approved by the Department.

8.205.5.B. Providers must take the following steps prior to dismissing a Member from their practice:

1. The provider shall give no less than 45 days notice to both the Member and the PCCM Entity, MCO or PIHP.
2. For Members with behavioral health needs who are at risk of dismissal, the provider must make a referral for care coordination to the Member's MCO, PIHP, or PCCM Entity prior to giving written notice of dismissal.
3. The provider shall give the Member a reasonable opportunity to find substitute care and information necessary to obtain the patient's medical records;

8.205.5.C. The PCCM Entity, MCO or PIHP shall respond within 48 hours of any request to coordinate Member access to a new provider.

8.205.6~~5~~ ESSENTIAL COMMUNITY PROVIDERS

8.205.6~~5~~.A In order to be eligible for designation as an Essential Community Provider, the following health care providers shall be determined to have historically served medically needy or medically indigent patients and demonstrated a commitment to serve low-income and medically indigent populations who make up a significant portion of their patient population or, in the case of a sole community provider, serve the medically indigent patients within their medical capability:

1. Disproportionate share hospitals.

2. Local county and district health departments, county nursing services and regional health department operating pursuant to Title 25, C.R.S., as amended.

3. Federally Qualified Health Centers (FQHCs).

4. School based health centers that can verify that 25% of students enrolled in the school are at or below 185% of the Federal Poverty Level and that services are offered to the entire student population enrolled in the school without regard to the patient's ability to pay.

5. Family Medicine Residency Training Programs that can verify that 25 % of the patients served are at or below 185% of the Federal Poverty Level.

6. Rural Health Clinics that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

7. State certified Title X Family. Planning Agencies that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

8. Sole community providers that are not located within a metropolitan statistical area, as designated by the U.S. Office of Management and Budget, and in whose community there is no other similar type of health care and the provider can verify that it provides

health care services to patients below 185% of the Federal Poverty Level within its medical capability.

9. New health care providers operating under a sponsoring or participating entity that qualifies as an Essential Community Provider.

10. Health care providers that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

8.205.6.B. In order to be eligible for designation as an Essential Community Provider, the provider shall waive charges or charge for services on a sliding scale for patients/families at or below 185% of the Federal Poverty Level.

8.205.6.C.~~7~~ Health care providers, except those set forth a 8.206.1(1) through (3), who seek to be designated as an Essential Community Provider, shall submit their application, including a copy of their sliding fee scale to the Department.

8.205.7~~8~~ QUALIFIED PHARMACY PROVIDERS

8.205.7~~8~~.A. An MCO~~A Managed Care Organization~~ shall contract with qualified pharmacy providers in a manner permitting a nursing facility to continue to comply with federal Medicaid requirements of participation.

8.205.7~~8~~.B. A qualified pharmacy provider shall meet all of the following requirements:

1. Employ, on a full-time basis, a pharmacist licensed by the State of Colorado.

2. Demonstrate a capability of procuring, preparing, dispensing and distributing pharmaceutical products in an institutional setting.

3. Demonstrate a capability of monitoring ~~clients~~ Members on an ongoing basis to identify, prevent and resolve drug-related problems including, but not limited to, the monitoring of drug-drug interactions and drag-allergy interactions.

4. Provide pharmaceutical consulting services twenty-four (24) hours per day.

5. Perform medication-use assessments with the assistance of a pharmacist licensed by the State of Colorado at least once each month. Such assessments shall be ~~client~~Member-centered, ensuring that the ~~client's~~ Member's medication regimen meets his or her needs.

6. Participate with the ~~client's~~ Member's physicians, nurses, dieticians and other health care professionals in inter-disciplinary care planning.

7. Provide continuous pharmaceutical care and services to ~~clients~~ Members twenty-four (24) hours per day every day.

8. Reasonably respond to emergency situations and maintain an emergency kit registered with the. Colorado. State Board of Pharmacy at each nursing home.

9. Utilize appropriate unit dose or unit of issue distribution systems to ensure that ~~clients~~ Members receive proper medications, at the proper time, and at the proper dosage.

10. Demonstrate its capability to provide physician orders and medication administration records on a monthly basis.

8.205.~~8~~9 PERSONS WITH SPECIAL HEALTH CARE NEEDS

8.205.~~8~~9.A. Persons with Special Health Care Needs shall mean persons having ongoing health conditions that

1. Have a biologic, psychologic or cognitive basis;

2. Have lasted or are virtually certain to last for at least one year; and

3. Produce one or more of the following sequelae:

   a. Significant limitation in areas of physical, cognitive or emotional function;

   b. Dependency on medical or assistive devices to minimize limitation of function or activities;

   c. In addition, for children:

      (i) Significant limitation in social growth or developmental function;

      (ii) Need for psychologic, educational, medical or related services over and above the usual for the child's age; or

      (iii) Special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.

8.205.9~~8.212.4~~ STATEWIDE SYSTEM OF COMMUNITY BEHAVIORAL HEALTH CARE~~BEHAVIORAL HEALTH SERVICES~~

8.205.9.A The Medicaid Statewide Managed Care System must include PIHPs to administer a statewide system of community behavioral health care.

8.205.9.B.~~8.212.4.A.~~ The following are required services of the statewide system of community~~Community~~ b~~B~~ehavioral h~~H~~ealth ~~Services program~~care:

1. Inpatient Behavioral Health Services -- A program in which the Member receives services in a hospital or health care facility 24 hours a day.

~~1. Inpatient Psychiatric Hospital Services:~~

   a. Inpatient Psychiatric Services ~~Under age 21 --~~ A program of psychiatric care in which the ~~client~~Member remains 24 hours a day in a psychiatric hospital, State Institute for Mental Disease (IMD), or other facility licensed as a hospital or Psychiatric Residential Treatment Facility by the State.
      i. Members under age 21 and members 65 years of age or older may receive services in an IMD.
      ii. Members ages 21-64 are excluded from receiving services in an IMD for more than 15 days within a month.

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

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

b. Residential and Inpatient Substance Use Disorder Services

i. Inpatient Substance Use Disorder Services – Substance use disorder services that provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. American Society of Addiction Medicine level 4 services are reimbursed fee for service and are not covered by the PIHP as part of the statewide system of community behavioral health care.

ii. Residential Substance Use Disorder Services – Substance use disorder services that are delivered in settings that provide 24-hour structure, support and clinical interventions for patients. These services are appropriate for Members who require time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment. Higher levels of residential treatment provide safe, stable living environments for Members who need them to establish or maintain their recovery apart from environments that promote continued use in the community.

2. Outpatient Services -- A program of care in which the ~~client~~Member receives services in a hospital or other health care facility, but does not remain in the facility 24 hours a day, including:

a. Physician Services, including psychiatric care – Behavioral health services provided within the scope of practice of medicine as defined by State law.

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

i. Individual Behavioral Health Therapy - Therapeutic contact with one ~~client~~Member of more than 30 minutes, but no more than two (2) hours.

ii. Individual Brief Behavioral Health Therapy- Therapeutic contact with one ~~client~~Member of up to and including 30 minutes.

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

iv. Family Behavioral Health Therapy~~ -- Face to face -~~ T~~t~~herapeutic contact with a ~~client~~Member and family member(s), or other persons significant to the ~~client~~Member, for improving ~~client~~Member-family functioning. Family behavioral health therapy is appropriate when intervention in the family interactions is expected to improve the ~~client's~~Member's emotional/behavioral health. The primary purpose of family behavioral health therapy is treatment of the ~~client~~Member.

v. Behavioral Health Assessment ~~-- Face to face -~~ C~~c~~linical assessment of a ~~client~~Member by a behavioral health professional that determines the nature of the ~~client's~~Member's problem(s), factors contributing to the

problem(s), a ~~client's~~Member's strengths, abilities and resources to help solve the problem(s), and any existing diagnoses.

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

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

viii. Intensive Outpatient Substance Use Disorder Services – Therapeutic contact with a member to help the member achieve changes in their alcohol and/or other drug use. Intensive outpatient treatment services are delivered with greater frequency than standard outpatient services. This level of care is appropriate for patients who have more complex needs. Allowable services include substance use disorder assessment, individual and family therapy, group therapy, and alcohol/drug screening counseling.

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

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

3~~4~~. Targeted Case Management – Case management services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

4~~5~~. School-Based Behavioral Health Services - Behavioral health services provided to school-aged children and adolescents on-site in their schools, with the cooperation of the schools.

5~~6~~. Drug Screening and Monitoring – Substance use disorder counseling services provided along with screening results to be discussed with client.

6~~7~~. Detoxification Services – Services relating to detoxification including all of the following: Physical assessment of detox progression including vital signs monitoring; level of motivation assessment for treatment evaluation; provision of daily living needs (includes hydration, nutrition, cleanliness and toiletry); safety assessment, including suicidal ideation and other behavioral health issues.

7~~8~~. Medication-Assisted Treatment – Administration of Methadone or another approved controlled substance to an opiate-dependent person for the purpose of decreasing or eliminating dependence on opiate substances.

8.~~212.4.B.~~ Alternative behavioral health services~~—~~Administration of non-traditional, community-based services not available through the State Plan but authorized through the Department's 1915(b) waiver with the Centers for Medicare and Medicaid Services.~~Alternative services of the Community Behavioral Health Services program are:~~

a~~2~~. Assertive Community Treatment (ACT) – Comprehensive, locally-based, individualized treatment for adults with serious behavioral health disorders, that is available 24 hours a day, 365 days a year. The ACT team actively engages Members in their community to develop skills and monitor status, rather than function as an office-based team. Services include case management, initial and ongoing behavioral health assessment, psychiatric services, employment and housing assistance, family support and education, and substance use disorders services.

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

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

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

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

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

g8. Respite Care – Temporary or short-term care of a child, youth or adult client provided by adults other than the birth parents, foster/adoptive parents, family members or caregivers that the ~~client~~Member normally resides with. Respite is designed to give the caregivers some time away from the ~~client~~Member to allow them to emotionally recharge and become better prepared to handle normal day-to-day challenges. Respite care providers are specially trained to serve individuals with behavioral health issues.

h1. Vocational -- Services designed to help adult and adolescent clients who are ineligible for state vocational rehabilitation services to gain employment skills and employment. Services are skill and support development interventions, educational services, vocational assessment, and job coaching.

