DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Rule Number: MSB 21-02-24-A
Division / Contact / Phone: Special Financing Division / Chandra Vital / 303-866-5506

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 20-02-24-A, Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960

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):

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

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 3/12/2021
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.960 with the proposed text beginning at 8.960.1 through the end of 8.960.3.F. This rule is effective March 12, 2021.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Rule Number: MSB 21-02-24-A
Division / Contact / Phone: Special Financing Division / Chandra Vital / 303-866-5506

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).

   Clarifies an Eligible Senior may have Medicare or Medicare Advantage Plan that has dental coverage. This rule change also incorporates the rule that Grantees of the Colorado Dental Health Care Program for Low-Income Seniors bill Medicare for procedures covered by Medicare or the Medicare Advantage Plan and the Colorado Dental Health Care Program is secondary to the Medicare dental coverage.

   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:

   Effective January 1, 2021, many Medicare Advantage Plans added dental benefits that seniors cannot opt out of. Dental coverage through Medicare Advantage Plans varies, with some plans offering a minimal dental benefit. Numerous seniors currently receiving services through the Colorado Dental Health Care Program for Low Income Seniors were in the middle of dental treatment plans on January 1, 2021, and their services stopped due to this Medicare Advantage Plan change. This left seniors with emergent dental needs, i.e., dentures, infections, extractions, etc. This rule change will allow Colorado's low income seniors to access necessary dental care not covered by Medicare Advantage or after Medicare Advantage benefits have been exhausted.

2. Federal authority for the Rule, if any:

   42 C.F.R. 162-1002(a)(4)

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   Sections 25.5-3-404(4), C.R.S. (2020)

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

DOCUMENT #

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Title of Rule: Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Rule Number: MSB 21-02-24-A
Division / Contact / Phone: Special Financing Division / Chandra Vital / 303-866-5506

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.

   Changing the rule will allow seniors with dental coverage through Medicare Advantage Plans to receive the dental care through the Colorado Dental Health Care Program for Low Income Seniors for services not covered by Medicare Advantage or after Medicare Advantage benefits have been exhausted. This rule change will benefit Colorado's low income seniors by ensuring they continue to access needed dental 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.

   There is no change in the cost or economic impact on eligible seniors.

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 Colorado Dental Health Care Program for Low-Income Seniors has a fixed appropriation and this rule change will not increase the Department's administrative costs for the program.

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

   Numerous seniors receiving services through the Colorado Dental Health Care Program for Low-Income Seniors had to cease treatment plans due to changes in the Medicare Advantage Plans. This rule change will allow these treatment plans to continue and seniors can continue receiving the needed dental health care to remain healthy.

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

This rule change is necessary to ensure that eligible seniors continue to receive the much-needed dental health care.

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

   This rule change is necessary to ensure eligible seniors receive the necessary dental health care to remain healthy. There are no other alternative methods for achieving this purpose.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.1 Definitions

Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.

Covered Dental Care Services include Diagnostic Imaging, Emergency Services, Endodontic Services, Evaluation, Oral and Maxillofacial Surgery, Palliative Treatment, Periodontal Treatment, Preventive Services, Prophylaxis, Removable Prosthesis, and Restorative Services as listed by alphanumeric procedure code in Appendix A.

C.R.S. means the Colorado Revised Statutes.

Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Dental Prosthesis means any device or appliance replacing one or more missing teeth and associated structures if required.

Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2019).

Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation.

Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty level for a household of that size.

Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is able to demonstrate lawful presence in the country, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior or client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans. An Eligible Senior shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective August 30, 2016), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to § 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.

Emergency Services means the need for immediate intervention by a Qualified Provider to stabilize an oral cavity condition.

Endodontic Services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues, including pulpectomy.

Evaluation means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions.

Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa)(4).

Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.

Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors in Appendix A. The Max Allowable Fee is the sum of the Program Payment and the Max Client Co-Pay.

Max Client Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in Appendix A for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.

Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2019).

Medicare ~~is~~means the federal health insurance program for people who are 65 or older; certain younger people with disabilities; or people with End-Stage Renal Disease.

Medicare Advantage Plans ~~are~~mean the plans offered by Medicare-approved private companies that must follow rules set by Medicare and may provide benefits for services Medicare does not, such as vision, hearing, and dental care.

Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2019).

Oral and Maxillofacial Surgery means the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Palliative Treatment for dental pain means emergency treatment to relieve the client of pain; it is not a mechanism for addressing chronic pain.

Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal disease progression.

Preventive Services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

Program Payment means the maximum amount by procedure listed in Appendix A for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors. Program Payment must not be less than the reimbursement schedule for fee-for-service dental fees under the medical assistance program established in Articles 4, 5, and 6 of 10 CCR 2505-10.

Prophylaxis means the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.

