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Title of Rule: Addition to the Medical Assistance Act Rule Concerning Outpatient Payment Rates for Opioid Antagonist, Section 8.300.6.A.4
Rule Number: MSB 22-07-27-A
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 22-07-27-A, Addition to the Medical Assistance Act Rule Concerning Outpatient Payment Rates for Opioid Antagonist, Section 8.300.6.A.4

3. This action is an adoption of: an amendment

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

   Sections(s) OP Pages, 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.A beginning at 8.300.6.A through the end of 8.300.6.A. This rule is effective October 30, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Addition to the Medical Assistance Act Rule Concerning Outpatient Payment Rates for Opioid Antagonist, Section 8.300.6.A.4
Rule Number: MSB 22-07-27-A
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).

   House Bill 22-1326 appropriates funding allowing the Department of Health Care Policy and Financing to reimburse opioid antagonist drugs outside of its current reimbursement methodology. Currently, there is no distinct reimbursement for the opioid antagonist drug Naloxone in the payment bundles used for outpatient hospital payment calculation. This rule change will allow the Department to make payment outside of the payment bundles, creating greater incentive to outpatient hospitals to provide take-home Naloxone to patients at-risk for opioid overdoses.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   HB 22-1326

Initial Review — Final Adoption **09/09/22**
Proposed Effective Date **10/30/22** — Emergency Adoption

DOCUMENT #01

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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.

   Persons benefiting from the proposed rule are Health First Colorado patients at-risk for opioid overdoses, as the rule will increase access to an opioid antagonist drug. Outpatient hospitals may bear the cost of the proposed rule when providing Naloxone if the payment rate is less than the acquisition cost of the drug, but in general this will increase the reimbursement rates associated with this drug compared to inaction.

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

   Outpatient hospitals may bear the cost of the proposed rule when providing Naloxone if the payment rate is less than the acquisition cost of the drug, but in general this will increase the reimbursement rates associated with this drug compared to inaction. The benefits of this rule are a probable reduction in deaths relating to opioid overdoses within the Health First Colorado population.

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 probable costs to the Department were considered in HB 22-1326. However, the Department is also seeking State Plan authority from Centers for Medicare and Medicaid Services for this modified payment method. This authority will allow for federal funding, thereby reducing the cost of this change to the State of Colorado.

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

   A probable benefit to the rule is wider distribution of a life-saving drug to the portion of the Health First Colorado population at-risk for opioid overdoses, in comparison to our current authority, which does not provide additional payment for take-home Naloxone.

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

   There are no less or intrusive methods for achieving the purpose of the proposed rule.

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

   The Department considered the modification of its payment bundle weights used in payment calculation for achieving the purpose of this rule. However, this would have resulted in an increased payment for all drugs within the same payment package as Naloxone, which would result in significant budgetary impacts to the Department. The Department could have reduced such costs through modification of other payment bundle rates, but this may have disincentivized the provision of other outpatient hospital procedures. The proposed rule most directly achieves its purpose, without modification of payments to unrelated 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) 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 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 January 1, 2022 for each hospital is calculated using the following method.

(1) Assign each hospital to one of the following groups based on hospital type and location:

(a) Pediatric Hospitals

(b) Critical Access Hospitals

(c) Non-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.

(3) Process Medicaid outpatient hospital claims from calendar year 2019 through the methodology described in 8.300.6.A.1.a-j using 3M's EAPG Relative Weights, scaled for budget neutrality purposes, and version 3.16 of the Enhanced Ambulatory Patient Grouping methodology. 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.

(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.

(5) 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.

(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.

4. Payments for Select Outpatient Hospital Opioid Antagonist Drugs

Pursuant to ~~C.R.S.~~C.R.S. § 25.5-5-509, effective July 8, 2022, payments for select Outpatient Hospital Opioid Antagonist Drugs that would have otherwise been

compensated through the EAPG methodology will be reimbursed at either the lower of the billed charges or the fee schedule rate.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Telemedicine Electronic-Health (eHealth) Entities
Rule Number: MSB 22-05-03-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 22-05-03-A, Revision to the Medical Assistance Act Rule concerning Telemedicine Electronic-Health (eHealth) Entities

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) 8.095 (NEW), 8.200.3.B and .3.D, 8.520.4.B, 8.700.1.C, 8.730.3.B, 8.740.1, 8.750.3.B, 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 beginning at 8.095 through the end of 8.095.8.A. Replace the current text at 8.200 with the proposed text beginning at 8.200.3.B through the end of 8.200.3.B.3. Replace the current text at 8.200.3.D with the proposed text beginning at 8.200.3.D.2.c.7 through the end of 8.200.3.D.2.c.7. Replace the current text at 8.520 with the proposed text beginning at 8.520.4.B.1.g through the end of 8.520.4.B.1.g. Replace the current text at 8.700 with the proposed text beginning at 8.700.1.C through the end of 8.700.1.C.1. Replace the current text 8.730 with the proposed text beginning at 8.730.3.B.11 through the end of 8.730.3.B.11. Replace the current text at 8.740 with the proposed text beginning at 8.740.1 through the end of 8.740.1. Replace the current text at 8.750.3 with the proposed text

*to be completed by MSB Board Coordinator

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beginning at 8.750.3.B through the end of 8.750.3.B. This rule is effective October 30, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Telemedicine Electronic-Health (eHealth) Entities
Rule Number: MSB 22-05-03-A
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).

