

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules concerning Buy-in Monthly Premium Waiver Extension, 8.100.6.Q.1.f.vii and 8.100.6.P.1.f.vi
Rule Number: MSB 24-03-19-A
Division / Contact / Phone: Office of Medicaid Operations / Nancy Brenes / 303-866-2897

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 24-03-19-A, This action is an adoption of: Revision to the Medical Assistance Eligibility Rules Concerning Buy-in monthly premium waiver extension
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) 8.100.6.Q.1.f.vii and 8.100.6.P.1.f.vi, 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 8.100.6.P with the proposed text beginning at 8.100.6.P.1.f.vi through the end of 8.100.6.P.1.f.vi. Replace the current text at 8.100.6.Q with the proposed text beginning at 8.100.6.Q.1.f.vii through the end of 8.100.6.Q.1.f.vii. This rule is effective August 30, 2024.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules concerning Buy-in Monthly Premium Waiver Extension, 8.100.6.Q.1.f.vii and 8.100.6.P.1.f.vi
Rule Number: MSB 24-03-19-A
Division / Contact / Phone: Office of Medicaid Operations / Nancy Brenes / 303-866-2897

STATEMENT OF BASIS AND PURPOSE

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

The proposed rule change will amend 10 CCR 2505-10 8.100.6.Q.1.f.vii. and 8.100.6.P.1.f.vi to incorporate changes to the duration of the extension period for the Working Adults with Disabilities (WAWD) and the Children's Buy-In with Disabilities (CBWD) programs. The current rule provides that the Department will waive premiums until the last day of the twelfth month following the end of the COVID-19 Public Health Emergency. The change will reflect that the Department will continue to waive premiums until further notice.

The rule must be updated to reflect the fact that the Department will continue to waive the collection of monthly premiums. No Colorado Benefits Management System changes are needed.

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:
N/A
4. State Authority for the Rule:
Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023)

Initial Review
Proposed Effective Date

06/14/24
08/30/24

Final Adoption
Emergency Adoption

07/12/24

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules concerning Buy-in Monthly Premium Waiver Extension, 8.100.6.Q.1.f.vii and 8.100.6.P.1.f.vi

Rule Number: MSB 24-03-19-A

Division / Contact / Phone: Office of Medicaid Operations / Nancy Brenes / 303-866-2897

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.

With the proposed rule, applicants and/or recipients of the Working Adults with Disabilities (WAWD) and the Children's Buy-In with Disabilities (CBWD) programs will continue to have their monthly premiums waived until further notice. This change may help members stay enrolled in the program since there is no monthly expense associated with continuous coverage.

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 will remove the requirement that applicants and/or recipients of the Working Adults with Disabilities (WAWD) and the Children's Buy-In with Disabilities (CBWD) programs will not have to incur the expense of paying a monthly premium.

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.

For FFY 23-24, the cost of continuing to waive monthly premiums for this population is \$3,713,593 in total funds and \$1,856,297 in HAS Fee funds.

For FFY 24-25, the cost of continuing to waive monthly premiums for this population is \$5,197, 631 in total funds and \$2,598,816 in HAS Fee funds.

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

Our budget department has advised that reinstating premiums could impact access to affordable care for the buy-in program population. Inaction could lead to a potential cost decrease in caseload and associated program costs due to reduced member enrollment.

DO NOT PUBLISH THIS PAGE

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

There are no less costly or less intrusive methods for achieving the 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.

There were no alternative methods considered for the proposed rule.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.6 Aged, Blind, and Disabled Medical Assistance Eligibility

8.100.6.P. Medicaid Buy-In Program for Working Adults with Disabilities.

1. To be eligible for the Medicaid Buy-In Program for Working Adults with Disabilities:
 - a. Applicants must be at least age 16.
 - b. Income must be less than or equal to 450% of FPL after income allocations and disregards. See 8.100.5.F for Income Requirements and 8.100.5.H for Income allocations and disregards. Only the applicant's income will be considered.
 - c. Resources are not counted in determining eligibility.
 - d. Individuals must have a disability as defined by Social Security Administration medical listing or a limited disability as determined by a state contractor.
 - e. Individuals must be employed. Please see Verification Requirements at 8.100.5.B.1.c.
 - i) Due to the federal COVID-19 Public Health Emergency, and required by the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss of employment will remain in the Buy-In program until the end of the federal Public Health Emergency. At the end of the federal Public Health Emergency effective May 11, 2023, members will be redetermined based on their current employment status and be required to be employed to be eligible for the program. New applicants enrolled will still need to meet the work requirement.
 - f. Individuals will be required to pay monthly premiums on a sliding scale based on income.
 - i) The amount of premiums cannot exceed 7.5% of the individual's income.

- ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.
- iii) Premium amounts are as follows:
 - 1) There is no monthly premium for individuals with income at or below 40% FPL.
 - 2) A monthly premium of \$25 is applied to individuals with income above 40% of FPL but at or below 133% of FPL.
 - 3) A monthly premium of \$90 is applied to individuals with income above 133% of FPL but at or below 200% of FPL.
 - 4) A monthly premium of \$130 is applied to individuals with income above 200% of FPL but at or below 300% of FPL.
 - 5) A monthly premium of \$200 is applied to individuals with income above 300% of FPL but at or below 450% of FPL.
- iv) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by \$10 or more.
- v) A change in a member's net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in the member's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due. The Department will waive premiums for the Medicaid Buy-In for Working Adults with Disability Program for member's who are within their 12 months postpartum period.
- vi) Due to the federal COVID-19 Public Health Emergency, the Department ~~will~~ waived premiums for the Medicaid Buy-In for Working Adults with Disability Program during the federal COVID-19 emergency declaration. ~~Effective May 11, 2023 the COVID-19 Public Health Emergency has ended.~~ The Department will continue to waive premiums until the last day of the twelfth month following the end of the COVID-19 Public Health past the end of the Emergency declaration and until further notice. The Department will notify all members as to when required premiums will resume.