8.205.9.C. The PIHPs must offer Members an initial or subsequent nonurgent behavioral health care visit where medically necessary and at appropriate therapeutic intervals in compliance with C.R.S. § 25.5-5-402 (3)(g).

8.205.10 UTILIZATION MANAGEMENT

8.205.10.A. The MCOs and PIHPs must ensure Covered Services delivered to Members are Medically Necessary as defined in Section 8.076.1.8 as well as Section 8.280 for Members under 21 years of age, delivered in the least restrictive setting, and most likely to address the Member's health care needs by employing Utilization Management best practices.

1. If it is determined that the Member does not meet criteria of Medical Necessity or the Member has a diagnosis not covered by the capitated payment arrangement, MCOs and PIHPs must inform the Member about how other appropriate Medicaid State Plan services may be obtained and coordinate referrals to appropriate providers within the region within 48 hours of request from the Member, a family member, legal guardian or designated advocate.

8.205.10.B. Utilization Management practices shall align with the following guidelines:

1. Establish and regularly update Utilization Management policies and procedures for evaluating the clinical appropriateness, efficacy, or efficiency of Covered Services, referrals, procedures or settings in accordance with the most recent national and industry standards or guidelines and with federal and department rules and regulations.
2. Ensure Utilization Management policies and procedures are designed in compliance with 42 CFR 438. Part 2.
3. Design and implement Utilization Management policies and procedures in compliance with the federal Mental Health Parity and Addiction Equity Act requirements defined in 42 CFR 438 Subpart K, including the application of financial requirements, treatment limitations, and non-quantitative treatment limitations, as well as the process for determining access to out-of-network providers.
4 Appropriately incorporate use of prior authorization and continued stay reviews for residential and inpatient behavioral health services that are not for treatment of an Emergency Medical Condition to ensure that the services requested or furnished are medically necessary and sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
    a. Utilize the American Society of Addiction Medicine criteria to determine medical necessity for residential and inpatient substance use disorder treatment services.
    b. Engage in care coordination and discharge planning to appropriately transition members across the continuum of care.
5. Make Utilization Management decision-making criteria available to members and providers upon request.
6. Designate an appropriately licensed medical professional to provide oversight and evaluation of the Utilization Management policies and activities.
7. Establish standards for Utilization Management personnel to consult with the ordering provider prior to denial or limitation of requested/provided services.
8. Ensure Utilization Management processes do not impede timely access to services.

8.205.10.C. The MCOs and PIHPs must ensure that the services requested or furnished are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

8.205.10.D. The PIHPs must cover all medically necessary Covered Services for covered behavioral health diagnoses under the Capitated Behavioral Health Benefit, regardless of any co-occurring conditions.

8.205.10.E. The MCOs and PIHPs must not deny a Covered Service based solely on the Member having a diagnosis of a co-occurring intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury.

8.205.10.F. The MCOs and PIHPs must not require prior authorization for the non-pharmaceutical components of medication-assisted treatment.

8.205.10.G. The MCOs must not impose any prior authorization requirements or step therapy requirements as a prerequisite to authorizing coverage for any prescription medication approved by the Food and Drug Administration for the treatment of substance use disorders.

8.205.10.H. The MCOs and PIHPs must coordinate State Plan covered services that are paid fee-for-service.

8.205.10.I. The MCOs and PIHPs must have a grievances and appeals process as specified in Section 8.209.

~~8.212.5~~8.205.11 EMERGENCY SERVICES

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

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

8.205.11.A. The MCOs and PIHPs must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO or PIHP, to the extent that services required to treat an emergency medical condition fall within the scope of services for which the MCO or PIHP is responsible.

8.205.11.B. The MCOs and PIHPs may not deny payment for treatment obtained under either of the following circumstances:

1. A Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition in 8.205.1.C of this section.
2. A representative of the MCO or PIHP instructs the Member to seek emergency services.

8.205.11.C. The MCOs and PIHPs may not:

1. Limit what constitutes an emergency medical condition with reference to of the definition in 8.205.1.C of this section, on the basis of lists of diagnoses or symptoms, except to the extent that services required to treat an emergency medical condition fall outside the scope of the services for which the MCO and PIHP is responsible; and
2. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's primary care provider, MCO, PIHP, or applicable State entity of the Member's screening and treatment within 10 calendar days of presentation for emergency services.

8.205.11.D. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

8.209 MEDICAID MANAGED CARE GRIEVANCE AND APPEAL PROCESSES

8.209.1 GENERAL PROVISIONS

Medicaid members or their Designated Client Representatives enrolled in Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), or Prepaid Ambulatory Health Plans (PAHPs) may access and utilize the Medicaid Managed Care Grievance and Appeal Systems. The Grievance and Appeal Systems shall include a Grievance process and an Appeal process for handling Grievances and Appeals at the MCO, ~~Prepaid Inpatient Health Plan (~~PIHP~~)~~, or ~~Prepaid Ambulatory Health Plan (~~PAHP~~)~~ level and access to the State Fair Hearing process for Appeals.

8.209.2 DEFINITIONS

8.209.2.A. Adverse Benefit Determination shall mean:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit;

2. The reduction, suspension or termination of a previously authorized service;

3. The denial, in whole or in part, of payment for a service;

4. The failure to provide services in a timely manner;

5. The failure to act within the timeframes provided in § 8.209.4 below;

6. The denial of a Medicaid member's request to exercise his or her right to obtain services outside the network for members in rural areas with only one MCO; or

7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

8.209.2.B. Appeal shall mean, for the purposes of this Section 8.209 only, a request for review by an MCO, PIHP, or PAHP of an Adverse Benefit Determination.

8.209.2.C. Designated Client Representative shall mean any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or Appeals about health care benefits and services.

8.209.2.D. Grievance shall mean an oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights.

8.209.2.E. Managed Care Organization (MCO) shall mean an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR 438.2, and that is:

1. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR 489; or

2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary of the U.S. Department of Health and Human Services to also make the services it provides to its Medicaid members as accessible (in terms of timelines, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and meets the solvency standards of 42 CFR 438.116.

8.209.2.F. Prepaid Inpatient Health Plan (PIHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.209.2.G. Prepaid Ambulatory Health Plan (PAHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; does not provide, arrange for, or otherwise has a responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.209.2.H. State Fair Hearing shall mean the formal adjudication process for Appeals described at 10 CCR 2505-10, §8.057.

8.209.3 GRIEVANCE AND APPEAL SYSTEM

8.209.3.A. The Grievance and Appeal System means the processes the~~is the overall system that includes Grievances and Appeals handled at the~~ MCO, PIHP, and PAHP implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them ~~level and access to the State Fair Hearing process for Appeals~~.

8.209.3.B. The MCO, PIHP, or PAHP shall provide a Department-approved description of the Grievance, Appeal and State Fair Hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the MCO, PIHP, or PAHP. The description shall include:

1. The member's right to request a State Fair Hearing after the MCO, PIHP, or PAHP has made a determination on a member's~~for~~ Appeal~~s~~, which is adverse to the member.

   a. The method to obtain a hearing~~, and~~

   ~~b. The rules that govern representation at the hearing.~~

2. The member's right to file Grievances and Appeals.

3. The requirements and timeframes for filing Grievances and Appeals.

4. The availability of assistance in the filing process.

5. The toll-free numbers that the member can use to file a Grievance or an Appeal by telephone.

6. The fact that, when requested by a member:

   a. Benefits will continue if the member files an Appeal or a request for State Fair Hearing within the timeframes specified for filing; and

   b. The member may be required to pay the cost of services furnished while the Appeal is pending if the final decision is adverse to the member.

8.209.3.C. The MCO, PIHP, or PAHP shall maintain record of Grievances and Appeals and submit a quarterly report to the Department. The record of each Grievance and Appeal shall include:

1. A general description of the reason for the Grievance or Appeal;

2. The date the Grievance or Appeal was received;

3. The date of each review, or if applicable, review meeting;

4. The resolution at each level of the Grievance or Appeal, if applicable;

5. The date of resolution ~~at each level~~ of the Grievance or Appeal; and

6. The name of the member for whom the Grievance or Appeal was filed.

8.209.4 APPEAL PROCESS

8.209.4.A. Notice of Adverse Benefit Determination

1. The MCO, PIHP, or PAHP shall send the member written notice for each Adverse Benefit Determination. The notice shall be in writing and shall be available in English and the prevalent non-English languages spoken by members throughout the State. “Prevalent” means a non-English language spoken by a significant number or percentage of members in the service area as identified by the State.

2. The notice shall state the following:

   a. The Adverse Benefit Determination the MCO, PIHP, or PAHP or its contractor has taken or intends to take;

   b. The reasons for the Adverse Benefit Determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s Adverse Benefit Determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;

   c. The member’s or the Designated Client Representative's right to file an MCO, PIHP, or PAHP Appeal;

   d. The date the Appeal is due;

   e. The member’s right to request a State Fair Hearing after receiving notice that the adverse benefit determination is upheld;

   f. The procedures for exercising the right to a State Fair Hearing;

   g. The circumstances under which expedited resolution is available and how to request it;

   h. The member’s right to have benefits continue pending resolution of the Appeal, and how to request that benefits be continued; and

   i. The circumstances under which the member may be required to pay the cost of these services.

