**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Federally Qualified Health Centers, Women's Health Services Reimbursement, Section 8.700.6.D
Rule Number: MSB 22-12-16-A
Division / Contact / Phone: Rates Division / Dawson LaRance / 303-866-3354

# 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 Revision to the Medical Assistance Rule concerning Federally Qualified Health Centers, Women's Health Services Reimbursement, Section 8.700.6.D

3. This action is an adoption of: an amendment

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

   Sections(s), 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 text at 8.700.6.D with the proposed text beginning at 8.700.6.D.6 through the end of 8.700.6.D.10. This rule is effective June 30, 2023.

*to be completed by MSB Board Coordinator

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Federally Qualified Health Centers, Women's Health Services Reimbursement, Section 8.700.6.D
Rule Number: MSB 22-12-16-A
Division / Contact / Phone: Rates Division / Dawson LaRance / 303-866-3354

## 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 wishes to make a couple changes to this rule. First being, the rule states "pending federal approval" which used to be true, however, APM 2 FQHC has received federal approval so we would like to remove this statement for accuracy purposes. Next, the Department would like to specify excluding dual eligible members from the population and attribution of the APM 2 program. This is how the program has always functioned for member attribution but is not reflected in this rule currently. Lastly, the Department wishes to add incentive payment for Chronic Conditions language.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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

Initial Review **04/14/23** Final Adoption **05/12/23**
Proposed Effective Date **06/30/23** Emergency Adoption

**DOCUMENT #06**

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Federally Qualified Health Centers, Women's Health Services Reimbursement, Section 8.700.6.D
Rule Number: MSB 22-12-16-A
Division / Contact / Phone: Rates Division / Dawson LaRance / 303-866-3354

# 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.

   Those affected by this amendment are FQHCs with the exclusions of dually eligible members within APM 2 attribution.

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 Department does foresee quantitative or qualitative impacts to the proposed amendment as this amendment serves to align and specify how APM 2 currently operates.

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 does not anticipate any probable costs to the Department or any other agency of the implementation and enforcement of this rule revision. APM 2 will continue to operate as it has in the past.

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

   The probable costs of inaction on this rule-update could lead to public confusion as to which Medicaid members APM 2 serves. APM 2 is a value-based payment model where participating providers can receive per-member-per-month payment as well as shared savings on chronic conditions management. We hope to align this rule with our APM 2 program operations so that there is no confusion on which members are captured and paid for within the program.

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

To reiterate what has been previously stated, this rule update does not have any foreseeable costs and is not intrusive. The proposed rule update serves the purpose of clarifying how APM 2 operates within this rule. The Department has consistently vocalized and informed the public and APM 2 participants that dually eligible Medicaid and Medicare members are excluded from member attribution.

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

   The Department has not considered other alternative methods for achieving the purpose of this rule. The Department is exercising its due diligence by recognizing where the Medical Services Board rule does not accurately align with program operations, therefore, the rule update is necessary.

## 8.700 FEDERALLY QUALIFIED HEALTH CENTERS

### 8.700.6 REIMBURSEMENT

8.700.6.D Encounter rates calculations

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

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

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

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

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

   b. The new base rates shall be the audited, calculated, inflated, and weighted average encounter rate for each separate rate, for the past three years. Base rates are recalculated (rebased) annually. Initial Base

rates shall be calculated when the Department has two year's data of costs and visits.

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

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

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

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

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

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

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

   d. Effective September 28, 2021, FQHC cost reports with fiscal year ends between May 31, 2021 and March 31, 2022 will be set using the previous year's rates multiplied by 2.7%.

   e. Starting with FQHC cost reports with fiscal year end May 31, 2022 the Department will restart the base rate setting process. For the first cost report submitted by an FQHC with fiscal year end May 31, 2022 and

after, base rates will be set based on one year's worth of data. For the second cost report submitted by an FQHC with fiscal year end May 31, 2022 and after, base rates will be set as a weighted average of two years' worth of data. After this, base rates will be set as specified in 8.700.6.D.2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

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

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

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

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

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

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

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

vii. The addition or removal of administrative staff;

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

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

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

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

xii. A change in ownership.

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

e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.D.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. An FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

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

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

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

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

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

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

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

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

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

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

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

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

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

v. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be

increased by the Medicare Economic Index (MEI) to become the new PPS rate.

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

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

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

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

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

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

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

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

minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

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

8. FQHCs may voluntarily elect to join APM 2 PMPM or the Chronic Condition Incentive Payment, or both. FQHCs will be eligible to earn incentive payment, which will not factor into rate-setting for APM 1 or APM 2, for participating in Chronic Condition Incentive Payment. Incentive payment thresholds will be specific to each FQHC. The Department will share thresholds each FQHC must meet to be eligible to receive incentive payments. Services that comprise the targets will also be published. FQHCs may opt into the APM 2 Chronic Conditions Incentive Payment quarterly on the first date of the calendar quarter. FQHCs will agree to the thresholds and services for incentive payments in the letter sent annually by the Department which confirms participation in the program. The Chronic Conditions Incentive Payment will be paid when FQHCs provide physical health services to full benefit Medicaid beneficiaries attributed to the FQHC, who are not geographically attributed or dually eligible for Medicare, and must also be diagnosed with one or more the following chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, hypertension, arrythmia/heart blockage, heart failure, gastro-esophageal reflux disease, Crohn's disease, ulcerative colitis, low back pain, osteoarthritis, and/or diabetes.

~~FQHCs will be eligible to earn extra revenue for participating in gainsharing. Incentive payment thresholds will be specific to each FQHC. The Department will share thresholds that show the targets FQHCs must meet to be eligible to receive extra payments. Services that comprise the targets will also be published. FQHCs will agree to the thresholds and services for incentive payments in the letter sent by the Department which confirms participation in the program~~

~~8.~~9. The Department will perform an annual reconciliation to ensure the PMPM reimbursement compensates APM 2 providers in an amount that is no less than their PPS per visit rate. The Department shall perform PPS reconciliations should the FQHC participating in APM 2 realize additional cost, not otherwise reimbursed under the PMPM, incurred as a result of extraordinary circumstances that cause traditional encounters to increase to a level where PMPM reimbursement is not sufficient for the operation of the FQHC.

~~9.~~10. PMPM and encounter rates for FQHC participating in APM 2 shall be effective on the 1st day of the month that falls at least 120 days after an FQHC's fiscal year end.

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Physician Services, Dental, Vision Services, Medicaid Managed Care Program Prospective Medical Payments to Primary Care Medical Providers, Section 8.700.7.A
Rule Number: MSB 22-12-20-A
Division / Contact / Phone: Rates Division / Dawson LaRance / 303-866-3354

# 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 22-12-20-A, Revision to the Medical Assistance Rule concerning Physician Services, Dental, Vision Services, Medicaid Managed Care Program Prospective Medical Payments to Primary Care Medical Providers, Section 8.700.7

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), 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 8.700.7.A with the proposed text beginning at 8.700.7.A.5 through the end of 8.700.7.A.6. Replace the current text at 8.700.7.E with the proposed text beginning at 8.700.7.E.1.a through the end of 8.700.7.E.1.c. This rule is effective June 30, 2023.

*to be completed by MSB Board Coordinator

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Physician Services, Dental, Vision Services, Medicaid Managed Care Program Prospective Medical Payments to Primary Care Medical Providers, Section 8.700.7.A
Rule Number: MSB 22-12-20-A
Division / Contact / Phone: Rates Division / Dawson LaRance / 303-866-3354

## 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 wants to make a revision to clarify the reconciliation process as well as member attribution in the non-FQHC APM 2 program. The Department requests to change the wording where the rule states that there is not an upwards reconciliation process. The Department reconciles for all providers and there must be a clarification that upward reconciliation exists. Next, within the Physician Services MSB rule section 8.200.7.A., the Department wishes to incorporate clarifying language around exclusions for member population and attribution. Currently, the rule does not state that APM 2 excludes dually eligible Medicaid/Medicare members. Because Medicare is the primary payer, APM 2 excludes dually eligible Medicare/Medicaid members from member population and attribution. The Department plans to add language to add the appropriate language to this rule for alignment with APM 2 non-FQHC operations.

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);

Initial Review **04/14/23** Final Adoption **05/12/23**
Proposed Effective Date **06/30/23** Emergency Adoption

**DOCUMENT #07**

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Physician Services, Dental, Vision Services, Medicaid Managed Care Program Prospective Medical Payments to Primary Care Medical Providers, Section 8.700.7.A
Rule Number: MSB 22-12-20-A
Division / Contact / Phone: Rates Division / Dawson LaRance / 303-866-3354

# REGULATORY ANALYSIS

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

   The proposed rule update affects non-federally qualified health centers. This revision has no anticipated cost to bear for the classes affected by the rule as we aim to incorporate language that providers will be reconciled upwards if per-member-per-month payments to the provider are found to be less than what providers would have received with fee-for-service. Further, this rule affects non-federally qualified health centers with the exclusions of geographically attributed and dually eligible members within APM 2 attribution. This rule revision aims to positively impact providers that serve Medicaid populations.

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 Department does not anticipate any quantitative or qualitative impacts by this rule revision. The APM 2 program will continue to operate as it has in the past with this proposed revision to align the Medical Services Board rule with APM 2 operations.

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 anticipated costs to the Department with this rule revision. The APM 2 program will continue to operate as normal with this revision to align the Medical Services Board rule with APM 2 operations.

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

   This rule revision aims to benefit providers by specifying that upwards reconciliation occurs when it is discovered that providers would have received higher payment with fee-for-service than the per-member-per-month capitation. APM 2 is not meant to negatively impact provider revenue for care delivery. Inaction on incorporating

this rule would negatively impact providers without an upwards reconciliation process. This rule will align how the program currently operates for upwards reconciliation.

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

   The proposed rule revision is the least costly and intrusive method for achieving the purpose of this revision as it aims to provide clarity to how APM 2 operates for reconciliation.

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 Payment Reform section of the Finance Office did not discuss alternative methods of achieving the purpose for the proposed rule revision. This rule does not have anticipated negative impacts to the Department and impacted stakeholders, nor is it a revision that brings large programmatic changes to the APM 2 program. This rule-revision only serves to benefit providers as well as align the operation of APM 2 with the Medical Services Board rule.

## 8.200 PHYSICIAN SERVICES

### 8.200.7 Prospective Medical Payments to Primary Care Medical Providers

8.200.7.A Definitions

1. APM code set refers to a set of Evaluation and Management (E&M) codes that are defined by the Department and included on the Department's Primary Care Alternative Payment Model Fee Schedule (https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule)

2. Gainsharing refers to upside only shared savings, where a participating PCMP can earn additional reimbursement for meeting metrics/thresholds that are defined by the Department.

3. Primary Care Medical Provider (PCMP) refers to an individual physician, advanced practice nurse or physician assistant, who participates in the Accountable Care Collaborative (ACC) as a Network Provider, with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

4. Prospective Payments refer to monthly payments made at the beginning of each month that are intended to cover primary care services for a PCMP's attributed members.

5. Qualifying Patients: The subset of medical assistance beneficiaries that are attributed to a PCMP, excluding those that are assigned to the PCMP on the basis of geographical attribution and excluding those who are eligible for Medicare. The Participating Physician's Qualifying Patients will change on an ongoing basis because of new patient attribution to the PCMP, removal of patients from the list of those attributed to the PCMP, change in attribution reason, and either gain or loss of dual Medicare and Medicaid enrollment.

6. Reconciliation refers to a process established by the Department to correct under- or overpayment for services rendered in the APM code set.

8.200.7.B Eligibility for Participation

1. Primary Care Medical Providers (PCMPs) enrolled in the ACC.

2. PCMPs must exceed a mathematical standard which is determined by the Department's actuary and this standard will be communicated to interested participants before the program starts.

3. This payment methodology is voluntary and PCMPs must elect to participate. The Department will send a letter to confirm a PCMP's intent to join the program. The PCMP then has 10 business days from the date of receipt of the letter to confirm or deny participation.

8.200.7.C Prospective Per Member Per Month (PMPM) Payments

1. PCMPs will earn monthly prospective payments for services in the APM code set

    a. The prospective PMPM payments will be PCMP specific.

    b. The PCMP will elect what percentage of their revenue for primary care services they will earn as a prospective PMPM payment.

        i. The amount of PMPM payment a PCMP will receive will be indicated in the letter sent by the Department to confirm participation in the program.

    c. PCMPs will earn the rest of their revenue from reduced fee for service in the corresponding percentage for the APM code set.

        i. The percentage reduction for the services included in the APM code set received, will be indicated in the letter sent by the Department to confirm participation in the program.

8.200.7.D Gainsharing

1. PCMPs will be eligible to earn extra revenue for participating in gainsharing.

    a. Gainsharing thresholds will be specific to each PCMP.

    b. The Department will publish thresholds for gainsharing that show the targets PCMPs must meet to be eligible to receive extra payments. Services that comprise the targets will also be published.

        i. PCMPs will agree to the thresholds and services for gainsharing in the letter sent by the Department which confirms participation in the program.

2. The PCMP may contest the Department's determination of the gainsharing payments. PCMPs who contest the Department's determination must first submit in writing to the Department the reason for contesting the determination within 60 days of receiving the gainsharing payment. The Department will review all contested determinations within 30 calendar days of receipt of the notice and will respond to the PCMP with its final decision. If the PCMP does not agree with the Department's final decision, the PCMP has the right to file an appeal with the Office of Administrative Courts in accordance with Section 8.050.3.

8.200.7.E Reconciliation

1. A PCMP will be responsible for meeting quality minimums that are established and accepted by the PCMP in the letter sent by the Department which confirms participation in the program. The quality minimums must be met for a PCMP to earn their full prospective PMPM payments.

    a. If the PCMP exceeds the quality minimums then they will not be subject to reconciliation, unless the PMPM payment is lower than the amount which would have been earned had the PCMP been reimbursed through the fee schedule payment.

    b. If the PCMP does not meet quality minimums then the Department will reduce the PMPM payment to equal the corresponding amount which would have been earned had the PCMP been reimbursed the fee schedule payment.

c. A PCMP will be made whole through an upward reconciliation process if the Department finds that a PCMP ~~was underpaid with the per-member-per-month capitation~~would have earned more had the PCMP been reimbursed the fee schedule payment. ~~and would have received a more in payment with fee-for-service.~~

2. Appeals Process for Prospective PMPM Payments

a. The PCMP may contest the Department's determination for reconciliation of prospective PMPM payments. PCMPs who contest the Department's determination must submit in writing to the Department the reason for contesting the determination within 60 days of receiving the notice of reconciliation of prospective PMPM payments. The Department will review all contested determinations within 30 calendar days of receipt of the notice and will respond to the PCMP with its final decision. If the PCMP does not agree with the Department's final decision, the PCMP has the right to file an appeal with the Office of Administrative Courts in accordance with Section 8.050.3.

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Supported Employment Services Expansion, Section 8.500
Rule Number: MSB 22-12-30-A
Division / Contact / Phone: OCL / Jenny Jordan / 303-866-5757

# 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 22-12-30-A, Revision to the Medical Assistance Rule concerning Supported Employment Services Expansion, Section 8.500

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 8.500 and 8.615, 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 8.500.5 with the proposed text beginning at 8.500.5.A.2 through the end of 8.500.5.A.13. Replace the current text at 8.500.5.B.2 with the proposed text beginning at 8.500.5.B.2 through the end of 8.500.5.B.13. Replace the current text at 8.500.94.A. with the proposed text beginning at 8.500.94.A through the end of 8.500.94.B.6. Replace the current text at 8.500.94.B.6.A beginning at 8.500.94.B.6.A through the end of 8.500.94.B.6.F.24. Replace the current text at 8.500.102.B with the proposed text beginning at 8.500.102.B through the end of 8.500.102.B. Replace the current text at 8.615.2 with the proposed text beginning at 8.615.2.A through the end of 8.615.2.A. This rule is effective June 30, 2023.

*to be completed by MSB Board Coordinator

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Supported Employment Services Expansion, Section 8.500
Rule Number: MSB 22-12-30-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).

   Senate Bill 21-039 directed Colorado's Department of Health Care Policy and Financing to create services to address on-going benefits counseling and line-of-sight supervision in the Developmental Disabilities (DD) and the Supported Living Services (SLS) Home and Community Based Services (HCBS) Waivers. It also stipulated that Supported Employment services should be removed from the Service Plan Authorization Limit (SPAL) in the SLS Waiver. These rule changes will insert language pertaining to the newly developed services (Benefits Planning and Workplace Assistance) into the service description sections of the HCBS DD and SLS Waivers. Benefits Planning service may be delivered via Telehealth, so this service will be inserted onto the list of Telehealth services. Supported Employment services (Individual Job Development, Individual Job Coaching, Workplace Assistance, Benefits Planning, and Job Placement) will be added to the list of services that are excluded from the Service Plan Authorization Limit (SPAL) for the HCBS SLS Waiver.

   These actions will help individuals with intellectual and developmental disabilities to have greater access to community employment opportunities by: 1) increasing awareness/ understanding regarding how income and public benefits interact 2) supporting individuals with elevated safety concerns at their worksites 3) allowing individuals enrolled on the SLS Waiver to not have to choose between Supported Employment services and other services that must remain within Service Plan Authorization Limit (SPAL). These changes are a step toward Colorado actively removing systematic barriers to employment and promoting the state's Employment First efforts.

   This rule revision will address items raised in Senate Bill 21-039. Specifically, it will add two new Supported Employment services (Benefits Planning and Workplace Assistance) to the HCBS Developmental Disabilities (DD) Waiver (Sections 8.500.5 A & B) and the HCBS Supported Living Services (SLS) Waiver (Section 8.500.94 A & B).

2. An emergency rule-making is imperatively necessary

| | | | |
|---|---|---|---|
| Initial Review | **04/14/23** | Final Adoption | **05/12/23** |
| Proposed Effective Date | **06/30/23** | Emergency Adoption | |

**DOCUMENT #08**

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

Explain:

n/a

3. Federal authority for the Rule, if any:

   n/a

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022); Section 25.5-6-413, C.R.S. (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.

   This is an expansion of benefits that does not impose cost on a specific class of person. The benefit expansion affects members enrolled in the Developmental Disabilities waiver and the Supported Living Services waiver. These members are adults with intellectual and developmental disabilities, and all members of these waivers can 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.

   The proposed rule is intended to reduce barriers to employment for waiver members. It achieves this in two ways, (1) by defining two new benefits, Workplace Assistance and Benefits Planning, and (2) by removing benefits connected to individual employment from the Service Plan Authorization Limit (SPAL) for members on the Supported Living Services waiver. These actions will help individuals with intellectual and developmental disabilities to have greater access to community employment opportunities by: 1) increasing awareness/understanding regarding how income and public benefits interact 2) supporting individuals with elevated safety concerns at their worksites 3) allowing individuals enrolled on the SLS Waiver to not have to choose between Supported Employment services and other services that must remain within Service Plan Authorization Limit (SPAL). These changes are a step toward Colorado actively removing systematic barriers to employment and promoting the state's Employment First efforts.

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.

**DO NOT PUBLISH THIS PAGE**

As reflected in the Final Fiscal Note for SB 21-039, the probable costs to the Department annually as a result of this rule are approximately $471,421 in direct benefit expenditures.

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

   Under SB 21-039, the Department was directed to seek federal approval for these changes and to collaborate with stakeholders to develop the standards and limitations that would define the new benefits. Inaction would be counter to this directive. In addition, inaction would result in perpetuation of system-imposed barriers to employment for Medicaid members with intellectual and developmental disabilities. Exclusion of these members from the workforce negatively impacts their lives as individuals, artificially constrains the size of the state workforce, and increases overall dependency on state benefits.

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

   The proposed rules define the standards and limitations of the new benefits and identifies which services fall outside of the SPAL. The new benefits and changes to the SPAL cannot be implemented without the proposed rules. There is no alternative method to achieve these goals.

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.

   Under SB 21-039, the Department was directed to seek federal approval for these changes and to collaborate with stakeholders to develop the standards and limitations that would define the new benefits.

## 8.500 HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES(HCBS-DD) WAIVER

### 8.500.5 HCBS-DD WAIVER SERVICES

### 8.500.5.A SERVICES PROVIDED

1. Behavioral Services
2. Benefits Planning
3~~2~~. Day Habilitation Services and Supports
4~~3~~. Dental Services
5~~4~~. Home Delivered Meals
6~~5~~. Non-Medical Transportation
7~~6~~. Peer Mentorship
8~~7~~. Residential Habilitation Services and Supports (RHSS)
9~~8~~. Specialized Medical Equipment and Supplies
10~~9~~. Supported Employment
11~~0~~. Transition Setup
12~~1~~. Vision Services
13~~2~~. ~~Benefits~~Workplace Assistance ~~Planning~~

### 8.500.5.B DEFINITIONS OF SERVICES

The following services are available through the HCBS-DD Waiver within the specific limitations as set forth in the federally approved HCBS-DD Waiver.

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

    a. Behavioral services shall address specific challenging behaviors of the Client and identify specific criteria for remediation of the behaviors.

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

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

d. Behavioral Services include:

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

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

iii) Behavioral consultation services are limited to eighty (80) units per service plan year. One unit is equal to fifteen (15) minutes of service.

iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

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

vi). Individual and Group Counseling Services include psychotherapeutic or psycho educational intervention that:

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

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

3) Counseling services are limited to two-hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral Line Services include direct one-to-one implementation of the Behavioral Support Plan and is:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a Client at risk of institutional placement and to address an identified challenging behavior that places the Client's health and safety or the safety of others at risk.

4) Behavioral Line Services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Requests for Behavioral Line Services shall be prior authorized in accordance with the Operating Agency's procedures.

2. Benefits Planning is the analysis and guidance provided to a member and their family/support network to improve their understanding of the potential impact of employment-related income on the member's public benefits. Public benefits include, but are not limited to: Social Security, Medicaid, Medicare, food/nutrition programs, housing assistance, and other federal, state, and local benefits. Benefits Planning gives the member an opportunity to make an informed choice regarding employment opportunities or career advancement.

a. Benefits Planning may only be provided by Certified Benefits Planners. A Certified Benefits Planner holds at least one of the following credentials:

i. Community Work Incentives Coordinator (CWIC);

ii. Community Partner Work Incentives Counselor (CPWIC);

iii. Credentialed Work Incentives Practitioner (WIP-C™).

b. Documentation of the Benefits Planner's certification and additional trainings shall be maintained and provided upon request by a surveyor or the Department.

c. Certified Benefits Planners must obtain and sustain a working knowledge of Colorado's Medicaid Waiver system as well as federal, state, and local benefits.

d. If the Certified Benefits Planner encounters a benefit situation that is beyond their expertise, consultation with technical assistance liaisons is expected.

e. Benefits Planning is available regardless of employment history or lack thereof, and can be accessed throughout the phases of a member's career such as: when considering employment, changing jobs, or for career advancement/exploration. Certified Benefits Planners support members by providing any of these core activities:

i. Intensive individualized benefits counseling;

ii. Benefits verification;

iii. Benefit summary & analysis (BS&A);

iv. Identifying applicable work incentives, and if needed, developing a work incentive plan for the member and team;

v. In addition to the core activities, Benefits Planning may also be utilized to:

1) Conduct an informational meeting with the member, alone or with their support network.

2) Assist with evaluating job offers, promotional opportunities (increase in hours/wage), or other job changes that the member is considering which changes income levels; and outlining the impact that change may have on public benefits.

3) Provide information on Waiver benefits (including Buy-In options), federal/state/local programs, and other resources that may support the member in maintaining benefits while pursuing employment.

4) Assist with referrals and connecting the member with identified resources, as needed; as well as coordinating with member, Case Manager, family, and other team members to promote accessing services/resources that will advance the member's desired employment goals.

5) Navigate complicated benefit scenarios and offer problem-solving strategies, so that the member may begin or continue working while maintaining eligibility for needed services.

6) Offer suggestions to the member and their family/support network regarding how to create and maintain a recordkeeping structure and reporting strategy related to benefit eligibility and requirements.

a) If the member needs assistance with the collection and submission of income statements and/or documentation related to the Social Security Administration (SSA), or other benefits managing organizations, and the member does not have other supports to do so, the Benefits Planner may assist on a temporary basis.

i. The Benefits Planning provider must maintain records which reflect the Benefits Planning activities that were completed for the member, including copies of any reports provided to the member.

f. In collaboration with the member's Case Manager and support team, a Benefits Planner can assist in accessing federal/state/local resources, evaluate the potential impact on benefits due to changes in income, and if there is a negative impact identified the Benefits Planner can help brainstorm alternatives to meet existing needs.

g. Benefits Planning shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation.

h. Benefits Planning services are limited to forty (40) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

3. Day Habilitation Services and Supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the Client's private residence or other residential living

arrangement, except when services are necessary in the residence due to medical or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence and personal choice.

b. Day Habilitation Services and Supports encompass three (3) types of habilitative environments: specialized habilitation services, supported community connections, and prevocational services.

c. Specialized Habilitation (SH) services are provided to enable the Client to attain the maximum functioning level or to be supported in such a manner that allows the Client to gain an increased level of self-sufficiency. Specialized habilitation services:

    i) Are provided in a non-integrated setting where a majority of the Clients have a disability,

    ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

    iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported Community Connections Services are provided to support the abilities and skills necessary to enable the Client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

    i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a Client's service plan,

    ii) Are conducted in a variety of settings in which the Client interacts with persons without disabilities other than those individuals who are providing services to the Client. These types of services may include socialization, adaptive skills and personnel to accompany and support the Client in community settings,

    iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

    iv) May be provided in a group setting or may be provided to a single Client in a learning environment to provide instruction when identified in the service plan.

    v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational Services are provided to prepare a Client for paid community employment. Services consist of teaching concepts including attendance, task

completion, problem solving and safety, and are associated with performing compensated work.

i) Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.

ii) Goals for Prevocational Services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations.

iv) Prevocational Services are provided to support the Client to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid community employment.

vi) Documentation shall be maintained in the file of each Client receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. Section 1400 et seq.).

f. The number of units available for day habilitation services in combination with prevocational services is four thousand eight hundred (4,800). When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and

g. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One unit equals fifteen (15) minutes of service.