- 2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation
- 3. Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Working Adults with Disabilities. This is also called "opt out."

8.100.6.Q. Medicaid Buy-In Program for Children with Disabilities

- 1. To be eligible for the Medicaid Buy-In Program for Children with Disabilities:
 - a. Applicants must be age 18 or younger.

- b. Household income will be considered and must be less than or equal to 300% of FPL after income disregards. The following rules apply:
 - i) 8.100.4.E - MAGI Household Requirements
 - ii) 8.100.5.F - Income Requirements
 - iii) 8.100.5.F.6 - Income Exemptions
 - iv) An earned income of \$90 shall be disregarded from the gross wages of each individual who is employed
 - v) A disregard of a 33% (.3333) reduction will be applied to the household's net income.
- c. Resources are not counted in determining eligibility.
- d. Individuals must have a disability as defined by Social Security Administration medical listing.
- e. Children age 16 through 18 cannot be employed. If employed, children age 16 through 18 shall be determined for eligibility through the Medicaid Buy-In Program for Working Adults with Disabilities.
- f. Families will be required to pay monthly premiums on a sliding scale based on household size and income.
 - i) For families whose income does not exceed 200% of FPL, the amount of premiums and cost-sharing charges cannot exceed 5% of the family's adjusted gross income. For families whose income exceeds 200% of FPL but does not exceed 300% of FPL, the amount of premiums and cost-sharing charges cannot exceed 7.5% of the family's adjusted gross income.
 - ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.
 - iii) For households with two or more children eligible for the Medicaid Buy-In Program for Children with Disabilities, the total premium shall be the amount due for one eligible child.
 - iv) Premium amounts are as follows:
 - 1) There is no monthly premium for households with income at or below 133% of FPL.
 - 2) A monthly premium of \$70 is applied to households with income above 133% of FPL but at or below 185% of FPL.
 - 3) A monthly premium of \$90 is applied to individuals with income above 185% of FPL but at or below 250% of FPL.
 - 4) A monthly premium of \$120 is applied to individuals with income above 250% of FPL but at or below 300% of FPL.

- v) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by \$10 or more.
- vi) A change in household net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in a member's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due. The Department will waive premiums for the Children with Disabilities Program members who are within their 12 months postpartum period.
- vii) Due to the federal COVID-19 Public Health Emergency, the Department ~~will~~ waived premiums for the ~~Department's~~ Children with Disabilities Program during the federal COVID-19 emergency declaration. ~~Effective May 11, 2023 the COVID-19 Public Health Emergency has ended.~~ The Department will continue to waive premiums past the end of the emergency declaration and until further notice. until the last day of the twelfth month following the end of the COVID-19 Public Health Emergency. The Department will notify all members as to when required premiums will resume.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation.
3. Verification requirements will follow the MAGI Category Verification Requirements found at 8.100.4.B.
4. Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Children with Disabilities. This is also called "opt out."

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical assistance Rule concerning Transition Coordination Services & Targeted Case Management – Transition Coordination (TCM-TC), Section 8.519.27 & 8.763

Rule Number: MSB 24-02-22-B

Division / Contact / Phone: Compliance and Innovation (CID) / Nora Brahe / 303-866-3566

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 24-02-22-B , Revision to the Medical assistance Rule concerning Transition Coordination Services & Targeted Case Management – Transition Coordination (TCM-TC), Section 8.519.27 & 8.763
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) 8.519.27 8.763, Colorado Department of Health Care Policy and Financing, Child Health Plan *Plus* (10 CCR 2505-3).
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 8.519.27 with the proposed text beginning at 8.519.27.A through the end of 8.519.27.H.1. Replace the current text at 8.763 with the proposed text beginning at 8.763 through the end of 8.763.C.1.d. This rule is effective August 30, 2024.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical assistance Rule concerning Transition Coordination Services & Targeted Case Management – Transition Coordination (TCM-TC), Section 8.519.27 & 8.763

Rule Number: MSB 24-02-22-B

Division / Contact / Phone: Compliance and Innovation (CID) / Nora Brahe / 303-866-3566

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 revision to Targeted Case Management (TCM-TC) Transition Coordination rules will expand the eligibility to individuals who are at-risk of being placed in an institutional setting.

Transition Coordination Services in the Department of Health Care Policy and Financing (the Department) was established April 30, 2018, by House Bill 18-1326, Support for Transitions from Institutional Settings. Passed with unanimous support, this enactment directs the Department to provide community transition services and supports to people who are in institutional settings, are eligible for Medicaid, and desire to transition to a home and community-based setting. Targeted Case Management-Transition Coordination (TCM-TC) officially began providing transition services to Medicaid members on January 1, 2019. Implementation of TCM-TC is based on the success of the Money Follows the Person (MFP) grant program, which Colorado implemented as the Colorado Choice Transitions (CCT) demonstration in 2013. Concluding December 31, 2018, the CCT program helped 702 people transition from institutional settings to the community

TCM-TC is a permanent Medicaid benefit that works in combination with the State Plan and waiver services to reduce barriers to community access, while supporting a variety of life-changing events for members living in the community. The purpose of the proposed TCM-TC rule revision is to expand eligibility for the benefit to individuals who are at-risk of admission to institutions or institution-like settings.

Informed choice is central to person-centered philosophy and members' potential to thrive in a less restrictive setting. Helping individuals who desire to live and receive services in a community-based setting supports informed choice. TCM-TC provides this assistance as well as acting as a bridge from institutional settings to community-based supports and services.

The need for the rule revision is further justified by Federally required assessments that indicate that more people living in institutional settings expressed an interest in living in home or community-based settings than current services can support.

A change in service eligibility will likely decrease the number of individuals who are placed in institutional settings.