3. The MCO, PIHP, or PAHP shall mail the notice of Adverse Benefit Determination within the following timeframes:

a. For termination, suspension or reduction of previously authorized Medicaid covered services, at least ten (10) calendar days before the date of Adverse Benefit Determination, except in the following circumstances:

i) The MCO, PIHP, or PAHP may shorten the period of advance notice to five (5) calendar days for the date of Adverse Benefit Determination if:

1) The MCO, PIHP, or PAHP has facts indicating probable fraud by the member; and

2) The facts have been verified, if possible, through secondary sources.

ii) The MCO, PIHP, or PAHP may mail notice not later than the date of Adverse Benefit Determination if:

1) The MCO, PIHP, or PAHP has factual information confirming the death of the member;

2) The MCO, PIHP, or PAHP receives a clear written statement signed by the member stating that:

a) ~~He or she~~The member no longer wishes services; or

b) Gives information that requires termination or reduction of services and indicates that ~~he/she~~the member understands that this is the result of supplying the information;

iii) The member has been admitted to an institution where ~~he/she~~the member is ineligible under the plan for further services;

iv) The member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;

v) The MCO, PIHP, or PAHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;

vi) A change in the level of medical care is prescribed by the member's physician;

vii) The notice involves an Adverse Benefit Determination made with regard to the preadmission screening requirements of 1919(e) (7) of the Social Security Act; or

viii) Notice may be made as soon as practicable before transfer or discharge when:

1) The safety of individuals in the facility would be endangered;

2) The health of individuals in the facility would be endangered;

3) The resident's health improves sufficiently to allow a more immediate transfer or discharge;

4) An immediate transfer or discharge is required by the resident's urgent medical needs; or

5) A resident has not resided in the facility for 30 days.

b. For denial of payment, at the time of any Adverse Benefit Determination affecting the claim.

c. For standard service authorization decisions that deny or limit services, within ten (10) calendar days. For expedited service authorizations, within seventy-two (72) hours.

i) If the MCO, PIHP, or PAHP extends the timeframe for making a service authorization decision, it must give the member written notice of the reason for extending the timeframe and inform the member of the right to file a Grievance to disagree with the timeframe extension.

ii) The MCO, PIHP, or PAHP must carry out its determination as expeditiously as the member's health condition requires, and no later than the date the extension expires.

d. For service authorization decisions not reached within the timeframes specified (which constitutes a denial and is thus an adverse benefit determination), on the date the timeframes expire.

8.209.4.B. The member of an MCO, PIHP, or PAHP shall file an Appeal within sixty (60) calendar days from the date of the MCO's, PIHP's, or PAHP's notice of Adverse Benefit Determination.

8.209.4.C. The MCO, PIHP, or PAHP shall give members reasonable assistance in completing any forms required by the MCO, PIHP, or PAHP, putting oral requests for a State Fair Hearing into writing and taking other procedural steps, including, but not limited to, providing interpretive services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

8.209.4.D. The MCO, PIHP, or PAHP shall send the member written acknowledgement of each Appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution.

8.209.4.E. The MCO, PIHP, or PAHP shall ensure that the individuals who make decisions on Appeals are individuals who:

1. Wwere not involved in any previous level of review or decision-making, nor a subordinate of any such individual, and

2. Wwho have the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease if deciding any of the following: an Appeal of a denial that is based on lack of medical necessity, a Grievance regarding denial of expedited resolution of an Appeal, or a Grievance or Appeal that involves clinical issues, and.

3. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

8.209.4.F. The MCO, PIHP, or PAHP shall accept Appeals orally or in writing., and the MCO, PIHP, or PAHP shall be responsible for following an oral Appeal with a written Appeal, which shall then be signed by the member or Designated Client Representative unless an expedited Appeal resolution is requested. An oral Appeal shall establish the date of the Appeal.

8.209.4.G. The MCO, PIHP, or PAHP shall provide the member a reasonable opportunity to present evidence, and legal or factual arguments~~allegations of fact or law~~, in person as well as in writing. The MCO, PIHP, or PAHP shall inform the member of the limited time available in the case of expedited resolution.

8.209.4.H. The MCO, PIHP, or PAHP shall provide the member and the Designated Client Representative opportunity, before and during the Appeal process, to examine the member's case file, including medical records and any other documents and records considered during the Appeal process.

8.209.4.I. The MCO, PIHP, or PAHP shall include as parties to the Appeal, the member and the Designated Client Representative or the legal representative of a deceased member's estate.

8.209.4.J. The MCO, PIHP, or PAHP shall resolve each Appeal, and provide notice as expeditiously as the member's health condition requires, not to exceed the following:

1. For standard resolution of an Appeal and notice to the affected parties, ten (10) working days from the day the MCO, PIHP, or PAHP receives the Appeal.

2. For expedited resolution of an Appeal and notice to affected parties, seventy-two (72) hours after the MCO, PIHP, or PAHP receives the Appeal.

8.209.4.K. The MCO, PIHP, or PAHP may extend timeframes for the resolution of Appeals by up to fourteen (14) calendar days:

1. If the member requests the extension; or

2. The MCO, PIHP, or PAHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO, PIHP, or PAHP shall:
   a. Make reasonable efforts to give the member prompt oral notice of the delay.

   b. Within 2 calendar days, give the member prior written notice of the reason for delay if the timeframe is extended and informs the member of their right to file a grievance if the member disagrees with the extension.

8.209.4.L. The MCO, PIHP, or PAHP shall notify the member in writing of the resolution of an Appeal. For notice of an expedited resolution, the MCO, PIHP, or PAHP shall also make reasonable efforts to provide oral notice.

8.209.4.M. The written notice shall include the results of the disposition/resolution process and the date it was completed.

1. For Appeals not resolved wholly in favor of the member, the written notice shall include:

   a. The right to request a State Fair Hearing and how to do so;

   b. The right to request and to receive benefits while the hearing is pending, and how to make the request; and

   c. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's Appeal determination.

8.209.4.N. The member of an MCO, PIHP, or PAHP shall exhaust the MCO, PIHP, or PAHP level Appeal process before requesting a State Fair Hearing. The member shall request a State Fair

Hearing within one hundred and twenty (120) calendar days from the date of the MCO's, PIHP's, or PAHP's notice of Appeal determination.

8.209.4.O. If the MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements regarding resolution and notification of an Appeal, the member is deemed to have exhausted the Appeals process and may request a State Fair Hearing.

8.209.4.P. In cases where the parent or guardian of a member submits a request for a third-party review to the Department of Human Services under 27-67-104 C.R.S. of the Child Mental Health Treatment Act, the member, parent or guardian and the MCO or PIHP shall have the right to request a State Fair Hearing. The request for the State Fair Hearing shall be submitted to the Division of Administrative Hearings within thirty (30) calendar days from the date of the determination. The State Fair Hearing shall be considered a member Appeal.

8.209.4.Q. The MCO, PIHP, or PAHP shall establish and maintain an expedited review process for Appeals when the MCO, PIHP, or PAHP determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

8.209.4.R. The MCO, PIHP, or PAHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's Appeal.

8.209.4.S. If the MCO, PIHP, or PAHP denies a request for expedited resolution, it shall transfer the Appeal in the timeframe for standard resolution, make reasonable effort to give the member prompt oral notice of the denial and send a written notice of the denial for an expedited resolution within two (2) calendar days and inform the member of the right to file a grievance if the member disagrees with the decision to deny the expedited review.

8.209.4.T. The MCO, PIHP, or PAHP shall, consistent with federal law, provide for the continuation of benefits while the MCO, PIHP, or PAHP level Appeal and the State Fair Hearing are pending if:

1. The member:

   a. Ffiles for continuation of servicesthe Appeal (a) within ten (10) calendar days of the MCO, PIHP, or PAHP sending the notice of Adverse Benefit Determination, or (b) on or before the intended date of the MCO's, PIHP's, or PAHP's proposed Adverse Benefit Determination, whichever is later;
   b. Files the request for the appeal within 60 calendar days following the notice of adverse benefit determination.

2. The Appeal involves the termination, suspension or reduction of a previously authorized course of treatment;

3. The services were ordered by an authorized provider;

4. The original period covered by the original authorization has not expired; and

5. The member requests extension of benefits.

8.209.4.U. If at the member's request, the MCO, PIHP, or PAHP continues or reinstates the member's benefits while the Appeal is pending, the benefits shall be continued until one of the following:

1. Tthe member withdraws the Appeal.,

2. The member fails to request a State fair hearing and continuation of benefits (services) within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse appeal resolution.~~ten days pass after the MCO, PIHP, or PAHP mails the notice providing the resolution of the Appeal against the member,~~

3. A~~a~~ State Fair Hearing office issues a final agency decision adverse to the member.~~, or the time period or service limits of a previously authorized service have been met.~~

8.209.4.V. If the final resolution of the Appeal upholds the MCO's, PIHP's, or PAHP's Adverse Benefit Determination, the MCO, PIHP, or PAHP may recover the cost of the services furnished to the member while the Appeal is pending to the extent that the services were furnished solely because of the requirements of this rule.

8.209.4.W. If the final resolution of the Appeal reverses the MCO's, PIHP's, or PAHP's Adverse Benefit Determination to deny, limit or delay services that were not furnished while the Appeal was pending, the MCO, PIHP, or PAHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

8.209.4.X. If the final resolution of the Appeal reverses the MCO's, PIHP's, or PAHP's Adverse Benefit Determination to deny authorization of services and the member received the services while the Appeal was pending, the MCO, PIHP, or PAHP must pay for those services.

8.209.5 GRIEVANCE PROCESS

8.209.5.A. The member of the MCO, PIHP, or PAHP can file a Grievance expressing his/her dissatisfaction with any matter other than an Adverse Benefit Determination at any time.

8.209.B. The MCO, PIHP, or PAHP shall send the member written acknowledgement of each Grievance within two (2) working days of receipt.

8.209.5.C. The MCO, PIHP, or PAHP shall ensure that the individuals who make decisions on Grievances are individuals who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual, and who have the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease if deciding a Grievance that involves clinical issues.

8.209.5.D. The MCO, PIHP, or PAHP shall accept Grievances orally or in writing.

1. The MCO, PIHP, or PAHP shall dispose of each Grievance and provide notice as expeditiously as the member's health condition requires, not to exceed fifteen (15) working days from the day the MCO, PIHP, or PAHP receives the Grievance.