   House Bill 21-1256 gave the Department authority, at C.R.S. § 25.5-5-320(1), to promulgate rules specifically relating to entities that deliver health-care or mental health-care services exclusively or predominately through telemedicine, otherwise referred to as Electronic-Health entities (eHealth Entities). The proposed rule creates a Telemedicine section in rule that delineates telemedicine service coverage and eligibility generally, while also defining eHealth Entities. Under the proposed rule, existing rule benefit sections that include telemedicine services will reference the new Telemedicine section rather than defining it in each benefit section separately.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   C.R.S. 25.5-5-320(1) (2021)

Initial Review **08/12/22** Final Adoption **09/09/22**
Proposed Effective Date **10/30/22** Emergency Adoption

DOCUMENT #03

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Telemedicine Electronic-Health (eHealth) Entities
Rule Number: MSB 22-05-03-A
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.

   Colorado's Medicaid program covered health care services provided through telemedicine prior to the passage of House Bill 21-1256, so long as the services meet the same standard of care as an in-person visit and are delivered using HIPAA-compliant technology. As such, members should not see a difference in services rendered. Providers that qualify as eHealth Entities are impacted by the proposed rule and will benefit from the availability of this new provider type.

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

   Providers that qualify as eHealth Entities benefit from the availability of this new provider type that is designed for their business model.

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.

   Colorado's Medicaid program covered health care services provided through telemedicine prior to the passage of HB 21-1256, so long as the services meet the same standard of care as an in-person visit and are delivered using HIPAA-compliant technology. As such, the addition of e-Health Entities is anticipated to be budget neutral.

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

   There are not anticipated costs to the Department for implementing the proposed rule, as telemedicine is already covered by Colorado Medicaid. The benefits of the rule are aligning Department rule with House Bill 21-1256 and creating a new provider type for provision of telemedicine services. The cost of inaction is misalignment between House Bill 21-1256 and Department rule. There are no benefits to inaction.

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

   There are no less costly methods or intrusive methods to align Department rule with House Bill 21-1256.

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

   There are no alternative methods for aligning Department rule with House Bill 21-1256.

8.095 Telemedicine

8.095.1.A DEFINITIONS

1. Electronic Health Entity (eHealth Entity) means a group practice that delivers services exclusively through telemedicine and is enrolled in a provider type that has an eHealth specialty. eHealth entities:

   a. Cannot be Primary Care Medical Providers;

   b. Can be either in-state or out-of-state.

2. Facilitated Visits means a Telemedicine visit where the rendering provider is at a distant site and the member is physically present with a support staff team member who can assist the provider with in-person activities.

3. HIPAA means the federal "Health Insurance Portability and Accountability Act of 1996", PUB. L. 104-191, as amended, which is incorporated herein by reference. Pursuant to C.R.S. § 24-4-103(12.5) (2022), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

4. Primary Care Medical Provider (PCMP) means an individual physician, advanced practice nurse or physician assistant, who contracts with a Regional Accountable Entity (RAE) in the Accountable Care Collaborative (ACC), with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

5. Telemedicine means the delivery of medical and health-care services and any diagnosis, consultation, or treatment using interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission).

8.095.2 CLIENT ELIGIBILITY

8.095.2.A. All Colorado Medicaid clients are eligible for medical and behavioral services delivered by telemedicine.

8.095.3 PROVIDER ELIGIBILITY

8.095.3.A. Any licensed provider enrolled with Colorado Medicaid is eligible to provide telemedicine services within the scope of the provider's practice.

8.095.3.B. Providers that meet the definition of an eHealth Entity shall enroll as the eHealth specialty.

8.095.4 COVERED SERVICES

8.095.4.A. Covered Telemedicine services must:

1. Meet the same standard of care as in-person care;

2. Be compliant with state and federal regulations regarding care coordination;

3. Be services the Department has approved for delivery through Telemedicine;

4. Be within the provider's scope of practice and for procedure codes the provider is already eligible to bill;

5. Be provided only where contact with the provider was initiated by the member for the services rendered; and

6. Be provided only after the member's consent, either verbal or written, to receive telemedicine services is documented.

8.095.4.B. eHealth Entities shall only provide:

1. Covered Telemedicine services, including Facilitated Visits.

8.095.5 PRIOR AUTHORIZATION REQUIREMENTS

8.095.5.A. The use of Telemedicine does not change prior authorization requirements for the underlying services provided.