2. An emergency rule-making is imperatively necessary

Initial Review

06/14/24

Final Adoption

07/12/14

Proposed Effective Date

08/30/24

Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

- ☐ 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:

42 U.S.C. §1396n(c) and The Social Security Act, §1915(c).

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2023);

C.R.S. § 25.5-6-1501(6)

Initial Review
Proposed Effective Date

06/14/24
08/30/24

Final Adoption
Emergency Adoption

07/12/14

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical assistance Rule concerning Transition Coordination Services & Targeted Case Management – Transition Coordination (TCM-TC), Section 8.519.27 & 8.763

Rule Number: MSB 24-02-22-B

Division / Contact / Phone: Compliance and Innovation (CID) / Nora Brahe / 303-866-3566

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.

Medicaid members who reside outside of institutional settings who are at-risk of placement in an institution or institutional-like settings, are willing to participate in the program, and have expressed a desire to remain in a community-based setting. Excluded are children under the age of 18.

Adults considered within the at-risk criteria will benefit from resources otherwise unavailable to them. Access to care can be a challenge for people in urgent situations. Expansion of TCM-TC to the at-risk population provides direct support to members who need assistance establishing plans for long-term care.

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

Individuals who are at-risk of entering higher levels of care will be identified so the appropriate level of care can be provided before their needs increase. The Department would serve Medicaid members with a person-centered, lower cost model than would occur in a qualified institution.

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 TCM-TC benefit has demonstrated a sustained successful state savings record. These savings will increase because of decreased utilization of high-cost Medicaid institutional services and maintaining utilization of community-based services.

The provision of quality care in the community is also cost-effective. Most members' needs can be met in the community for a cost that is less than the cost of living in an institution.

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

DO NOT PUBLISH THIS PAGE

Medicaid members in risky situations can be served at the level of care they need before those needs rise to the point of requiring a higher level of care. The increased cost of higher levels of care can therefore be mitigated.

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

The rule revision, as a matter of both state policy intention and federal compliance, will uphold policies of least restrictive environment and those requirements of the CMS Final Settings Rule (42 C.F.R. § 441.301), including maximizing individual choice, autonomy, rights, community integration, among other principles. These policies and the services' person-centered commitment, will be balanced with each individual's health and safety needs.

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.

Alternative methods of preventing placement in an institutional setting include utilization of HCBS and Regional Accountable Entity care coordination, and community-based providers.

TCM-TC in conjunction with waiver Transition Services is a comprehensive package of wrap-around services specifically designed to provide a higher level of support for individuals adjusting from institutional care to community-based living. TCM-TC acts as a bridge to ensure members are connected to necessary long-term supports and services. As such, TCM-TC, in conjunction with waiver Transition Services provides a viable ongoing pathway to sustainable community living for people who would otherwise likely be placed in restrictive settings.

The option of transition coordination services may be enhanced, substituted, or supplemented with other Department initiatives including initiative's helping an individual explore and coordinate other effective, low-cost alternatives or supplements to state funded resources. Through supporting any mix or alternatives of supports, state-funded and/or not state funded, the Department is committed to working toward supporting individual's access to quality, effective, individualized services in a way that best services individuals' needs and upholds fiscal responsibility and a commitment to reducing cost impact on the state.

8.519.27 Transition Coordination Services

8.519.27.A Definitions

1. At-Risk means a Medicaid member who lives outside of an institutional facility and has either received a Level of Care Screening to access Medicaid nursing facility services or is at risk for institutionalization as determined by the Department.

~~An individual that is currently living in a community setting.~~

~~An individual with a physical disability over the age of 21 who is enrolled in the State Medicaid program.~~

~~The presence of a co-occurring disability (such as mental illness or an intellectual or developmental~~

~~disability) does not exclude an individual with a physical disability from the Target Population.~~

~~An individual is not excluded from the Target Population by virtue of having or lacking Unpaid Supports.~~

2. At Risk Diversion means a Person-Centered process through which services are arranged or provided to enable an At-Risk population member to avoid admission to an institution or institution-like setting to live instead in a less restrictive setting in the community.

3. Case Management Agency (CMA) means a public, private, or non-governmental non20 profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to sections [25.5-10-209.5 C.R.S.] and pursuant to a provider participation agreement with the state department.

- 4.2. Community Needs and Preferences Assessment means the assessment that is completed by the Transition Options Team (TOT) to ensure a comprehensive understanding of the member's health conditions, functional needs, transition needs, behavioral concerns, social and cultural considerations, educational interests, risks and other areas that may require services and/or community resource support.

53. Community Risk Level means the potential for a member living in a community-based arrangement to require emergency services, to be admitted to an institution or institution-like setting hospital, skilled nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities, be evicted from their home or be involved with law enforcement due to identified risk factors.

64. Corrective Action Plan (CAP) means a written plan by the Transition Coordination Agency (TCA), and approved by the Department, which includes a detailed description of actions to be taken to correct non-compliance with regulations, and/or 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. Corrective Action Plans may be requested by the Department at any time.

857. Post-Transition Monitoring means the activities performed by a Transition Coordination Agency (TCA) that occur after a member has successfully transitioned moved into the community or has been diverted from institutionalization and is a recipient of home-and community-based services.