8.209.5.E. The MCO, PIHP, or PAHP may extend timeframes for the disposition of Grievances by up to fourteen (14) calendar days:

1. If the member requests the extension; or

2. The MCO, PIHP, or PAHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO, PIHP, or PAHP shall:
   a. Make reasonable efforts to give the member prompt oral notice of the delay.

   b. G~~g~~ive the member prior written notice of the reason for delay if the timeframe is extended and inform the Member of the right to file a grievance if the member disagrees with the decision.

8.209.5.F. The MCO, PIHP, or PAHP shall notify the member in writing of the disposition of a Grievance in the format established by the Department.

8.209.5.G. The written notice shall include the results of the disposition/resolution process and the date it was completed.

8.209.5.H. If the member is dissatisfied with the disposition of a Grievance provided by the MCO, PHIP, or PAHP, the member may bring the unresolved Grievance to the Department.

1. The Department will acknowledge receipt of the Grievance and dispose of the issue.

2. The disposition offered by the Department will be final.

8.209.6 OMBUDSMAN ASSISTANCE CONCERNING SERVICES FOR ~~CLIENTS~~ MEMBERS ENROLLED IN MCOS, PIHPS, and PAHPS

8.209.6.A. An Ombudsman under contract with the Department of Health Care Policy and Financing shall provide Ombudsman assistance concerning services for members enrolled in Medicaid MCOs, PIHPS, and PAHPs.

8.209.6.B. Upon request, the Ombudsman shall respond to and analyze a Grievance from a member enrolled in a Medicaid MCO, PIHP, or PAHP, or that member's Designated Client Representative, by:

1. Assisting the member or Designated Client Representative to articulate the Grievance, to understand the options available to resolve the Grievance and his/her rights and responsibilities, and to negotiate the appropriate Grievance process for his/her MCO, PIHP, or PAHP;

2. Acting as the member's Designated Client Representative if the member requests except that the Ombudsman shall not act as the Designated Client Representative in any State Fair Hearing as described at 10 CCR 2505-10, §8.057;

3. Facilitating problem resolution with the MCO, PIHP, or PAHP, or its network providers;

4. Referring members to other agencies as appropriate, including agencies that can directly assist members in a State Fair Hearing;

5. Conducting and reporting member satisfaction studies and/or quality assessment surveys authorized by the Department to measure member experience and satisfaction with Ombudsman staff and services;

6. Providing members with information on the exclusions and limitations that may be imposed on care, services, equipment and supplies under the Medicaid benefits structure;

7. Having a practical understanding of all applicable provisions of Title X, Article 16, C.R.S. and Medicaid Volume 8 rules; and

8. Avoiding any relationship or circumstance which creates or gives the appearance of a conflict of interest.

8.209.7 COMPLIANCE REQUIREMENTS FOR ALL MCOS, PIHPS, PAHPS AND THE OMBUDSMAN

8.209.7.A. MCOs, PIHPs, PAHPs, and the Ombudsman shall recognize and ensure members' rights to make and file Grievances and to Appeal Adverse Benefit Determinations through the Grievance and Appeal process for any reason.

8.209.7.B. For members with a disability, if the medical necessity of a requested procedure has not been established by the MCO, PIHP, or PAHP, the requesting physician must be consulted in person or by telephone before a final determination is made. If the requesting physician is not available, another network provider of the member/Designated Client Representative's choice shall be consulted. Such consultation shall be referenced in the notice. If the requesting physician is not available and the member/Designated Client Representative does not choose another network provider within two working days of the MCO's, PIHP's, or PAHP's request to make such a choice, the MCO, PIHP, or PAHP may proceed without consultation.

8.209.7.C. MCOs, PIHPs, PAHPs, and the Ombudsman shall develop written procedures for accepting, processing, and responding to all Grievances and Appeals from Medicaid members. For MCOs, PIHPs, and PAHPs, summaries of these procedures shall be disseminated to all participating providers and shall include summaries in the Member Handbook as described in Department contract requirements. The MCO, PIHP, or PAHP shall provide its complete Grievance and Appeal procedures to subcontractors and ensure subcontractor compliance with these rules and the MCO's, PIHP's, or PAHP's procedures. MCOs, PIHPs, PAHPs, and the Ombudsman shall obtain written approval from the Department for their internal Grievance and Appeals procedures.

8.209.7.D. MCOs, PIHPs, PAHPs, and the Ombudsman shall establish and maintain a timely and organized system(s) for recording, tracking, and resolving Medicaid members' Grievances and Appeals as specified in contract.

8.209.7.E. MCOs, PIHPs, PAHPS, and the Ombudsman shall confidentially maintain original records of all Grievances and Appeals from Medicaid members, including the original Grievance or Appeal, Adverse Benefit Determination, or resolution taken by the entity, and evidence of review activities. All such information shall be archived for ten (10) years from the date of the initial Grievance or Appeal.

8.209.7.F. MCOs, PIHPs, and PAHPs shall ensure that neither cultural, expressive, or receptive communication differences negatively impact the Grievance and Appeals process. MCOs, PIHPs, and PAHPs shall provide services to facilitate members' and Designated Client Representatives' effective use of the Grievance and Appeals process, inclusive of qualified interpreters for (1) persons with communication disabilities or differences and (2) non-English-speaking members. The MCO, PIHPs, or PAHP shall consult with the member or the Designated Client Representative about the individual or medium that will assist, and such assistance shall be at the cost of the MCO, PIHP, or PAHP.

8.209.7.G. MCOs, PIHPs, and PAHPs shall provide the member, Designated Client Representative, or any other person, upon written release from the member or the member's legal guardian, access to or a copy of medical records, at no cost to the member, for dates of service occurring during enrollment in the MCO, PIHP, or PAHP. Such records shall be provided within a time frame that provides members copies of their records prior to any decision on a Grievance or Appeal, or in two weeks or less, if required by C.R.S. § § 25-1-801 and 25-1-802. The MCO, PIHP, or PAHP is only obligated to provide one copy of the member's medical records free of charge for each of the Medicaid member's Grievances or Appeals.

8.209.7.H. MCOs, PIHPs, and PAHPs shall monitor participating network subcontractors or providers to ensure compliance with all Grievance and Appeals rules and contract requirements.

8.209.7.I. MCOs, PIHPs, PAHPs, and the Ombudsman shall handle specific Medicaid member Grievance and Appeals information in the same way that medical record information is handled confidentially under State and Federal law and regulations.

8.209.7.J. Upon request by a member, the member's Designated Client Representative, or the member's provider, the MCO, PIHP, or PAHP shall disclose its standards for denial of treatments or other benefits on the grounds that such treatment or other covered benefit is not medically necessary, appropriate, effective, or efficient free of charge.

8.209.7.K. To assist members in making inquiries and filing Grievances and Appeals, MCOs, PIHPs, PAHPs, and the Ombudsman shall ensure that members and Designated Client Representatives can contact them during routine business hours through a toll-free telephone number.

~~**8.212 COMMUNITY BEHAVIORAL HEALTH SERVICES**~~

~~**8.212.1 ENROLLMENT**~~

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

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

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

~~3. Qualified Individuals 1 (QI 1).~~

~~4. Special Low Income Medicare Beneficiaries (SLMB).~~

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

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

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

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

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

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

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

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

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

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

12. Individuals while determined presumptively eligible for Medicaid.

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

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

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

8.212.2 INDIVIDUAL EXEMPTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.212.3 CLIENT RIGHTS AND PROTECTIONS

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

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

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

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

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

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

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

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

8.212.4 BEHAVIORAL HEALTH SERVICES

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

1. Inpatient Psychiatric Hospital Services:

   a. Under age 21 -- A program of psychiatric care in which the client remains 24 hours a day in a psychiatric hospital, State Institute for Mental Disease (IMD), or other facility licensed as a hospital by the State.

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

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

2. Outpatient Services -- A program of care in which the client receives services in a hospital or other health care facility, but does not remain in the facility 24 hours a day, including:

   a. Physician Services, including psychiatric care – Behavioral health services provided within the scope of practice of medicine as defined by State law.

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

      i. Individual Behavioral Health Therapy - Therapeutic contact with one client of more than30 minutes, but no more than two (2) hours.

      ii. Individual Brief Behavioral Health Therapy- Therapeutic contact with one client of up to and including 30 minutes.

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

      iv. Family Behavioral Health Therapy – Face to face therapeutic contact with a client and family member(s), or other persons significant to the client, for improving client-family functioning. Family behavioral health therapy is appropriate when intervention in the family interactions is expected to

improve the client's emotional/behavioral health. The primary purpose of family behavioral health therapy is treatment of the client.

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

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

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

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

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

4. Targeted Case Management – Case management services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

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

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

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

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

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

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

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

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

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

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

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

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

8. Respite Care – Temporary or short-term care of a child, youth or adult client provided by adults other than the birth parents, foster/adoptive parents, family members or caregivers that the client normally resides with. Respite is designed to give the caregivers some time

away from the client to allow them to emotionally recharge and become better prepared to handle normal day-to-day challenges. Respite care providers are specially trained to serve individuals with behavioral health issues.

8.212.5 EMERGENCY SERVICES

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

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

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

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

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

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

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

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

8.212.6 ESSENTIAL COMMUNITY PROVIDERS

8.212.6.A. In order to be eligible for designation as an Essential Community Provider, the following health care providers shall be determined to have historically served medically needy or medically indigent patients and demonstrated a commitment to serve low-income and medically indigent populations who make up a significant portion of their patient population or, in the case of a sole community provider, serve the medically indigent patients within their medical capability:

1. Disproportionate share hospitals.

2. Local county and district health departments, county nursing services and regional health department operating pursuant to Title 25, C.R.S., as amended.

3. Federally Qualified Health Centers (FQHCs).

4. School based health centers that can verify that 25% of students enrolled in the school are at or below 185% of the Federal Poverty Level and that services are offered to the entire student population enrolled in the school without regard to the patient's ability to pay.