8.095.6 RECORDKEEPING.

8.095.6.A. eHealth Entities must maintain a Release of Information in compliance with current HIPAA standards to facilitate communication with the member's PCMP.

8.095.7 REIMBURSEMENT

8.095.7.A Pursuant to C.R.S. § 25.5-5-320(2) (2022), the reimbursement rate for a Telemedicine service shall, as a minimum, be set at the same rate as the Colorado Medicaid rate for a comparable in-person service.

8.095.8 NON-COVERED SERVICES

8.095.8.A Services not otherwise covered by Colorado Medicaid are not c~~C~~overed when delivered through Telemedicine.

8.200 PHYSICIAN SERVICES

8.200.3. BENEFITS

8.200.3.B ~~Telemedicine is the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio, interactive video or interactive data communication instead of in-person contact~~ Physician services may be provided as telemedicine in accordance with Section 8.095.

~~1. Physician services may be provided as telemedicine.~~

~~2. Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.~~

~~3. Telemedicine includes interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission). Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care.~~

8.200.3.C Services and goods generally excluded from coverage are identified in Section 8.011.11.

8.200.3.D Physician Services

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

2. Speech – Language and Hearing Services

c. ELIGIBLE PLACES OF SERVICE

i. Eligible Places of Service shall include:

1. Office

2. Home

3. School

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

4. FQHC

5. Outpatient Hospital

6. Community Based Organization

7. Telemedicine in accordance with Section 8.095~~, including interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission). Any health benefits provided through interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) must meet the same standard of care as in-person care~~.

8.520 HOME HEALTH SERVICES

8.520.4. Covered Services

8.520.4.B. Place of Service

1. Services shall be provided in the client's place of residence or one of the following places of service:

   a. Assisted Living Facilities (ALFs);

   b. Alternative Care Facilities (ACFs);

   c. Group Residential Services and Supports (GRSS) including host homes, apartments or homes where three or fewer clients reside. Services shall not duplicate those that are the contracted responsibility of the GRSS;

   d. Individual Residential Services and Supports (IRSS) including host homes, apartments or homes where three or fewer clients reside Services shall not duplicate those that are the contracted responsibility of the IRSS; or

   e. Hotels, or similar temporary accommodations while traveling, will be considered the temporary place of residence for purposes of this rule.

   f. Nothing in this section should be read to prohibit a client from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

   g. Telemedicine may be provided in accordance with Section 8.095~~Services may be provided using interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) instead of in-person contact. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care~~.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

8.700.1.C. The visit definition includes interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounters in accordance with Section 8.095.

1. Any health benefits provided through interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) must meet the same standard of care as in-person care in accordance with Section 8.095.

8.730 FAMILY PLANNING SERVICES

8.730.3 Provider Eligibility

8.730.3.B. Eligible places of service include:

1. Office
2. Clinic
3. Public Health Agency
4. Home
5. School
6. School-based Health Center
7. Federally Qualified Health Center
8. Rural Health Center
9. Hospital
10. Ambulatory Surgery Center

11. Telemedicine may be provided in accordance with Section 8.095~~, including interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission). Any health benefits provided through interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) must meet the same standard of care as in-person care~~.

8.740 RURAL HEALTH CLINICS

8.740.1 DEFINITIONS

Rural Health Clinic (RHC) means a clinic or center that:

1. Has been certified as a Rural Health Clinic under Medicare.

2. Is located in a rural area, which is an area that is not delineated as an urbanized area by the Bureau of the Census.

3. Has been designated by the Secretary of Health and Human Services as a Health Professional Shortage Area (HPSA) through the Colorado Department of Public Health and Environment.

4. Is not a rehabilitation facility or a facility primarily for the care and treatment of mental diseases.

Visit means a face-to-face encounter, or an interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounter in accordance with Section 8.095, between a clinic client and a health professional providing the services set forth in 8.740.4. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care.

8.750 COMMUNITY MENTAL HEALTH CENTERS/CLINICS

8.750.3 COVERED SERVICES

8.750.3.B. Community Mental Health Centers/Clinics shall provide medically necessary rehabilitation services in an outpatient setting. Covered services shall include:

1. Case management services, including but not limited to:

   a. Service planning and program linkage.

   b. Referral recommendations.

   c. Monitoring and follow up.

   d. Client advocacy.

   e. Crisis management.

2. Group psychotherapy services shall be face-to-face, or interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) in accordance with Section 8.095, services that are insight-oriented, behavior modifying, and that involve emotional interactions of the group members. Group psychotherapy services shall assist in providing relief from distress and behavior issues with other clients who have similar problems and who meet regularly with a practitioner. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care

3. Individual psychotherapy services shall be face-to-face, or interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) in accordance with Section 8.095, services that are tailored to address the individual needs of the client. Services shall be insight-oriented, behavior modifying and/or supportive with the client in an office or outpatient facility setting. Individual psychotherapy services are limited to thirty-five visits per State fiscal year. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care