- ~~968~~. Pre-Transition Coordination means the activities by the 1 TCA that occur before a member has transitioned into the community to prepare the member for success in community living and integration.
- ~~4079~~. Risk Factors mean factors that include but are not limited to health, safety, environmental, community integration, service interruption, inadequate support systems and substance abuse that may contribute to an individual's community risk level.
- ~~44810~~. Risk Mitigation Plan means the document that records the risk mitigation planning process. Risk Mitigation Plans are used to complete Pre-Transition and Diversion strategy development, conduct post-discharge monitoring of effectiveness of risk prevention strategies, document identification of additional risk factors, and revise risk incident response plans.
- ~~43911~~. Risk Mitigation Planning means the process of identifying risk factors, developing options and actions to enhance opportunities and prevent adverse consequences that would result if risk is not managed. Risk mitigation planning includes identifying planned actions to take in response to an adverse consequence should a risk be realized.
- ~~4012~~. Community Needs and Preferences Transition-Assessment means the process of capturing a comprehensive understanding of the member's health conditions, functional needs, transition needs, behavioral concerns, social and cultural considerations, educational interests, risks and other areas important to community integration and transition to a home and community-based setting.
- ~~5413~~. Transition Coordination Services means support provided to a member who is transitioning or being diverted from a skilled nursing facility, extended SNF LOC hospital stay, intermediate care facility for individuals with intellectual disabilities, or regional center and includes the following activities: comprehensive assessment for transition or diversion, community risk assessment, development of a transition or diversion plan, referral and related activities, and monitoring and follow up activities as they relate to the transition or diversion.
- ~~6214~~. Transition Coordinator (TC) means a person who provides Transition or Diversion Coordination Services and meets all regulatory requirements for a TC.
- ~~7315~~. Transition Coordination Agency (TCA) 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 Transition/diversion Coordination Transition or Diversion support pursuant to a provider participation agreement with the Department.
- ~~8416~~. Transition Options Team options team (TOT) means the group of people involved in supporting and implementing the transition or diversion, to include the person receiving services, the TC, the guardian, may include the home- and community- based services case manager, nursing facility social worker and others chosen by the individual receiving services as being valuable to participate in the transition process. The TOT is convened to work in a cooperative and supportive manner to develop and implement the transition or diversion plan, and to serve in an advocacy role with the member.
- ~~9517~~. Transition period means the period of time in which the member 1 receives Transition Coordination for the purpose of successful integration into community living. A transition period is complete when the member has successfully established community residence and is no longer in need of Transition Coordination based on the member's community risk level, or the member or guardian requests that TCM-TC services are discontinued..
- ~~204618~~. Transition or Diversion Plan means the written document that identifies person-centered goals, assessed needs, and the choices and preferences of services and supports to address the

identified goals and needs; appropriate services and additional community supports; outlines the process and identifies responsibilities of transition options team members; details a risk mitigation plan; and establishes a timeline that will support an individual in transitioning to **or remaining in** a community setting of their choosing.

4719. Transition **or Diversion p**lanning means the completion of the TCM-TC **C**ommunity **N**needs and **P**references **A**assessment and **R**isk **M**itigation **P**lan, facilitation of a **t**Ttransition **or Diversion R**ecommendation, and developing a **t**Ttransition **or Diversion P**lan, in coordination with the **T**Otransition options team.

4820. Transition **R**ecommendation means a recommendation made by the **T**Otransition options team regarding transition. The recommendation is made solely on availability of necessary supports and services identified by the **C**ommunity **N**needs and **P**reference **A**assessment and the **R**isk **M**itigation **P**lan.

8.519.27.B Qualifications of Transition Coordination Agencies

1. In order to be approved as a TCA, the agency shall meet all of the following qualifications:
 - a. Have a physical location in Colorado.
 - b. Be a public or private not for profit or **for profitfor-profit** agency.
 - c. Demonstrate proof the agency has employed staff that meet TC qualifications.
 - d. Have a minimum of two **(2)** years of agency experience in assisting at-risk individuals to access medical, social, education and/or other services. Transition coordination agencies providing transition coordination in Colorado prior to December 31, 2018 are exempt from this requirement.
 - e. Provide transition **or diversion** coordination to members who select the agency and also reside in the county/counties for which the agency has elected to provide services.
 - f. Possess the administrative capacity to deliver transition **or diversion** coordination.
 - g. Have established community referral systems and demonstrate linkages and referral ability to make community referrals for services with other agencies.
 - h. Demonstrate ability to meet all applicable requirements contained within Sections 8.519.27, 8.763, the Medicaid State Plan and the provider participation agreement.
 - i. Financial reserves shall match one **(1)** month of expenditures associated to the number of members expected through that catchment area and provide stability for TCs, members and service providers.
 - j. All agencies are required to submit an audited financial statement or 1 equivalent to the Department for review upon request.
 - k. Possess and maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department's minimum requirements.

8.519.27.C Functions of all Transition Coordination Agencies

1. In order to be approved as a TCA, the agency shall perform all of the following functions:

- a. TCAs must be in compliance with all required agency performance standards and training guidelines to be in good standing with the Department. Failure to comply with required standards and training guidelines may result in suspension of referrals until a corrective plan is submitted by the TCA and approved by the Department.
- b. TCAs shall be responsible to maintain sufficient documentation, as defined in TCM-TC training, of all transition **or diversion** coordination activities performed and to support claims within the Department designated data system and internal agency records.
- c. TCAs may not provide guardianship services for any member for whom they provide transition **or diversion** coordination services.
- d. TCAs shall be responsible to maintain, or have access to, information about public and private, state and local services, supports and resources and shall make information available to the member and/or persons inquiring upon their behalf.
- e. TCAs shall respond to referrals for transition coordination support within **two (2)** business days and **within one (1) business day for diversion coordination referrals and** specify whether the referral is accepted or not by completing the Transition Services Referral Form.
- f. TCAs shall assign and meet with the member within **ten (10)** state business days after accepting a **transition** referral **and two (2) state business days after accepting a diversion referral.**
- g. TCAs shall assign one (1) primary person who ensures transition **or diversion** coordination is provided to **f** the member.
- h. TCAs shall provide coordination in accordance with state business days as defined in 24-11-101(1) C.R.S.
- i. TCAs shall maintain all documents, records, communications, notes, and other materials that relate to any work performed.
- j. TCAs shall possess appropriate financial management capacity and systems to document and track services and costs in accordance with state and federal regulations**s.**
- k. TCAs shall maintain and update records of persons receiving transition **or diversion** coordination in accordance with reporting requirements of the Department's data system.
- l. TCAs shall establish and maintain working relationships with community- based resources, supports, and organizations, hospitals, service providers, and other organizations that assist in meeting the needs of members.
- m. TCAs shall have a system for recruiting, hiring, evaluating, and terminating employees. Transition coordination agencies' employment policies and practices shall comply with all federal and state laws.
- n. TCAs shall ensure staff have access to statutes and regulations relevant to the provision of authorized services and shall ensure that appropriate employees are oriented to the content of statutes and regulations. **TCAs****ransition coordination agencies** shall provide transition coordination for members without discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability.