5. Family Medicine Residency Training Programs that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

~~6. Rural Health Clinics that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.~~

~~7. State certified Title X Family Planning Agencies that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.~~

~~8. Sole community providers that are not located within a metropolitan statistical area, as designated by the U.S. Office of Management and Budget, and in whose community there is no other similar type of health care and the provider can verify that it provides health care services to patients below 185% of the Federal Poverty Level within its medical capability.~~

~~9. New health care providers operating under a sponsoring or participating entity that qualifies as an Essential Community Provider.~~

~~10. Health care providers that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.~~

~~8.212.6.B. In order to be eligible for designation as an Essential Community Provider, the provider shall waive charges or charge for services on a sliding scale for patients/families at or below 185% of the Federal Poverty Level.~~

~~8.212.6.C. Health care providers, except those set forth a 8.212.6.A(1) through (3), who seek to be designated as an Essential Community Provider, shall submit their application, including a copy of their sliding fee scale to the Department.~~

8.215 MEDICAID STATEWIDE MANAGED CARE SYSTEM~~COMMUNITY MENTAL HEALTH SERVICES PROGRAM~~ CAPITATION RATE SETTING

8.215.1 DEFINITIONS

8.215.1.A. Actuary – Individuals who both meet the qualifications of the division of insurance, and who also are Members of the American Academy of Actuaries, and therefore are able to provide for actuarial certification of Medicaid rates in accordance with 42 CFR 438.6(c).

The Department incorporates by reference 42 CFR 438.6(c). No amendments or later additions of this regulation are incorporated. Copies are available 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.

8.215.1.B. Actuarially sound rates – For a defined population, a per member per month risk capitation amount that meets the requirements of 42 CFR 438.6(c) and is certified as actuarially sound by an actuary acting in his/her professional capacity.

~~Behavioral health organization – the managed care entity contracting with the Department to provide behavioral health services to Medicaid eligible individuals on a risk contracting basis.~~

8.215.1.C. Enrollee – A person who is eligible ~~for mental health services provided for in 10 CCR 2505-10 Section 8.212.4 from a behavioral health organization~~ to receive services under a risk contract with the Department as a participant in the Medicaid Statewide Managed Care System.

8.215.1.D. Independent actuary – An actuary contracted by the Department who has not and will not contract with a Colorado Medicaid provider during the rate setting or rate effective periods and whose employer has not and will not provide actuarial services to a ~~behavioral health~~

~~organization~~ Managed Care Organization or Prepaid Inpatient Health Plan participating in the Medicaid Statewide Managed Care System during the rate setting or rate effective periods.

8.215.1.E. Managed Care Organization (MCO) shall mean an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR § 438.2 to operate as part of the State agency's Medicaid Statewide Managed Care System as defined in Section 8.205.

8.215.1.F. Medicaid Statewide Managed Care System means the program defined in Section 8.205.

8.215.1.G. Prepaid Inpatient Health Plan (PIHP) shall mean an entity that administers the State agency's statewide system of community behavioral health care as defined in Section 8.205.9 under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.215.2 LEGAL BASIS

The Medicaid Statewide Managed Care System~~community mental health services program~~ is authorized by state law at 25.5-5-~~411~~, C.R.S. Part 4.~~(2009)~~

8.215.3 GENERAL PROVISIONS

8.215.3.A. The Department shall make prepaid capitation payments based on actuarially certified rates to MCOs and PIHPs~~behavioral health organizations~~ based upon a scope of services defined in the MCOs and PIHPs~~behavioral health organization~~ contracts.

8.215.3.B. The Department shall contract with an independent actuary to prepare and certify actuarially sound rate ranges.

8.215.3.C. The Department's contracts with the MCOs and PIHPs~~behavioral health organizations~~ shall contain rates within the actuarially certified rate ranges prepared by the independent actuary.

8.215.3.D. Rates calculations shall include estimates of future utilization of covered services that are:

1. Relevant to the expected or reasonable use of services by the MCOs and PIHP's~~behavioral health organization's~~ enrollees, and

2. Based upon data that are of sufficient quality for rate setting.

8.215.3.E. To determine a reasonable cost of the service utilization described above in 8.215.3.D, the Department shall establish a price per unit of service. Such pricing:

1. Shall be consistent with the principles of actuarial soundness.

2. May be based upon the Medicaid fee-for-service payment for like services, provider costs, MCO or PIHP~~behavioral health organization~~ contracted rates, or other sources.

8.215.3.G. Data used to set rates shall be made available in summary form to any interested stakeholder.

8.215.3.H~~3~~. The MCOs and PIHPs are required to~~Requiring that behavioral health organizations~~ maintain medical loss ratios of no less than~~in excess of~~ 85% of total Medicaid capitations. Medical loss ratios of less than 85% shall result in a refund of premiums due to the Department in an amount such that the recalculated medical loss ratio, accounting for the premium change, meets the agreed upon threshold.~~the amount the medical loss is less than that threshold.~~

8.215.4 RATE SETTING TIMELINE

8.215.4.A. The Department shall publish a rate setting timeline when starting the process of establishing actuarially sound rate ranges.

8.215.4.B. The rate setting timeline shall provide explicitly for stakeholder feedback as part of the rate setting process.

8.215.4.C. The independent actuary shall consider stakeholder feedback in collaboration with the Department.

1. The decision to adopt the stakeholder feedback in the calculations of the actuarially sound rate ranges shall be at the discretion of the independent actuary.

2. Notwithstanding the above, the independent actuary is encouraged to ~~adopt~~ fully consider stakeholder feedback ~~when~~, ~~after~~ in consultation with the Department, when the feedback provides for better quality or efficiency in the process of calculating actuarially sound rate ranges, and the feedback is consistent with principles of efficiency, economy and actuarial soundness.

8.215.5 CERTIFICATIONS

8.215.5.A. To the extent that the data used in rate setting come from the MCO or PIHPs~~behavioral health organizations~~, the MCO or PIHP~~behavioral health organization~~ shall provide a certification that the data supplied by the MCO or PIHP~~behavioral health organization~~ to the Department are accurate, truthful and represent costs and utilization solely for services covered under the MCO or PIHP~~behavioral health organization~~ contract for Medicaid eligible enrollees of that MCO or PIHP~~behavioral health organization~~.

8.215.5.B. In accordance with 25.5-5-4084 (e~~k~~) and prior to entering into a contract with the Department, the MCO or PIHP~~behavioral health organization~~ shall certify that the rates set forth in the contract are sufficient to assure the financial stability of the MCO or PIHP~~behavioral health organization~~.

8.215.5.C. In accordance with 25.5-5-4084 (f)(I) and prior to entering into a contract with the Department, the MCO or PIHP~~behavioral health organization~~ shall retain an actuary to certify that the capitation rates set forth in the contract between the MCO or PIHP~~behavioral health organization~~ and the Department comply with all applicable federal and state requirements that govern said capitation payments. This certification must explicitly reference that the capitation rates conform to the federal requirement that rates be actuarially sound.

8.215.6 COST CONTAINMENT MECHANISMS

8.215.6.A. The Department shall establish cost-effective, capitated rates for the statewide system of community behavioral health care defined in Section 8.205.9~~community mental health services~~ in a manner that includes cost containment mechanisms.

8.215.6.B. The cost containment mechanisms shall be consistent with the principles of actuarial soundness, as determined by the independent actuary.

8.215.6.C. These cost containment mechanisms shall include:

1. Limiting costs and data considered in rate setting to that reasonable based upon enrollees' need for services within the scope of services in the PIHPs'~~behavioral health organizations'~~ contracts.

2. Establishing health status based risk adjusted case rates for a negotiated portion of the actuarially sound capitation rate. Case rates shall be calculated based upon a statewide average cost, providing PIHPsBHOs an incentive for efficiency relative to peers.

~~3. Requiring that behavioral health organizations maintain medical loss ratios in excess of 85% of total Medicaid capitations. Medical loss ratios of less than 85% shall result in a refund due the Department in the amount the medical loss is less than that threshold.~~

8.215.6.D. The Department may, upon consultation and feedback from the PIHPsbehavioral health organizations and the stakeholder community, implement other cost containment mechanisms that it finds necessary to constrain rate growth to a level that is sustainable and appropriate.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Base Wage Requirement for Direct Care Workers, Section 8.511
Rule Number: MSB 22-01-18-A
Division / Contact / Phone: Benefits & Services Management / Erin Thatcher / 303-866-5788

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 21-08-05-A, Revision to the Medical Assistance Act Rule concerning Base Wage Requirement for Direct Care Workers, Section 8.511

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) 8.511, 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*

Insert the newly proposed text at 8.511 with the proposed text beginning at 8.511 through the end of 8.511. This rule is effective April 14, 2022.

*to be completed by MSB Board Coordinator

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Rule Number: MSB 22-01-18-A
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STATEMENT OF BASIS AND PURPOSE

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

   The rule requires all Direct Care Workers to receive a minimum base wage of $15 per hour for services named within and effective January 1, 2022. The rule requires providers to notice eligible staff and provide required reporting. The purpose of this rule is to enforce the base wage requirement, enforce provider reporting responsibilities, and utilize the unique funding opportunity of the American Rescue Plan Act (ARPA) to increase and bolster the direct care workforce. Colorado is one of the nation's fastest aging states, 70% of older adults will need long-term care, and they increasingly seek Home and Community-Based services. The need for workers has been outpacing the supply for many years. Additionally, impacts of the COVID-19 pandemic on the direct care workforce has highlighted that these workers bear great health and safety risks while earning some of the state's lowest wages. Colorado will continue to lose necessary workers and fail to adequately recruit new workers if it does not raise wages to align with the value and importance of these workers' critical services.

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:

   An emergency rule is imperative because the Department has state and federal approval to use ARPA funding to increase Direct Care Worker wages as of January 1, 2022 and needs to ensure that it is implemented correctly and efficiently. Waiting until a later date to establish this rule would further strain these workers who are, and have been, persisting on less than a living wage and contribute to less accessible HCBS for community members. Without this rule to support bolstering the direct care workforce, members will not receive critical care and will face greater health and safety risks. Additionally, the Department seeks to immediately align with Governor Polis's directive for a base wage of $15 per hour per press release "Colorado Increasing the Minimum Wage for Workers" issued September 21, 2021.