43. Dental services are available to individuals age twenty-one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i) Dental insurance premiums and co-pays/co-insurance,

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv). Non-intravenous sedation,

v) Basic and deep cleanings,

vi). Mouth guards,

vii) Topical fluoride treatment, and

viii) Retention or recovery of space between teeth when indicated.

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

v) Non-emergency extractions including simple, surgical, full and partial

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of dentures, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures. Implants are a benefit only when the procedure is necessary to support a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval.

e. Implants shall not be a benefit for a Client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail.

f. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at Section 8.076.1.8or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the Client.

g. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodontic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

h. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

i. Preventative and basic services are limited to $2,000 per service plan year. Major services are limited to $10,000 for the five (5) year renewal period of the waiver.

54. Home Delivered Meals as defined at Section 8.553.1.

65. Non-Medical Transportation enables Clients to gain access to Day Habilitation Services and Supports, Prevocational Services and Supported Employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.

a. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized and documented in the Service Plan.

b. Non-Medical Transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-Medical Transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip accessed each way to and from day habilitation and supported employment services.

c. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. Section 431.53 or transportation services under the Medicaid State Plan, defined at 42 C.F.R. Section 440.170 (a).

76. Peer Mentorship as defined at Section 8.553.1.

87. Residential Habilitation Services and Supports (RHSS) are delivered to ensure the health and safety of the Client and to assist in the acquisition, retention or improvement in skills necessary to support the Client to live and participate successfully in the community.

a. Services may include a combination of lifelong, or extended duration supervision, training or support that is essential to daily community living, including assessment and evaluation, and includes training materials, transportation, fees and supplies.

b. The living environment encompasses two (2) types that include individual Residential Services and Supports (IRSS) and Group Residential Services and Supports (GRSS).

c. All RHSS environments shall provide sufficient staff to meet the needs of the Client as defined in the service plan.

d. The following RHSS activities assist Clients to reside as independently as possible in the community:

i) Self-advocacy training, which may include training to assist in expressing personal preferences, increasing self-representation, increasing self-protection from and reporting of abuse, neglect and exploitation, advocating for individual rights and making increasingly responsible choices,

ii) Independent living training, which may include personal care, household services, infant and childcare when the Client has a child, and communication skills,

iii) Cognitive services, which may include training in money management and personal finances, planning and decision making,

iv) Implementation of recommended follow-up counseling, behavioral, or other therapeutic interventions. Implementation of physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

v) Medical and health care services that are integral to meeting the daily needs of the Client and include such tasks as routine administration of medications or tending to the needs of Clients who are ill or require attention to their medical needs on an ongoing basis,

vi) Emergency assistance training including developing responses in case of emergencies and prevention planning and training in the use of equipment or technologies used to access emergency response systems,

vii) Community access services that explore community services available to all people, natural supports available to the Client and develop methods to access additional services, supports, or activities needed by the Client,

viii) Travel services, which may include providing, arranging, transporting or accompanying the Client to services and supports identified in the service plan, and

ix) Supervision services which ensure the health and safety of the Client or utilize technology for the same purpose.

e. All direct care staff not otherwise licensed to administer medications must complete a training class approved by the Colorado Department of Public Health and Environment and successfully complete a written test and a practical and competency test.

f. Reimbursement for RHSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of Clients or to meet the requirements of the applicable life safety code.

98. Specialized Medical Equipment and Supplies include:

a. Devices, controls or appliances that enable the Client to increase the Client's ability to perform activities of daily living,

b. Devices, controls or appliances that enable the Client to perceive, control or communicate within the Client's environment,

c. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items,

d. Durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to address Client functional limitations, or

e. Necessary medical supplies in excess of Medicaid State Plan limitations or not available under the Medicaid State Plan.

f. All items shall meet applicable standards of manufacture, design and installation.

g. Specialized medical equipment and supplies exclude those items that are not of direct medical or remedial benefit to the Client.

109. Supported Employment includes intensive, ongoing supports that enable a Client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the Client's disabilities needs supports to perform in a regular work setting.

a. Supported Employment may include assessment and identification of vocational interests and capabilities in preparation for job development and assisting the Client to locate a job or job development on behalf of the Client.

b. Supported Employment may be delivered in a variety of settings in which Clients interact with individuals without disabilities, other than those individuals who are providing services to the Client, to the same extent that individuals without disabilities employed in comparable positions would interact.

c. Supported Employment is work outside of a facility-based site, which is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities.

d. Supported Employment is provided in community jobs, enclaves or mobile crews.

e. Group Employment including mobile crews or enclaves shall not exceed eight (8) Clients.

f. Supported Employment includes activities needed to sustain paid work by Clients including supervision and training.

g. When Supported Employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a Client as a result of the Client's disabilities.

h. Documentation of the Client's application for services through the Colorado Department of Labor and Employment Vocational Rehabilitation shall be

maintained in the file of each Client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education CCT (20 U.S.C. Section 1400 et seq.).

i. Supported Employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

j. Supported Employment shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation.

k. The limitation for Supported Employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of Supported Employment and shall not be reimbursed:

i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,

ii) Payments that are distributed to users of supported employment, and

iii) Payments for training that are not directly related to a Client's supported employment.

m. If a member is employed, the supervision the member needs while at work shall be clearly documented in their Person-Centered Support Plan (PCSP). A member's supervision level at work must be based on the member's specific work-related support needs.

i. The level of supervision by paid caregivers may be lower at work than in other community settings, and the member should not be over-supported or limited in their availability to work based on supervision needs identified for other settings.

11~~0~~. Transition Setup services as defined at Section 8.553.1.

12~~1~~. Vision Services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a Client who is at least twenty-one (21) years of age.

a. Lasik and other similar types of procedures are only allowable when:

i) The procedure is necessary due to the Client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective.

ii) Prior authorized in accordance with Operating Agency procedures.

13~~2~~. Workplace Assistance services provide work-related supports for members with elevated supervision needs who, because of valid safety concerns, may need assistance from a paid caregiver that is above and beyond what could be regularly supported by the

workplace supervisor, co-workers, or job coach, in order to maintain an individual job in an integrated work setting for which the member is compensated at or above minimum wage. Training/Job Coaching, accommodations, technology, and natural supports are to be used to maximize the member's independence and minimize the need for the consistent presence of a paid caregiver. As such, the degree to which the member must be supported by a paid caregiver through the Workplace Assistance service, shall be based on the specific safety-related need(s) identified in the person-centered planning process for the member at their worksite.

a. Workplace Assistance:

i. is provided on an individual basis, not within a group and cannot overlap with job coaching;

ii. occurs at the member's place of employment, during the member's work hours, and when needed may also be used:

1) immediately before or after the member's employment hours,

2) during work-related events at other locations;

iii. includes but is not limited to: promoting integration, furthering natural support relationships, reinforcing/modeling safety skills, assisting with behavioral support needs, redirecting, reminding to follow work-related protocols/ strategies, and ensuring other identified needs are met so the member can be integrated and successful at work;

iv. may include activities beyond job-related tasks that support integration at work, such as assisting, if necessary, during breaks, lunches, occasional informal employee gatherings, and employer-sponsored events.

b. Workplace Assistance is appropriate for and available to:

—Members who require Intensive Supervision or have a documented need which warrants a Rights Modification requiring extensive supervision, such as, a court order or the member meeting Public Safety Risk or Extreme Risk-to-Self criteria pursuant to Section 8.612.5(i) definitions.

i. Members whose support team agrees there is justification for a paid caregiver to be present for a portion of the hours worked due to safety concerns; and those needs are beyond what could be addressed through natural supports, technology, or intermittent Job Coaching.

1) The specific safety concerns identified by members and their support teams may include, but are not limited to:

a) regularly demonstrating behaviors that cause direct harm to themselves or others;

b) intentionally or unintentionally putting themselves in unsafe situations frequently;

c) often demonstrating poor safety awareness or making poor decisions related to personal safety.

2) A member's supervision level is not the sole factor which justifies the need for this service, therefore, the supervision level shall not be elevated in order to access the service. The member's supervision level at the worksite shall be based on actual need related to the member at work.

c. Prior to Workplace Assistance being authorized, including at the Person-Centered Support Plan's annual renewal, the member and their support team shall determine that alternatives to paid caregiver supports were fully explored, by considering the factors listed below. Documentation of these considerations shall be reflected in the member's Case Management record.

i. Job Coaching services have been or will be leveraged to promote the member's independence and minimize the need for the presence of a paid caregiver by ensuring adequate job training, advocating for appropriate accommodations, promoting natural supports, integrating technology, and using systematic instruction techniques.

ii. The specific safety concern(s) to be addressed and how the Workplace Assistance staff could support the member in addressing the safety concerns while facilitating integration and independence at work.

iii. The nature of the job and work location, the member's longevity with the employer, the degree of continuity at the member's place of employment, and the likelihood of the member putting themselves/others in harm's way, despite training, technology, and cues from natural supports.

iv. The member's desire to have a paid caregiver present for the identified time periods.

v. The Supported Employment provider's informed opinion regarding the need for paid caregiver support beyond intermittent Job Coaching. This opinion should be grounded in Employment First concepts as evidenced by:

1) The provider's completion of a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification); or

2) If the Supported Employment provider does not possess this credentialing, then the Supported Employment provider or the Case Manager may consult with:

a) by someone who does possess either a Training Certificate or Certification

b) or a representative from the Department of Health Care Policy and Financing who oversees the Workplace Assistance benefit.

d. Workplace Assistance staff shall consistently seek to promote the member's independence and integration at work.

i) Where possible, efforts should be made to reduce or eliminate the need for Workplace Assistance services over time, and the efforts and progress shall be documented by the provider.

ii) The training for Workplace Assistance staff should:

1) include fundamentals of Employment First principles with emphasis on promoting independence and inclusion;

2) provide insight regarding a paid caregiver's role at a member's place of employment such that the Workplace Assistance staff's presence does not hinder the member's interaction with co-workers, customers, and other community members.

**8.500.94 HCBS-SLS WAIVER SERVICES**

8.500.94.A. SERVICES PROVIDED

1. Assistive Technology
2. Behavioral Services
3. Benefits Planning
4~~3~~. Day Habilitation services and supports
5~~4~~. Dental Services
6~~5~~. Health Maintenance
7~~6~~. Home Accessibility Adaptations
8~~7~~. Home Delivered Meals
9~~8~~. Homemaker Services
10~~9~~. Life Skills Training (LST)
11~~0~~. Mentorship
12~~1~~. Non-Medical Transportation
13~~2~~. Peer Mentorship
14~~3~~. Personal Care
15~~4~~. Personal Emergency Response System (PERS)
16~~5~~. Professional Services, defined below in 8.500.94.B.14
17~~6~~. Respite

187. Remote Supports

198. Specialized Medical Equipment and Supplies

2019. Supported Employment

210. Transition Setup

221. Vehicle Modifications

232. Vision Services

243. ~~Benefits Planning~~Workplace Assistance

8.500.94.B The following services are available through the HCBS-SLS waiver within the specific limitations as set forth in the federally approved HCBS-SLS waiver.

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

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

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

   c. Training or technical assistance for the Client, or where appropriate, the family members, guardians, caregivers, advocates, or authorized representatives of the Client,

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

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

   f. Assistive technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid state plan or third party resource.

   g. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

   h. When the expected cost is to exceed $2,500 per device three estimates shall be obtained and maintained in the case record.

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

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

i) Purchase, training or maintenance of service animals,

ii) Computers,

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

iv) Training or adaptation directly related to a school or home educational goal or curriculum.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver unless an exception is applied for and approved. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health and safety of the Client or that enable the Client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures within thirty (30) days of the request.

2. Benefits Planning is the analysis and guidance provided to a member and their family/support network to improve their understanding of the potential impact of employment-related income on the member's public benefits. Public benefits include, but are not limited to: Social Security, Medicaid, Medicare, food/nutrition programs, housing assistance, and other federal, state, and local benefits. Benefits Planning gives the member an opportunity to make an informed choice regarding employment opportunities or career advancement.

a. Benefits Planning may only be provided by Certified Benefits Planners. A Certified Benefits Planner holds at least one of the following credentials:

i. Community Work Incentives Coordinator (CWIC);

ii. Community Partner Work Incentives Counselor (CPWIC);

iii. Credentialed Work Incentives Practitioner (WIP-C™).

b. Documentation of the Benefits Planner's certification and additional trainings shall be maintained and provided upon request by a surveyor or the Department.

c. Certified Benefits Planners must obtain and sustain a working knowledge of Colorado's Medicaid Waiver system as well as federal, state, and local benefits.

d. If the Certified Benefits Planner encounters a benefit situation that is beyond their expertise, consultation with technical assistance liaisons is expected.

e. Benefits Planning is available regardless of employment history or lack thereof, and can be accessed throughout the phases of a member's career such as: when considering employment, changing jobs, or for career advancement/exploration. Certified Benefits Planners support members by providing any of these core activities:

i. Intensive individualized benefits counseling;

ii. Benefits verification;

iii. Benefit summary & analysis (BS&A);

iv. Identifying applicable work incentives, and if needed, developing a work incentive plan for the member and team;

v. In addition to the core activities, Benefits Planning may also be utilized to:

1) Conduct an informational meeting with the member, alone or with their support network.

2) Assist with evaluating job offers, promotional opportunities (increase in hours/wage), or other job changes that the member is considering which changes income levels; and outlining the impact that change may have on public benefits.

3) Provide information on Waiver benefits (including Buy-In options), federal/state/local programs, and other resources that may support the member in maintaining benefits while pursuing employment.

4) Assist with referrals and connecting the member with identified resources, as needed; as well as coordinating with member, Case Manager, family, and other team members to promote accessing services/resources that will advance the member's desired employment goals.

5) Navigate complicated benefit scenarios and offer problem-solving strategies, so that the member may begin or continue working while maintaining eligibility for needed services.

6) Offer suggestions to the member and their family/support network regarding how to create and maintain a recordkeeping structure and reporting strategy related to benefit eligibility and requirements.

7) If the member needs assistance with the collection and submission of income statements and/or documentation related to the Social Security Administration (SSA), or other benefits managing organizations, and the member does not have other supports to do so, the Benefits Planner may assist on a temporary basis.

f. The Benefits Planning provider must maintain records which reflect the Benefits Planning activities that were completed for the member, including copies of any reports provided to the member.

g. In collaboration with the member's Case Manager and support team, a Benefits Planner can assist in accessing federal/state/local resources, evaluate the potential impact on benefits due to changes in income, and if there is a negative

impact identified the Benefits Planner can help brainstorm alternatives to meet existing needs.

h. Benefits Planning shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation.

i. Benefits Planning services are limited to forty (40) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

32. Behavioral services are services related to the Client's intellectual or developmental disability which assist a Client to acquire or maintain appropriate interactions with others.

a. Behavioral services shall address specific challenging behaviors of the Client and identify specific criteria for remediation of the behaviors.

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

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

d. Behavioral Services:

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

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

iii) Behavioral consultation services are limited to eighty (80) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

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

vi) Individual or group counseling services include psychotherapeutic or psychoeducational intervention that:

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

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

3) Counseling services are limited to two hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral line services include direct one on one (1:1) implementation of the behavioral support plan and are:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a Client at risk of institutional placement, and that places the Client's health and safety or the safety of others at risk

4) Behavioral line services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. All behavioral line services shall be prior authorized in accordance with Operating Agency procedure

43. Day habilitation services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the Client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.

b. Day habilitation services and supports encompass three (3) types of habilitative environments; specialized habilitation services, supported community connections, and prevocational services.

c. Specialized habilitation (SH) services are provided to enable the Client to attain the maximum functional level or to be supported in such a manner that allows the Client to gain an increased level of self-sufficiency. Specialized habilitation services:

i) Are provided in a non-integrated setting where a majority of the Clients have a disability,

ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported community connections services are provided to support the abilities and skills necessary to enable the Client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a Client's service plan,

ii) Are conducted in a variety of settings in which the Client interacts with persons without disabilities other than those individuals who are providing services to the Client. These types of services may include socialization, adaptive skills and personnel to accompany and support the Client in community settings,

iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

iv) May be provided in a group setting or may be provided to a single Client in a learning environment to provide instruction when identified in the service plan.

v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational services are provided to prepare a Client for paid community employment. Services include teaching concepts including attendance, task completion, problem solving and safety and are associated with performing compensated work.

i) Prevocational services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.

ii) Goals for prevocational services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than 50 percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor regulations.

iv) Prevocational services are provided to support the Client to obtain paid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving prevocational services shall occur at least once every five years to determine whether or not the person has developed the skills necessary for paid community employment.

vi) Documentation shall be maintained in the file of each Client receiving this service that the service is not available under a program funded under Section 110 of the rehabilitation act of 1973 or the Individuals with Educational Disabilities Act (20 U.S.C. Section 1400 *et seq.*).

f. Day habilitation services are limited to seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

g. The number of units available for day habilitation services in combination with prevocational services and supported employment shall not exceed seven thousand one hundred and twelve (7,112) units.

54. Dental services are available to individuals age twenty-one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i) Dental insurance premiums and co-payments

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv) Non-intravenous sedation,

v) Basic and deep cleanings,

vi) Mouth guards,

vii) Topical fluoride treatment,

viii) Retention or recovery of space between teeth when indicated, and

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

v) Non-emergency extractions including simple, surgical, full and partial,

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth,

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of,

crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures

d. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at Section 8.076.1.8 r available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the Client

e. Implants shall not be a benefit for Clients who use tobacco daily due to substantiated increased rate of implant failures for chronic tobacco users.

f. Subsequent implants are not a covered service when prior implants fail.

g. Full mouth implants or crowns are not covered.

h. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodontic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

i. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

j. Preventative and basic services are limited to two thousand ($2,000) per service plan year. Major services are limited to ten thousand ($10,000) for the five (5) year renewal period of the waiver.

6~~5~~. Health maintenance activities are available only as a participant directed supported living service in accordance with Section 8.500.94.C. Health maintenance activities means routine and repetitive health related tasks furnished to an eligible Client in the community or in the Client's home, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out. Services may include:

a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection. Skin care may include wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional,

b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation,

c. Mouth care performed when:

   i) there is injury or disease of the face, mouth, head or neck,

   ii) in the presence of communicable disease,

   iii) the Client is unconscious, or

   iv) oral suctioning is required,

d. Dressing, including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary,

e. Feeding

   i) When suctioning is needed on a stand-by or other basis,

   ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study,

   iii) Syringe feeding, OR

   iv) Feeding using an apparatus,

f. Exercise prescribed by a licensed medical professional including passive range of motion,

g. Transferring a Client when he/she is unable to assist or the use of a lift such as a Hoyer is needed,

h. Bowel care provided to a Client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the Client is unable to assist,

i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters,

j. Medical management required by a medical professional to monitor blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections,

k. Respiratory care, including:

   i) Postural drainage,

   ii) Cupping,

   iii) Adjusting oxygen flow within established parameters,

   iv) Suctioning of mouth and nose,

   v) Nebulizers,

vi) Ventilator and tracheostomy care,

vii) Prescribed respiratory equipment.

8.500.94.B.6. HOME ACCESSIBILITY ADAPTATIONS

8.500.94.B.6.a DEFINITIONS

Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for specific Home and Community-Based Services waivers pursuant to Sections 25.5-10-209.5 and 25.5-6-106, C.R.S. and pursuant to a provider participation agreement with the state Department.

Case Manager means a person who provides case management services and meets all regulatory requirements for case managers.

The Division of Housing (DOH) is a division within the Colorado Department of Local Affairs that is responsible for approving Home Accessibility Adaptation PARs, oversight on the quality of Home Accessibility Adaptation projects, and inspecting Home Accessibility Adaptation projects, as described in these regulations.

1. DOH oversight is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, all oversight functions shall be performed by the Department unless specifically allowed by the Participant or their guardian to be performed by DOH.

Home Accessibility Adaptations means the most cost-effective physical modifications, adaptations, or improvements in a Participant's existing home setting which, based on the Participant's medical condition or disability: Participant

1. Are necessary to ensure the health and safety of the Participant;

2. Enable the Participant to function with greater independence in the home; or

3. Prevent institutionalization or support the deinstitutionalization of the Participant.

Home Accessibility Adaptation Provider means a provider agency that meets the standards for Home Accessibility Adaptation described in Section 8.500.94.B.6.e and is an enrolled Medicaid provider.

Person-Centered Planning means Home Accessibility Adaptations that are agreed upon through a process that is driven by the Participant and can include people chosen by the Participant, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations; and where the Participant is provided necessary information, support, and choice Participant to ensure that the Participant directs the process to the maximum extent possible.

**8.500.94.B.6.b INCLUSIONS**

8.500.94.B.6.b.i Home Accessibility Adaptations may include, but are not limited to the following:

a) Installing or building ramps;

b) Installing grab-bars or other Durable Medical Equipment (DME) if such installation cannot be performed by a DME supplier;

c) Widening or modification of doorways;

d) Modifying a bathroom facility for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

e) Modifying a kitchen for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

f) Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies;,

g) Installing stair lifts or vertical platform lifts;

h) Modifying an existing second exit or egress window to lead to an area of rescue for emergency purposes;

i) The modification of a second exit or egress window must be approved by the Department or DOH at any funding level as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the Participant.

i) Safety enhancing supports such as basic fences, strengthened windows, and door and window alerts.

8.500.94.B.6.b.ii Previously completed Home Accessibility Adaptations, regardless of original funding source, shall be eligible for maintenance or repair within the Participant's remaining funds while remaining subject to all other requirements of Section 8.500.94.B.6.

8.500.94.B.6.b.iii All adaptations, modifications, or improvements must be the most cost-effective means of meeting the Participant's identified need.

8.500.94.B.6.b.iv Adaptations, modifications, or improvements to rental properties should be portable and able to move with the Participant whenever possible.

8.500.94.B.6.b.v The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per Participant over the five-year life of the waiver.

a) Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the Participant, or enable the Participant to function with greater independence in the home, if:

i) The adaptation decreases the need for paid assistance in another waiver service on a long-term basis, and

ii) Either:

1. There is an immediate risk to the Participant's health or safety, or

2. There has been a significant change in the Participant's needs since a previous Home Accessibility Adaptation.

b) Requests to exceed the limit shall be prior authorized in accordance with all other Department requirements found in this rule at Section 8.500.94.B.6.

**8.500.94.B.6.c. EXCEPTIONS AND RESTRICTIONS**

8.500.94.B.6.c.i. Home Accessibility Adaptations must be a direct benefit to the Participant and not for the benefit or convenience of caregivers, family Participants, or other residents of the home.

8.500.94.B.6.c.ii. Duplicate adaptations, such as adaptations to multiple bathrooms within the same home, are prohibited.

8.500.94.B.6.c.iii. Adaptations, improvements, or modifications as a part of new construction costs are prohibited.

a) Finishing unfinished areas in a home to add to or complete habitable square footage is prohibited.

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

i) improve entrance or egress to a residence; or,

ii) configure a bathroom to accommodate a wheelchair.

c) Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department requirements found in this rule at Section 8.500.94.B.6.

8.500.94.B.6.c.iv. The purchase of items available through the Durable Medical Equipment (DME) benefit is prohibited.

8.500.94.B.6.c.v. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Participant's individual ability and needs are prohibited.

8.500.94.B.6.c.vi. Upgrades beyond what is the most cost-effective means of meeting the Participant's identified need, including, but not limited to items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

8.500.94.B.6.c.vii. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:

a) Roof repair,

b) Central air conditioning,

c) Air duct cleaning,

d) Whole house humidifiers,

e) Whole house air purifiers,

f) Installation or repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,

g) Monthly or ongoing home security monitoring fees,

h) Home furnishings of any type,

i) HOA fees.

8.500.94.B.6.c.viii. Home Accessibility Adaptation projects are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.

8.500.94.B.6.c.ix. If a Participant lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding, the Participant's Home Accessibility Adaptation funds may not be used unless reasonable accommodations have been denied.

8.500.94.B.6.c.x. The Department may deny requests for Home Accessibility Adaptation projects that exceed usual and customary charges or do not meet local building requirements, the Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The Home Modification Benefit Construction Specifications (2018) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2018 Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to Section 24-4-103(12.5), C.R.S., 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 Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

**8.500.94.B.6.d CASE MANAGEMENT AGENCY RESPONSIBILITIES**

8.500.94.B.6.d.i. The Case Manager shall consider alternative funding sources to complete the Home Accessibility Adaptation. The alternatives considered and the reason they are not available shall be documented in the case record.