- o. TCAs shall provide information and reports as required by the Department including, but not limited to, data and records necessary for the Department to conduct operations.
- p. TCAs shall allow access by authorized personnel of the Department, or its contractors, for the purpose of reviewing services and supports funded by the Department and shall cooperate with the Department in evaluation of such services and supports.
- q. TCAs shall establish agency procedures sufficient to execute transition or diversion coordination according to the provisions of these regulations. Such procedures shall include, but are not limited to:
 - i. Referral mManagement
 - ii. Assessment of community needs and preferences
 - iii. Transition or Diversion pPlanning
 - iv. Risk mMitigation pPlanning
 - v. Service and support coordination for non-Medicaid transition or diversion-related services and supports
 - vi. Monitoring of the Risk Mitigation transition and tTtransition or Diversion Pplans. review
 - vii. Denial and discontinuation of tTtransition or Diversion cCoordination sServices
 - viii. Management of interstate TCM-TC transfers
 - ix. Complaint Procedure that includes the requirement to share information, such as points of contact within the agency, to members, families and referring agencies who may wish to file a complaint

8.519.27.D Qualifications of Transition Coordinators

1. TCs must be employed by an approved TCA. TC minimum experience:
 - a. A bachelor's degree; or
 - b. Five (5) years of relevant experience in the field of LTSS, which includes Developmental Disabilities; or
 - c. Some combination of education and relevant experience appropriate to the requirements of the position.
 - d. Relevant 1 experience is defined as:
 - i. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or nonprofit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and,

- ii. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.
- iii. For members for whom the TC is providing transition or diversion coordination, TCs may not:
 - 1) Be related by blood or marriage to the member
 - 2) Be related by blood or marriage to any paid caregiver of the member
 - 3) Be financially responsible for the member
 - 4) Be the member's legal guardian, authorized representative, or be empowered to make decisions on the member's behalf through a power of attorney

8.519.27.E Training

1. TCs must complete and document the following trainings within sixty (60) days from the date of hire and prior to providing transition or diversion coordination services independently, and thereafter on an annual basis:
 - a. Assessment of community needs/preferences and risk factors
 - b. Transition or Diversion Planning
 - c. Risk Mitigation Plan development, monitoring and revision
 - d. Referral 1 for non-Medicaid services
 - e. Monitoring services
 - f. Case documentation
 - g. Person-centered approaches to planning and practice
 - h. Housing voucher application and housing navigation services

8.519.27.F Functions of Transition Coordinators

1. TCs must perform all the following activities. These activities are the only activities billable under transition coordination:
 - a. Coordinate transition options team (TOT) activities including:
 - i. Facilitate completion of an assessment which identifies preferences, needs and any risk factors the member may have in a community-based setting within six (6) weeks of first meeting with the member for a Transition Plan and within one (1) week of first meeting with the member for a Diversion Plan.
 - ii. Facilitate development of a Risk Mitigation Plan to address identified risk factors within eight (8) weeks of accepting a transition referral and two (2) weeks of accepting a diversion referral.

- iii. Identify supports and services that will be required to address the member's's needs, ~~preferences~~preferences, and risk factors.
 - iv. **Complete** a transition recommendation from the TOT within six (6)weeks of first meeting with the member but not before the first TOT meeting. . I
 - v. Facilitate completion of a ~~tT~~transition **or Diversion P**plan if the member chooses to proceed with the ~~transition or diversion~~
- b. **Conduct Pre-Transition or Diversion** Coordination including:
- i. Facilitate completion of transition **or diversion** assessment, **R**risk **M**itigation and **T**ransition **or Diversion P**plans
 - ii. Complete, as needed, housing voucher application, including assistance to obtain necessary documents
 - iii. Collaborate, as needed, with housing navigation services to obtain a voucher and locate housing
 - iv. Assist member to create a transition **or diversion** budget
 - v. Collaborate with housing navigation services, Division of Housing, voucher administrators **and property managers to establish** a community-based living arrangement **for eligible members**.
 - vi. Coordinate any medication, home modification and/or durable medical equipment needs with the nursing facility or HCBS case manager prior to discharge to ensure that all components of the **Transition or Diversion Plan** are in place prior to discharge
 - vii. Assist member in preparing for discharge, including being present at the nursing facility on the day of discharge to ensure requirements of discharge plan are addressed
 - viii. Meet with the member at their home on the day of discharge to ensure that providers and services needed upon discharge are in place and the household set-up is complete
- c. **Conduct Post-Transition or Diversion** Monitoring that meets the member's need as documented in the risk mitigation plan and occurs at the frequency and type to meet the member's community risk level Post-**Transition or Diversion** monitoring includes:
- i. Ensuring that members receive services in accordance with their **Transition/Diversion Plan** and **Risk Mitigation Plan**
 - ii. **Post-Transition or Diversion Monitoring** may include as determined by the community risk level:
 - 1) Face-to-face in the member's residence
 - 2) Face-to- face in the community.
 - 3) By telephone, electronic, video or virtual communication