Qualified Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:

1. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2019);

2. A community-based organization or foundation;

3. A Federally Qualified Health Center, safety-net clinic, or health district;

4. A local public health agency; or

5. A private dental practice.

Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.

Removable Prosthesis means complete or partial Dental Prosthesis, which after an initial fitting by a dentist, can be removed and reinserted by the eligible senior.

Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic needs of the client.

Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2019).

8.960.2 Legal Basis

The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (2019).

8.960.3 Request of Grant Proposals and Grant Award Procedures

8.960.3.A Request for Grant Proposals

Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at https://www.colorado.gov/hcpf/research-data-and-grants at least 30 days prior to the due date.

8.960.3.B Evaluation of Grant Proposals

Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

1. The review panel will be comprised of individuals who are deemed qualified by reason of training and/or experience and who have no personal or financial interest in the selection of any particular applicant.

2. The sole objective of the review panel is to recommend to the Department's executive director those proposals which most accurately and effectively meet the goals of the program within the available funding.

3. Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:

    a. Outreach to and identify Eligible Seniors;

    b. Collaborate with community-based organizations; and

c. Serve a greater number of Eligible Seniors or serve Eligible Seniors who reside in a geographic area designated as a Dental HPSA.

4. The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on the estimated percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department.

8.960.3.C Grant Awards

The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

8.960.3.D Qualified Grantee Responsibilities

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

1. Identify and outreach to Eligible Seniors and Qualified Providers;

2. Demonstrate collaboration with community-based organizations;

3. Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;

4. Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and moneys spent for a minimum of six (6) years;

5. For Eligible Seniors with dental coverage through a Medicare Advantage Plan, bill the Medicare Advantage Plan for dental procedures covered by the Medicare Advantage Plan prior to seeking payment from the Department. The Colorado Dental Health Care Program is secondary to the Medicare Advantage Plan dental coverage;

6~~5~~. Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;

7~~6~~. Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and

8~~7~~. Submit an annual report as specified under section 8.960.3.F.

8.960.3.E Invoicing

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.

1. Invoices shall include the number of Eligible Seniors served, the alphanumeric code and procedure description as listed in Appendix A, and any other information required by the Department.

2. The Department will pay no more than the established Program Payment per procedure rendered, as listed in Appendix A.

3. Eligible Seniors shall not be charged more than the Max Client Co-Pay as listed in Appendix A.

4. Qualified Grantees shall not bill the Department for any procedures covered by Medicare Advantage Plans that have been billed and paid by the Medicare Advantage Plans;

5. Qualified Grantees shall indicate on the invoice if the Eligible Senior has dental coverage through a Medicare Advantage Plan and any claim to the Medicare Advantage Plan was adjudicated prior to billing the Department;

64. Qualified Grantees may invoice for no more than seven (7) percent of the Program Payment for administrative costs.

8.960.3.F Annual Report

On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

The annual report shall be completed in a format specified by the Department and shall include:

1. The number of Eligible Seniors served;

2. The types of Covered Dental Care Services provided;

3. An itemization of administrative expenditures;

4. The procedures and amounts billed to Medicare Advantage Plans for Eligible Seniors; and

54. Any other information deemed relevant by the Department.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the RHC Rule Concerning Adding Provider Types to RHC Visit, Section 8.740
Rule Number: MSB 21-03-09-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-03-09-A, Revision to the RHC Rule Concerning Adding Provider Types to RHC Visit, Section 8.740

3. This action is an adoption of: an amendment

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

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

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 3/9/2021
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.740 with the proposed text beginning at 8.740.4 through the end of 8.740.6. This rule is effective March 12, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the RHC Rule Concerning Adding Provider Types to RHC Visit, Section 8.740
Rule Number: MSB 21-03-09-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this rule is to change the definition of a payable encounter at Rural Health Clinics. The amended rule adds licensed professional counselors, licensed marriage and family therapists, and licensed addiction counselors to the provider types that can generate a billable encounter.

   This rule is necessary to maintain access to mental health services at RHCs. Without the rule, RHCs would be unable to provide services with the provider types that had been providing the services in the past. The change maintains care practices that have been present since prior to July 1, 2018.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   The Medical Assistance Program changed coverage on July 1, 2018 to pay for short term behavioral health services as a state plan benefit for all Medicaid clients enrolled in the Behavioral Health Managed Care program. Previously these services were only available through the Managed Care Entities for clients enrolled in the behavioral health program. RHCs have been providing the services as contractors with the Managed Care Entities that cover behavioral health for Colorado Medicaid. When providing services under the managed care plan, visits with licensed professional counselors, licensed marriage and family therapists, and licensed addiction counselors were paid as encounters to the RHC using the prospective payment system. If we did not add these providers to the definition of an RHC visit, we would be out of compliance for paying for these services. If we no longer paid RHCs for these services, it would have a great detrimental effect on behavioral health services provided in rural areas. Therefore, this rule is necessary for the preservation of public health, safety and welfare as well as to comply with state or federal law.