1) The Case Manager must confirm that the Participant is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding. Case Managers may request confirmation of a property owner's obligations through DOH.

8.500.94.B.6.d.ii. The Case Manager may prior authorize Home Accessibility Adaptation projects estimated at less than $2,500 without DOH or Department approval, contingent on Participant approval and confirmation of Home Accessibility Adaptation fund availability.

8.500.94.B.6.d.iii. The Case Manager shall obtain prior approval by submitting a Prior Authorization Request form (PAR) to DOH for Home Accessibility Adaptation projects estimated above $2,500.

1) The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6. Home Accessibility Adaptations submitted with improper documentation will not be approved.

2) The Case Manager and CMA are responsible for retaining and tracking all documentation related to a Participant's Home Accessibility Adaptation funding use and communicating that information to the Participant and Home Accessibility Adaptation providers. The Case Manager may request confirmation of a Participant's Home Accessibility Adaptation fund use from the Department or DOH.

3) The Case Manager shall discuss any potential plans to move to a different residence with the Participant or their guardian and advise them on the most prudent utilization of available funds.

8.500.94.B.6.d.iv. Home Accessibility Adaptations estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1) An occupational or physical therapist (OT/PT) shall assess the Participant's needs and the therapeutic value of the requested Home Accessibility Adaptation. When an OT/PT with experience in Home Accessibility Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Accessibility Adaptation would contribute to a Participant's ability to remain in or return to his/her home, and how the Home Accessibility Adaptation would increase the Participant's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

a) The evaluation must be performed in the home to be modified. If the Participant is unable to access the home to be modified without the modification, the OT/PT must evaluate the Participant and home separately and

document why the Participant was not able to be evaluated in the home.

2) The evaluation may be provided by a home health agency or other qualified and approved OT/PT through the Medicaid Home Health benefit.

a) A Case Manager may initiate the OT/PT evaluation process before the Participant has been approved for waiver services, as long as the Participant is Medicaid eligible.

b) A Case Manager may initiate the OT/PT evaluation process before the Participant physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

c) OT/PT evaluations performed by non-enrolled Medicaid providers may be accepted when an enrolled Medicaid provider is not available. A Case Manager must document the reason why an enrolled Medicaid provider is not available.

3) The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Participant's needs. The Case Manager shall document these alternatives and why they did not meet the Participant's needs in the Participant's case file.

8.500.94.B.6.d.v. The Case Manager shall assist the Participant in soliciting bids according to the following procedures:

1) The Case Manager shall assist the Participant in soliciting bids from at least two Home Accessibility Adaptation Providers for Home Accessibility Adaptations estimated to cost $2,500 or more. Participant choice of provider shall be documented throughout.

2) The Case Manager must verify that the provider is an enrolled Home Accessibility Adaptation Provider for Home Accessibility Adaptations.

4) The bids for Home Accessibility Adaptations at all funding levels shall include a breakdown of the costs of the project and the following:

a) Description of the work to be completed,

b) Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour,

c) Estimate for building permits, if needed,

d) Estimated timeline for completing the project,

e) Name, address and telephone number of the Home Accessibility Adaptation Provider,

f) Signature, physical or digital, of the Home Accessibility Adaptation Provider,

g) Signature, physical or digital, or other indication of approval, such as email approval, of the Participant or their guardian, that indicates all aspects of the bid have been reviewed with them,

h) Signature, physical or digital of the home owner or property manager if the home is not owned by the Participant or their guardian.

5) Home Accessibility Adaptation Providers have a maximum of thirty (30) days to submit a bid for the Home Accessibility Adaptation project after the Case Manager has solicited the bid.

a) If the Case Manager has made three attempts to obtain a bid from a second Home Accessibility Adaptation Provider and the provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

6) The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements found in this rule section 8.500.94.B.6. and the recommendations of the OT/PT evaluation.

a) If a Participant or homeowner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

7) A revised PAR and Change Order request shall be submitted for any changes from the original approved PAR according to the procedures found in this rule section 8.500.94.B.6.

8.500.94.B.6.d.vi. If a property to be modified is not owned by the Participant, the Case Manager shall obtain physical or digital signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein.

1) Written consent of the homeowner or property manager is required for all projects that involve permanent installation within the Participant’s residence or installation or modification of any equipment in a common or exterior area.

2) The authorization shall include confirmation that the home owner or property manager agrees that if the Participant vacates the

property, the Participant may choose to either leave the modification in place or remove the modification, that the home owner or property manager may not hold any party responsible for removing all or part of a Home Accessibility Adaptation project, and that if the Participant chooses to remove the modification, the property must be left in equivalent or better than its pre-modified condition.

8.500.94.B.6.d.vii. If the CMA does not comply with the process described above resulting in increased cost for a Home Accessibility Adaptation, the Department may hold the CMA financially liable for the increased cost.

8. 500.94.B.6.d.vii. The Department or DOH may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Accessibility Adaptation PAR. Visit may be completed using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk (e.g. natural disaster, pandemic, etc.).

**8.500.94.B.6.e PROVIDER RESPONSIBILITIES**

8.500.94.B.6.e.i. Home Accessibility Adaptation Providers shall conform to all general certification standards and procedures set forth in Section 8.500.98.

8.500.94.B.6.e.ii. Home Accessibility Adaptation Providers shall be licensed in the city or county in which the Home Accessibility Adaptation services will be performed, if required by that city or county.

8.500.94.B.6.e.iii. Home Accessibility Adaptation Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 60 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

1) If any changes to the approved scope of work are made without DOH or Department authorization, the cost of those changes will not be reimbursed.

2) Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 30 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi

8.500.94.B.6.e.iv. The Home Accessibility Adaptation Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at provider's expense.

1) The provider shall give the Participant or their guardian all manufacturer's or seller's warranties on completion of work.

8.500.94.B.6.e.v. The Home Accessibility Adaptation Provider shall comply with the Home Modification Benefit Construction Specifications (2018) developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8.500.94.B.6.e.vi. A sample of Home Accessibility Adaptation projects set by the Department shall be inspected upon completion by DOH, a state, local or county building inspector in accordance with state, local, or county procedures, or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Accessibility Adaptation projects may be inspected by DOH upon request by the Participant at any time determined to be reasonable by DOH. Participants must provide access for inspections.

1) DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion for sampled projects, or receipt of a Participant's reasonable request.

2) DOH shall produce a written inspection report within the time frame agreed upon in the Home Accessibility Adaptations work plan that notes the Participant's specific complaints. The inspection report shall be sent to the Participant, Case Manager, and provider.

3) Home Accessibility Adaptation Providers must repair or correct any noted deficiencies within twenty (20) days or the time required in the inspection report, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 20 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

8.500.94.B.6.e.vii. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Accessibility Adaptation Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be a basis for non-payment or recovery of payment by the Department.

1) Volunteer work on a Home Accessibility Adaptation project approved by the Department shall be completed under the supervision of the Home Accessibility Adaptation Provider as stated on the bid.

a) Volunteer work must be performed according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

b) Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family

of the Participant, or work performed by a private contractor hired by the Participant or family, must be described and agreed upon, in writing, by the provider responsible for completing the Home Accessibility Adaptation, according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

**8.500.94.B.6.f REIMBURSEMENT**

8.500.94.B.6.f.i Payment for Home Accessibility Adaptation services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two equal payments.

8.500.94.B.6.f.ii. The Home Accessibility Adaptation Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8.500.94.B.6.f.iii. The Home Accessibility Adaptation Provider may submit a claim for final payment when the Home Accessibility Adaptation project has been completed satisfactorily as shown by the submission of the following documentation to DOH:

1) Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;

2) Required permits;

3) One-year written warranty on materials and labor; and

4) Documentation in the Participant's file that the Home Accessibility Adaptation has been completed satisfactorily through:

a) Receipt of the inspection report approving work from the state, county, or local building, plumbing, or electrical inspector;

b) Approval by the Participant, representative, or other designee;

c) Approval by the homeowner or property manager;;

d) A final on-site inspection report by DOH or its designated inspector; or

e) DOH acceptance of photographs taken both before and after the Home Accessibility Adaptation.

8.500.94.B.6.f.iv. If DOH notifies a Home Accessibility Adaptation Provider that an additional inspection is required, the provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8.500.94.B.6.f.v. The Home Accessibility Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Accessibility Adaptation Provider Bid form or Home Accessibility Adaptation Provider Change Order form.

1) All required repairs noted on inspections shall be completed before the Home Accessibility Adaptation Provider submits a final claim for reimbursement.

2) If a Home Accessibility Adaptation Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the provider during an inspection. The provider shall only be reimbursed for the value of the work completed satisfactorily.

a) A Home Accessibility Adaptation Provider may request DOH perform one (1) reconsideration of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the provider's expense.

8.500.94.B.6.f.vi. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies in the inspection report.

1) Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 7 day deadline and be supported by documentation, including Participant notification.

2) The Home Accessibility Adaptation reimbursement reduced pursuant to this subsection shall be considered part of the Participant's remaining funds.

8.500.94.B.6.f.vii. The Home Accessibility Adaptation Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Participant. The Home Accessibility Adaptation Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the Participant's DME benefit.

8~~7~~. Home Delivered Meals as defined at Section 8.553.1.

9~~8~~. Homemaker services are provided in the Client's home and are allowed when the Client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of homemaker services:

a. Basic homemaker services include cleaning, completing laundry, completing basic household care or maintenance within the Client's primary residence only in the areas where the Client frequents.

i) Assistance may take the form of hands-on assistance including actually performing a task for the Client or cueing to prompt the Client to perform a task.

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

b. Enhanced homemaker services include basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning

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

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

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

2) To increase the independence of the Client,

iii) Incidental basic homemaker service may be provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the Client.

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

10~~9~~. Life Skills Training (LST) as defined at Section 8.553.1.

11~~0~~. Mentorship services are provided to Clients to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising and include:

a. Assistance in interviewing potential providers,

b. Assistance in understanding complicated health and safety issues,

c. Assistance with participation on private and public boards, advisory groups and commissions, and

d. Training in child and infant care for Clients who are parenting children.

e. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services.

f. Mentorship services are limited to one hundred and ninety-two (192) units (forty-eight (48) hours) per service-plan year. One (1) unit is equal to fifteen (15) minutes of service.

g. Units to provide training to Clients for child and infant care shall be prior authorized beyond the one hundred and ninety-two (192) units per service plan year in accordance with Operating Agency procedures.

121. Non-medical transportation services enable Clients to gain access to day habilitation, prevocational and supported employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band

a. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the service plan.

b. Non-medical transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-medical transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip charge assessed each way to and from day habilitation and supported employment services.

c. Transportation provided to destinations other than to day program or supported employment is limited to four (4) trips per week reimbursed at mileage band one

d. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. 440.170. Non-emergency medical transportation is a benefit under the Medicaid State Plan, defined at 42 C.F.R. Section 440.170(a)(4).

132. Peer Mentorship as defined at Section 8.553.

143. Personal Care is assistance to enable a Client to accomplish tasks that the Client would complete without assistance if the Client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the Client or cueing to prompt the Client to perform a task. Personal care services include:

a. Personal care services include:

i) Assistance with basic self-care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.

ii) Assistance with money management,

iii) Assistance with menu planning and grocery shopping, and

iv) Assistance with health related services including first aide, medication administration, assistance scheduling or reminders to attend routine or as needed medical, dental and therapy appointments, support that may include accompanying Clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.

b. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service.

c. If the annual functional needs assessment identifies a possible need for skilled care: then the Client shall obtain a home health assessment.

i. The Client shall obtain a home health assessment, or

ii. The Client shall be informed of the option to direct his/her health maintenance activities pursuant to Section 8.510, et seq.

154. Personal Emergency Response System (PERS) is an electronic device that enables Clients to secure help in an emergency. The Client may also wear a portable "help" button to allow for mobility. PERS services are covered when the PERS system is connected to the Client's phone and programmed to a signal a response center when a "help" button is activated, and the response center is staffed by trained professionals.

a. The Client and the Client's case manager shall develop a protocol for identifying who should to be contacted if the system is activated.

165. Professional services are provided by licensed, certified, registered or accredited professionals and the intervention is related to an identified medical or behavioral need. Professional services include:

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

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

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

d. Professional services may be reimbursed only when:

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

ii) The intervention is related to an identified medical or behavioral need, and

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

e. A pass to community recreation centers shall only be used to access professional services and when purchased in the most cost effective manner including day passes or monthly passes.

f. The following services are excluded under the HCBS Waiver from reimbursement;

i) Acupuncture,

ii) Chiropractic care,

iii) Fitness trainer

iv) Equine therapy,

v) Art therapy,

vi) Warm water therapy,

vii) Experimental treatments or therapies, and.

viii) Yoga.

176. Respite service is provided to Clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the Client.

a. Respite may be provided:

i) In the Client's home and private place of residence,

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

iii) In the community.

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

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

ii) Individual Day: the Client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period.

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

iv) Group: the Client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.

c. The following limitations to respite services shall apply:

i) Federal financial participation shall not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved pursuant to. by the state that is not a private residence.

ii) Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver.

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

187. Remote Supports means services as defined at Section 8.488

198. Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the Client's disability and that enable the Client to increase the Client's ability to perform activities of daily living or to safely remain in the home and community. Specialized medical equipment and supplies include:

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

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

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

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

i) Items that are not of direct medical or remedial benefit to the Client are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement. These include but are not limited to; vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

20 ~~19~~. Supported Employment services includes intensive, ongoing supports that enable a Client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the Client's disabilities needs supports to perform in a regular work setting.

a. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development and assisting the Client to locate a job or job development on behalf of the Client.

b. Supported employment may be delivered in a variety of settings in which Clients interact with individuals without disabilities, other than those individuals who are providing services to the Client, to the same extent that individuals without disabilities employed in comparable positions would interact.

c. Supported employment is work outside of a facility-based site, that is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities,

d. Supported employment is provided in community jobs, enclaves or mobile crews.

e. Group employment including mobile crews or enclaves shall not exceed eight Clients.

f. Supported employment includes activities needed to sustain paid work by Clients including supervision and training.

g. When supported employment services are provided at a work site where individuals without disabilities are employed, service is available only for the

adaptations, supervision and training required by a Client as a result of the Client's disabilities.

h. Documentation of the Client's application for services through the Colorado Department of Labor and Employment Division for Vocational Rehabilitation shall be maintained in the file of each Client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. Section 1400, et seq.).

i. Supported employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

j. Supported employment shall not take the place of nor shall it duplicate services received through the Division for Vocational Rehabilitation.

k. The limitation for supported employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of supported employment and shall not be reimbursed:

i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,

ii) Payments that are distributed to users of supported employment, and

iii) Payments for training that are not directly related to a Client's supported employment.

m. If a member is employed, the supervision the member needs while at work shall be clearly documented in their Person-Centered Support Plan (PCSP). A member's supervision level at work must be based on the member's specific work-related support needs.

i) The level of supervision by paid caregivers may be lower at work than in other community settings, and the member should not be over-supported or limited in their availability to work based on supervision needs identified for other settings.

21~~0~~. Transition Setup as defined at Section 8.553.1.

22~~1~~. Vehicle modifications are adaptations or alterations to an automobile or van that is the Client's primary means of transportation; to accommodate the special needs of the Client; are necessary to enable the Client to integrate more fully into the community; and to ensure the health and safety of the Client.

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

b. Items and services specifically excluded from reimbursement under the HCBS Waiver include:

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

ii) Purchase or lease of a vehicle, and

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

c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Operating Agency may approve a higher amount. Such requests shall ensure the health and safety of the Client, enable the Client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no duplication.

232. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a Client who is at least 21 years of age

a. Lasik and other similar types of procedures are only allowable when:

b. The procedure is necessary due to the Client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and

c. Prior authorized in accordance with Operating Agency procedures.

24. Workplace Assistance services provide work-related supports for members with elevated supervision needs who, because of valid safety concerns, may need assistance from a paid caregiver that is above and beyond what could be regularly supported by the workplace supervisor, co-workers, or job coach, in order to maintain an individual job in an integrated work setting for which the member is compensated at or above minimum wage. Training/Job Coaching, accommodations, technology, and natural supports are to be used to maximize the member's independence and minimize the need for the consistent presence of a paid caregiver. As such, the degree to which the member must be supported by a paid caregiver through the Workplace Assistance service, shall be based on the specific safety-related need(s) identified in the person-centered planning process for the member at their worksite.

a. Workplace Assistance:

i. is provided on an individual basis, not within a group, and cannot overlap with job coaching;

ii. occurs at the member's place of employment, during the member's work hours, and when needed may also be used:

1) immediately before or after the member's employment hours,

2) during work-related events at other locations;

iii. includes but is not limited to: promoting integration, furthering natural support relationships, reinforcing/modeling safety skills, assisting with behavioral support needs, redirecting, reminding to follow work-related protocols/ strategies, and ensuring other identified needs are met so the member can be integrated and successful at work;

iv. may include activities beyond job-related tasks that support integration at work, such as assisting, if necessary, during breaks, lunches, occasional informal employee gatherings, and employer-sponsored events.

b. Workplace Assistance is appropriate for and available to:

i. Members who require Intensive Supervision or have a documented need which warrants a Rights Modification requiring extensive supervision, such as, a court order or the member meeting Public Safety Risk or Extreme Risk-to-Self criteria pursuant to Section 8.612.5(i) definitions.

ii. Members whose support team agrees there is justification for a paid caregiver to be present for a portion of the hours worked due to safety concerns; and those needs are beyond what could be addressed through natural supports, technology, or intermittent Job Coaching.

1) The specific safety concerns identified by members and their support teams may include, but are not limited to:

a) regularly demonstrating behaviors that cause direct harm to themselves or others;

b) intentionally or unintentionally putting themselves in unsafe situations frequently;

c) often demonstrating poor safety awareness or making poor decisions related to personal safety.

2) A member's supervision level is not the sole factor which justifies the need for this service, therefore, the supervision level shall not be elevated in order to access the service. The member's supervision level at the worksite shall be based on actual need related to the member at work.

c. Prior to Workplace Assistance being authorized, including at the Person-Centered Support Plan's annual renewal, the member and their support team shall determine that alternatives to paid caregiver supports were fully explored, by considering the factors listed below. Documentation of these considerations shall be reflected in the member's Case Management record.

i. Job Coaching services have been or will be leveraged to promote the member's independence and minimize the need for the presence of a paid caregiver by ensuring adequate job training, advocating for appropriate accommodations, promoting natural supports, integrating technology, and using systematic instruction techniques.

ii. The specific safety concern(s) to be addressed and how the Workplace Assistance staff could support the member in addressing the safety concerns while facilitating integration and independence at work.

iii. The nature of the job and work location, the member's longevity with the employer, the degree of continuity at the member's place of employment, and the likelihood of the member putting themselves/others in harm's way, despite training, technology, and cues from natural supports.

iv. The member's desire to have a paid caregiver present for the identified time periods.

v. The Supported Employment provider's informed opinion regarding the need for paid caregiver support beyond intermittent Job Coaching. This opinion should be grounded in Employment First concepts as evidenced by:

1) The provider's completion of a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification); or

2) If the Supported Employment provider does not possess this credentialing, then the Supported Employment provider or the Case Manager may consult with:

a) by someone who does possess either a Training Certificate or Certification

b) or a representative from the Department of Health Care Policy and Financing who oversees the Workplace Assistance benefit.

d. Workplace Assistance staff shall consistently seek to promote the member's independence and integration at work.

i. Where possible, efforts should be made to reduce or eliminate the need for Workplace Assistance services over time, and the efforts and progress shall be documented by the provider.

ii. The training for Workplace Assistance staff should:

1) include fundamentals of Employment First principles with emphasis on promoting independence and inclusion;

2) provide insight regarding a paid caregiver's role at a member's place of employment such that the Workplace Assistance staff's presence does not hinder the member's interaction with co-workers, customers, and other community members.

8.500.102.A The service plan authorization limit (SPAL) sets an upper payment limit of total funds available to purchase services to meet a Client's ongoing service needs within one (1) service plan year.

8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations, vehicle modifications, health maintenance activities available under the Consumer Directed Attendant Support Services (CDASS), home delivered meals, life skills training, peer mentorship, ~~and~~ transition setup, individual job coaching, individual job development, job placement, workplace assistance, and benefits planning.

## 8.615 TELEHEALTH DELIVERY OF HOME AND COMMUNITY-BASED SERVICES

### 8.615.2 INCLUSIONS

A. HCBS Telehealth may be used to deliver support through the following authorized HCBS waiver services:

1. Adult Day Services - Basic, Tier 1; defined at Section 8.491.1;

2. Adult Day Services - Brain Injury, Tier 1; defined at Sections 8.515.3 and 8.515.70;

3. Behavioral Management and Education; defined at Section 8.516.40;

4. Behavioral Services - Behavioral Consultation; defined in Sections 8.500.5.B.1. and, 8.500.94.B.2, ;

5. Behavioral Services - Behavioral Counseling, Group, defined in Sections 8.500.5.B.1, and 8.500.94.B.2, ;

6. Behavioral Services - Behavioral Counseling, Individual, defined in Sections 8.500.5.B.1, and 8.500.94.B.2,;

7. Behavioral Services - Behavioral Plan Assessment; defined in Sections 8.500.5.B.1 and , 8.500.94.B.2,;

8. Benefits Planning; defined in Sections 8.500.5.B.2 and 8.500.94.B.3

9. Bereavement Counseling; defined at Section 8.504.1;

10~~9~~. Community Connector; defined at Section 8.503.40.A.3;

1~~0~~. Day Habilitation; defined at Section 8.500.5.B.2;

12~~1~~. Expressive Therapy - Art and Play Therapy, Group; defined at Sections 8.504.1 and 8.504.2.D;

13~~2~~. Expressive Therapy - Art and Play Therapy, Individual; defined at Sections 8.504.1 and 8.504.2.D;

14~~3~~. Expressive Therapy - Music Therapy, Group; defined at Sections 8.504.1 and 8.504.2.D;

15~~4~~. Expressive Therapy - Music Therapy, Individual; defined at Sections 8.504.1 and 8.504.2.D;

16~~5~~. Independent Living Skills Training; defined at Section 8.516.10;

17~~6~~. Mental Health Counseling, Family; defined at Section 8.516.50;

18~~7~~. Mental Health Counseling, Group; defined at Section 8.516.50;

19~~8~~. Mental Health Counseling, Individual; defined at Section 8.516.50;

20~~19~~. Mentorship; defined at Section 8.500.94B.10;

21~~0~~. Movement Therapy; defined in Sections 8.500.94B.15 and 8.503.40.A.8;

22~~1~~. Palliative Supportive Care - Care Coordination; defined at Section 8.504.1;

23~~2~~. Substance Abuse Counseling, Family; defined at Section 8.516.60;

24~~3~~. Substance Abuse Counseling, Individual; defined at Section 8.516.60;

25~~4~~. Supported Employment - Job Coaching, Individual, defined in Sections 8.500.5.B.9 and 8.500.98.C;

26~~5~~. Supported Employment - Job Development, Levels 1-6, Individual, defined in Sections 8.500.5.B.9 and 8.500.98.C;

27~~6~~. Transition Services - Life Skills Training; defined at Section 8.553.1;

28~~7~~. Transition Services - Peer Mentorship; defined at Section 8.553.1;

29~~8~~. Therapeutic Life Limiting Illness Support, Family; defined at Sections 8.504.1 and 8.504.2.B;

30~~29~~. Therapeutic Life Limiting Illness Support, Group; defined at Sections 8.504.1 and 8.504.2.B;

31~~0~~. Therapeutic Life Limiting Illness Support, Individual; defined at Sections 8.504.1 and 8.504.2.B;

32~~1~~. Wrap Around Service - Intensive Support; defined at Section 8.508.100.H; and,

33~~2~~. Wrap Around Service - Transition Support; defined at Section 8.508.100.M~~;~~

B. HCBS Telehealth may only be used to deliver consultation for the following services:

1. Adaptive Therapeutic Recreational Fees and Equipment, defined at Section 8.503.40.A.1;

2. Assistive Technology; defined in Sections 8.500.94.B.1 and, 8.503.40.A.2;

3. Home Modification and Adaptation; defined in Sections 8.493.1, 8.500.94.B.6, and 8.503.40.A.5; and

4. Vehicle Modifications, defined in Sections 8.500.94.B.20 and 8.503.40.A.12.

5. Providers shall follow all billing policies and procedures as outlined in the Department's current waiver billing manuals and rates/fees schedules and may not bill separately for consultation.

**DO NOT PUBLISH PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2022-23 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 8.3000
Rule Number: MSB 22-11-22-A
Division / Contact / Phone: Special Financing / Riley De Valois / 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 22-11-22-A, Revision to the Medical Assistance Rule concerning FFY 2022-23 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) 3.8000, 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.B through the end of 8.3000.E.9. This rule is effective June 30, 2023.