3. Federal authority for the Rule, if any:

Initial Review — Final Adoption
Proposed Effective Date **01/01/2022** Emergency Adoption **12/10/2021**

DOCUMENT #11

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021); Senate Bill 21-286 contained in 25.5-6-18 C.R.S. (2021) FY 2022-23 Department Budget Request approved by JBC on November 1, 2021.

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REGULATORY ANALYSIS

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

   Direct Care Workers are the most impacted by this proposed rule. They will benefit from an increased base wage, which will promote stability for the workers themselves, HCBS providers and members receiving services. The Department has increased reimbursement rates to offset costs to HCBS provider agencies in implementation of this rule. Provider agencies and Department staff will be impacted in the effort to implement and monitor compliance with this rule.

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

   Probable quantitative and qualitative impact of the proposed rule upon Direct Care Workers include reducing the financial gap between current hourly median wage and hourly wage needed to achieve adequate economic security, enabling workers to forgo second or third jobs to earn additional wages, and increasing community awareness for the impact and importance of these workers. HCBS provider agencies will be more likely to retain current staff and become more competitive in their recruitment, will better meet service needs of their members, and may experience their local communities seeking their services. HCBS providers may incur penalties and recoupment if they do not comply with the necessary reporting requirements of this rule as these requirements are intended to ensure providers are equally committed to supporting and growing their direct care workforce.

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 will utilize funding authorized through ARPA to fund the associated rate increases and complete the auditing requirements needed for the implementation of this rule. No additional budgetary impact is expected from the implementation of this rule.

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

   The Department received authority from the state and federal government to mitigate the growing crisis impacting the direct care workforce utilizing ARPA funds. Increasing workers' base wage will improve retention and recruitment in this field and better meet the needs of HCBS members. Providers are receiving a rate increase to offset the cost of the base wage and are only required to provide minimal administrative processing and reporting to ensure the base wage is implemented correctly. If we do not implement this, our members will be at risk of decompensation and institutionalization. HCBS providers rely on a steady and qualified population of workers to serve a diverse community of members in community settings. If a provider is unable to hire and retain qualified staff, members will go without the necessary services that enable them to live independently. As the pandemic continues, we must ensure that members are able to avoid hospitalization due to gaps in care and access to care.

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 solutions to achieve the purpose of this 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.

   This rule is needed to ensure that the funding is allocated per the Department's approved ARPA spending plan. Reimbursement rates have been increased to offset provider costs associated with the base wage, and providers must report their compliance with funding parameters. There is no other way to achieve purpose of this rule outside of implementing a rule.

8.511 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.511.1 DEFINITIONS

Definitions below only apply to Section 8.511.

A. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of Home and Community-Based Services (HCBS). For the purposes of this rule, the base wage shall be $15.00 effective January 1, 2022.

B. Department means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

C. Direct Care Worker means a non-administrative employee or independent contractor of a Provider Agency or Participant Directed Program Employer of Record who provides hands-on care, services, and support to older adults and individuals with disabilities across the long-term services and supports continuum within home and community-based settings.

D. Minimum Wage means the rate of pay established in accordance with Section 15 of Article XVIII of the State Constitution and any other minimum wage established by federal or local laws or regulations. In addition to state wage requirements, federal or local laws or regulations may apply minimum, overtime, or other wage requirements to some or all Colorado employers and employees. If an employee is covered by multiple minimum or overtime wage requirements, the requirement providing a higher wage, or otherwise setting a higher standard, shall apply.

E. Plan of Correction means a formal, written response from a provider agency to the Department on identified areas of non-compliance with requirements listed in Section 8.511.4.

F. Participant Directed Program means a service model that provides participants who are eligible for Home and Community-Based Services the ability to manage their own in-home care, or have care managed by an authorized representative, provided by a direct care worker. Participant Directed Program participants, or their authorized representative, operate as Employers of Record with an established FEIN.

G. Provider means any person, public or private institution, agency, or business enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods. Pursuant to this rule, a provider that renders qualifying service(s) accepts responsibility to ensure qualifying Direct Care Workers currently under their employment are paid, at a minimum, the base wage.

H. Per Diem wage means daily rate of pay for Direct Care Workers for the provision of Home and Community-Based Services (HCBS). For purposes of this rule, the per diem wage shall apply to Direct Care Workers of residential service providers.

8.511.2 QUALIFYING SERVICES

A. Effective January 1, 2022, the Department will increase reimbursement rates for select Home and Community-Based Services. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher. Services requiring Direct Care Workers to be paid at least the base wage are as follows:

1. Adult Day Services

2. Alternative Care Facility (ACF)

3. Community Connector

4. Consumer Directed Attendant Support Services (CDASS)

5. Group Residential Support Services (GRSS)

6. Homemaker

7. Homemaker Enhanced

8. In-Home Support Services (IHSS)

9. Individual Residential Support Services (IRSS)

10. Job Coaching

11. Job Development

12. Mentorship

13. Personal Care

14. Prevocational Services

15. Respite

16. Specialized Habilitation

17. Supported Community Connections

18. Supported Living Program

B. In the event that a Direct Care Worker, based on state or local minimum wage laws, is eligible for a minimum wage that exceeds the base wage requirement, the Provider is required to compensate at the higher wage.

C. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage effective January 1, 2022 by the percent of the Department's January 1, 2022 reimbursement rate increase.

8.511.3 PROVIDER RESPONSIBILITIES

A. The Provider must ensure that contact information on file with the Department is accurate; information shall be utilized by the Department to complete oversight responsibilities per Section 8.511.4.

B. Providers shall notify Direct Care Workers who are affected by the base wage requirement each fiscal year up to and including Fiscal Year 2023-2024.

1. Provider shall utilize the Department provided letter.

C. Providers shall publish and make readily available the Department's designated contact for Direct Care Workers to submit questions, concerns or complaints regarding the base wage requirement.

D. On or before June 30, 2022 and June 30, 2023, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.

1. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after January 1, 2022.

d. Direct Care Workers' hourly base wage as of November 1, 2021 and current hourly base wage.

e. Current service(s) provided by each employee.

2. IRSS Providers and/or Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after January 1, 2022.

d. Direct Care Workers' per diem wage as of December 1, 2021 and per diem wage as of January 1, 2022.

3. CDASS Authorized Representatives/Employers of Record are exempt from attestation requirements.

E. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the listed services within Section 8.511 received at a minimum the base wage or a per diem wage increase.

F. Records shall be retained for no less than six (6) years and shall be made available for inspection by the Department upon request. Records may include, but are not limited to:

1. Payroll summaries and details

2. Timesheets

3. Paid time off records

4. Cancelled checks (front and back)

5. Direct deposit confirmations

6. Independent contractor documents or agreements

7. Per diem wage documents

8. Accounting records such as: accounts receivable and accounts payable

8.511.4 REPORTING & AUDITING REQUIREMENTS

A. The Department has ongoing discretion to request information from providers to demonstrate that all Direct Care Workers received the wage (base or per diem) increase. All records related to the base wage requirement received by the Provider for the services listed in Section 8.511.2 shall be made available to the Department upon request, within specified deadlines.

B. Providers shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by the Department.

C. Failure to provide adequate documents and timely responses may result in the Provider being required to submit a plan of correction and/or recoupment of funds.

D. If a plan of correction is requested by the Department, the Provider shall have forty-five (45) business days from the date of the request to respond. The Provider must notify the Department in writing within five (5) business days of receipt of the request if they will not be able to meet the deadline. The Provider must explain the rationale for the delay and the Department may or may not grant an extension in writing.

E. Upon the Department's receipt of the plan of correction, the Department will accept, request modifications, or reject the proposed plan of correction. Modifications or rejections will be accompanied by a written explanation. If a plan of correction is rejected, the Provider must resubmit a new plan of correction along with any requested documentation to the Department for review within five (5) business days of notification.

F. The Department may recoup part or all of the funding resulting from the base wage increase if the Department determines the Provider is not in compliance with Section 8.511.

G. If such determination is made to recoup funds, the Provider will be notified by the Department. All recoupments will be conducted pursuant to C.R.S. Section 25.5-4-301 and 10 C.C.R. 2505-10, Section 8.050.6, Informal Reconsideration and Appeals of Overpayments Resulting from Review or Audit Findings.

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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 22-01-18-B, Revision to the Medical Assistance Act Rule concerning Pediatric Personal Care Minimum Wage

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) 8.535, 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 8.535 with the proposed text beginning at 8.535.2 through the end of 8.535.2.D. This rule is effective April 14, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Pediatric Personal Care Minimum Wage, Section 8.535
Rule Number: MSB 22-01-18-B
Division / Contact / Phone: Health Programs Office / 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 rule requires pediatric personal care Direct Care Workers to receive a minimum base wage of $15 per hour for services named within and effective January 1, 2022. The rule requires providers to notice eligible staff and provide required reporting. The purpose of this rule is to enforce the base wage requirement, enforce provider reporting responsibilities, and utilize the unique funding opportunity of the American Rescue Plan Act (ARPA) to increase and bolster the direct care workforce. The need for workers has been outpacing the supply for many years. Additionally, impacts of the COVID19 pandemic on the direct care workforce has highlighted that these workers bear great health and safety risks while earning some of the state's lowest wages. Colorado will continue to lose necessary workers and fail to adequately recruit new workers if it does not raise wages to align with the value and importance of these workers' critical services.

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:

   An emergency rule is imperative because the Department has state and federal approval to use ARPA funding to increase Direct Care Worker wages as of January 1, 2022 and needs to ensure that it is implemented correctly and efficiently. Waiting until a later date to establish this rule would further strain these workers who are, and have been, persisting on less than a living wage and contribute to less accessible pediatric personal care services. Without this rule to support bolstering the direct care workforce, members will not receive critical care and will face greater health and safety risks. Additionally, the Department seeks to immediately align with Governor Polis's directive for a base wage of $15 per hour per press release "Colorado Increasing the Minimum Wage for Workers" issued September 21, 2021.