- d. Post-Transition or Diversion Monitoring includes:
 - i. Provision of support services to aid in sustaining community-based living
 - ii. Response to risk incidents and notifying the CMA and Adult Protection Services (APS) as required
 - iii. Revision of Risk Mitigation Plan as needed
 - iv. Assessing the need for independent living skills training
 - v. Problem-solving community integration issues
 - vi. Supporting community integration activities
 - vii. Monitoring service provision, to include contacting guardians, providers, and case management agencies
 - viii. Requesting that member completes a TCM-TC satisfaction survey prior to discharge and at the end of the transition or diversion period to evaluate the member's experience of the following:
 - 1) Transition or Diversion Planning
 - 2) Transition or Diversion Plan implementation
 - 3) Transition or Diversion Coordination process
 - 4) Level and adequacy of services provided
 - 5) Overall member satisfaction
- e. Post-transition or Diversion Monitoring may not duplicate services for Life Skills Training (LST), defined in 10 CCR 2505-10, § 8.553.3; Transition Setup defined in 10 CCR 2505-10, § 8.553.4; Home Delivered Meals, defined in 10 CCR 2505-10, § 8.553.5; and Peer Mentorship, defined in 10 CCR 2505-10, § 8.553.6.

8.519.27. GF Transition Coordination Agencies Approval

- 1. A TCA shall maintain Department provider approval in accordance with quality assurance standards and requirements set forth in the Department's rules and direction. Department approval is needed for continued receipt of TCM-TC referrals.
 - a. Approval as a TCA shall be based on an evaluation of the agency's performance in the following areas:
 - i. The frequency of requests for TCA changes and/or complaints received by the Department pertaining to agency performance
 - ii. The agency's compliance with program requirements, including compliance with transition coordination standards adopted by the Department
 - iii. The agency's performance of administrative functions, including, timely reporting, program management, on-site visits to individuals, community coordination and outreach and individual monitoring;

- iv. Financial accountability
 - v. The maintenance of qualified and trained personnel to perform transition coordination duties
 - vi. Continual performance and quality assurance activities and
 - vii. Overall member satisfaction as indicated by member satisfaction surveys
2. The Department or its designee shall conduct reviews of the TCA
 - a. At least sixty (60) days prior to expiration of the previous approval date the Department shall notify the TCA of the outcome of the review, which may be approval, provisional approval, or denial of approval.
 - b. The Department shall conduct evaluations as needed based on incidents of member, nursing facility and/or provider complaints regarding TCA performance and/or non-compliance with TCM-TC agency requirements.

8.519.27.HG Conflict of Interest for Transition Coordination Agencies

1. If a TCA also provides services under HCBS waivers, a policy must be in place to avoid conflict of interest and provide a free choice of providers to members. The HCBS case management agency shall be responsible for all service brokering for Medicaid HCBS services.

8.763 TARGETED CASE MANAGEMENT - TRANSITION COORDINATION

1. Transition Coordination means support provided to a member who is moving from a congregate setting other than an assisted living facility or being diverted from possible institutionalization and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition or diversion.

8.763.A Eligibility

1. To be eligible for Transition Coordination, members must be adult Medicaid recipients, who reside in a congregate setting other than an assisted living facility and are willing to participate and have expressed interest in moving to a home and community-based setting or have been identified as being at risk for institutionalization by the Department. Members may also be Medicaid recipients receiving Home and Community Based Services (HCBS) provided by the State operated Regional Centers (RC) who want to move to a private Home and Community Based Services Provider. Services are expected to begin while an individual is living in a facility and continue through integration into community living, based on the community risk assessment. Excluded are children under the age of 18.

8.763.B Services

1. Transition Coordination is provided pursuant to ~~10-CCR-2505-10, s~~Section 8.519.27.

8.763.C Limitations on Service

1. Transition Coordination is limited to 360 units per member per transition or diversion. A unit of service is defined as each completed 15-minute increment that meets the description of a Transition Coordination activity. When an individual has a documented need for additional units,

the 360-unit cap may be exceeded to ensure the health and welfare of the member. The Transition 1 Coordinator shall submit documentation to the Department including:

- a. A copy of the community risk assessment describing the member's current needs.
- b. The number of additional units requested.
- c. A history of Transition Coordination units provided to date and outcomes of those services
- d. An explanation of the additional Transition Coordination supports to be provided by the transition coordinator using any additional approved units.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation for Children and Siblings, Section 8.014
Rule Number: MSB 23-08-23-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 23-08-23-A, Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation for Children and Siblings, Section 8.014
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) 8.014.1, 8.014.3, and 8.014.6, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)?
If yes, state effective date:
Is rule to be made permanent? (If yes, please attach notice of hearing).

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.014.1 with the proposed text beginning at 8.014.1.L through the end of 8.014.1.R. Replace the current text at 8.014.3 with the proposed text beginning at 8.014.3.C through the end of 8.014.3.D. Replace the current text at 8.014.6.A.8 with the proposed text beginning at 8.014.6.A.8 through the end of 8.014.6. This rule is effective August 30, 2024.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation for Children and Siblings, Section 8.014
Rule Number: MSB 23-08-23-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

The proposed rule will add children and/or siblings of a member, or the children of the member's escort, to the list of additional passengers for non-emergent medical transportation (NEMT) in the following circumstances:

- If a member does not have access to childcare for their children for the duration of the trip to and from the medical services, the child(ren) may accompany the member
- If a member's escort does not have access to childcare for the member's siblings for the duration of the trip to and from the member's medical services, the member's siblings may accompany the member
- If a member's escort does not have access to childcare for their children for the duration of the trip to and from the member's medical services, the escort's children may accompany the member

The proposed rule ensures that members have access to NEMT when they do not have childcare for their children for duration of the trip to and from the medical services, or for the children of the member's escort or the member's siblings when the member requires an escort and the escort does not have access to childcare for the duration of the trip.

NEMT providers may not charge for the additional passengers authorized under the proposed rule.