*to be completed by MSB Board Coordinator

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning FFY 2022-23 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 8.3000
Rule Number: MSB 22-11-22-A
Division / Contact / Phone: Special Financing / Riley De Valois / 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) 2022-23 Hospital Affordability and Sustainability (HAS) provider fees and supplemental payments.
The Department submitted a state plan amendment (SPA) on 12/27/2022 to the Centers for Medicare and Medicaid Services (CMS) and expects approval in the next several months. We expect to present FFY 2022-23 HAS provider fees and supplemental payments to the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board on 02/28/2023. FFY 2022-23 provider fees and supplemental payments will be implemented only after the CHASE Board, the CMS, and the MSB approval. For FFY 2022-23, hospitals will pay $1.23 billion in fees, which will generate $3.86 billion in federal funds for Colorado. Hospitals will receive $1.69 billion in supplemental and quality incentive payments. Currently, more than 668,000 Coloradans are enrolled in Medicaid and CHP+ coverage financed with hospital provider fees. As the hospital provider fee funds the Department's administrative costs, there is no impact on state General Fund.
The amendment revises the Essential Access Hospital Supplemental Payment calculation methodology, the Disproportionate Share Hospital Supplemental Payment allotment and calculation methodology, as well as removes measure group language from the Hospital Quality Incentive Payment (HQIP) indicating it can be found elsewhere. Further, language regarding a scoring review and reconsideration period has been added for HQIP to give the Department authority about score revisions in the event a hospital does not agree with the preliminary scores.

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:

Not necessary

3. Federal authority for the Rule, if any:

| | | | |
|---|---|---|---|
| Initial Review | **04/14/23** | Final Adoption | **05/12/23** |
| Proposed Effective Date | **06/30/23** | Emergency Adoption | |

**DOCUMENT #09**

N/A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S.(2022);
   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 2022-23 Healthcare Affordability & Sustainability (HAS) Fees & Supplemental Payments Amendment, Section 8.3000
Rule Number: MSB 22-11-22-A
Division / Contact / Phone: Special Financing / Riley De Valois / 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 $3.3 billion in annual health care expenditures for more than 668,000 Coloradans and will provide more than $464 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 $3.3 billion in annual health care expenditures for more than 668,000 Coloradoans and more than $464 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.

**DO NOT PUBLISH THIS PAGE**

If no action is taken, there will not be enough HAS fee to fund Colorado Medicaid and CHP+ expansions, affecting over 668,000 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

8.3000.A 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 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.

### 8.3000.B~~1~~: DEFINITIONS

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

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

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

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

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

6. "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.

7. "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.

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

9. "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.

10. “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.

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

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

13. “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.

14. “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.

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

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

    a. ~~1.~~ Outpatient Hospital Supplemental Medicaid Payment described in Section 8.3000~~4~~.E.2~~B~~.,

    b. ~~2.~~ Inpatient Hospital Supplemental Medicaid Payment described in Section 8.3000~~4~~.E.3~~C~~., and

    c. ~~3.~~ Essential Access Hospital Supplemental Medicaid Payment described in Section 8.3000~~4~~.E.5~~E~~.

~~The HTP Supplemental Medicaid Payments 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.~~

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

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

19. “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.

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

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

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

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

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

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

26. “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.

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

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

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

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

31. “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.

32. “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.

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

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

35. “Rehabilitation Hospital” means an inpatient rehabilitation facility.

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

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

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

39. “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.

40. “Supplemental Medicaid Payments” means the:

    a. ~~1.~~ Outpatient Hospital Supplemental Medicaid Payment described in 8.30004.E.2~~B~~.,

    b. ~~2.~~ Inpatient Hospital Supplemental Medicaid Payment described in 8.30004.E.3~~C~~.,

    c. ~~3.~~ Essential Access Hospital Supplemental Medicaid Payment described in 8.30004.E.5~~E~~.,

    d. ~~4.~~ Hospital Quality Incentive Payment described in 8.30004.E.6~~F~~., and

    e. ~~5.~~ Rural Support Program Hospital Supplemental Medicaid Payment described in 8.30004.E.7~~G~~.

41. “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.

42. “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%

**8.3000.C~~2~~: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS**

8.3000.C.1~~2.A~~. DATA REPORTING

a. ~~1.~~ For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Enterprise shall distribute a data reporting template to all hospitals. The Enterprise shall include instructions for completing the data reporting template, including definitions and descriptions of each data element to be reported. Hospitals shall submit the requested data to the Enterprise within thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Enterprise may estimate any data element not provided directly by the hospital.

    i. ~~a.~~ For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the collection of fees, payments to hospitals shall be processed by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

    ii. ~~b.~~ For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the disbursement of payments, payments to hospitals shall be processed through a warrant (paper check) by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

b. ~~2.~~ Hospitals shall submit days and charges for Medicaid Managed Care, out-of-state Medicaid, and uninsured patients, Managed Care Days, and any additional elements requested by the Enterprise.

c. ~~3.~~ The Enterprise shall distribute a data confirmation report to all hospitals annually. The data confirmation report shall include a listing of relevant data elements used by the Enterprise in calculating the Outpatient Services Fee, the Inpatient Services Fee and the supplemental payments. The data confirmation report shall clearly state the manner and timeline in which hospitals may request revisions to the data elements recorded by the

Enterprise. Revisions to the data will not be permitted by a hospital after the dates outlined in the data confirmation report.

d. ~~4.~~ The hospital shall certify that based on best information, knowledge, and belief, the data included in the data reporting template is accurate, complete, and truthful, is based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

8.300~~2.B~~0.C.2. FEE ASSESSMENT AND COLLECTION

a. ~~1.~~ Establishment of Electronic Funds Process. The Enterprise shall utilize an Automated Clearing House (ACH) debit process to collect the Outpatient Services Fee and Inpatient Services Fee from hospitals and an Electronic Funds Transfer (EFT) payment process to deposit supplemental payments in financial accounts authorized by hospitals. The Enterprise shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.

b. ~~2.~~ The Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and collected in twelve monthly installments. Payments to hospitals will be calculated on an annual basis and disbursed in twelve monthly installments.

i. ~~a.~~ For those hospitals that participate in the electronic funds process utilized by the Enterprise, fees will be assessed and payments will be disbursed on the second Friday of the month, except when State offices are closed during the week of the second Friday, then fees will be assessed and payment will be disbursed on the following Friday of the month. If the Enterprise must diverge from this schedule due to unforeseen circumstances, the Enterprise shall notify hospitals in writing or by electronic notice as soon as possible.

1) ~~i.~~ The Enterprise may assess fees and disburse payments for Urban Center Safety Net Specialty Hospitals on an alternate schedule determined by the Department.

ii. ~~b.~~ At no time will the Enterprise assess fees or disburse payments prior to the state fiscal year for which they apply.

~~iii.~~c. ~~3.~~ Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds process utilized by the Enterprise for the collection of fees and the disbursement of payments unless the Enterprise has approved an alternative process. A hospital requesting to not participate in the electronic fee collection process and/or payment process must submit a request in writing or by electronic notice to the Enterprise describing an alternative fee collection process and/or payment process. The Enterprise shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

i. ~~a.~~ For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the collection of fees, payments to hospitals shall be processed by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

ii. ~~b.~~ For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the disbursement of payments, payments to hospitals shall be processed through a warrant (paper check) by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

**8.~~3003~~3000.D: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE**

8.300~~3.A~~0.D.1. OUTPATIENT SERVICES FEE

a. ~~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).

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

c. ~~3.~~ Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as ~~1.6365~~1.8705% of total hospital outpatient charges with the following exception.

i. ~~a.~~ High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to ~~1.6228~~1.8548% of total hospital outpatient charges.

8.300~~0.D.2~~3.B. INPATIENT SERVICES FEE

a. ~~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).

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

c. ~~3.~~ Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $~~105.53~~114.10 per day for Managed Care Days and $~~471.76~~510.05 per day for all Non-Managed Care Days with the following exceptions:

i. ~~a.~~ High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $~~55.10~~59.57 per day for Managed Care Days and $~~246.31~~266.30 per day for all Non-Managed Care Days, and.

ii. ~~b.~~ Essential Access Hospitals' Inpatient Services Fee is discounted to $~~42.21~~45.64 per day for Managed Care Days and $~~188.70~~204.02 per day for Non-Managed Care Days.

8.300~~3.C.~~0.D.3 ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

a. ~~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.

b. ~~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.

c. ~~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.

8.300~~3.D.~~0.D.4 REFUND OF EXCESS FEES

~~a. 1. If, at any time, fees have been collected for which the intended expenditure has not received approval for federal Medicaid matching funds by CMS at the time of collection, the Enterprise shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Enterprise shall notify each hospital of its refund amount in writing or by electronic notice. The refunds shall be paid to each hospital according to the process described in Section 8.3002.B.~~

a. ~~2.~~ ~~After~~ Within ninety days of the close of ~~each State~~ a federal fiscal year ~~and no later than the following August 31,~~ the Enterprise shall present to the Enterprise Board a summary of revenues received~~fees collected,~~ and expenditures made or encumbered~~, and interest earned in~~ through the Fund during the ~~State~~ federal fiscal year ~~to the Enterprise Board~~. The Enterprise shall also present to the Enterprise Board the federal fiscal year ending Fund balance and the Fund reserve limit.

a. The Fund reserve limit shall equal an Enterprise Board approved percent, multiplied the total CHASE funding obligation for the subsequent federal fiscal year.

b. ~~a.~~ If the federal fiscal year ending Fund balance is greater than the Fund reserve limit the difference shall be refunded back to hospitals based on the percent of total fees paid during the federal fiscal year. The Enterprise shall notify each hospital of its fee refund within thirty days and the fee refund will occur within sixty days of CHASE Board review and approval.

c. If the federal fiscal year ending Fund balance is less than the Fund reserve limit the difference shall be reduced from the funds available for supplemental payments in the subsequent federal fiscal year.

~~1) If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Enterprise has not expended or encumbered those fees at the close of each State fiscal year:i. The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less the minimum Fund reserve recommended by the Enterprise Board.~~

2) ii. The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the federal fiscal year.

3) iii. The Enterprise shall notify each hospital of its refund in writing or by electronic notice by September 15 each year. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.3002.B.

**8.3004 3000.E: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS**

8.3004.A 0.E.1. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

a. 1. All Supplemental Medicaid Payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Enterprise.

b. 2. No hospital shall receive a DSH Payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the Disproportionate Share Hospital Payment, described in 10 CCR 2505-10, Section 8.3004.D, exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, the hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction shall 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 Disproportionate Share Hospital Limit.

c. 3. In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital 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.B 0.E.2. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

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

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

c. 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, Privately-Owned Hospitals, for urban hospitals, and Rrural Hhospitals, 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 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~~0.E.3. INPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

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

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

c. ~~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, Privately-Owned Hospitals, ~~for~~ urban hospitals, and R~~r~~ural H~~h~~ospitals, ~~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.~~0.E.4 DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

a. ~~1.~~ Qualified hospitals.

i. ~~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.

ii. ~~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.

iii. ~~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

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

c. ~~3.~~ Calculation methodology for payment.

i. ~~a.~~ Total funds for the payment shall equal $~~226,610,302~~244,068,958.

ii. ~~b.~~ A qualified hospital with CICP write-off costs greater than ~~1,000.00~~700% of the state-wide average shall receive a payment equal to 96.00% of their Hospital-Specific DSH Limit. A qualified Critical Access Hospital shall receive a payment equal to 96.00% 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~~2,400 Medicaid Days shall receive a payment equal to ~~50.00~~96.00% of their Hospital-Specific DSH Limit.

iii. ~~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.

iv. ~~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.

v. ~~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%.

1) ~~i.~~ A new CICP hospital is a hospital approved as a CICP provider after October 1, ~~2021~~2022.

2) ~~ii.~~ A low MIUR hospital is a hospital with a MIUR less than or equal to ~~15.00~~22.50%.

8.3004~~.E~~0.E.5. ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

a. ~~1.~~ Qualified hospitals. Essential Access Hospitals are qualified receive this payment.

b. ~~2.~~ Calculation methodology for payment. For each qualified hospital, the annual payment shall equal ~~the percentage of beds to total beds for all qualified hospitals, multiplied by~~ the available Essential Access funds divided by the total number of qualified Essential Access ~~h~~Hospitals.

8.3004~~.F.~~0.E.6 HOSPITAL QUALITY INCENTIVE PAYMENT

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

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

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

i. ~~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 scale for measures a hospital is not eligible to complete. ~~There are fifteen measures separated into three measure groups.~~ The measures and measure groups are published annually in the Colorado Medicaid Provider Bulletin.

~~1) The measures and measure groups are:~~

~~2) Maternal Health and Perinatal Care Measure Group~~

~~3) 1. Exclusive Breast Feeding~~

~~4) 2. Cesarean Section~~

~~5) 3. Perinatal Depression and Anxiety~~

~~6) 4. Maternal Emergencies and Preparedness~~

~~7) 5. Reduction of Peripartum Racial and Ethnic Disparities~~

~~8) 6. Reproductive Life/Family Planning~~

~~9) Patient Safety Measure Group~~

~~10) 7. Zero Suicide~~

~~11) 8. Clostridium Difficile~~

~~12) 9. Sepsis~~

~~13) 10. Antibiotics Stewardship~~

~~14) 11. Adverse Event~~

~~15) 12. Culture of Safety Survey~~

~~16) 13. Handoffs and Sign-Outs~~

~~17) Patient Experience Measure Group~~

~~18) 14. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)~~

~~19) 15. Advance Care Plan~~

~~20)~~1) Adjusted Medicaid Discharges equal inpatient Medicaid discharges multiplied by a discharge adjustment factor.

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

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

ii. ~~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.

1) 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) |

2) 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.

d) A hospital shall have the opportunity to request a reconsideration of points awarded that are provided with the preliminary scoring letter.

i. To be considered for payment, a hospital shall submit a survey through the data collection tool on or before May 31 of each year.

ii. A preliminary scoring letter containing the scores and scoring rationale shall be provided to a hospital that submits a survey within ninety calendar days of May 31. The preliminary scoring letter will be delivered to each hospital that submitted a survey via the data collection tool.

iii. A hospital that believes a measure in the preliminary scoring letter was inaccurately scored may submit a reconsideration request within ten business days of delivery of the preliminary scoring letter. The request must be made by electronic notice.

1) The reconsideration request must be provided following the process established through the HQIP scoring review and reconsideration period user guide. Reconsideration requests may not be accepted if they are not provided through this process.

iv. A response to the reconsideration request shall be provided within ten business days upon receipt of the reconsideration request via electronic notice. The response shall provide whether a change to a measure score was made or if the reconsideration request was denied.

v. If a hospital is not satisfied with the reconsideration response, the hospital may request the reconsideration be escalated to the Special Financing Division Director within five business days of delivery of the reconsideration response. Any escalations must be provided to the Department via electronic notice.

1) The escalation request must be provided following the process established through the HQIP scoring review and reconsideration period user guide. Escalation requests may not be accepted if they are not provided through this process.

vi. A response to the escalation request shall be provided to the hospital within ten business days via electronic notice. The response shall provide whether a change to a measure score was made or if the escalation request was denied. The escalation response is final, and points awarded may not be reconsidered further.

~~i.~~vii. No other reconsiderations of points awarded, both preliminary and final, may be accepted by the Department outside of this process. The Department's decision is not an adverse action subject to administrative or judicial review under the Colorado Administrative Procedure Act (ACA).

8.300~~4.G.~~0.E.7 RURAL SUPPORT PROGRAM HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

a. ~~1.~~ Qualified hospitals. Hospitals that meet all the following criteria:

i. ~~a.~~ Is state licensed as a Critical Access Hospital or is a Rural Hospital, participating in Colorado Medicaid,

ii. ~~b.~~ Is a nonprofit hospital, and

iii. ~~c.~~ Meets one of the below:

1) ~~i.~~ Their average net patient revenue for the three-year 2016, 2017, and 2018 cost report period is in the bottom ten percent (10%) for all Critical Access Hospitals and Rural Hospitals, or

2) ~~ii.~~ Their funds balance for the 2019 cost report period is in the bottom two and one-half percent (2.5%) for all Critical Access Hospitals and Rural Hospitals not in the bottom 10% of the three-year average net patient revenue for all Critical Access Hospitals and Rural Hospitals,

b. ~~2.~~ Calculation methodology for payment. For a qualified hospital, the annual payment shall equal twelve million dollars ($12,000,000) divided by the number of qualified hospitals.

c. ~~3.~~ The payment shall be calculated once and reimbursed in monthly installments over the subsequent five federal fiscal years.

d. ~~4.~~ A qualified hospital must submit an attestation form every year to receive the available funds. If a qualified hospital does not submit the required attestation form their funds for the year shall be redistributed to other requalified hospitals.

8.300~~4.H~~0.E.8 REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENTS AND DISPROPORTIONATE SHARE HOSPITAL PAYMENT

a. ~~1.~~ The Enterprise shall calculate the Supplemental Medicaid Payments and DSH Payment under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Supplemental Medicaid Payments and DSH Payment 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 payment made each year, the methodology to calculate such payment, and the payment reimbursement 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 Supplemental Medicaid Payments or the DSH Payment to be reimbursed.

8.3004.I0.E.9 HOSPITAL TRANSFORMATION PROGRAM

a. Qualified hospitals shall participate in the Hospital Transformation Program (HTP). The HTP leverages supplemental payments as incentives designed to improve patient outcomes and lower Medicaid cost. Qualified hospitals are required to complete certain reporting activities. Qualified hospitals not completing a reporting activity shall have their supplemental Medicaid payments reduced. The reduced supplemental Medicaid payments shall be paid to qualified hospitals completing the reporting activity. The HTP is a multi-year program with a program year (PY) being on a federal fiscal year (October 1 through September 30) basis.

i. 1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients shall participate in the HTP except as provided below.

ii. 2. Excluded hospitals. Psychiatric Hospitals, Rehabilitation Hospitals, or Long-Term Care Hospitals shall not participate in the HTP.

iii. 3. Calculation methodology for payment.

1) a. Each program year includes reporting activities that a qualified hospital is required to complete. A qualified hospital not completing a reporting activity shall have their HTP Supplemental Medicaid Payments reduced by a designated percent.

2) b. The dollars not paid to those qualified hospitals shall be redistributed to qualified hospitals completing the reporting activity. A qualified hospital's distribution shall equal their percent of HTP Supplemental Medicaid Payments to the total HTP Supplemental Medicaid Payments for all qualified hospitals completing the reporting activity, multiplied by the total reduced dollars for qualified hospitals not completing the reporting activity.

3) c. The reduction and redistribution shall be calculated using the HTP Supplemental Medicaid Payments effective during the reporting activity period. The reduction and redistribution for reporting activities shall occur at the same time during the last quarter of the subsequent program year.

4) e. There are five HTP reporting activities. The reporting activities are listed below, along with the total percent at-risk associated with each reporting activity.

a) i. Application (1.5% at-risk total) – Qualified hospitals must provide interventions and measures focusing on improving processes of care and health outcomes and reducing avoidable utilization and cost. The percent at-risk shall be scored on timely and satisfactory submission.

b) ii. Implementation Plan (1.5% at-risk total) – Qualified hospitals must submit a plan to implement interventions with clear milestones that shall impact their measures. The percent at-risk shall be scored on timely and satisfactory submission.

c) iii. Quarterly Reporting (0.5% at-risk per report) – Qualified hospitals must report quarterly on the different activities that occurred in that quarter. For any given quarter, this includes interim activity reporting, milestone reporting, self-reported data associated

with the measures, and Community and Health Neighborhood Engagement (CHNE) reporting. The percent at-risk shall be scored on timely and satisfactory submission.

d) ~~iv.~~ Milestone Report (2.0% at-risk per report in PY 2, 4.0% at-risk per report in PY 3) – Qualified hospitals must report on achieved/missed milestones over the previous two quarters. The percent at-risk shall be scored on timely and satisfactory submission and for achievement of milestones. Qualified hospitals that miss a milestone can have the reduction for the milestone reduced by 50% if they submit a course correction plan with the subsequent Milestone Report. A course correction reduction for a missed milestone can only be done once per intervention.

e) ~~v.~~ Sustainability Plan (8.0% at-risk total) – Qualified hospitals must submit a plan demonstrating how the transformation efforts will be maintained after the HTP is over. The percent at-risk shall be scored on timely and satisfactory submission.

5) ~~f.~~ A qualified hospital not participating in the HTP may have the entirety of their HTP Supplemental Medicaid Payments withheld.

iv. A hospital shall have the opportunity to request a reconsideration of scores for reporting compliance, milestone completion (including milestone amendments and course corrections), and performance measure data accuracy.

1) The scoring review and reconsideration period begins when the Department notifies hospitals of initial scores. This period consists of multiple steps that will span 45 business days.

a) The Department completes initial review of reports within 20 business days of report due date.

b) The Department notifies hospital of scores available for viewing and the scoring review and reconsideration period begins within 21 business days of report due date.

c) The hospital request for reconsideration is due within 10 business days of release of initial scores.

d) The Department issues final scores and reconsideration decisions within 14 business day of the scoring review and reconsideration period close date.

2) All hospitals will receive electronic notification when initial scores are released to the Department's web portal.

3) To submit a request for reconsideration of an initial score, a hospital must utilize the scoring review and reconsideration form available on the Department's web portal. It must identify the specific scoring elements the hospital would like reconsidered and the rationale for the reconsideration request. The form must be emailed following the proper guidelines as mentioned on the form.

4) Late report submissions and report revisions are not accepted through the reconsideration process.

a) The hospital will receive an electronic notification of the outcome of the reconsideration request.

5) If a hospital is not satisfied with the reconsideration response, the hospital may request the reconsideration be escalated to the Project Manager or the Special Financing Division Director. Initial escalations to the Project Manager must be made within five business days of delivery of the reconsideration response. Final escalations to the Special Financing Division Director must be made within 15 business days of delivery of the reconsideration response. Any escalations must be provided to the Department via electronic notice.

a) The escalation request must be provided following the process established through the HTP scoring review and reconsideration period user guide. Escalation requests may not be accepted if they are not provided through this process.

6) A response to the initial escalation request shall be provided to the hospital within ten business days via electronic notice. A response to the final escalation request shall be provided to the hospital within 20 business days via electronic notice. Any response shall provide whether a change to a measure score was made or if the escalation request was denied. The escalation response is final, and points awarded may not be reconsidered further.

~~2)~~7) No other reconsiderations of scores, both preliminary and final, may be accepted by the Department outside of this process. The Department's decision is not an adverse action subject to administrative or judicial review under the Colorado Administrative Procedure Act (ACA).

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revisions to the Medical Assistance Rule concerning the Creation of the Nursing Home Wage Enhancement Supplement Payment, Section 8.443.21
Rule Number: MSB 23-01-24-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

# 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 23-01-24-A, Revisions to the Medical Assistance Rule concerning 8.443.21, Creation of the Nursing Home Wage Enhancement Supplement Payment

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) 8.443.21, 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 8.443.21 with the proposed text beginning at 8.443.21.A.6.
This rule is effective June 30, 2023.

*to be completed by MSB Board Coordinator

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revisions to the Medical Assistance Rule concerning the Creation of the Nursing Home Wage Enhancement Supplement Payment, Section 8.443.21
Rule Number: MSB 23-01-24-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

## 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 (H.B.) 22-1333 establishes a new annual supplemental payment to nursing homes for the increase in hourly wages to at least fifteen dollars per hour ($15/hour) for all employees. The rule establishes the wage enhancement supplemental payment detailing the calculation methodology and how nursing homes are eligible the payment.

   The wage enhancement supplemental payment replaces the minimum wage supplemental payment previously included in this section of rule. The proposed rule will increase Nursing homes eligible for the payment from Medicaid enrolled Denver Metro nursing homes to all Medicaid enrolled nursing homes in Colorado. The proposed rule will also increase Medicaid supplemental payments for employee compensation from $500 thousand to $8.5 million per state fiscal year.

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 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. (2022);

   25.5-4-402.4(4)(b), (g), C.R.S.

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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.

   Nursing homes will benefit from the proposed rule. Specifically, the number of nursing homes eligible for the payment will increase from 60 with the current local minimum wage supplemental payment to 180+ with the proposed wage enhancement supplemental payment. Nursing home employees currently reimbursed less than $15/hour will also benefit as their hourly wages will be increased. The state and federal governments will bear the costs of the proposed rule by funding the supplemental payment to nursing homes.

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 wage enhancement supplemental payment will equal $8.7 million per state fiscal year. The supplemental payment will be used to increase employee wages to at least $15/hour.

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 state funding obligation is approximately $4.35 million per state fiscal year. The supplemental payment will occur annually until the Colorado statewide minimum wage equals at least $15/hour. Additional costs include increased administration burden on Department staff for the calculation and administration of the supplemental payment.

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

   The benefit of the proposed rule includes additional reimbursement to nursing homes and increased wages to nursing home employees. The cost of the proposed rule is the additional administrative burden on Department staff to calculate and

administer the supplemental payment. The cost of the proposed rule also includes an increased state funding obligation.

The cost of inaction includes not being compliant with state statute.

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

   There are no other methods that are less costly or intrusive that still 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 alternative methods were seriously considered by the Department to achieve the desired goal of the proposed rule.

**8.443.21 ~~MINIMUM~~ WAGE ENHANCEMENT SUPPLEMENTAL PAYMENT**

8.443.21.A The Department shall pay a supplemental payment to eligible class I nursing facility providers ~~for the increase in hourly wages~~that pay their employees an hourly wage as described in ~~due to a local government increasing their minimum hourly wage above the statewide minimum hourly wage pursuant to~~ section 25.5-6-208(1)(a), C.R.S.