3. Federal authority for the Rule, if any:

1902(bb) SSA

4. State Authority for the Rule:

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

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Title of Rule: Revision to the RHC Rule Concerning Adding Provider Types to RHC Visit, Section 8.740
Rule Number: MSB 21-03-09-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

REGULATORY ANALYSIS

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

   Medicaid clients that receive care at Rural Health Clinics will be impacted by this rule. The emergency rule will support access to care and continuity of care at RHCs. No class of persons will bear any costs of the proposed rule. Medicaid clients will 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 impact is neutral to Medicaid clients. The services were available at RHCs previously through the behavioral health managed care program. Medicaid policy changed to allow these services through fee for service coverage.

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 costs probable with this rule change. It continues coverage of the services with no change to the payment mechanism. Overall, this policy change is expected to save funds when implemented by all providers including RHCs.

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

   There are no probable costs associated with the proposed rule. Probable benefits of action will align coverage between RHCs and FQHCs and other behavioral health providers. With inaction, there may be some probable cost savings due to RHC providers being unable to be paid for a subset of behavioral health services. There are no foreseen probable benefits of inaction. Probable detriments are that many Medicaid clients in rural areas will have their behavioral health treatment fragmented. RHCs will not be able to provide these services and be paid.

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 less intrusive to achieve the purpose of the proposed rule.

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

   The Department has considered not changing the rule as an alternative method to achieve the integration of physical and mental health. That method would have been detrimental to the integration of the short term behavioral health policy. There is no other way to pay for the RHC services except through the Prospective Payment System methodology under the Social Security Act (Title XIX, Section 1902(bb)). The short-term behavioral health policy fosters integration of physical and behavioral health from a single health care entity. To facilitate integration without this rule for RHCs would be to abandon the short-term behavioral health policy for a large number of clients living in rural areas because there would be no way to pay for these services. The alternative methods would not achieve the purpose of this rule.

8.740 RURAL HEALTH CLINICS

8.740.1 DEFINITIONS

Rural Health Clinic means a clinic or center that:

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

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

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

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

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

8.740.2 REQUIREMENTS FOR PARTICIPATION

8.740.2.A. A Rural Health Clinic shall be certified under Medicare.

8.740.2.B. A Rural Health Clinic providing laboratory services shall be certified as a clinical laboratory in accordance with 10 C.C.R 2505-10, Section 8.660.

8.740.3 CLIENT CARE POLICIES

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

8.740.3.B. The policies shall include:

1. A description of the services the Rural Health Clinic furnishes directly and those furnished through agreement or arrangement. See section 8.740.4.A.4.

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

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

8.740.4 SERVICES

8.740.4.A. The following services may be provided by a certified Rural Health Clinic:

1. General services

   a. Outpatient primary care services that are furnished by a physician assistant, clinical psychologist, clinical social worker, nurse practitioner, ~~or~~ nurse midwife, licensed professional counselor, licensed marriage and family therapist, or licensed addiction counselor as defined in their respective practice acts.

   b. Part-time or intermittent visiting nurse care.

   c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.740.4.A.1.a and b.

2. Laboratory services. Rural Health Clinics furnish basic laboratory services essential to the immediate diagnosis and treatment of the client.

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

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

8.740.5 PHYSICIAN RESPONSIBILITIES

8.740.5.A. A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on client referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.740.6 ALLOWABLE COSTS

8.740.6.A. The following types and items of cost shall be included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician who owns, is employed by, or furnishes services under contract to a Rural Health Clinic.

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

3. Costs of services and supplies incident to the services of a physician, physician assistant, clinical psychologist, clinical social worker, nurse practitioner, ~~or~~ nurse-midwife, licensed professional counselor, licensed marriage and family therapist, or licensed addiction counselor.

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

5. Costs of services purchased by the Rural Health Clinic.

8.740.7 REIMBURSEMENT

8.740.7.A. The Department shall reimburse Rural Health Clinics a per visit encounter rate. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.740.7.B. The encounter rate shall be the higher of:

1. The Prospective Payment System (PPS), as 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, BIPA is incorporated herein by reference. No amendments or later editions are incorporated. The Acute Care Benefits Section Manager at the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of BIPA, or the materials may be examined at any publications depository library.

2. The Medicare rate.

    a. The Medicare rate for hospital based Rural Health Clinics with fewer than 50 beds shall be based on actual costs.

    b. The Medicare rate for all other Rural Health Clinics is the Medicare upper payment limit for Rural Health Clinics.

8.740.7.C. The Department will reimburse Long-Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices separate from the Rural Health Clinic per visit encounter rate. Reimbursement will be the lower of:

1. 340B acquisition costs;

2. Submitted charges; or

3. Fee schedule as determined by the Department.