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:

Initial Review
Proposed Effective Date

06/14/24
08/30/24

Final Adoption
Emergency Adoption

07/12/24

DOCUMENT #

DO NOT PUBLISH THIS PAGE

42 C.F.R. § 431.53 (2024)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);

Sections 25.5-1-801, C.R.S. (2024)

Initial Review
Proposed Effective Date

06/14/24
08/30/24

Final Adoption
Emergency Adoption

07/12/24

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation for Children and Siblings, Section 8.014

Rule Number: MSB 23-08-23-A

Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

Members who utilize non-emergency medical transportation (NEMT) and have children or siblings, member escorts with children, and NEMT providers are affected by 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 ensures that a member's access to NEMT is not limited by a lack of childcare for the children of the member, the children of the member's escort, or the member's siblings.

Stakeholders have raised access to care concerns for members who do not have childcare available when they require NEMT transportation to medically necessary services. Allowing children and siblings to ride along as additional passengers without cost, so members can utilize NEMT transportation for medically necessary services, is less costly than members missing medically necessary services due to lack of childcare, which may result in the need for future, more costly, medical services.

NEMT providers bear the additional cost of transporting children and siblings under the proposed rule. As such, the Department included Section 8.014.3.D.2., which authorizes NEMT providers to refuse transport of members that require multiple loadings in accordance with the proposed rule, if such loading is either not possible due to vehicle constraints or it conflicts with their internal policy.

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 proposed rule does not have a budget impact to the Department because the additional passengers authorized under the rule are not eligible for reimbursement under Section 8.014.6.A.8.

DO NOT PUBLISH THIS PAGE

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

The proposed rule does not impose any additional costs on the Department. The costs of accommodating the additional passengers authorized by the proposed rule are born entirely by NEMT providers. However, NEMT providers may elect to not transport a member that requires multiple loadings under the proposed rule. The benefits of the proposed rule are access to NEMT for members with children and/siblings, and member escorts with children, when they do not have childcare available during the trip to and from medical services. The cost of inaction is lack of access to NEMT for members who do not have childcare for children or siblings during their NEMT trip, or for the children of their escort. There are no benefits to inaction.

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

There are no less costly or less intrusive methods for achieving the 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 for achieving the purpose for the proposed rule were seriously considered by the Department.

8.014 NON-EMERGENT MEDICAL TRANSPORTATION

8.014.1. DEFINITIONS

[SECTIONS 8.014.1.A-K UNAFFECTED BY THIS RULEMAKING]

~~8.014.1.L. Medicaid Client Transport (MCT) Permit means a permit issued by the Colorado Department of Regulatory Agencies Public Utilities Commission (PUC) in accordance with the PUC statute at Section 40-10.1-302, C.R.S.~~

8.014.1.~~ML~~. Mode means the method of transportation.

8.014.1.~~NM~~. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment. Non-emergency care may be scheduled or unscheduled. This may include Urgent Care transportation and hospital discharge transportation.

8.014.1.~~ON~~. Program of All Inclusive Care for the Elderly (PACE) is a capitated rate benefit which provides all-inclusive long-term care to certain individuals as defined in Section 8.497.

8.014.1.~~PO~~. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.014.1.~~QP~~. State Designated Entity (SDE) means the organization responsible for administering NEMT.

8.014.1.~~RQ~~. "Sibling " means a person 18 years of age or under, or an At-Risk Adult, who is one of two or more individuals descended from one or two mutual parents. The term also includes stepsiblings, former stepsiblings, and/or adoptive siblings. This also includes an individual that is considered by state or tribal law to be a sibling of the member or the individual would have been considered a sibling of the member under state or tribal law but for a termination or other disruption of parental rights, such as the death of a parent.

~~8.014.1.R~~ Stretcher Van means a vehicle that can legally transport a ~~client member~~ in a prone or supine position when the ~~client member~~ does not require medical attention en route. This may be by stretcher, board, gurney, or another appropriate device.

[SECTIONS 8.014.1.S-W UNAFFECTED BY THIS RULE CHANGE]

[SECTION 8.014.2 UNAFFECTED BY THIS RULE CHANGE]

8.014.3. PROVIDER ELIGIBILITY AND RESPONSIBILITIES

[SECTION 8.014.3.A-B UNAFFECTED BY THIS RULE CHANGE]

8.014.3.C. NEMT transportation providers must maintain a Trip report for each NEMT Trip provided and must, at a minimum, include:

1. The pick-up address;
2. The destination address;
3. Date and time of the Trip;

4. Client's name or identifier, and the name of any additional passengers authorized under Section 8.014.3.D;
5. Confirmation that the driver verified the client's identity;
6. Confirmation by the client, Escort, or medical facility that the Trip occurred;
7. The actual pick-up and drop off time;
8. The driver's name; and
9. Identification of the vehicle in which the Trip was provided.

8.014.3.D. Multiple Loading

1. NEMT providers may not transport more than one client-member at the same time, unless the additional passenger is an Escort, with the following exceptions:
 - a. If the member does not have access to childcare for the member's Child(ren), or access to care for an At-Risk Adult the member is responsible for, for the duration of the trip to and from the medically necessary non-emergency services, the Child(ren) or At-Risk Adult, or both, may accompany the member.
 - b. If an Escort does not have access to childcare for the member's Sibling(s) for the duration of the trip to and from the member's medically necessary non-emergency services, the Sibling(s) may accompany the member and the Escort.
 - c. If an Escort does not have access to childcare for the Escort's Child(ren), or access to care for an At-Risk Adult the Escort is responsible for, for the duration of the trip to and from the member's medically necessary non-emergency services, the Child(ren) or At-Risk Adult, or both, may accompany the member and the Escort.
2. Providers may refuse to transport members that require multiple loadings in accordance with Sections 8.014.3.D.1.a-c when such loading is either not possible due to vehicle constraints or it conflicts with their internal policy.
3. The names of additional passengers authorized under this Section 8.014.3.D. must be included in the Trip report required under Section 8.014.3.C.