Annually, the Department shall calculate the supplemental payment for an eligible class 1 nursing facility provider by multiplying ~~their~~its percent of total Medicaid hours for all eligible class 1 nursing facility providers by the annual appropriations.

1. Medicaid hours are calculated as Medicaid patient days multiplied by total hours-per-day.

   a. Medicaid patient days are determined using Medicaid fee-for-service (FFS) patient days and Medicaid Hospice Room & Board (R&B) patient days from the most recent calendar year.

      i. The Department shall annualize or estimate Medicaid FFS patient days and Medicaid Hospice R&B patient days for eligible class 1 nursing facility providers with less than a full calendar year of patient days.

   b. Total hours-per-day are calculated as total hours divided by total days.

      i. Total hours are from the most recently filed unaudited MED-13 cost report.

      ii. Total days are from the most recently filed unaudited MED-13 cost report.

      iii. Total hours-per-day for eligible class 1 nursing facility providers without a MED-13 cost report shall equal the average hours-per-day for comparable eligible class 1 nursing facility providers by Medicaid patient days (FFS and Hospice R&B) and rural/urban designation.

2. Payments made to rural eligible class 1 nursing facility providers shall be increased by an additional twenty percent (20%). Payments made to all other eligible class 1 nursing facility providers shall be reduced by a corresponding amount. A rural eligible class 1 nursing facility provider is located outside of a metropolitan statistical area as defined by the U.S. Office of Management and Budget.

3. For state fiscal year 2022-23, a class 1 nursing facility provider is eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour as of April 30, 2023. For state fiscal year 2023-24, a class 1 nursing facility provider is eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour for the period May 1, 2023 through December 31, 2023. For all subsequent state fiscal years, a class 1 nursing facility provider is eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour for the previous calendar year.

   a. A newly enrolled class 1 nursing facility provider shall be eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour for the portion of the payment period they are Medicaid enrolled.

4. An eligible class 1 nursing facility provider shall certify that all employees are paid a base hourly wage of at least fifteen dollars per hour. The certification shall be due by the last

business day of April each year. The certification shall be made by the Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

5. At least ten percent (10%) of all eligible class 1 nursing facility providers may be reviewed for compliance, at the Department's discretion. If selected by the Department, an eligible class 1 nursing facility provider shall provide payroll journal data for all employees for the payment period within ten business days of request.

a. If payroll journal data is not provided within ten business of request or the provided payroll journal data is incomplete, a class 1 nursing facility provider the Department may determine that the provider is not ~~be~~ eligible for the payment.

~~1. At least once a year, the Department shall calculate the supplemental payment for an eligible class 1 nursing facility provider by multiplying each eligible employee's minimum hourly wage gap by the eligible employee's paid hours. The sum of this calculation for all eligible employees is multiplied by the eligible class 1 nursing facility provider's Medicaid utilization percentage.~~

~~a. An eligible class 1 nursing facility provider resides within a local government that increases its minimum hourly wage above the statewide minimum hourly wage or resides within fifteen (15) driving miles of a class 1 nursing facility provider required to increase its minimum hourly wage above the statewide minimum hourly wage.~~

~~i. A local government means any city, home rule city, town, territorial charter city, city and county, county, or home rule county.~~

~~b. An eligible employee is an employee whose hourly wage increases to or above the local government minimum hourly wage when the local government minimum wage is enacted.~~

~~2. The minimum hourly wage gap is calculated as the difference between the enacted local government minimum hourly wage and the hourly wage for an eligible employee immediately before the local government minimum hourly wage is enacted.~~

~~a. Hourly wages for an eligible employee include the base hourly wage and the overtime hourly wage.~~

~~b. The overtime local government minimum hourly wage is limited to one and one-half times (1.5x) the local government minimum hourly wage.~~

~~c. Hourly wages exclude any shift differential adjustments.~~

~~3. The paid hours include base, overtime, paid time off, and shift differential hours.~~

~~4. The Medicaid utilization percentage is a class 1 nursing facility provider's Medicaid patient days divided by total patient days.~~

~~a. Medicaid patient days are determined using Medicaid paid claims for the most recent calendar year with at least four months of claims runout. The Department shall annualize or estimate Medicaid patient days for class 1 nursing facility providers with less than a full year of paid claims.~~

b. Total patient days are reported by a class 1 nursing facility provider to the Department for the most recent calendar year with at least four months of claim runout. The Department shall annualize or estimate total patient days for class 1 nursing facility providers reporting less than a full year.

5. A class I nursing facility provider that resides within a local government that increases its minimum hourly wage above the statewide minimum hourly wage shall provide the Department with data necessary to calculate the supplemental payment. Class 1 nursing facility providers not providing the Department with data necessary to calculate the supplemental payment may not receive the supplemental payment.

6. A class I nursing facility provider that resides within fifteen (15) driving miles of a class I nursing facility provider required to increase its minimum hourly wage above the statewide minimum hourly wage, and that applies to the Department for the supplemental payment, shall provide documentation sufficient to prove that hourly wages have been increased in line with the adjacent local government minimum hourly wage. Class 1 nursing facility providers not providing the Department with data necessary to calculate the supplemental payment may not receive the supplemental payment.

7. The supplemental payment shall be limited by available appropriations. If the total supplemental payment for all eligible class 1 nursing facility providers is greater than available appropriations, the Department shall reduce all supplemental payments by a designated percent so that the total supplemental payment for all eligible class 1 nursing facility providers is less than or equal to available appropriations.

8. The submission of data for the calculation of the supplemental payment shall be considered the application for the supplemental payment. The submission of such data must include a statement by the licensed owner or corporate officer certifying that the data is true and accurate. Instructions for the data submission process will be communicated annually to all eligible class I nursing facility providers.

9. The Minimum Wage Supplemental Psupplemental payment shall only be made if there is available federal financial participation is available under the Upper Payment Limit after all other Medicaid fee-for-service payments and Medicaid supplemental payments are considered.

## 8.443.22 SKILLED NURSING FACILITY ENHANCED PAYMENTS

8.443.22.A The Department will make one-time payments to eligible Class 1 nursing facility providers, pursuant to C.R.S. § 25.5-6-210. The one-time payments will take effect only upon the passage and effective date of House Bill (H.B.) 22-1247. The payments are separated into a Medicaid enhanced payment, a workforce enhanced payment, and a hospital discharge payment.

1. The Medicaid enhanced payment will pay nursing facility providers for serving a disproportionate share of Medicaid and high-need populations.

   a. The payment will equal $7,000,000, divided by the number of eligible nursing facility providers. Eligible nursing facility providers will meet all the following criteria:

      i. Medicaid resident count is equal to or greater than 90% of total resident count. Medicaid resident count and total resident count determined using the most recently finalized quarterly case mix index (CMI) report.

ii. Preadmission Screening & Resident Review (PASRR) II Medicaid resident count is greater than the statewide average PASRR II Medicaid resident count, plus one standard deviation. PASRR II Medicaid resident count determined using the most recently completed comprehensive minimum data set (MDS) resident assessment for calendar year 2021.

2. The workforce enhanced payment will pay nursing facility providers to support hiring new employees and increase workforce retention.

   a. The payment will equal $17,588,000, multiplied by the percentage of Medicaid patient days to total statewide Medicaid patient days.

   b. Medicaid patient days are determined using MMIS pulled data for calendar year 2021.

   c. The payment will be reported as revenue and offset against expenses on the cost report, for the cost reporting period in which the payment is received.

3. The hospital discharge payment will pay nursing facility providers to incentivize admitting Medicaid members from hospitals.

   a. The payment will equal a per-Medicaid discharge rate, multiplied by hospital Medicaid residents discharged to a nursing home provider.

      i. The per-Medicaid discharge rate will equal an amount such that the total hospital discharge payment made to all nursing facility providers will equal $2,413,000. The per-Medicaid discharge rate for complex discharges will be increased by a multiplier.

      ii. Medicaid discharges are equal to Medicaid residents discharged from a hospital to a nursing facility provider during the period May 1, 2022 through June 30, 2022 and remaining within the nursing facility provider for at least sixty (60) calendar days. Both Medicaid discharges and length-of-stay will be determined using MMIS pulled data.

      iii. A complex discharge is a discharge for a Medicaid resident with a PASRR II designation and/or a Medicaid resident deemed too difficult to place.

      iv. The PASRR II designation will be determined using the most recently completed comprehensive MDS resident assessment during the period July 1, 2021 through June 30, 2022.

4. The payments will only be made if there is available federal financial participation under the Upper Payment Limit after all other nursing facility provider MMIS and supplemental payments are considered.

5. Nursing facility providers will provide data necessary to administer and to evaluate the effectiveness of the payments.

   a. Nursing facility providers will provide:

      i. Employment and wage data within thirty (30) calendar days of request.

ii. Quarterly financial statements will be due within thirty (30) calendar days of quarter end. Financial statements are due beginning with the quarter following the most recent cost report submission.

b. Reporting instructions will be provided to nursing facility providers before any data or financial statements are due.

c. Management companies, or other corporate structures, operating a nursing facility provider will provide quarterly financial statements will be due within thirty (30) calendar days of quarter end. Financial statements are due beginning with the quarter following the most recent cost report submission.

d. Submissions will be certified by the nursing home provider's Chief Executive Officer, Chief Financial Officer, or an individual with delegated signatory authority.

e. A skilled nursing facility provider not providing employment/wage data or financial statements may have the entirety of their payments recovered.

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Payment for Inpatient Hospital Services, Section 8.300
Rule Number: MSB 22-12-14-A
Division / Contact / Phone: Finance Office / Diana Lambe / 303-866-5526

# 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 22-12-14-A, Revision to the Medical Assistance Rule concerning Payment for Inpatient Hospital Services, Section 8.300

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

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

### PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300.1.K with the proposed text beginning at 8.300.1.K through the end of 8.300.1.K. Replace the current text at 8.300.5 with the proposed text beginning at 8.300.5 through the end of 8.300.5.A.7. Replace the current text at 8.300.5.E.3 with the proposed text beginning at 8.300.5.E.3 through the end of 8.500.5.E.3. Replace the current text at 8.300.7.A with the proposed text beginning at 8.300.7.A through the end of 8.300.7.B.1. This rule is effective June 30, 2023.

*to be completed by MSB Board Coordinator

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Rule concerning Payment for Inpatient Hospital Services, Section 8.300
Rule Number: MSB 22-12-14-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).

   Currently, Health First Colorado's base rate methodology relies on Medicare's inpatient hospital base rate calculations, which has evolved significantly since Colorado's initial adoption of this methodology. As Medicare's methodology has evolved, it has become less applicable to both the diversity of the types of hospitals serving Medicaid members as well as those hospitals' cost profiles. This rule change provides the Department with a payment methodology design that is better adapted to a Medicaid population and hospitals within Colorado. Further, adopting this update will allow the Department flexibility, alternating between re-basing rates every year and regularly implementing new versions of APR-DRGs in the off years.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 440.10 (2021)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   Section 25.5-102(1)(a), C.R.S. (2021)

**DO NOT PUBLISH THIS PAGE**

# 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.

   This rule may increase/decrease hospital's inpatient base rate which is part of the payment calculation for inpatient claims.

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

   Some hospitals may experience an increase in inpatient claim payments and others may experience a decrease in inpatient claim payments.

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

   This change in the methodology for inpatient base rates will remain budget neutral as it was before.

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

   The inpatient hospital base rate methodology hasn't been updated in 20+ years. By not implementing the base rate methodology changes, hospitals would continue to be paid on the old methodology.

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

   There are no other methods to implement this change.

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 inpatient base rate methodology must be updated to ensure the Department is paying hospitals based on matters that are most important to Health First Colorado.

## 8.300 HOSPITAL SERVICES

### 8.300.1 Definitions

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

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

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

**8.300.1.D.** Department means the Department of Health Care Policy and Financing.

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

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

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

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

**8.300.1.I.** Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

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

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

1. A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

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

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

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

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

6. A Spine/Brain Injury Treatment Specialty Hospital licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital OR CMS-certified as a Rehabilitation Hospital is a Not-for Profit Hospital as determined by the CMS Cost Report for the most recent fiscal year. A Spine/Brain Injury Treatment Specialty Hospital primarily serves an inpatient population requiring long term acute care and extensive rehabilitation for recent spine/brain injuries. To qualify as a Spine/Brain Injury Treatment Specialty Hospital, for at least 50% of Medicaid members discharged in the preceding calendar year the hospital must have submitted Medicaid claims including spine/brain injury treatment codes (previously grouped to APR-DRG 40, 44, 55, 56, and 57). The Department shall revoke the designation if the percentage of Medicaid members discharged falls below the 50% requirement for a calendar year. Designation is removed the calendar year following the disqualifying year.

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

8. A Medicare Dependent Hospital is defined as set forth at 42 C.F.R § 412.103. 42 C.F.R. § 412.108(1) (2019) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This regulation 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 § 24-4-410(12.5)(V)(b), the Department 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.

9. A Non-independent Urban Hospital is a hospital which reports a name of the home office of the chain with which they are affiliated on the CMS-2552-10 Cost Report in Worksheet S-2 Part 1, Line 141, Column 1, with the exception of individual hospitals reporting an affiliation not reported amongst other hospitals located in Colorado.

10. A Sole Community Hospital (SCH) is defined by CMS which classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in 412.64) and meets one of the following conditions. No more than 25 percent of residents who become hospital inpatients or no more that 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger within its service area. The hospital has fewer than 50 beds and intermediary certifies that the hospital would have met the criteria in paragraph (a)(I)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specially services at the hospital are inaccessible for at least 30 days in each 2 out of 3 years.

11. For the purposes of Section 8.300: Hospital Services, Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as hospitals which Medicare pays on a prospective basis and which provide data in the Medicare IPPS IMPACT file and supporting data files/tables from which to create their PPS rate. Conversely, non-Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as Pediatric and Critical Access Hospitals for which Medicare does not pay on a prospective basis and which do not have data available on the Medicare IPPS IMPACT file or supporting data files/tables.

12. Rebasing years are every other odd year starting in state fiscal year 2023-24. Non-rebasing years are every other even year starting in state fiscal year 2024-25.

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

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

**8.300.1.N.** Medical Necessity is defined at Section 8.076.1.

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

**8.300.1.P.** Observation Stay means a stay in the Hospital for no more than forty-eight hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a

complication of an Outpatient procedure. Only rarely will an Observation Stay exceed twenty-four hours in length.

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

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

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

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

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

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

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

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

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

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

**8.300.1.AA.** Trim Point Day (Outlier Threshold Day) means the day during an inpatient stay after which Outlier Days are counted. The Trim Point Day occurs 2.58 standard deviations above the average length of stay for each DRG. Beginning July 1, 2020, the Trim Point Day for delivery and neonate DRGs is equal to the Trim Point Day as calculated in the applicable Hospital-Specific Relative Value National File for Delivery and Neonate DRGs.

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

**8.300.1.CC.** Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To

qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

## 8.300.2 Requirements for Participation

### 8.300.2.A In-Network Hospitals

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

    a. be located in Colorado

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

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

    d. have a fully executed contract with the Department.

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

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

### 8.300.2.B Out-of-Network Hospitals

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

1. the services meet the definition of Emergency Care;

2. the services are covered benefits;

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

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

### 8.300.2.C Out-of-State Hospitals

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

### 8.300.2.D Hospitals with Swing-Bed Designation

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

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

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

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

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

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

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

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

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

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

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

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

5. Personal Needs Funds and Patient Payments

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

**8.300.3 Covered Hospital Services**

**8.300.3.A Covered Hospital Services - Inpatient**

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

1. Inpatient Hospital services include:

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

    b. professional services of hospital staff;

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

d. emergency room services;

e. drugs, blood products;

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

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

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

3. Prior to July 1, 2020, Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

   Beginning July 1, 2020, reimbursement for a mother's hospitalization for delivery does not include reimbursement for the newborn's hospitalization. Services shall be reimbursed under the identification number of each client.

4. Psychiatric Hospital Services

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

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

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

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

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

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

5. Inpatient Hospital Dialysis

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

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

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

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

6. Inpatient Subacute Care

Administration of subacute care by an enrolled hospital in its inpatient hospital or alternate care facilities is covered for the duration of the Coronavirus Disease 2019 (COVID-19) public health emergency. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Members may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital.

**8.300.3.B Covered Hospital Services – Outpatient**

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

1. Observation Stays

Observation stays are a covered benefit as follows:

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

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

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

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

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

2. Outpatient Hospital Psychiatric Services

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

a. Psychiatric outpatient services are not a Medicaid benefit in freestanding psychiatric hospitals.

3. Emergency Care

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

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

**8.300.3.C. Bariatric Surgery**

1. Eligible Clients

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

i) The client has clinical obesity; and

ii) It is Medically Necessary.

2. Eligible Providers

a. Providers must enroll in Colorado Medicaid.

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

c. Preoperative evaluations and treatment may be performed by:

i) Primary care physician,

ii) Nurse Practitioner,

iii) Physician Assistant,

iv) Registered dietician,

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

3. Eligible Places of Service

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

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

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

4. Covered Services and Limitations

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

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

b. Covered primary procedures Include:

i) Roux-en-Y Gastric Bypass;

ii) Adjustable Gastric Banding;

iii) Biliopancreatic Diversion with or without Duodenal Switch;

iv) Vertical-Banded Gastroplasty;

v) Vertical Sleeve Gastroplasty.

c. Criteria for Primary Procedures

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

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

1) BMI of 40 or higher, or

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

a) Severe cardiac disease;

b) Type 2 diabetes mellitus;

c) Obstructive sleep apnea or other respiratory disease;

d) Pseudo-tumor cerebri;

e) Hypertension;

f) Hyperlipidemia;

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

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

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

iii) The client must have made at least one clinically supervised attempt to lose weight lasting at least six consecutive months or longer within the

past eighteen months of the prior authorization request, monitored by a registered dietician that is supervised by a physician, nurse practitioner, or physician's assistant.

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

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

2) A psychiatric or psychological assessment, conducted by a licensed mental health professional, no more than three months prior to the requested authorization. The assessment must address both potential psychiatric contraindications and client's ability to comply with the long-term postoperative care plan.

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

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

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

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

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

d. Revision Procedures

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

ii) Indications for surgical revision:

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

2) Esophagitis, unresponsive to nonsurgical treatment;

3) Hemorrhage or hematoma complicating a procedure;

4) Excessive bilious vomiting following gastrointestinal surgery;

5) Complications of the intestinal anastamosis and bypass;

6) Stomal dilation, documented by endoscopy;

7) Documented slippage of the adjustable gastric band;

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

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

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

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

e. Non-Covered Services:

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

ii) Repeat procedures not associated with surgical complications.

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

iv) During pregnancy.

5. Prior Authorization Requirements

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

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

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

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

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

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

i) Commitment to lose weight;

ii) Expectations of the surgical outcome;

iii) Willingness to make permanent life-style changes;

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

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

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

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

**8.300.4 Non-Covered Services**

The following services are not covered benefits:

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

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

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

**8.300.5 Payment for Inpatient Hospital Services**

**8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services**

1. Peer Groups

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

a. Pediatric Hospitals

b. ~~Urban Safety Net Hospitals~~

~~c.~~ Rural Hospitals

~~d~~c. Urban Hospitals

2. Base Payment and Outlier Payment

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

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

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

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

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

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

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

For in-state Colorado DRG Hospitals (both PPS and non-PPS), the starting point shall be the hospital-specific Medicare Federal base rate with the specific adjustments listed. The Operating Federal Portion and Federal Capital Rate (source: CMS Tables 1A-1B & IE) will be adjusted by the Wage Index and Geographic Adjustment Factor (GAF) from the CMS IMPACT File. For CAH and Pediatric hospitals (non-PPS Medicare hospitals), both adjustment factors as listed above will be set to 1.0 and the corresponding labor and non-labor related amounts will be applied because these factors are not available from CMS. Additionally, the Quality and Meaningful Electronic Health Records (EHR) User adjustments will be applied to all PPS hospitals as indicated on the CMS corrected IMPACT file, while all non-PPS hospitals are assumed to have submitted Quality Data and be meaningful EHR users since no data exists for them. The corrected Medicare base rate IMPACT File shall be used to set the Federal Base Rate and other adjustments detailed above effective on October 1 of the previous fiscal year.

b. Policy Adjustments

Indirect Medical Education (IME) / Value Based Purchasing Adjustment (VBP) Factor / Readmission Adjustment Factor and Hospital Acquired Conditions (HAC) Reduction:

**1)** For PPS hospitals, Operating IME% will be multiplied by Adjusted Operating Federal Portion and the Capital IME% will be multiplied by the Adjusted Federal Capital Rate. The VBP Adjustment Factor and Readmission Adjustment Factor taken from CMS Final Rule Correcting Amendment Tables 16B and 15 respectively will be multiplied by the Adjusted Operating Federal Portion. The Hospital Acquired Conditions Reduction taken from the most recent CMS.gov Data Set as of January 1 will be applied against the Medicare Federal Base Rate with Wage Index/GAF Adjustments.

**2)** For non-PPS hospitals, Operating & Capital IME % are not calculated in the IMPACT File so the Department's Contractor will compute their Operating and Capital IME using the most recently available cost report as of January 1 in rebasing years and will require that hospitals have a CMS approved teaching program as detailed in Section 8.300.5.A.3.e. Additionally, non-PPS Hospitals will have the opportunity to review their calculated Operating and Capital IME percent during a 30-day review period and request

changes if necessary. The VBP Adjustment Factor, Readmission Adjustment Factor and HAC Reduction will not be applied to non-PPS hospitals since they are not calculated by CMS.

c. Mutually Exclusive Medicaid Add-ons:

Four Add-ons will be mutually exclusive and applied as described here and will be applied as a percentage against the Medicare Federal Base Rate w/Wage Index/GAF Adjustments as detailed below.

1) Critical Access Hospital (CAH) Add-on will be set at 25% and is only open to those hospitals categorized as CAH by Medicare,

2) Sole Community Hospital (SCH)/Medicare Dependent Hospital (MDH) will be set at 20% and is only open those hospitals categorized as SCH/MDH in section 8.300.1.K,

3) Low Discharge Add-on based on the average of up to three years of Total Discharges of most recently available cost reports on HCRIS as of January 1 of rebasing years and excludes hospitals that are classified as Pediatric, SCH/MDH or CAH. For hospitals with subunits of Psychiatric, Rehabilitation and other subunits discharges in those subunits with be added to total discharges. The percentage add-on is set at 10% and distributed on a sliding scale with a ceiling of 2,500 and floor of 500 discharges,

4) The Pediatric Add-on is open only to hospitals defined as Pediatric in Section 8.300.1.K.3 and the percentage add-on is set at 25%.

d. Remaining Medicaid Add-ons:

The remaining add-ons are open to all hospitals who qualify and are applied as a percentage of the Medicare Federal Base Rate with Wage Index/GAF Adjustments and distributed on a sliding scale between the respective ceiling and floor.

1. Payer Mix Add-on is based on the percentage of Medicaid patient days treated at the hospital using up to three years of the most recently available cost reports. The add-on is set at up to 10% with a ceiling and floor of 50% and 35% respectively. For hospitals with subunits of Psychiatric, Rehabilitation and other subunits Payer Mix utilization in those subunits with be added to the calculations.

2. Operating Cash Flow Margin Percent Add-on (also known as the solvency metric) is set at 20% with a ceiling of 8% and floor of 0%. The source for this data is up to 3 years of Hospital Transparency Data that is generated by each hospital and sent into the Department. The Operating Cash Flow Margin Percent Add-on is calculated for all hospitals and is based on the maximum of the hospital or the hospital system's operating cash flow margin percent. System hospital list can be found ~~i~~on the ~~IP/OP billing manual~~Department's website. Operating Cash Flow Margin Percent is calculated by taking (Total Operating Net Income + Depreciation Expense) / Total Operating Revenue.

e. Application of Graduate Medical Education (GME) Cost Add-on to Determine Medicaid Inpatient Base Rate:

1) The Medicaid Inpatient base rate shall be equal to the rate as calculated in Sections 8.300.5.A.3.a-b plus the GME Medicaid hospital-specific cost add-on. The GME Medicaid hospital-specific cost add-on is calculated from the most recently available Medicare/Medicaid cost report (CMS 2552) worksheet B, Part I. Partial year cost reports shall not be used to calculate the GME cost add-on. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals. State University Teaching Hospitals shall receive reimbursement for GME costs as described in Section 8.300.9.B.

The GME Medicaid hospital-specific cost add-on shall be an estimate of the cost per discharge for GME based on: Medicare approved GME program where legitimate GME expenses have been reported in accordance with Medicare's rules detailed in 42 C.F.R. § 413.75, et. seq. GME will be calculated when the following two criteria are met:

i. Hospitals that appear on the most recent list as of January 1 of CMS qualified teaching hospitals on the CMS Open Payments website or the hospital will need to provide documentation to the State by proving Medicare approval of the GME program.

ii. Have countable GME costs in the most recent cost report available as of January 1 of rebasing years in worksheet B, part 1 and discharges from worksheet S-3, part I.