3. Federal authority for the Rule, if any:

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Pediatric Personal Care Minimum Wage, Section 8.535
Rule Number: MSB 22-01-18-B
Division / Contact / Phone: Health Programs Office / 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.

   Direct Care Workers are the most impacted by this proposed rule. They will benefit from an increased base wage, which will promote stability for the workers themselves, pediatric personal care providers and members receiving services. The Department has increased reimbursement rates to offset costs to pediatric personal care provider agencies in implementation of this rule. Provider agencies and Department staff will be impacted in the effort to implement and monitor compliance with this rule.

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

   Probable quantitative and qualitative impact of the proposed rule upon Direct Care Workers include reducing the financial gap between current hourly median wage and hourly wage needed to achieve adequate economic security, enabling workers to forgo second or third jobs to earn additional wages, and increasing community awareness for the impact and importance of these workers. Pediatric personal care provider agencies will be more likely to retain current staff and become more competitive in their recruitment, will better meet service needs of their members, and may experience their local communities seeking their services. Pediatric personal care providers may incur penalties and recoupment if they do not comply with the necessary reporting requirements of this rule as these requirements are intended to ensure providers are equally committed to supporting and growing their direct care workforce.

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 will utilize funding authorized through ARPA to fund the associated rate increases and complete the auditing requirements needed for the implementation of this rule. No additional budgetary impact is expected from the implementation of this rule.

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

   The Department received authority from the state and federal government to mitigate the growing crisis impacting the direct care workforce utilizing ARPA funds. Increasing workers' base wage will improve retention and recruitment in this field and better meet the needs of members receiving pediatric personal care services. Providers are receiving a rate increase to offset the cost of the base wage and are only required to provide minimal administrative processing and reporting to ensure the base wage is implemented correctly. Pediatric personal care providers rely on a steady and qualified population of workers to serve members. If a provider is unable to hire and retain qualified staff, members will go without the necessary services that enable them to live independently. As the pandemic continues, we must ensure that members are able to avoid hospitalization due to gaps in care and access to care.

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 solutions to achieve the purpose of this 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.

   This rule is needed to ensure that the funding is allocated per the Department's approved ARPA spending plan. Reimbursement rates have been increased to offset provider costs associated with the base wage, and providers must report their compliance with funding parameters. There is no other way to achieve purpose of this rule outside of implementing a rule.

8.535 PEDIATRIC PERSONAL CARE SERVICES

8.535.1 Pediatric Personal Care Services are provided in accordance with the provisions of Appendix A, which sets forth the coverage standards for the benefit.

8.535.2 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.535.2.A DEFINITIONS

1. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of pediatric personal care services. For the purposes of this rule, the base wage shall be $15.00 effective January 1, 2022.

2. Department means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

3. Direct Care Worker means a non-administrative employee or independent contractor of a Provider Agency or Participant Directed Program Employer of Record who provides hands-on care, services, and support for personal pediatric care.

4. Minimum Wage means the rate of pay established in accordance with Section 15 of Article XVIII of the State Constitution and any other minimum wage established by federal or local laws or regulations. In addition to state wage requirements, federal or local laws or regulations may apply minimum, overtime, or other wage requirements to some or all Colorado employers and employees. If an employee is covered by multiple minimum or overtime wage requirements, the requirement providing a higher wage, or otherwise setting a higher standard, shall apply.

5. Plan of Correction means a formal, written response from a provider agency to the Department on identified areas of non-compliance with requirements listed in Section 8.535.2.D.

~~Participant Directed Program means a service model that provides participants who are eligible for pediatric personal care services the ability to manage their own in-home care, or have care managed by an authorized representative, provided by a direct care worker. Participant Directed Program participants, or their authorized representative, operate as Employers of Record with an established FEIN.~~

6. Provider means any person, public or private institution, agency, or business enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods. Pursuant to this rule, a provider that renders qualifying service(s) accepts responsibility to ensure qualifying Direct Care Workers currently under their employment are paid, at a minimum, the base wage.

7. Per Diem wage means daily rate of pay for Direct Care Workers for the provision of pediatric personal care services. For purposes of this rule, the per diem wage shall apply to Direct Care Workers of residential service providers.

8.535.2.B QUALIFYING SERVICES

1. Effective January 1, 2022, the Department will increase reimbursement rates for pediatric personal care services. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher.

2. In the event that a Direct Care Worker, based on state or local minimum wage laws, is eligible for a minimum wage that exceeds the base wage requirement, the Provider is required to compensate at the higher wage.

3. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage effective January 1, 2022 by the percent of the Department's January 1, 2022 reimbursement rate increase.

8.535.2.C PROVIDER RESPONSIBILITIES

1. The Provider must ensure that contact information on file with the Department is accurate; information shall be utilized by the Department to complete oversight responsibilities per Section 8.535.2.D.

2. Providers shall notify Direct Care Workers who are affected by the base wage requirement each fiscal year up to and including Fiscal Year 2024-2025.

    a. Provider shall utilize the Department approved letter.

3. Providers shall publish and make readily available the Department's designated contact for Direct Care Workers to submit questions, concerns or complaints regarding the base wage requirement.

4. On or before June 30, 2022, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.

    a. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

        i. Full-time or part-time employment status.

        ii. Whether the Direct Care Worker is an Employee or Independent Contractor.

        iii. Employee start date if after January 1, 2022.

        iv. Direct Care Workers' hourly base wage as of November 1, 2021 and current hourly base wage.

        v. Current service(s) provided by each employee.

    b. IRSS Providers and/or Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

        i. Full-time or part-time employment status.

        ii. Whether the Direct Care Worker is an Employee or Independent Contractor.

        iii. Employee start date if after January 1, 2022.

        iv. Direct Care Workers' per diem wage as of December 1, 2021 and per diem wage as of January 1, 2022.

    ~~CDASS Authorized Representatives/Employers of Record are exempt from attestation requirements.~~

5. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the pediatric personal care services received at a minimum the base wage or a per diem wage increase.

6. Records shall be retained for no less than six (6) years and shall be made available for inspection by the Department upon request. Records may include, but are not limited to:

    a. Payroll summaries and details

    b. Timesheets

    c. Paid time off records

    d. Cancelled checks (front and back)

    e. Direct deposit confirmations

    f. Independent contractor documents or agreements

    g. Per diem wage documents

    h. Accounting records such as: accounts receivable and accounts payable

8.535.2.D REPORTING AND AUDITING REQUIREMENTS

1. The Department has ongoing discretion to request information from providers to demonstrate that all Direct Care Workers received the wage (base or per diem) increase. All records related to the base wage requirement received by the Provider for the services listed in Section 8.535.2.B shall be made available to the Department upon request, within specified deadlines.

2. Providers shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by the Department.

3. Failure to provide adequate documents and timely responses may result in the Provider being required to submit a plan of correction and/or recoupment of funds.

4. If a plan of correction is requested by the Department, the Provider shall have forty-five (45) business days from the date of the request to respond. The Provider must notify the Department in writing within five (5) business days of receipt of the request if they will not be able to meet the deadline. The Provider must explain the rationale for the delay and the Department may or may not grant an extension in writing.

5. Upon the Department's receipt of the plan of correction, the Department will accept, request modifications, or reject the proposed plan of correction. Modifications or rejections will be accompanied by a written explanation. If a plan of correction is rejected, the Provider must resubmit a new plan of correction along with any requested documentation to the Department for review within five (5) business days of notification.

6. The Department may recoup part or all of the funding resulting from the base wage increase if the Department determines the Provider is not in compliance with Section 8.511.

7. If such determination is made to recoup funds, the Provider will be notified by the Department. All recoupments will be conducted pursuant to C.R.S. Section 25.5-4-301 and 10 C.C.R. 2505-10, Section 8.050.6, Informal Reconsideration and Appeals of Overpayments Resulting from Review or Audit Findings.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning the Modification of Outpatient Hospital Payment Rates through EAPG Grouper Update, Section 8.300.6
Rule Number: MSB 22-01-18-C
Division / Contact / Phone: Fee-for-Service Rates / Andrew Abalos / 2130

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 21-11-08-A, Revision to the Medical Assistance Act Rule concerning the Modification of Outpatient Hospital Payment Rates through EAPG Grouper Update, Section 8.300.6

3. This action is an adoption of: an amendment

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

   Sections(s) 8.300.6, 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 8.300.6 with the proposed text beginning at 8.300.6.A.1 through 8.300.6.A.3. This rule is effective April 14, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning the Modification of Outpatient Hospital Payment Rates through EAPG Grouper Update, Section 8.300.6
Rule Number: MSB 22-01-18-C
Division / Contact / Phone: Fee-for-Service Rates / Andrew Abalos / 2130

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule modifies language in the outpatient hospital services payment Section 8.300.6, authorizing the modification of base rate and weight setting to accommodate a transition to a new version of the Enhanced Ambulatory Patient Grouping (EAPG) methodology. Currently, outpatient hospital services are reimbursed through the EAPG methodology, which is a system which is developed and maintained by 3M Health Information Systems. The Department currently reimburses using version 3.10 of EAPGs and will be transitioning to version 3.16 effective January 1, 2022. This is necessary to allow the Department to continue reimbursing hospitals using an up to date versions of the CPT/HCPCS code sets, while adjusting hospital base rates to minimize financial impacts to hospitals through the transition.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   The current version of the EAPG methodology will disallow payment to providers billing codes that are effective as of January 1, 2022. Inaction may prevent the delivery of crucial services to members of Health First Colorado. Therefore, updating rule language to accommodate and pay for such codes while adjusting hospital-specific base rates is imperatively necessary for the preservation of public health, safety and welfare.

3. Federal authority for the Rule, if any:

   42 CFR 440.10 (2021)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   Section 25.5-102(1)(a), C.R.S. (2021)

Initial Review
Proposed Effective Date
Final Adoption
Emergency Adoption

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Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

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Title of Rule: Revision to the Medical Assistance Act Rule concerning the Modification of Outpatient Hospital Payment Rates through EAPG Grouper Update, Section 8.300.6
Rule Number: MSB 22-01-18-C
Division / Contact / Phone: Fee-for-Service Rates / Andrew Abalos / 2130

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.