[SECTION 8.014.3.E UNAFFECTED BY THIS RULE CHANGE]

[SECTIONS 8.014.4-5 UNAFFECTED BY THIS RULE CHANGE]

8.014.6. NON-COVERED NEMT SERVICES AND GENERAL LIMITATIONS

- 8.014.6.A. The following services are not covered or reimbursable to NEMT providers as part of a NEMT service:

[SECTIONS 8.014.6.A.1-7 UNAFFECTED BY THIS RULE CHANGE]

8. Charges for additional passengers, including Siblings, ~~or~~ Children or At-Risk Adults authorized under Section 8.014.3.D, not receiving a medical service, except when acting as an Escort under Section 8.014.5.D.1.

[SECTIONS 8.014.6.A.9-12 UNAFFECTED BY THIS RULE CHANGE]

[SECTION 8.014.6.B UNAFFECTED BY THIS RULE CHANGE]

[SECTIONS 8.014.7-8 UNAFFECTED BY THIS RULE CHANGE]

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act concerning the Coverage of
FDA-Approved Imported Drugs, Section 8.800.4.B.

Rule Number: MSB 24-05-29-B

Division / Contact / Phone: Pharmacy Office / Korri Conilogue / 303-866-6398

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 24-05-29-B, Revision to the Medical Assistance Act concerning
the Coverage of FDA-Approved Imported Drugs, Section 8.800.4.B.

3. This action is an adoption of: N/A

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

Sections(s) 8.800.4.B, Colorado Department of Health Care Policy and Financing, Staff
Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No

If yes, state effective date:

Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.800.4. with the proposed text beginning at 8.800.4.A
through the end of 8.800.4.B.1.e. This rule is effective August 30, 2024.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act concerning the Coverage of FDA-Approved Imported Drugs, Section 8.800.4.B.

Rule Number: MSB 24-05-29-B

Division / Contact / Phone: Pharmacy Office / Korri Conilogue / 303-866-6398

STATEMENT OF BASIS AND PURPOSE

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

The purpose of this proposed rule change is to allow the Department the authority to cover FDA-approved imported drugs and other selected prescribed drugs that are not covered outpatient drugs. This would help members to maintain access to critical drugs that have become unavailable in the United States in addition to allowing the Department to cover a broader number of prescribed products for members. Therefore, the Department is seeking an amendment to 10 C.C.R. 2505-10, Section 8.800.4.B, to include selected prescribed drugs that are not covered outpatient drug as a covered benefit.

2. An emergency rule-making is imperatively necessary

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

Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

Section 25.5-1-303, C.R.S. (2024)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act concerning the Coverage of
FDA-Approved Imported Drugs, Section 8.800.4.B.

Rule Number: MSB 24-05-29-B

Division / Contact / Phone: Pharmacy Office / Korri Conilogue / 303-866-6398

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.

Medicaid members who require drugs that are affected by shortages in the US and members who require other prescribed drugs that are not covered outpatient drugs will benefit from expanded coverage. The proposed rule would result in no additional cost to Medicaid members. The Department will bear the cost of the additional coverage.

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

Qualitatively, allowing for coverage of these prescribed products will help to mitigate the possible negative health consequences of not having access to a medically necessary prescribed product. Quantitatively there is no impact.

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 annual aggregate increase in prescribed drug expenditures (including state funds and federal funds) is \$39,091 (state share \$11,336; federal share \$27,755) in FFY 2024 and \$40,851 (state share \$11,846; federal share \$29,004) in FFY 2025.

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

The cost of inaction is that members who are affected by drug shortages and who require medically necessary prescribed products that are not covered outpatient drugs would go without treatment. There are no benefits of inaction.

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

There is not a less costly or less intrusive method.

DO NOT PUBLISH THIS PAGE

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

There are no alternatives.

8.800 PHARMACEUTICALS

8.800.4 DRUG BENEFITS

8.800.4.A. Only those drugs designated by companies participating in the federally approved Medical Assistance Program drug rebate program and not otherwise excluded according to these rules are regular drug benefits. Notwithstanding the foregoing, drugs not covered by rebate agreements may be reimbursed if the Department has made a determination that the availability of the drug is essential, such drug has been given an "A" rating by the U. S. Food and Drug Administration (FDA), and a prior authorization has been approved. Prescribed drugs not covered by rebate agreements may also be reimbursed if approved for importation by the FDA when medically necessary for drug shortages, if approved by the FDA under emergency use authorization, if available over-the-counter (OTC), or if non-traditional prescribed products such as insect repellent. Reimbursement of any drugs that are regular drug benefits may be restricted as set forth in these rules.

8.800.4.B. Pursuant to 42 U.S.C. 1396r-8 (d)(2), certain drugs or classes of drugs may be excluded from coverage or may be subject to restrictions.

1. The following are covered with restrictions:

- a. Agents when used for weight gain;
- b. Agents when used for the symptomatic relief of cough and colds;
- c. Prescription vitamin and mineral products, except prenatal vitamins and fluoride, for documented deficiency; ~~and~~
- d. Non-prescription Drugs; and
- e. Selected prescribed drugs that are not covered outpatient drugs. Such prescribed drugs may include ~~over-the-counter (OTC)~~ nutritional supplements, drugs approved by the ~~Food and Drug Administration (FDA)~~ under emergency use authorization (EUA), FDA-approved imported drugs, and non-traditional prescribed products such as insect repellent.

2. The following are excluded from coverage:

- a. Agents when used for anorexia or weight loss;
- b. Agents when used to promote fertility;
- c. Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; and
- d. Agents used for the treatment of sexual or erectile dysfunction unless such agents are used to treat a condition, other than a sexual or erectile dysfunction, for which the agents have been approved by the FDA.