2) Ten percent of the GME Medicaid hospital-specific cost add-on shall be applied.

f. Application of Adjustment Based on General Assembly Funding

In rebasing years, for all in-state, Colorado DRG Hospitals (both PPS and non-PPS), the starting point for the Medicaid Inpatient base rate, as determined in Section 8.300.5.A.3.a - e, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Additionally, a 10% corridor has been implemented to prevent any hospital's inpatient base rate from increasing or decreasing more than 10% each rebasing year.

g. Annual Adjustments

The Medicaid Inpatient base rates are rebased every other year as described in Section 8.300.5.A.3.a - f and are effective each July 1. In non-rebasing years, the Medicaid Inpatient base rates will be adjusted by the State Budget Action as set by Legislature and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department and/or adjustments necessary to balance the DRG payment equation.

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

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

rate setting effective on July 1 of each fiscal year, the Medicare base rate used shall be the Medicare base rate effective on October 1 of the previous fiscal year.

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

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

b. Application of Adjustment Based on General Assembly Funding

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

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

i The Medicaid Inpatient base rate shall be equal to the rate as calculated in 10 CCR 2505-10 Sections 8.300.5.A.3.a and 8.300.5.A.3.b, plus any Medicaid hospital-specific cost add-ons. The Medicaid hospital-specific cost add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1. Partial year cost reports shall not be used to calculate the cost add-ons.

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

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

d. Application of Adjustments for Certain Hospitals

For Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals, the Medicaid Inpatient base rate shall receive an additional adjustment factor for

~~the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process.~~

~~e. Annual Adjustments~~

~~The Medicaid Inpatient base rates are adjusted annually (rebased) and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department. For fiscal year 21-22, the Medicaid Inpatient Base Rates from fiscal year 20-21 will be adjusted by the percentage change in the budget as appropriated by the General Assembly. For fiscal year 22-23, the Medicaid Inpatient Base Rates from fiscal year 21-22 will be adjusted by the percentage change in the budget as appropriated by the General Assembly.~~

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

The Medicaid Inpatient base rate for new in-~~network~~ state Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered "new" until the next Inpatient rate rebasing ~~period~~ year after the Hospital's contract effective date. For the next Inpatient rate rebasing ~~period~~year, the Hospital's Medicaid Inpatient base rate shall be equal to the rate as determined in ~~10 CCR 2505-10~~ Section 8.300.5.A.3-6. If the Hospital does not have a Medicare Inpatient base rate or a~~n~~ full year ~~audited~~ Medicare/Medicaid cost report to compute a starting point as described in ~~10 CCR 2505-10~~ Section 8.300.5.A.3.a, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals

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

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

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

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

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

**8.300.5.B Abbreviated Client Stays**

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

**8.300.5.C Transfer Pricing**

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

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

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

**8.300.5.D APR-DRG Payment Methodology Exclusions**

1. Long-acting reversible contraceptives (LARC) devices, inserted following a delivery, are excluded from the DRG Relative Weight calculation and are paid according to the Department's fee schedule.

2. Pursuant to § 25.5-5-509, C.R.S. opiate antagonists identified by the Department shall be paid according to the Department's fee schedule when dispensed to a medical assistance recipient upon discharge.

**8.300.5.E Payments to Non-DRG Hospitals for Inpatient Services**

1. Payments to Psychiatric Hospitals

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

      i Step 1: Day 1 through Day 7

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

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

2. Payment to State-Owned Psychiatric Hospitals

   The Department shall reimburse State-Owned Psychiatric Hospitals on an interim basis according to a per diem rate. The Department will determine the per diem rate based on an estimate of 100% of Medicaid costs from the Hospital's Medicare cost report. Periodically, the Department will audit actual costs and may require a cost settlement to insure reimbursement is 100% of actual audited Medicaid costs.

3. Payments to Long-Term Care and Rehabilitation Hospitals (excludes distinct part units and satellite locations as defined under ~~10 CCR 2505 10~~Section 8.300) shall be divided into three (3) subgroups: Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital.

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

   a. Payments to Long-Term Care Hospitals:

      i. Step 1: Day 1 through Day 21

      ii. Step 2: Day 22 through Day 35

      iii. Step 3: Day 36 through Day 56

      iv. Step 4: Day 57 through remainder of stay

   b. Payments to Rehabilitation Hospitals:

      i. Step 1: Day 1 through Day 6

      ii. Step 2: Day 7 through Day 10

      iii. Step 3: Day 11 through Day 14

      iv. Step 4: Day 14 through remainder of stay

   c. Payments to Spine/Brain Injury Treatment Specialty Hospitals:

      i. Step 1: Day 1 through Day 28

      ii. Step 2: Day 29 through Day 49

      iii. Step 3: Day 50 through Day 77

      iv. Step 4: Day 78 through remainder of stay

   d. The Classification-specific per diem for 2019, the year of this methodology implementation shall be calculated using the following method:

      i. The Department shall assign the claims submitted by each hospital for fiscal year 2017 to one of the following peer groups:

         1) Long-Term Care Hospital

         2) Rehabilitation Hospital

3) Spine/Brain Injury Treatment Specialty Hospital

ii. The Department shall process Medicaid inpatient hospital claims from state fiscal year 2017 through the methodology described in Section 8.300.5.D.3 a-c. This will create per diems that are budget neutral to fiscal year 2017.

iii. The Department shall adjust the per diems annually to reflect budget changes. For state fiscal year 2018, rates shall be increased 1.4%. For state fiscal year 2019, rates shall be increased 1%. The Department shall adjust rates in subsequent years by the percentage changes in the budget as appropriated by the General Assembly.

**8.300.5.E [Emergency rule expired 04/10/2021]**

**8.300.5.F Payment for Inpatient Subacute Care**

1. Inpatient Subacute Care days shall be paid at a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved by the Centers for Medicare and Medicaid Services (CMS), for the State in which such hospital is located.

**8.300.5.G Payment for High Acuity In-State Services**

1. The Department may negotiate a higher reimbursement rate for in-state inpatient hospital services up to, but no greater than, 100% of the costs anticipated by the hospital—which must be demonstrated by evidence, including but not limited to an anticipated cost report submitted to the Department for review—where, as determined by the Department, all of the following conditions are fulfilled:

   a. The in-state inpatient payment methodology insufficiently accounts for the level of acuity;

   b. All other placement options have been exhausted; and

   c. The services have been reviewed and authorized by the Medical Director for the Department.

**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 new, in-state hospitals, such hospitals will be assigned to a Pediatric, Long Term Acute Care, or Rehabilitation peer group depending on hospital type. If a provider does not meet the criteria for any of the above

peer groups, it will be assigned to a Rural or Urban peer group based on location. The hospital will receive a base rate of the average peer-group rate as calculated from Colorado hospitals base rate statistics.

(7) For all hospitals, the Medicaid Outpatient base rate, as determined in 8.300.6.A.k.(1)-(6), 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.

Out-of-Network DRG Hospitals will be reimbursed for Outpatient Hospital Services based on the system of Enhanced Ambulatory Patient Grouping described in Section 8.300.6.A.1. Such hospitals will be assigned to a Pediatric, Long Term Acute Care, or Rehabilitation peer group depending on hospital type. If a provider does not meet the criteria for any of the above peer groups, it will be assigned to a Rural or Urban peer group based on location. The hospital will receive a base rate of 90% of the average peer group rate as calculated from Colorado hospitals base rate statistics. Out-of-Network DRG Hospitals will periodically have their Medicaid Outpatient base rates adjusted as determined in Section 8.300.6.A.k.7.

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. § 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.

## 8.300.7 Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care

GME costs for Medicaid managed care clients shall be paid directly to qualifying Hospitals rather than to managed care organizations (MCOs).

### 8.300.7.A GME for Medicaid Managed Care – Inpatient Services

1. The Hospital cost report used for the most recent rebasing year shall be used to determine the Medicaid Inpatient GME cost per day for each Hospital that has GME costs in its fee-for-service base rate, excluding State University Teaching Hospitals. Each Hospital's GME cost per day shall be computed when Hospital rates are rebased according to the schedule outlined in Section 8.300.5.A.3.e. Years when rates are updated with the State Budget Action as set by Legislature, GME cost per day will remain unchanged from the cost report rebasing year.

2. MCOs shall provide to the Department Inpatient days by Hospital for discharges (net of adjustments) during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

3. The Medicaid managed care Inpatient days for each Hospital shall be the total of the Inpatient days for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the GME cost per day to determine the Inpatient GME reimbursement for each Hospital per quarter. The GME reimbursement will be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

**8.300.7.B GME for Medicaid Managed Care – Outpatient Services**

1. The Hospital cost report used for the most recent rebasing year shall be used to determine the Outpatient GME cost-to-charge ratio for each Hospital that has a graduate medical education program. Each Hospital's GME cost-to-charge ratio shall be computed when Hospital rates are rebased according to the schedule outlined in Section 8.300.5.A.3.e. Years when rates are updated with the State Budget Action as set by Legislature, GME cost-to-charge ratio will remain unchanged from the cost report rebasing year.

2. MCOs shall provide to the Department Outpatient charges for Medicaid clients by Hospital for Outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

3. The Medicaid managed care Outpatient charges for each Hospital shall be the total of the Outpatient charges for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the cost-to-charge ratio and reduced by 28 percent to determine the Outpatient GME reimbursement for each Hospital per quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

**8.300.8 Disproportionate Share Hospital Adjustment**

**8.300.8.A** Federal regulations require that Hospitals which provide services to a disproportionate share of Medicaid recipients shall receive an additional payment amount to be based upon the following minimum criteria:

1. A Hospital must have a Medicaid Inpatient utilization rate at least one standard deviation above the mean Medicaid Inpatient utilization rate for Hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and

2. A Hospital must have at least two obstetricians with staff privileges at the Hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.

a. In the case where a Hospital is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term “obstetrician” includes any physician with staff privileges at the Hospital to perform non-emergency obstetric procedures.

3. Number (2) above does not apply to a Hospital in which:

a. the Inpatients are predominantly under 18 years of age; or

b. does not offer non-emergency obstetric services as of December 21, 1987.

4. The Medicaid Inpatient utilization rate for a Hospital shall be computed as the total number of Medicaid Inpatient days for a Hospital in a cost reporting period, divided by the total number of Inpatient days in the same period.

5. The low income utilization rate shall be computed as the sum of:

a. The fraction (expressed as a percentage),

i. the numerator of which is the sum (for a period) of

1) total revenues paid the Hospital for client services under a State Plan under this title and

2) the amount of the cash subsidies for client services received directly from state and local governments; and

ii. the denominator of which is the total amount of revenues of the Hospital for client services (including the amount of such cash subsidies) in the period; and

b. a fraction (expressed as a percentage),

i. the numerator of which is the total amount of the Hospital’s charge for Inpatient Hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (I) (ii) of subparagraph a) of Section 1923 of the Social Security Act, in the period reasonably attributable to Inpatient Hospital services, and

ii the denominator of which is the total amount of the Hospital’s charges for Inpatient Hospital services in the Hospital in the period.

6. The numerator under subparagraph (b)(i) shall not include contractual allowances and discounts.

**8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment**

1. Eligible hospitals will receive a Disproportionate Share Hospital Supplemental Payment according to the terms defined in 10 CCR 2505-10 section 8.3004.D.

**8.300.9 Supplemental Inpatient Hospital Payments**

**8.300.9.A Family Medicine Residency Training Program Payment**

A Hospital qualifies for a Family Medicine Residency Training Program payment when it is recognized by the Commission on Family Medicine and has at least 10 residents and interns. The Family Medicine Residency Training Program payment will only be made to Medicaid in-network Hospitals. For each program which qualifies under this section, the additional Inpatient Hospital payment will be calculated based upon historical data and paid in 12 equal monthly installments. The Family Medicine Residency Training Program payment is a fixed amount subject to annual appropriation by the General Assembly.

**8.300.9.B State University Teaching Hospital Payment**

State University Teaching Hospitals shall receive a supplemental Inpatient Hospital payment for GME costs associated with Inpatient Hospital Services provided to Medicaid fee-for-service and managed care clients. The State University Teaching Hospital payment is calculated based on GME costs and estimated Medicaid discharges using the same methodology as that used to calculate the GME add-on to the Medicaid Inpatient base rate described in 10 CCR 2505-10 Section 8.300.5.A.3.c., and the GME payments to Hospitals for Medicaid managed care described in 10 CCR 2505-10 Section 8.300.7. The State University Teaching Hospital payment is a fixed amount subject to annual appropriation by the General Assembly.

**8.300.10 Patient Payment Calculation for Nursing Facility Clients Who are Hospitalized**

**8.300.10.A** When an eligible client is admitted to the Hospital from a nursing facility, the nursing facility shall, at the end of the month, apply all of the available patient payment to the established Medicaid rate for the number of days the client resided in the nursing facility. The nursing facility shall notify the county department of any amount of patient payment that applies, using form AP-5615. An allowed exception to the usual five (5) day completion requirement is that the AP-5615 for hospitalized clients may be completed at the end of the month. If the nursing facility has calculated an excess amount, the county will notify the Hospital of the amount. If directed by the county department, the nursing facility shall transfer the excess amount to the Hospital and this payment will be shown as a patient payment when the Hospital submits a claim to the Medicaid Program.

**8.300.10.B** The Hospital is responsible for collecting the correct amount of patient payment due from the client, the client's family, or representatives. Failure to collect patient payment, in whole or in part, does not allow the Hospital to bill Medicaid for the patient payment.

**8.300.11. Payment for Hospital Beds Designated as Swing Beds**

**8.300.11.A Swing Bed Payment Rates**

1. Payment for swing-bed services will be made at the average rate per client day paid to Class I nursing facilities for services furnished during the previous calendar year.

2. Oxygen provided to swing-bed clients shall be reimbursed as specified in 10 CCR 2505-10, Sections 8.580 and 8.585.

3. Clients shall be required to contribute their patient payment to the cost of their nursing care. Collection as well as determination of the patient payment amount shall be in accordance with 10 CCR 2505-10, Section 8.482.

**8.300.11.B Swing Bed Claim Submission**

1. Hospitals shall submit claims for swing-bed routine services as nursing facility claims.

2. Ancillary services (services not required to be provided by nursing facilities participating in the Medicaid program within their per diem rate, but reimbursable under Medicaid, including but not limited to laboratory and radiology) shall be billed separately on the appropriate claim form.

### 8.300.12 Utilization Management

All participating in-network Hospitals are required to comply with utilization management and review, program integrity and quality improvement activities administered by the Department's utilization review vendor, external quality review organization or other representative.

### 8.300.12.A Conduct of Reviews

1. All reviews will be conducted in compliance with 10 CCR 2505-10, Sections 8.076, Program Integrity, and 8.079, Quality Improvement.

2. Reviews will be conducted relying on the professional expertise of health professionals, prior experience and professional literature; and nationally accepted evidence-based utilization review screening criteria whenever possible. These criteria shall be used to determine the quality, Medical Necessity and appropriateness of a health care procedure, treatment or service under review.

3. The types of reviews conducted may include, but are not limited to the following:

    a. Prospective Reviews;

    b. Concurrent Reviews;

    c. Reviews for continued stays and transfers;

    d. Retrospective Reviews.

4. These reviews, for selected Inpatient or Outpatient procedures and/or services, shall include but are not limited to:

    a. Medical Necessity;

    b. Appropriateness of care;

    c. Service authorizations;

    d. Payment reviews;

    e. DRG validations;

    f. Outlier reviews;

    g. Second opinion reviews; and

    h. Quality of care reviews.

5. If criteria for Inpatient hospitalization or outpatient Hospital services are not met at any point in a hospitalization (i.e., at the point-of-admission review, Continued Stay Review or Retrospective Review) the provider will be notified of the finding.

a. When appropriate, payment may be adjusted, denied or recouped.

6. When the justification for services is not found, a written notice of denial shall be issued to the client, attending physician and Hospital. Clients and providers may follow the Department's procedures for appeal. See 10 CCR 2505-10 Sections 8.050, Provider Appeals, and 8.057, Recipient Appeals.

**8.300.12.B Corrective Action**

1. Corrective action may be recommended when documentation indicates a pattern of inappropriate utilization or questionable quality of care.

2. If corrective action does not resolve the problem, the Department shall initiate sanctions, as set forth in 10 CCR 2505-10, Section 8.076.

3. Retrospective Review may be performed as a type of corrective action for an identified Hospital or client.

**8.300.12.C Prior Authorization of Swing-Bed Care**

Care for Medicaid clients in hospital beds designated as swing beds shall be prior authorized and subject to the Continued Stay Review process in accordance with the criteria and procedures found in 10 CCR 2505-10, Sections 8.393 and 8.400 through 8.415. Prior authorization requires a level of care determination using the Uniform Long Term Care 100.2 and a Pre-Admission Screening and Resident Review (PASRR) screening.

**8.300.13 – 8.375.60 [Repealed effective 11/30/2009]**

## 8.310 DIALYSIS TREATMENT CENTERS

### 8.310.1 Definitions

Acute Kidney Injury (AKI) is the sudden loss of kidney function, the ability of the kidneys to remove waste and excess fluid. AKI is typically a condition in which kidney function can be expected to recover after a short period of time with treatment (i.e. pharmaceuticals or dialysis). However, AKI can progress to a complete recovery of kidney function, development of Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD).

Chronic Kidney Disease (CKD) is the slow loss of kidney function over time until the kidneys reach ESRD.

Dialysis is the process of cleaning the blood when the kidneys have failed and are no longer filtering the blood to remove waste and excess fluid. Kidney failure can stem from AKI or CKD. Dialysis includes both peritoneal dialysis and hemodialysis.

End Stage Renal Disease (ESRD) is defined as irreversible and permanent damage to the kidneys that requires either a regular course of dialysis treatment or kidney transplantation to maintain life.

Provider means a Dialysis Treatment Center that is hospital-affiliated or independent of a licensed hospital, and licensed by the Colorado Department of Public Health and Environment to provide outpatient dialysis services or training for home or self-dialysis.

Home Dialysis Training is a program that trains Clients to perform dialysis in the client's home with little or no professional assistance, and trains other individuals to assist clients in performing home dialysis.

Self-Dialysis Training is a program that trains Clients to perform self-dialysis in the treatment facility with little or no professional assistance, and trains other individuals to assist Clients in performing self-dialysis.

**8.310.2. Eligibility**

**8.310.2.A. Client Eligibility**

1. Any Colorado Medicaid Client diagnosed with CKD, AKI or ESRD, which requires dialysis treatments to restore kidney function or maintain life shall be eligible.

**8.310.2.B. Provider Eligibility**

1. To provide services, a Dialysis Treatment Center must be:

    a. Enrolled in the Colorado Medical Assistance Program;

    b. Certified by the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicare program as a dialysis treatment center;

    c. Certified by the Colorado Department of Public Health and Environment

**8.310.2.C. Prior Authorization**

1. Prior Authorization is not required for services listed at Section 8.310.3.B.

**8.310.3. General Services**

**8.310.3.A. Provider Requirements**

1. The Provider must utilize the most cost efficient method of dialysis treatment appropriate for each client, as assessed through an evaluation for peritoneal dialysis based upon an individual medical diagnosis and condition.

2. The Provider Facility must develop and implement a written, individualized comprehensive plan of care for each patient, which must include:

    a. The services necessary to address the patient's needs;

    b. The comprehensive assessment and changes in the patient's condition;

    c. Measurable and expected outcomes, and estimated timetables to achieve these outcomes;

    d. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards; and

    e. The plan of care must represent the selection of a suitable treatment modality (e.g., dialysis or transplantation) and dialysis setting (e.g., home, self-care) for each patient (42 CFR 405, 410, 413, 414, 488 and 494).

### 8.310.3.B. Covered Dialysis Services

The following are covered services under the Colorado Medicaid Dialysis Center Program:

1. In-Center Dialysis

    a. Dialysis treatments completed by facility staff, and all necessary equipment and supplies.

    b. In-Center dialysis is a benefit when the client meets one of the following conditions:

        i) The client requires dialysis treatments prior to completing home dialysis training;

        ii) Training to perform self-treatment in the home environment is contraindicated;

        iii) The client is otherwise not a proper candidate for self-treatment in a home environment;

        iv) The home environment of the eligible client contraindicates self-treatment; or

        v) The eligible client is awaiting a kidney transplant.

    c. Self-dialysis may be performed within the facility with limited professional assistance, if the client has completed an appropriate course of training.

        i) The benefit includes training of the client by qualified personnel.

2. Home Dialysis

    a. To be eligible for home dialysis a client or client's caregiver must receive appropriate training to perform dialysis at home.

    b. The benefit includes training by qualified personnel, necessary supplies, and equipment for dialysis services.

    c. The Benefit includes delivery, installation, and maintenance of equipment for home dialysis

3. The following are included in the Dialysis Center reimbursement and should not be billed separately:

    a. Costs associated with home dialysis other than necessary delivery, equipment, installation, maintenance, supplies, or training.

    b. Blood and blood products.

    c. Additional staff time or personnel costs.

    d. Routine Laboratory Services

i) All laboratory services considered routine for dialysis treatment, and performed by a dialysis treatment facility, are included as part of the dialysis treatment reimbursement.

ii) A Provider performing routine laboratory services must be a certified clinical laboratory.

e. Routine Pharmaceuticals for Dialysis Treatment

i) All pharmaceuticals considered routine for dialysis treatment, and dispensed by a dialysis treatment facility, are included as part of the dialysis treatment reimbursement.

ii) Pharmaceuticals not dispensed by the dialysis provider are billed by and reimbursed to the dispensing pharmacy.

**8.310.3.C. Non-Covered Services**

The following are non-covered services under the Colorado Medicaid Dialysis Center benefit:

1. Personal care items such as slippers or toothbrushes.

## 8.320 COMMUNITY CLINIC, INCLUDING FREESTANDING EMERGENCY DEPARTMENTS

### 8.320.1 Definitions

A. Community Clinic (CC) means a hospital-owned health care facility, licensed as a Community Clinic under 6 CCR 1011-1, Chapter IX or as a Freestanding Emergency Department (FSED) under 6 CCR 1011-1, Chapter XIII and enrolled as a CC provider type, that provides health care services on an ambulatory basis.

B. CMS means the Centers for Medicare and Medicaid Services.

C. Department means the Department of Health Care Policy and Financing.

D. Emergency Care Services, for the purposes of this rule, has the same meaning as Section 8.300.1.I.

E. Observation Stay means a stay in the CC for no more than 48 hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed 24 hours.

### 8.320.2 Requirements for Enrollment as a CC

8.320.2.A.

1. The facility is licensed as a Community Clinic or FSED by the Colorado Department of Public Health and Environment (CDPHE) in accordance with CDPHE rule at 6 CCR 1011-1, Chapter IX or Chapter XIII; and

2. The facility location is certified by CMS under the operating hospital's Medicare certification.

### 8.320.3 Services

8.320.3.A The following services provided by a CC are eligible for reimbursement:

1. Outpatient services, as defined in the Department's rule at 10 CCR 2505-10, section 8.300.3.B, section 8.300.B.2, 8.300.B.3; and

2. Observation stays, as defined in the Department's rule at 10 CCR 2505-10, section 8.300.3.B.1.

**8.320.4 Reimbursement**

8.320.4.A CC services are reimbursed as:

1. Outpatient services, in accordance with the Department's rule at 10 CCR 2505-10, section 8.300.6, using the hospital base rate for the hospital that is identified in the CMS certification of the CC.

## 8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM

The long-term care Single Entry Point system consists of Single Entry Point Agencies, representing geographic districts throughout the state, for the purpose of enabling persons in need of long-term services and supports to access appropriate services and supports.

### 8.390.1 DEFINITIONS

A. Agency Applicant means a legal entity seeking designation as the provider of Single Entry Point Agency functions within a Single Entry Point district.

B. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers), chosen by the individual, conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources.

C. Case Management means the assessment of an individual seeking or receiving long-term services and supports' needs, the development and implementation of a Support Plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic reassessment of such individual's needs.

D. Corrective Action Plan means a written plan by the CMA, which includes a detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action.

E. Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to, injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

F. Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.

G. Failure to Satisfy the Scope of Work means acts or failures to act by the Single Entry Point Agency that constitute nonperformance or breach of the terms of its contract with the Department.

H. Financial Eligibility means an individual meets the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources.

I. Functional Eligibility means an individual meets the level of care criteria for a Long-Term Services and Supports (LTSS) Program as determined by the Department.

J. Functional Needs Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, friends and/or caregivers) chosen by the individual and a written evaluation by the case manager utilizing the ULTC 100.2, with supporting diagnostic information from the individual's medical provider, to determine the individuals level of care and medical necessity for admission or continued stay in certain Long-Term Services and Supports (LTSS) Programs.

K. Home and Community Based Services (HCBS) waivers means services and supports authorized through a waiver under Section 1915(c) of the Social Security Act and provided in home- and community-based settings to individuals who require an institutional level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

L. Information Management System (IMS) means an automated data management system approved by the Department to enter case management information for each individual seeking or receiving long-term services as well as to compile and generate standardized or custom summary reports.

M. Intake, Screening and Referral means the initial contact with individuals by the Single Entry Point Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

N. Long-Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

O. LTSS Program means any of the following: publicly funded programs, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI) (where applicable), Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-Term Home Health (LTHH).

P. Pre-Admission Screening and Resident Review (PASRR) means the pre-screening of individuals seeking nursing facility admission to identify individuals with mental illness (MI) and/or intellectual disability (ID), to ensure that individuals are placed appropriately, whether in the community or in a NF, and to ensure that individuals receive the services they require for their MI or ID.