   Health First Colorado members will benefit by maintaining access to care for outpatient hospital services. Hospitals will also be impacted as payment for such services will also change, though their hospital-specific rates will be adjusted for the purpose of maintaining revenue neutrality.

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

   Health First Colorado members will see no change through approval of the proposed rule. Hospitals will see shifts in payment for various services, though payment rates have been adjusted so that, on aggregate, hospitals should see minimal change in payment.

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 foresees no probable costs to the Department and to any other agency through the implementation and enforcement of the proposed rule. This has no anticipated effect on state revenues.

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

   A benefit of the proposed rule is allowing hospitals to continue billing using up to date standards and continue providing outpatient hospital services to Health First Colorado members. The costs of the proposed rule are possible variations in aggregate reimbursements to hospitals, though the base rate changes will minimize any signification variation. The cost of inaction is potential barriers in access to care for Health First Colorado members, as services billed using new CPT/HCPCS codes would not be reimbursed. There are no benefits of inaction.

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

   There are no less costly or less intrusive methods for achieving 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.

   As the EAPG methodology version update is required, there are no alternative methods of achieving the purpose for the proposed rule. However, the Department examined several variations of altering payment rates for the purpose of minimizing financial impact to hospitals. Service-specific payment adjustments were rejected, as altering such rates would disproportionately benefit certain hospitals while harming others, while also undermining the integrity of the payment methodology. Different corridor hospital-specific rate adjustments were also considered, but were rejected as this change is required to be budget neutral to the state, and such corridors would create or maintain significant and disproportionate reimbursements to hospitals for outpatient services.

8.300 HOSPITAL SERVICES

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4 percent (28.4%) or billed charges less 28.4 percent (28.4%).

Effective July 1, 2015, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28 percent (28%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Effective October 31, 2016, DRG Hospitals will be reimbursed for Outpatient Hospital Services based on a system of Enhanced Ambulatory Patient Grouping and a Hospital-specific Medicaid Outpatient base rate. The reimbursement for Outpatient Hospital Services shall be referred to as the EAPG Payment.

a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR 2505-10, Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific Medicaid Outpatient base rate. If the billed amount is less than the EAPG Payment, reimbursement will be the billed amount.

b. The EAPG Payment is calculated for each detail on the claim. Claim details with the same dates of service are grouped into a visit. Claims containing details describing charges for emergency room, treatment room services or patients placed under observation will have all its details grouped into a single visit.

c. Each detail on a claim is assigned an EAPG. EAPGs can have the following types:

    (1) Per Diem

    (2) Significant Procedure. Subtypes of Significant Procedures Are:

        (a) General Significant Procedures

        (b) Physical Therapy and Rehabilitation

        (c) ~~Mental~~ Behavioral Health and Counseling

(d) Dental Procedure

(e) Radiologic Procedure

(f) Diagnostic or Therapeutic Significant Procedure

(3) Medical Visit

(4) Ancillary

(5) Incidental

(6) Drug

(7) Durable Medical Equipment

(8) Unassigned

d. A detail will be subject to EAPG Consolidation when it is assigned the same Significant Procedure EAPG as a detail not already subjected to EAPG Consolidation for that visit. EAPG Consolidation will also occur for details assigned EAPGs considered to be clinically similar to another EAPG during the visit. Details subject to EAPG Consolidation will have an EAPG Payment calculated using an EAPG Weight of 0.

e. A detail will be subject to EAPG Packaging when its assigned EAPG is considered an ancillary service to a Significant Procedure EAPG or Medical Visit EAPG present on the claim for that visit. Details describing additional undifferentiated medical visits and services will be exempt from EAPG Packaging. A detail is also subject to EAPG Packaging when it is assigned a Medical Visit EAPG while a Significant Procedure EAPG is present on the claim for that visit. Details assigned Significant Procedure EAPGs that are ~~of subtypes Physical Therapy and Rehabilitation and Radiologic~~ not General Significant Procedures do not cause details with Medical Visit EAPGs to be subject to EAPG Packaging. Details subject to EAPG Packaging will be calculated using an EAPG Weight of 0.

f. A detail will qualify for Multiple Significant Procedure Discounting when a Significant Procedure of the same subtype is present on the claim for that visit. Details qualifying for Multiple Significant Procedure Discounting are ordered by their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG Weight will have its EAPG Payment calculated at 100 percent (100%) of its EAPG Weight. The qualifying detail for that visit with the next greatest EAPG Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG Weight. All other qualifying details for that visit will have its EAPG Payment calculated at 25 percent (25%) of its EAPG Weight.

g. Details assigned the same Ancillary EAPG on the same visit will qualify for Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment for all other details qualifying for Repeat Ancillary Discounting for that visit and EAPG will be calculated using 25 percent (25%) of their EAPG Weights.

h. Details describing terminated procedures will be subject to Terminated Procedure Discounting. EAPG Payment for a detail subject to Terminated Procedure Discounting is calculated using 50 percent (50%) of the EAPG Weight. Terminated procedures are not subject to other types of discounting.

i. Details describing bilateral services will have EAPG Payment calculated using 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

j. Details describing 340B Drugs will have an EAPG Payment calculated using 80 percent (80%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

k. The Hospital-specific Medicaid Outpatient base rate for ~~the year of the methodology implementation~~January 1, 2022 for each hospital is calculated using the following method.

(1) Assign each hospital to one of the following ~~peer~~ groups based on hospital type and location:

(a) Pediatric Hospitals

(b) ~~Urban~~ Critical Access Hospitals

(c) ~~Rural Hospitals~~Non-~~independent Urban~~Critical Access, System Hospitals

(d) Independent Hospitals

(e) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals

(2) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals are assigned their same hospital-specific base rate as effective immediately prior to January 1, 2022.

(~~2~~3) Process Medicaid outpatient hospital claims from ~~state fiscal year~~calendar year ~~2015~~2019~~, known as the Base Year,~~ through the methodology described in 8.300.6.A.1.a-j using ~~Colorado's~~ 3M's EAPG Relative Weights, scaled for budget neutrality purposes, and version 3.16 of the Enhanced Ambulatory Patient Grouping methodology. ~~For lines with incomplete data, estimations of EAPG Adjusted Weights will be used.~~ Hospital payment rates from version 3.10 of the methodology are then compared to the version 3.16 payment rates using the hospital-specific base rates immediately prior to January 1, 2022.

(~~3~~4) For Critical Access Hospitals, a weighted average base rate by outpatient hospital visit is calculated. EAPG payments for Critical Access Hospitals under version 3.10 and 3.16 are calculated using this weighted average base rate, then an inflation factor is applied to determine a revenue neutral rate for the Critical Access Hospital group. This inflation factor is then applied to all Critical Access Hospital rates effective immediately prior to January 1, 2022. For all other hospitals, with the exception of Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, a revenue neutral rate is calculated which aligns

payment under version 3.16 of EAPGs to payments calculated under version 3.10. ~~Calculate costs from hospital charge data using the computation of the ratio of costs to charges from the CMS-2552-10 Cost Report. After the application of inflation factors to account for the difference in cost and caseload from state fiscal year 2015 to the implementation period, costs and EAPG Adjusted Weights are aggregated by peer group and are used to form peer group base rates. Each hospital is assigned the peer group base rate depending on their respective peer group assigned in 8.300.6.A.1.k.(1).~~

(~~4~~5) ~~For each hospital, calculate the projected EAPG payment by multiplying its peer group base rate by its hospital-specific EAPG Adjusted Weights as calculated in 8.300.6.A.1.k.(2). If the projected payment exceeds a +/- 10% difference in payment from the prior outpatient hospital reimbursement methodology, the hospital will receive an adjustment to their base rate to cap its resulting gains or losses in projected EAPG payments to 10%~~For Critical Access Hospitals, the average and standard deviation of their rates with the inflation factor applied is calculated. All Critical Access Hospitals with a rate falling below 1 standard deviation of the average is given a rate at 1 standard deviation below the average. For Critical Access Hospitals with a rate above 2 standard deviations of the average is given a rate at 2 standard deviations above the average. For each other hospital group, except Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, the average and standard deviation of their rates are calculated. For hospitals that have a rate below 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations below the group's average rate. For hospitals that have a rate above 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations above the group's average rate.

(~~5~~6) For all hospitals, the Medicaid Outpatient base rate, as determined in 8.300.6.A.k.(1)-(4), shall be adjusted by an equal percentage, when required due to changes in the available funds appropriated by the General Assembly. The application of this change to the Medicaid Outpatient base rate shall be determined by the Department.

l. Effective June 1, 2020, by the modification of the EAPG Weights, the allowed reimbursement of outpatient hospital drugs shall be increased by 42.93% for drugs provided at Critical Access Hospitals and Medicare Dependent Hospitals, and decreased by 3.47% for drugs provided at non-independent urban hospitals.

2. Payments to Out-of-Network DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

Effective October 31, 2016, Out-of-Network DRG Hospitals will be reimbursed for Outpatient Hospital Services based the system of Enhanced Ambulatory Patient Grouping described in 10 CCR 2505-10 Section 8.300.6.A.1. Such hospitals will be

assigned to a Rural or Urban peer group depending on hospital location and will receive a base rate of 90% of the respective peer group base rate as calculated in 8.300.6.A.1.k.(3). Out-of-Network DRG Hospitals will periodically have their Medicaid Outpatient base rates adjusted as determined in 8.300.6.A.k.(5).

3. Payments for Outpatient Hospital Specialty Drugs

Effective August 11, 2018, for services meeting the criteria of an Outpatient Hospital Specialty Drug that would have otherwise been compensated through the EAPG methodology, a hospital must submit a request for authorization to the Department prior to administration of the drug. If the request is approved, then the payment will be negotiated between the Department and the hospital on a case-by-case basis.