Q. Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to certify level of care.

R. Reassessment means a periodic comprehensive reevaluation with the individual receiving services, appropriate collaterals, chosen by the individual, and case manager, to re-determine the individual's level of functioning, service needs, available resources and potential funding resources.

S. Resource Development means the study, establishment and implementation of additional resources or services which will extend the capabilities of community LTSS systems to better serve individuals receiving long-term services and individuals likely to need long-term services in the future.

T. Single Entry Point (SEP) means the availability of a single access or entry point within a local area where an individual seeking or currently receiving LTSS can obtain LTSS information, screening, assessment of need and referral to appropriate LTSS programs and case management services.

U. Single Entry Point Agency means the organization selected to provide intake, screening, referral, eligibility determination, and case management functions for persons in need of LTSS within a Single Entry Point District.

V. Single Entry Point District means one or more counties that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of LTSS.

W. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support Planning informs the individual seeking or receiving services of his or her rights and responsibilities.

X. Target Group Criteria means the factors that define a specific population to be served through an HCBS waiver. Target Group Criteria can include physical or behavioral disabilities, chronic conditions, age, or diagnosis, and May include other criteria such as demonstrating an exceptional need.

**8.390.2 LEGAL AUTHORITY**

Pursuant to Section 25.5.6.105, C.R.S., the State Department is authorized to provide for a statewide Single Entry Point system.

**8.390.3 CHARACTERISTICS OF INDIVIDUALS RECEIVING SERVICES IN LTSS PROGRAMS**

A. An individual served by the SEP Agency shall meet the following criteria:

1. The individual requires skilled, maintenance and/or supportive services long term;

2. The individual has functional impairment in activities of daily living (ADL) and/or a need for supervision, necessitating LTSS provided in a nursing facility, an alternative residential setting, the individual's home or other services and supports in the community;

3. The individual receives or is eligible to receive medical assistance (Medicaid) and/or financial assistance under one or more of the following programs: Old Age Pension, Aid to Blind, Aid to Needy Disabled, Supplemental Security Income, or Colorado Supplemental, or as a 300% eligible, as defined at 8.485.50.T, receiving LTSS in a nursing facility or through one of the HCBS Programs.

**8.391 SINGLE ENTRY POINT DISTRICT DESIGNATION**

**8.391.1.A. District Designation Requirements**

Single Entry Point (SEP) districts shall meet the following requirements:

1. Counties composing a multi-county district shall be contiguous.

2. A single county may be designated a district provided the county serves a monthly average of 200 or more individuals for LTSS programs.

3. Multi-county districts shall not be required to serve a minimum number of individuals receiving services.

4. Each district shall assure adequate staffing and infrastructure by the district's SEP agency, including at least one full-time case manager employed by the SEP agency, to provide coverage for all case management functions and administrative support, in accordance with rules at Section 8.393.

**8.391.1.B. Changes in Single Entry Point District Designation**

1. In order to change SEP district designation, a county or district shall submit an application to the Department, six (6) months prior to commencement date of the proposed change. The application shall include the following information:

   a. The geographic boundaries of the proposed SEP district;

   b. Assurances that the proposed district meets all criteria set forth in Department rules for SEP district designation;

   c. The designation of a contact person for the proposed district; and

   d. A resolution supporting the application passed by the county commissioners of each county or parts of counties in the proposed district.

2. The application shall be approved provided the proposed district meets the SEP district designation requirements.

**8.391.2 Single Entry Point Agency Selection**

A. Except as otherwise provided herein, upon a change in SEP district designation or upon expiration of the district's existing SEP agency contract, a SEP district may select a county agency, including a county department of social/human services, a county nursing service, an area agency on aging or a multicounty agency to serve as the SEP agency for the district. Once the SEP functions in a district are provided through a contract between the Department and an entity other than as listed above, the SEP agency for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.

B. The agency selected by the SEP district shall serve as the SEP agency for the district unless the agency selected by the district has previously had its SEP agency contract terminated by the Department.

C. The SEP district's selection shall be delivered to the Department no less than six (6) months prior to the effective date of the change in district designation or expiration of the contract with the district's existing SEP agency.

D. If the SEP district has not delivered to the Department its selection within the timeframe specified in subsection (C) of this rule, the SEP agency for the district shall be selected by the Department pursuant to applicable state statutes and regulations.

**8.391.3 Single Entry Point Contract**

A. A SEP agency shall be bound to the terms of the contract between the agency and the Department including quality assurance standards and compliance with the Department's rules for SEP agencies and for LTSS Programs.

**8391.4 Certification of Single Entry Point Agencies**

1. A SEP agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the Department's rules and in the contract between the agency and the Department.

    a. Certification as a SEP agency shall be based on an evaluation of the agency's performance in the following areas:

        i. The quality of the services provided by the agency;

        ii. The agency's compliance with program requirements, including compliance with case management standards adopted by the Department;

        iii. The agency's performance of administrative functions, including reasonable costs per individual receiving services, timely reporting, managing programs in one consolidated unit, on-site visits to individuals, community coordination and outreach and individual monitoring;

        iv. Whether targeted populations are being identified and served;

        v. Financial accountability; and

        vi. The maintenance of qualified personnel to perform the contracted duties.

    b. The Department or its designee shall conduct reviews of the SEP agency.

    c. At least sixty (60) days prior to expiration of the previous year's certification, the Department shall notify the SEP agency of the outcome of the review, which may be approval, provisional approval, or denial of certification.

**8.391.4.A. Provisional Approval of Certification**

1. In the event a SEP agency does not meet all of the quality assurance standards established by the Department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of individuals receiving services.

2. The agency will receive notification of the deficiencies, a request to submit a corrective action plan to be approved by the Department and upon receipt and review of the corrective action plan, at the Department's option, a second sixty-day (60) provisional certification may be approved.

3. The Department or its designee shall provide technical assistance to facilitate corrective action.

**8.391.4.B. Denial of Certification**

In the event certification as a SEP agency is denied, the procedure for SEP agency termination or non-renewal of contract shall apply.

**8.392 FINANCING OF THE SINGLE ENTRY POINT SYSTEM - Single Entry Point agencies are paid for deliverables completed and accepted by the Department and a Per Member Per Month (PMPM) payment for ongoing case management activities performed as identified in contract.**

**8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY**

**8.393.1.A Administration of a Single Entry Point**

1. The SEP Agency shall be required by federal or state statute, mission statement, by-laws, articles of incorporation, contracts, or rules and regulations which govern the Agency, to comply with the following standards:

    a. The SEP Agency shall serve persons in need of LTSS programs as defined in Section 8.390.3;

    b. The SEP Agency shall have the capacity to accept funding from multiple sources;

    c. The SEP Agency may contract with individuals, for-profit entities and not-for-profit entities to provide some or all SEP functions;

    d. The SEP Agency may receive funds from public or private foundations and corporations; and

    e. The SEP Agency shall be required to publicly disclose all sources and amounts of revenue.

2. For individuals with intellectual or developmental disabilities seeking or receiving services, the SEP will refer to the appropriate Community Centered Board (CCB) for programs that serve this population. In the event that the individual is eligible for programs administered by both the SEP and the CCB, the individual will have the right to choose the program in which he or she will participate.

**8.393.1.B. Community Advisory Committee**

1. The SEP Agency shall, within thirty (30) days of designation, establish a community advisory committee for the purpose of providing public input and guidance for SEP Agency operation.

    a. The membership of the Community Advisory Committee shall include, but not be limited to, regional representation from the district's county commissioners, area agencies on aging, medical professionals, LTSS providers, LTSS ombudsmen, human service agencies, county government officials and individuals receiving LTSS.

    b. The Community Advisory Committee shall provide public input and guidance to the SEP Agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall SEP Agency operations, service quality, individual satisfaction and other related professional problems or issues.

**8.393.1.C. Personnel System**

1. The SEP Agency shall have a system for recruiting, hiring, evaluating and terminating employees.

a. SEP Agency employment policies and practices shall comply with all federal and state affirmative action and civil rights requirements.

b. The SEP Agency shall maintain current written job descriptions for all positions.

**8.393.1.D. Information Management**

1. The SEP Agency shall, in a format specified by the Department, be responsible for the collection and reporting of summary and individual-specific data including but not limited to information and referral services provided by the Agency, program eligibility determination, financial eligibility determination, Support Planning, service authorization, critical incident reporting, monitoring of health and welfare, monitoring of services, resource development and fiscal accountability.

   a. The SEP Agency shall have adequate phone and computer hardware and software, compatible with - IMS with such capacity and capabilities as prescribed by the Department to manage the administrative requirements necessary to fulfill the SEP Agency responsibilities.

   b. The SEP Agency shall have adequate staff support to maintain a computerized information system in accordance with the Department's requirements.

**8.393.1.E. Recordkeeping**

1. The SEP Agency shall maintain individual records in accordance with program requirements.

   a. The case manager shall use the Department-prescribed IMS for purposes of documentation of all case activities, monitoring of service delivery, and service effectiveness. If applicable, the individual's designated representative (such as guardian, conservator, or person given power of attorney) shall be identified in the case record, with a copy of appropriate documentation.

2. If the individual is unable to sign a form requiring his/her signature because of a medical condition, a digital signature or any mark the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of a guardian or authorized representative will be accepted.

**8.393.1.F. Confidentiality of Information**

The SEP Agency shall protect the confidentiality of all records of individuals seeking and receiving services in accordance with State statute (Section 26-1-114). Release of information forms obtained from the individual must be signed, dated, and kept in the client’s record. Release of information forms shall be renewed at least annually, or sooner if there is a change of provider. Fiscal data, budgets, financial statements and reports which do not identify individuals by name or Medicaid ID number, and which do not otherwise include protected health information, are open records.

**8.393.1.G. Individual Rights**

1. The SEP Agency shall assure the protection of the rights of individuals receiving services as defined by the Department under applicable programs.

a. The SEP Agency shall assure that the following rights are preserved for all individuals served by the SEP Agency, whether the individual is a recipient of a state-administered program or a private pay individual:

i. The individual and/or the individual's authorized representative is fully informed of the individual's rights and responsibilities;

ii. The individual and/or the individual's authorized representative participates in the development and approval of, and is provided a copy of, the individual's Support Plan;

iii. The individual and/or the individual's authorized representative selects service providers from among available qualified and willing providers;

iv. The individual and/or the individual's authorized representative has access to a uniform complaint system provided for all individuals served by the SEP Agency; and

v. The individual who applies for or receives publicly funded benefits and/or the individual's authorized representative has access to a uniform appeal process, which meets the requirements of Section 8.057, when benefits or services are denied or reduced and the issue is appealable.

2. At least annually, the SEP Agency shall survey a random sample of individuals receiving services to determine their level of satisfaction with services provided by the agency.

a. The random sample of individuals shall constitute ten (10) individuals or ten percent (10%) of the SEP Agency's average monthly caseload, whichever is higher.

b. If the SEP Agency's average monthly caseload is less than ten (10) individuals, all individuals shall be included in the survey.

c. The individual satisfaction survey shall conform to guidelines provided by the Department.

d. The results of the individual satisfaction survey shall be made available to the Department and shall be utilized for the SEP Agency's quality assurance and resource development efforts.

e. The SEP Agency shall assure that consumer information regarding LTSS is available for all individuals at the local level.

**8.393.1.H. Access**

1. There shall be no physical barriers which prohibit individual participation, in accordance with the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.

a. The SEP Agency shall not require individuals receiving services to come to the Agency's office in order to receive SEP services.

b. The SEP Agency shall comply with nondiscrimination requirements, as defined by federal and Department rules and outlined in contract.

c. The functions to be performed by a SEP Agency shall be based on a case management model of service delivery.

**8.393.1.I. Staffing Patterns**

1. The SEP Agency shall provide staff for the following functions: receptionist/clerical, administrative/supervisory, case management, and medical consulting services.

   a. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, and assisting SEP Agency staff with clerical duties.

   b. The administrative/supervisory function of the SEP Agency shall include, but not be limited to, supervision of staff, training and development of Agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, resource development, marketing, liaison with the Department, and, as needed, providing case management services in lieu of the case manager.

   c. The case management function shall include, but not be limited to, all of the case management functions defined in Section 8.393.1.M. for SEP case management services, as well as resource development and attendance at staff development and training sessions.

   d. Medical consultant services functions shall include, but not be limited to, employing or otherwise contracting with a physician and/or registered nurse who shall provide consultation to SEP Agency staff regarding medical and diagnostic concerns and Adult Long-Term Home Health prior authorizations.

**8.393.1.J. Qualifications of Staff**

1. The SEP case manager(s) hired on or after October 8, 2021 shall meet minimum standards for HCBS case managers required in Section 8.519.5.B and shall be able to demonstrate competency in pertinent case management knowledge and skills.

2.. The case manager must demonstrate competency in each of the following areas:

   a. Application of a person-centered approach to planning and practice;

   b. Knowledge of and experience working with populations served by the SEP Agency;

   c. Interviewing and assessment skills;

   d. Knowledge of the policies and procedures regarding public assistance programs;

   e. Ability to develop Support Plans and service agreements;

   f. Knowledge of LTSS and other community resources; and

   g. Negotiation, intervention and interpersonal communication skills.

3. The SEP Agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of LTSS.

**8.393.1.M. Functions of the Case Manager.**

1. The SEP Agency's case manager(s) shall be responsible for: intake, screening and referral, assessment/reassessment, development of Support Plans, ongoing case management, monitoring of individuals' health and welfare, documentation of contacts and case management activities in the Department-prescribed IMS, resource development, and case closure.

    a. The case manager shall contact the individual at least once within each quarterly period, or more frequently if warranted by the individual's condition or as determined by the rules of the LTSS Program in which the individual is enrolled.

    b. The case manager shall have in-person monitoring at least one (1) time during the Support Plan year. The case manager shall ensure one required monitoring is conducted in-person with the Member, in the Member's place of residence.. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

    c. The case manager shall complete a new ULTC-100.2 during a face-to-face reassessment annually, or more frequently if warranted by the individual's condition or if required by the rules of the LTSS Program in which the individual is enrolled. Upon Department approval, reassessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

    d. The case manager shall monitor the delivery of services and supports identified within the Support Plan and the Prior Authorization Request (PAR). This includes monitoring:

        i. The quality of services and supports provided;

        ii. The health and safety of the individual; and

        iii. The utilization of services.

    e. The following criteria may be used by the case manager to determine the individual's level of need for case management services:

        i. Availability of family, volunteer, or other support;

        ii. Overall level of functioning;

        iii. Mental status or cognitive functioning;

        iv. Duration of disabilities;

        v. Whether the individual is in a crisis or acute situation;

        vi. The individual's perception of need and dependency on services;

vii. The individual's move to a new housing alternative; and

viii. Whether the individual was discharged from a hospital or Nursing Facility.

**8.393.1.N. Functions of the Single Entry Point Agency Supervisor**

1. SEP Agencies shall provide adequate supervisory staff who shall be responsible for:

   a. Supervisory case conferences with case managers on a regular basis;

   b. Approval of indefinite lengths of stay, pursuant to 8.402.15;

   c. Regular, systematic review and remediation of case records and other case management documentation, on at least a sample basis;

   d. Communication with the Department when technical assistance is required by case managers and the supervisor is unable to provide answers after reviewing the regulations and other departmental publications;

   e. Allocation and monitoring of staff to assure that all standards and time frames are met; and

   f. Assumption of case management duties when necessary.

**8.393.1.L. Training of Single Entry Point Agency Staff**

1. SEP Agency staff, including supervisors, shall attend training sessions as directed and/or provided by the Department for SEP agencies.

   a. Prior to start-up, the SEP Agency staff shall receive training provided by the Department or its designee, which will include, but not be limited to, the following content areas:

      i. Background information on the development and implementation of the SEP system;

      ii. Mission, goals, and objectives of the SEP system;

      iii. Regulatory requirements and changes or modifications in federal and state programs;

      iv. Contracting guidelines, quality assurance mechanisms, and certification requirements; and

      v. Federal and state requirements for the SEP Agency.

   b. During the first year of Agency operation, in addition to an Agency's own training, the Department or its designee will provide in-service and skill development training for SEP Agency staff. Thereafter, the SEP Agency will be responsible for in-service and staff development training.

**8.393.1.M. Provision of Direct Services**

1. The SEP Agency may be granted a waiver by the Department to provide direct services provided the Agency complies with the following:

    a. The SEP Agency shall document at least one of the following in a formal letter of application for the waiver:

        i. The service is not otherwise available within the SEP district or within a sub-region of the district; and/or

        ii. The service can be provided more cost effectively by the SEP Agency, as documented in a detailed cost comparison of its proposed service with all other service providers in the district or sub-region of the district.

    b. The SEP Agency that is granted a waiver to provide direct services due to its ability to provide the service cost effectively shall provide an annual report, at such time and on a form as prescribed by the Department, which includes a cost comparison of the service with other service providers in the area in order to document continuing cost effectiveness.

    c. The SEP Agency shall assure the Department that efforts have been made, and will continue to be made, to develop the needed service within the SEP district or within the sub-region of the district, as a service external to the SEP Agency. The SEP Agency shall submit an annual progress report, at such time as prescribed by the Department, on the development of the needed service within the district.

    d. The direct service provider functions and the SEP Agency functions shall be administratively separate.

    e. In the event other service providers are available within the district or sub-region of the district, the SEP Agency case manager shall document in the individual's case record that the individual has been offered a choice of providers.

### 8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

The SEP Agency shall provide intake and screening for LTSS Programs, information and referral assistance to other services and supports, eligibility determination, case management and, if applicable, Utilization Management services in compliance with standards established by the Department. The SEP Agency shall provide sufficient staff to meet all performance standards. In the event a SEP Agency sub-contracts with an individual or entity to provide some or all service functions of the SEP Agency, the sub-contractor shall serve the full range of LTSS programs served by the SEP Agency. Subcontractors must abide by the terms of the SEP Agency's contract with the Department and are obligated to follow all applicable federal and state rules and regulations. The SEP Agency is responsible for subcontractor performance.

#### 8.393.2.A. Protective Services

1. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of mistreatment, abuse, neglect, exploitation or a harmful act, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence and/or the local law enforcement agency. The agency shall ensure that employees and contractors obligated by statute, including but not limited to, Section 19-13-304, C.R.S., (Colorado Children's Code), Section 18-6.5-108, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and Section 26-3.1-102, C.R.S., (Human

Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

**8.393.2.B. Intake, Screening and Referral**

1. The intake, screening and referral function of a SEP Agency shall include, but not be limited to, the following activities:

    a. The completion of the intake, screening and referral functions using the Department's IMS;

        SEPs may ask referring agencies to complete and submit an intake and screening form to initiate the process;

    b. The provision of information and referral to other agencies as needed;

    c. A screening to determine whether a functional eligibility assessment is needed;

    d. The identification of potential payment source(s), including the availability of private funding resources; and

    e. The implementation of a SEP Agency procedure for prioritizing urgent inquiries.

2. When LTSS are to be reimbursed through one or more of the publicly funded LTSS programs served by the SEP system:

    a. The SEP Agency shall verify the individual's demographic information collected during the intake;

    b. The SEP Agency shall coordinate the completion of the financial eligibility determination by:

        i. Verifying the individual's current financial eligibility status; or

        ii. Referring the individual to the county department of social services of the individual's county of residence for application; or

        iii. Providing the individual with financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides; and

        iv. Conducting and documenting follow-up activities to complete the functional eligibility determination and coordinate the completion of the financial eligibility determination.

    c. The determination of the individual's financial eligibility shall be completed by the county department of social services for the county in which the individual resides, pursuant to Section 8.100.7 A-U.

    d. Individuals shall be notified by the SEP Agency at the time of their application for publicly funded long term services and supports that they have the right to appeal actions of the SEP Agency, the Department, and contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

e. The county department shall notify the SEP Agency of the Medicaid application date for the individual seeking services upon receipt of the Medicaid application.

f. The county shall not notify the SEP Agency for individuals being discharged from a hospital or nursing facility or Adult Long-Term Home Health.

**8.393.2.C. Initial Assessment**

1. For additional guidance on the ULTC-100.2, as well as the actual tool itself, see Section 8.401.1. GUIDELINES FOR LONG TERM CARE SERVICES

   a. The SEP Agency shall complete the ULTC 100.2 within the following time frames:

      i. For an individual who is not being discharged from a hospital or a nursing facility, the individual assessment shall be completed within ten (10) working days after receiving confirmation that the Medicaid application has been received by the county department of social services, unless a different time frame specified below applies.

      ii. For a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the SEP Agency shall complete the assessment within five (5) working days after notification by the nursing facility.

      iii. For a resident who is being admitted to the nursing facility from the hospital, the SEP Agency shall complete the assessment, including a PASRR Level 1 Screen within two (2) working days after notification.

         1) For PASRR Level 1 Screen regulations, refer to 8.401.18, PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

   b. For an individual who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the SEP Agency shall complete the assessment within five (5) working days after notification by the nursing facility.

   c. For an individual who is being transferred from a hospital to an HCBS program, the SEP Agency shall complete the assessment within two (2) working days after notification from the hospital.

2. Under no circumstances shall the start date for functional eligibility based on the See Section 8.486.30, ASSESSMENT.

3. The SEP Agency shall complete the ULTC 100.2 for LTSS Programs, in accordance with Section 8.401.1.

   a. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may complete the ULTC 100.2 for CHCBS.

4. The SEP Agency shall assess the individual's functional status face-to-face in the location where the person currently resides.. Upon Department approval, assessment

may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.). .

5. The SEP Agency shall conduct the following activities for a comprehensive assessment of an individual seeking services:

   a. Obtain diagnostic information through the Professional Medical Information Page (PMIP) form from the individual's medical provider for individuals in nursing facilities, HCBS Programs for Community Mental Health Supports (HCBS-CMHS), Persons with a Brain Injury (HCBS-BI), Elderly, Blind and Disabled (HCBS-EBD), Persons with a Spinal Cord Injury (HCBS-SCI) and Children with a Life Limiting Illness (HCBS-CLLI).

      i. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may obtain diagnosis(es) information from the individual's medical provider.

   b. Determine the individual's functional capacity during an evaluation, with observation of the individual and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in Section 8.401.1.

   c. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.15.

   d. Determine the need for long-term services and supports on the ULTC 100.2 during the evaluation.

   e. For HCBS Programs and admissions to nursing facilities from the community, the original ULTC-100.2 copy shall be sent to the provider agencies, and a copy shall be placed in the individual's case record. If there are changes in the individual's condition which significantly change the payment or services amount, a copy of the ULTC-100.2 must be sent to the provider agency, and a copy is to be maintained.

   f. When the SEP Agency assesses the individual's functional capacity on the ULTC-100.2, the assessment is not an adverse action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into an LTSS Program by the SEP based on the ULTC-100.2 thresholds for functional eligibility. The appeal process is governed by the provisions of Section 8.057.

6. The case manager and the nursing facility shall complete the following activities for discharges from nursing facilities:

   a. The nursing facility shall contact the SEP Agency in the district where the nursing facility is located to inform the SEP Agency of the discharge if placement into home- or community-based services is being considered.

b. The nursing facility and the SEP case manager shall coordinate the discharge date.

c. When placement into HCBS Programs is being considered, the SEP Agency shall determine the remaining length of stay.

i. If the end date for the nursing facility is indefinite, the SEP Agency shall assign an end date not past one (1) year from the date of the most recent assessment.

ii. If the ULTC 100.2 is less than six (6) months, the SEP Agency shall generate a new certification page that reflects the end date that was assigned to the nursing facility.

iii. The SEP Agency shall complete a new ULTC 100.2 if the current completion date is six (6) months old or older. The assessment results shall be used to determine level of care and the new length of stay.

iv. The SEP Agency shall send a copy of the ULTC-100.2 certification page to the eligibility enrollment specialist at the county department of social services.

v. The SEP Agency shall submit the HCBS prior authorization request to the Department or its fiscal agent.

7. For individuals receiving services in HCBS Programs who are already determined to be at the nursing facility level of care and seeking admission into a nursing facility, the SEP Agency shall:

a. Coordinate the admission date with the facility;

b. Complete the PASRR Level 1 Screen, and if there is an indication of a mental illness or developmental disability, submit to the Department or its agent to determine whether a PASRR Level 2 evaluation is required;

c. Maintain the Level 1 Screen in the individual's case file regardless of the outcome of the Level 1 Screen; and

d. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the ULTC 100.2 is not six (6) months old or older.

**8.393.2.D. Reassessment**

1. The case manager shall commence a regularly scheduled reassessment at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a reassessment of an individual receiving services within twelve (12) months of the initial individual assessment or the most recent reassessment. A reassessment shall be completed sooner if the individual's condition changes or if required by program criteria.

2. The case manager shall update the information provided at the previous assessment or reassessment, utilizing the ULTC 100.2.

3. Reassessment shall include, but not be limited to, the following activities:

a. Assess the individual's functional status face-to-face, in the location where the person currently resides.. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

b. Review Support Plan, service agreements and provider contracts or agreements;

c. Evaluate effectiveness, appropriateness and quality of services and supports;

d. Verify continuing Medicaid eligibility, other financial and program eligibility;

e. Annually, or more often if indicated, complete a new Support Plan and service agreements;

f. Inform the individual's medical provider of any changes in the individual's needs;

g. Maintain appropriate documentation, including type and frequency of LTSS the individual is receiving for certification of continued program eligibility, if required by the program;

h. Refer the individual to community resources as needed and develop resources for the individual if the resource is not available within the individual's community; and

j. Submit appropriate documentation for authorization of services, in accordance with program requirements.

4. The SEP Agency shall be responsible for completing reassessments of individuals receiving care in a nursing facility. A reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a reassessment or if the case manager assigns a definite end date. The nursing facility shall be responsible to send the SEP Agency a referral for a new assessment as needed.

5. In order to assure quality of services and supports and the health and welfare of the individual, the case manager shall ask for permission from the individual to observe the individual's residence as part of the reassessment process, but this shall not be compulsory of the individual. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.). .

**8.393.2.E. Support Plan**

1. The nursing facility shall be responsible for developing a Support Plan for individuals residing in nursing facilities.

2. The SEP Agency shall develop the Support Plan (SP) for individuals not residing in nursing facilities within fifteen (15) working days after determination of program eligibility.

3. The SEP Agency shall:

a. Address the functional needs identified through the individual assessment;

b. Offer informed choices to the individual regarding the services and supports they receive and from whom, as well as the documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but that may not be available;

c. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

d. Reflect cultural considerations of the individual and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and individuals who have limited English proficiency;

e. Formalize the Support Plan agreement, including appropriate physical or digital signatures, in accordance with program requirements;

f. Contain prior authorization for services, in accordance with program directives, including cost containment requirements;

g. Contain prior authorization of Adult Long-Term Home Health Services, pursuant to Sections 8.520-8.527;

h. Include a method for the individual to request updates to the plan as needed;

i. Include an explanation to the individual of complaint procedures;

j. Include an explanation to the individual of critical incident procedures; and

k. Explain the appeals process to the individual.

4. The case manager shall provide necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions and shall ensure that the development of the Support Plan:

a. Occurs at a time and location convenient to the individual receiving services;

b. Is led by the individual, the individual's parent's (if the individual is a minor), and/or the individual's authorized representative;

c. Includes people chosen by the individual;

d. Addresses the goals, needs and preferences identified by the individual throughout the planning process;

e. Includes the arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the individual regarding service provision and formalizing provider agreements in accordance with program rules; and

f. Includes referral to community resources as needed and development of resources for the individual if a resource is not available within the individual's community.

5. Prudent purchase of services:

   a. The case manager shall arrange services and supports using the most cost-effective methods available in light of the individual's needs and preferences.

   b. When family, friends, volunteers or others are available, willing and able to support the individual at no cost, these supports shall be utilized before the purchase of services, providing these services adequately meet the individual's needs.

   c. When public dollars must be used to purchase services, the case manager shall encourage the individual to select the lowest-cost provider of service when quality of service is comparable.

   d. The case manager shall assure there is no duplication in services provided by LTSS programs and any other publicly or privately funded services.

6. In order to assure quality of services and supports and health and welfare of the individual, the case manager shall observe the individual's residence prior to completing and submitting the individual's Support Plan. Upon Department approval, observation may be completed using virtual technology methods may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

**8.393.2.F. Cost Containment**

1. If the case manager expects that the cost of services required to support the individual will exceed the Department-determined Cost Containment Review Amount, the Department or its agent will review the Support Plan to determine whether the individual's request for services is appropriate and justifiable based on the individual's condition and quality of life and, if it is, will sign the Prior Authorization Request.

   a. The individual may request of the case manager that existing services remain intact during this review process.

   b. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:

      i. The individual's appeal rights pursuant to Section 8.057; and

      ii. Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.

**8.393.2.G. Ongoing Case Management**

1. The functions of the ongoing case manager shall be:

   a. Assessment/Reassessment: The case manager shall continually identify individuals' strengths, needs, and preferences for services and supports as they change or as indicated by the occurrence of critical incidents;

b. Support Plan Development: The case manager shall work with individuals to design and update Support Plans that address individuals' goals and assessed needs and preferences;

c. Referral: The case manager shall provide information to help individuals choose qualified providers and make arrangements to assure providers follow the Support Plan, including any subsequent revisions based on the changing needs of individuals;

d. Monitoring: The case manager shall ensure that individuals obtain authorized services in accordance with their Support Plan and monitor the quality of the services and supports provided to individuals enrolled in LTSS Programs. Monitoring shall:

1. Be performed when necessary to address health and safety and services in the care plan;

2. Include activities to ensure:

A. Services are being furnished in accordance with the individual's Support Plan;

B. Services in the Support Plan are adequate; and

C. Necessary adjustments in the Support Plan and service arrangements with providers are made if the needs of the individual have changed;

3. Include an in-person contact and observation with the individual in their place of residence, at least once per certification period. Additional in person monitoring shall be performed when required by the individual's condition or circumstance. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.)

e. Remediation: The case manager shall identify, resolve, and to the extent possible, establish strategies to prevent Critical Incidents and problems with the delivery of services and supports.

2. The case manager shall assure quality of services and supports, the health and welfare of the individual, and individual safety, satisfaction and quality of life, by monitoring service providers to ensure the appropriateness, timeliness and amount of services provided. The case manager shall take corrective actions as needed.

3. The case manager may require the Contractor to revise the Support Plan and Prior Authorization if the results of the monitoring indicate that the plan is inappropriate, the services as described in the plan are untimely, or the amount of services need to be changed to meet the Client's needs.

4. Ongoing case management shall include, but not be limited to, the following tasks:

a. Review of the individual's Support Plan and service agreements;

b. Contact with the individual concerning their safety, quality of life and satisfaction with services provided;

c. Contact with service providers to coordinate, arrange or adjust services, to address quality issues or concerns and to resolve any complaints raised by individuals or others;

d. Conflict resolution and/or crisis intervention, as needed;

e. Informal assessment of changes in individual functioning, service effectiveness, service appropriateness and service cost-effectiveness;

f. Notification of appropriate enforcement agencies, as needed; and

g. Referral to community resources as needed.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or mis-utilization of any public assistance benefit, and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with Department of Human Services Income Maintenance Rules at 9 C.C.R. 2503-8, Section 3.810 and Section 8.076.

6. The case manager shall contact the individual at least quarterly, or more frequently as determined by the individual's needs or as required by the program.

7. The case manager shall review the Department prescribed assessment and the Support Plan with the individual every six (6) months. The review shall be conducted by telephone or at the individual's place of residence, place of service or other appropriate setting as determined by the individual's needs or preferences.

8. The case manager shall complete a new ULTC 100.2 when there is a significant change in the individual's condition and when the individual changes LTSS programs.

9. The case manager shall contact the service providers, as well as the individual, to monitor service delivery as determined by the individual's needs and as required by the authorities applicable to the service.

10. Case Managers shall report critical incidents within 24 hours of notification within the State Approved IMS.

    a. Critical Incident reporting is required when the following occurs

        i. Injury/Illness;

        ii. Missing Person;

        iii. Criminal Activity;

        iv. Unsafe Housing/Displacement;

        v. Death;

        vi. Medication Management Issues;

vii. Other High-Risk Issues;

viii. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;

ix. Damage to the Consumer's Property/Theft.

b. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the Agency administrator or designee.

c. Case Managers shall comply with mandatory reporting requirements set forth at Section 18-6.5-108, C.R.S, Section 19-3-304, C.R.S and Section 26-3.1-102, C.R.S.

d. Each Critical Incident Report must include:

i. incident type

a. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at Section 19-1-103, 26-3.1-101, 16-22-102 (9), and 25.5-10-202 C.R.S.

b. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues, missing persons, unsafe housing or displacement, other high risk issues.

ii. Date and time of incident;

iii. Location of incident, including name of facility, if applicable;

iv. Individuals involved;

v. Description of incident, and

vi. Resolution of incident, if applicable.

e. The Case Manager shall complete required follow up activities and reporting in the State approved IMS within assigned timelines.

**8.393.2.H. Case Recording/Documentation**

1. The SEP Agency shall complete and maintain all required records included in the State approved IMS and shall maintain individual case records at the Agency level for any additional documents associated with the individual applying for or enrolled in a LTSS Program.

2. The case record and/or IMS shall include:

a. Identifying information, including the individual's state identification (Medicaid) number and Social Security number (SSN);

b. All State-required forms; and

c. Documentation of all case management activity required by these regulations.

3. Case management documentation shall meet all the following standards:

a. Documentation must be objective and understandable for review by case managers, supervisors, program monitors and auditors;

b. Entries must be written at the time of the activity or no later than five (5) business days from the time of the activity;

c. Entries must be dated according to the date of the activity, including the year;

d. Entries must be entered into Department's IMS;

e. The person making each entry must be identified;

f. Entries must be concise, but must include all pertinent information;

g. All information regarding an individual must be kept together, in a logical organized sequence, for easy access and review by case managers, supervisors, program monitors and auditors;

h. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact or is a judgment or conclusion on the part of anyone;

i. All persons and agencies referenced in the documentation must be identified by name and by relationship to the individual;

j. All forms prescribed by the Department shall be completely and accurately filled out by the case manager; and

k. Whenever the case manager is unable to comply with any of the regulations specifying the time frames within which case management activities are to be completed, due to circumstances outside the SEP Agency's control, the circumstances shall be documented in the case record. These circumstances shall be taken into consideration upon monitoring of SEP Agency performance.

4. Summary recording to update a case record shall be entered into the IMS at least every six (6) months, whenever a case is transferred from one SEP Agency to another, and when a case is closed.

**8.393.2.I. Resource Development Committee**

1. The SEP Agency shall assume a leadership role in facilitating the development of local resources to meet the LTSS needs of individuals seeking or receiving services who reside within the SEP district served by the SEP Agency.

2. Within 90 days of the effective date of the initial contract, the SEP Agency's community advisory committee shall appoint a resource development committee.

3. The membership of the resource development committee shall include, but not be limited to, representation from the following local entities: Area Agency on Aging (AAA), county

departments of social services, county health departments, home health agencies, nursing facilities, hospitals, physicians, community mental health centers, community centered boards, vocational rehabilitation agencies, and individuals receiving long-term services.

4. In coordination with the resource development efforts of the Area Agency on Aging (AAA) that serves the district, the resource development committee shall develop a local resource development plan during the first year of operation.

    a. The resource development plan shall include:

        i. An analysis of the LTSS resources available within the SEP district;

        ii. Gaps in LTSS resources within the SEP district;

        iii. Strategies for developing needed resources; and

        iv. A plan for implementing these strategies, including the identification of potential funding sources, potential in-kind support and a time frame for accomplishing stated objectives.

    b. The data generated by the SEP Agency's intake, screening and referral, individual assessment, documentation of unmet individual needs, resource development for individuals and data available through the Department shall be used to identify persons most at risk of nursing facility care and to document the need for resources locally.

5. At least annually, the resource development committee shall provide progress reports on the implementation of the resource development plan to the community advisory committee and to the Department.

**8.393.3 DENIALS/DISCONTINUATIONS/ADVERSE ACTIONS**

**8.393.3.A. Denial Reasons and Notification Actions**

1. Individuals seeking or receiving services shall be denied or discontinued from services under publicly funded programs served by the SEP system if they are determined ineligible for any of the reasons below. Individuals shall be notified of any of the adverse actions and appeal rights as follows:

    a. Financial Eligibility

        i. The eligibility enrollment specialist from the county department of social services shall notify the individual of denial or discontinuation for reasons of financial eligibility and shall inform the individual of appeal rights in accordance with Section 8.057.

        ii If the individual is found to be financially ineligible for LTSS programs, the SEP Agency shall notify the individual of the adverse action and inform the individual of their appeal rights in accordance with Section 8.057. The case manager shall not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the Department.

b. Functional Eligibility and Target Group

i. The SEP Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual does not meet the functional eligibility threshold for LTSS Programs or nursing facility admissions; or

2) The individual does not meet the target group criteria as specified by the HCBS Program.

c. Receipt of Services

i. The SEP Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual has not received long-term services or supports for thirty (30) days;

2) The individual has two (2) times in a thirty-day consecutive period refused to schedule an appointment for assessment, or monitoring required by these regulations;

3) The individual has failed to keep three scheduled assessment appointments within a thirty-day consecutive period; or

4) The SEP Agency does not receive the completed Professional Medical Information Page (PMIP) form, when required.

d. Institutional Status

i. The SEP Agency shall notify the individual of denial or discontinuation by sending the Notice of Services Status (LTC-803) when the case manager determines that the individual does not meet the following program eligibility requirements.

1) The individual is not eligible to receive HCBS services while a resident of a nursing facility, hospital, or other institution; or

2) The individual who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty (30) days or more.

e. Cost-Effectiveness/Service Limitations

i. During the Support Planning process in conjunction with the initial assessment or reassessment, the individual seeking or receiving services shall not be eligible for the HCBS program if the case manager determines the individual’s needs are more extensive than the HCBS program services are able to support, the individual’s health and safety

cannot be assured in a community setting, and/or the cost containment review process is not met as outlined in Section 8.393.2.F.

1) If the case manager determines that the individual is ineligible for an HCBS Program, the case manager shall:

a) Obtain any other documentation necessary to support the determination; and

b) Inform the individual of their appeal rights pursuant to Section 8.057.

2. The Long-Term Care Waiver Program Notice Action (LTC-803) shall be completed in the IMS for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, and at the time of discontinuation.

3. In the event the individual appeals a denial or discontinuation action, except for reasons related to financial eligibility, the case manager shall attend the appeal hearing to defend the denial or discontinuation action.

**8.393.3.B. Case Management Actions Following a Denial or Discontinuation**

1. In the case of denial or discontinuation, the case manager shall provide appropriate referrals to other community resources, as needed, within one (1) working day of discontinuation.

2. The case manager shall notify all providers on the Support Plan within one (1) working day of discontinuation.

3. The case manager shall follow procedures to close the individual's case in the IMS within one (1) working day of discontinuation for all HCBS Programs.

4. If a case is discontinued before an approved HCBS Prior Authorization Request (PAR) has expired, the case manager shall submit to the Department or its fiscal agent, within five (5) working days of discontinuation, a copy of the current PAR form on which the end date is adjusted (and highlighted in some manner on the form); and the reason for discontinuation shall be written on the form.

**8.393.3.C. Notification**

1. The SEP Agency shall notify the county eligibility enrollment specialist of the appropriate county department of social services:

a. At the same time it notifies the individual seeking or receiving services of the adverse action;

b. When the individual has filed a written appeal with the SEP Agency; and

c. When the individual has withdrawn the appeal or a final Agency decision has been entered.

2. The SEP Agency shall provide information to individuals seeking and receiving services regarding their appeal rights when individuals apply for publicly funded LTSS and whenever the individual requests such information, whether or not adverse action has been taken by the SEP Agency.

**8.393.4. COMMUNICATION**

A. In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the eligibility enrollment specialist of any and all changes affecting the participation of an individual receiving services in SEP Agency-served programs, including changes in income, within one (1) working day after the case manager learns of the change. The case manager shall provide the eligibility enrollment specialist with copies of the certification page of the approved ULTC-100.2 form.

2. If the individual has an open adult protective services (APS) case at the county department of social services, the case manager shall keep the individual's APS worker informed of the individual's status and shall participate in mutual staffing of the individual's case.

3. The case manager shall inform the individual's physician of any significant changes in the individual's condition or needs.

4. The case manager shall report to the Colorado Department of Public Health and Environment (CDPHE) any congregate facility which is not licensed.

**8.393.5 FUNCTIONAL ELIGIBILITY DETERMINATION**

A. The SEP Agency shall be responsible for the following:

1. Ensuring that the ULTC 100.2 is completed in the IMS in accordance with Section 8.401.1 and justifies that the individual seeking or receiving services should be approved or disapproved for admission to or continued stay in an applicable LTSS program.

2. Once the assessment is complete in the IMS, the case manager shall generate a certification page in the IMS within three (3) business days for hospital discharge to a Nursing Facility, within six (6) business days for Nursing Facility discharge and within eleven (11) business days of receipt of referral.

3. If the assessment indicates approval, the SEP Agency shall notify the appropriate parties.

4. If the assessment indicates denial, the SEP Agency shall notify the appropriate parties in accordance with 8.393.3.A.2.

5. If the individual or individual's legally authorized representative appeals, the SEP Agency shall process the appeal request, according to Section 8.057.

**8.393.6. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES**

**8.393.6.A. Intercounty Transfers**

1. SEP agencies shall complete the following procedures to transfer individuals receiving case management services to another county within the same SEP district:

a. Notify the current county department of social services eligibility enrollment specialist of the individual's plans to relocate to another county and the date of transfer, with financial transfer details at Section 8.100.3.C.

b. If the individual's current service providers do not provide services in the area where the individual is relocating, make arrangements, in consultation with the individual, for new service providers.

c. In order to assure quality of services and supports and health and welfare of the individual, the case manager must observe and evaluate the condition of the individual's residence. Upon Department approval, observation may be completed using virtual technology methods. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

d. If the individual is moving from one county to another to enter an Alternative Care Facility (ACF), forward copies of the following individual records to the ACF prior to the individual's admission to the facility:

i. ULTC 100.2, certified by the SEP;

ii. The individual's updated draft Prior Authorization Request (PAR) and/or Post Eligibility Treatment of Income (PETI) form; and

iii. Verification of Medicaid eligibility status.

**8.393.6.B. Inter-district Transfers**

1. SEP Agencies shall complete the following procedures in the event an individual receiving services transfers from one SEP district to another SEP district:

a. The transferring SEP Agency shall contact the receiving SEP Agency by telephone and give notification that the individual is planning to transfer, negotiate a transfer date and provide all necessary information.

b. The transferring SEP Agency shall notify the original county department of social services eligibility enrollment specialist of the individual's plan to transfer and the transfer date, and eligibility enrollment specialist shall follow rules described in Section 8.100.3.C. The receiving SEP Agency shall coordinate the transfer with the eligibility enrollment specialist of the new county.

c. The transferring SEP Agency shall make available in the IMS the individual's case records to the receiving SEP Agency prior to the relocation.

d. If the individual is moving from one SEP District to another SEP District to enter an ACF, the transferring SEP Agency shall forward copies of the individual's records to the ACF prior to the individual's admission to the facility, in accordance with section 8.393.6.A.

e. To ensure continuity of services and supports, the transferring SEP Agency and the receiving SEP Agency shall coordinate the arrangement of services prior to the individual's relocation to the receiving SEP Agency's district and within ten (10) working days after notification of the individual's relocation.

f. The receiving SEP Agency shall complete a face-to-face meeting with the individual in the individual's residence and a case summary update within ten (10) working days after the individual's relocation, in accordance with assessment procedures for individuals served by SEP Agencies. Upon Department approval, meeting may be completed using virtual technology methods or may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.)

g. The receiving SEP Agency shall review the Support Plan and the ULTC 100.2 and change or coordinate services and providers as necessary.

h. If indicated by changes in the Support Plan, the receiving SEP Agency shall revise the Support Plan and prior authorization forms as required by the publicly funded program.

i. Within thirty (30) calendar days of the individual's relocation, the receiving SEP Agency shall forward to the Department, or its fiscal agent, revised forms as required by the publicly funded program.

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Creation of the Medical Assisatance Rule concerning Mobile Crisis Response, Section 8.020
Rule Number: MSB 22-12-13-C
Division / Contact / Phone: Health Programs Office / Alex Lyons / 303-866-2865

# 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 22-13-22-C, Creation of the Medical Assisatance Rule concerning Mobile Crisis Response, Section 8.020

3. This action is an adoption of: new rule section

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

   Sections(s) 8.020 (NEW), 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 8.020. This rule is effective June 30, 2023.

*to be completed by MSB Board Coordinator

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Creation of the Medical Assisatance Rule concerning Mobile Crisis Response, Section 8.020
Rule Number: MSB 22-12-13-C
Division / Contact / Phone: Health Programs Office / Alex Lyons / 303-866-2865

## 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 creating a mobile crisis response benefit. Mobile crisis teams will be dispatched to members experiencing a behavioral health crisis. A new rule section is required to authorize a benefit to enable providers to be reimbursed for this program.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Section 27-60-104, C.R.S. (2022)
   Sections 25.5-1-301 through 25.5-1-303 (2022)

Initial Review **04/14/23** Final Adoption **05/12/23**
Proposed Effective Date **06/30/23** Emergency Adoption

**DOCUMENT #12**

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Creation of the Medical Assisatance Rule concerning Mobile Crisis Response, Section 8.020
Rule Number: MSB 22-12-13-C
Division / Contact / Phone: Health Programs Office / Alex Lyons / 303-866-2865

# 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.

   All Colorado Medicaid members will be eligible for the mobile crisis response benefit from its implementation. The cost, as with Medicaid programs generally, is borne by a combination of state and federal 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 Department anticipates that mobile crisis response will improve access to appropriate medical care and mental health services for Medicaid members experiencing a behavioral health crisis. This rule permits providers of this benefit to be reimbursed for their services. This rule will allow for members not enrolled in the capitated behavioral health program to have access to the mobile crisis response benefit, that will allow members to continue to be serviced in their communities and in lieu of unnecessary hospitalizations.

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 bear the cost of enforcing this rule and ensuring that providers meet the requirements specified in the rule. Overall, the cost of managing and supervising the mobile crisis response benefit will be carried by the Behavioral Health Administration within the Department of Human Services.

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

   The Department anticipates that this rule will result in increased access to crisis services, an existing benefit under the behavioral health capitation program. The increase in state costs from higher utilization is expected to be offset by applying an 85% enhanced federal match available through American Rescue Plan Act (ARPA) for all mobile crisis response services. The probable benefit is that members will have a greater opportunity to receive mobile crisis services that can mitigate the

need for unnecessary hospitalizations. Likewise, rejecting this rule would likely prevent the implementation of the mobile crisis response benefit, which would leave utilization and access at current levels. This would also prevent the State from drawing down the 85% enhanced federal match.

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

   There is likely no less costly alternative to expanding access to mobile crisis services. The Department is able to draw down an enhanced 85% federal match for Mobile Crisis services by implementing these changes. This is projected to offset the costs of the increase in utilization.

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

   The Department considered not implementing the changes to the crisis services. This was rejected as it would mean that the Department would be unable to drawn down the 85% enhanced federal match and members would continue to have unmet needs through the current behavioral health program.

## 8.020 MOBILE CRISIS RESPONSE

### 8.020.A DEFINITIONS

1. Behavioral Health Crisis means a significant disruption in a person's mental or emotional stability or functioning resulting in an urgent need for immediate assessment and treatment to prevent a further or serious deterioration in the person's mental or physical health.

2. Mobile Crisis Response (MCR) means the community-based brief intervention, stabilization, and de-escalation of a member experiencing a Behavioral Health Crisis.

### 8.020.B MEMBER ELIGIBILITY

1. All Colorado Medicaid members are eligible for MCR services.

### 8.020.C PROVIDER ELIGIBILITY

1. A Medicaid enrolled provider that is endorsed as a MCR provider by the Behavioral Health Administration (BHA) is eligible to receive reimbursement for MCR covered services.

### 8.020.D COVERED SERVICES

1. MCR covered services include:

    a. Community-based crisis interventions to members in self-defined Behavioral Health Crises, such interventions include:

        i. Screening,

        ii. Assessment,

        iii. De-escalation,

        iv. Safety planning, and

        v. Coordination with culturally responsive referrals to appropriate resources, including health, social, and other services and supports.

    b. MCR providers must meet a member where they are in the community (most commonly at home or at a location in the community requested by the caller) within one (1) hour of dispatch to urban areas, and within two (2) hours of dispatch to rural and frontier areas.

        i. An initial Mobile Crisis Response must be a paired response by any two members of the MCR team.

        ii. MCR services may be provided via Telemedicine in accordance with Section 8.095 by any one (1) member of the MCR provider's team, where appropriate.

        iii. The initial Telemedicine face-to-face crisis response must include at least (1) in-person responder from the MCR team.

    c. Covered services must be performed during the following episodes of care:

        i. The initial face-to-face crisis response;

ii. The initial follow-up consultation twenty-four (24) hours after the initial crisis and for up to five days after; and

iii. Secondary follow-up to ensure warm handoff and scheduling appointments to referrals within seven (7) days of referral by the MCR provider.

**8.020.E NON-COVERED SERVICES**

8.020.E.1 MCR does not include:

a. Services provided in institutions or medical facilities, including but not limited to:

i. Inpatient hospital services.

ii. Inpatient psychiatric hospital services.

iii. Emergency Department services.

iv. Psychiatric Residential Treatment Facilities.

v. Qualified Residential Treatment Programs.

vi. Inpatient Drug and Alcohol Rehabilitation Centers.

vii. Prisons and Jails.

viii. Other settings that offer crisis services, such as Community Mental Health Centers (CMHCs), Certified Community Behavioral Health Clinics (CCBHCs) or comprehensive behavioral health providers.

b. Secure Transportation services as described in Section 8.019.

c. Medical diagnosis, evaluation, medication, and treatment.

d. Higher levels of medical care.

**8.020.6 REIMBURSEMENT**

1. Reimbursement is in accordance with the Department's fee schedule.

**8.020.7 PRIOR AUTHORIZATION REQUIREMENTS**

1. Prior authorization is not required.