DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765
Rule Number: MSB 21-11-30-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-11-30-A, Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765

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) 8.765, 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: 12/10/2021
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.765 with the proposed text beginning at 8.765 through the end of 8.765.1. Insert the newly proposed text beginning at 8.765.14 through the end of 8.765.14.F. This rule is effective December 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765
Rule Number: MSB 21-11-30-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).
   Revises the rules for child-serving residential facilities to include the new Qualified Residential Treatment Program (QRTP) license type. The new license type will take effect October 1, 2021 in accordance with the federal Family First Prevention Services Act (FFPSA) and there will be a grace period until June 30, 2022 for all facilities enrolled with Medicaid to be in compliance. The revision will allow the Department to reimburse new QRTP facilities in compliance with the FFPSA and align Department rule with the Colorado Department of Human Services' new QRTP license type. QRTPs will provide a trauma-informed model of care to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

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 Qualified Residential Treatment Program provisions of the Family First Prevention Services Act, Pub.L. 115-123, Div. E, Title VII, § 50734, Feb. 9, 2018, 132 Stat. 252, were to go into effect October 1, 2018. However, the U.S. Department of Health and Human Services issued Program Instruction PI-18-07 permitting requests for delayed effective dates up to two years past the statutory deadline. The Colorado Department of Human Services applied for, and received, an extension until December 31, 2020, but no later than September 29, 2021. This rule is imperatively necessary to comply with federal law to implement the delayed effective date for the Family First Prevention Services Act provisions pertaining to Qualified Residential Treatment Programs and to align with the parallel Colorado Department of Human Services license.

3. Federal authority for the Rule, if any:

   Pub.L. 115-123, Div. E, Title VII, § 50734, Feb. 9, 2018, 132 Stat. 252

   42 CFR 440.160 (2021)

DO NOT PUBLISH THIS PAGE

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   CRS § 25.5-5-202(1)(i) (2021)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765
Rule Number: MSB 21-11-30-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Members currently residing in Residential Child Care Facilities (RCCF), and RCCF providers, will be impacted 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.

   RCCF providers will have costs associated with changing their model of care and the requirement that QRTPs be 16 beds or less. For our members, services provided in a QRTP will be trauma-informed and designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances, in a setting limited to 16 beds. Members who require this level of care will receive services within the state and better tailored to their needs.

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

   The Department anticipates the proposed rule to be budget neutral because RCCF services will be phased out and the same funds will be applied QRTP payment.

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

   The probable costs of the proposed rule are RCCF providers being required to obtain the Qualified Residential Treatment Program license. The probable benefit of the proposed rule is aligning with the Federal Family First Prevention Services Act (FFPSA) and aligning with Colorado Department of Human Services license requirements. The probable cost of inaction is non-compliance with the FFPSA. There are no probable 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 methods or less intrusive methods to align Department rule with the FFPSA and with Colorado Department of Human Services license requirements.

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

   There are no alternative methods to align Department rule with the FFPSA and with Colorado Department of Human Services license requirements.

8.765 SERVICES FOR CLIENTS IN ~~PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES OR RESIDING IN~~ RESIDENTIAL CHILD CARE FACILITIES AS DEFINED BELOW

8.765.1 DEFINITIONS

Assessment means the process of continuously collecting and evaluating information to develop a client's profile on which to base a Plan of Care, service planning, and referral.

Clinical Staff means medical staff that are at a minimum licensed at the level of registered nurse, performing within the authority of the applicable practice acts.

Colorado Client Assessment Record (CCAR) means a clinical instrument designed to assess the behavior/mental health status of a medically eligible client. The CCAR is used to identify current diagnosis and clinical issues facing the client, to measure progress during treatment and to determine mental health medical necessity. This instrument is used for children in the custody of a county department of human/social services or Division of youth corrections and for those children receiving mental health services in an RCCF through the Child Mental Health Treatment Act.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the Colorado Medicaid program's benefit under Section 8.280 for children and adolescents that provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21.

Emergency Safety Intervention means the use of Restraint and Seclusion as an immediate response to an Emergency Safety Situation.

Emergency Safety Situation means unanticipated behavior of the client that places the client or others at serious threat of violence or injury if no intervention occurs and that calls for Emergency Safety Intervention.

Emergency Services means emergency medical and crisis management services.

Independent Assessment means a process to assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool. The assessment determines whether treatment in a Qualified Residential Treatment Program (QRTP) provides the most effective and appropriate level of care for the child in the least restrictive environment, in accordance with Colorado Department of Human Services regulations.

Independent Team means a team certifying the need for Psychiatric Residential Treatment Facility (PRTF) services that is independent of the Referral Agency and includes a physician who has competence in the diagnosis and treatment of mental illness and knowledge of the client's condition.

Interdisciplinary Team means staff in a PRTF comprised of a physician, and a Licensed Mental Health Professional, registered nurse or occupational therapist responsible for the treatment of the client.

Licensed Mental Health Professional means a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a psychiatrist licensed pursuant to part 1 of article 36 of title 12, C.R.S., a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S., or a social worker licensed pursuant to part 4 of article 43 or title 12, C.R.S., that is supervised by a licensed clinical social worker. Sections 12-43-301, et seq, 12-36-101, et seq, 12-43-401, et seq, 12-43-501, et seq and 12-43-601, et seq, C.R.S. (2005) are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care

Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

Medication Management Services means review of medication by a physician at intervals consistent with generally accepted medical practice and documentation of informed consent for treatment.

Multidisciplinary Team means staff in a Residential Child Care Facility (RCCF) providing mental health services comprised of at least one Licensed Mental Health Professional and other staff responsible for the treatment of the client and may include a staff member from the Referral Agency.

Plan of Care means a treatment plan designed for each client and family, developed by an Interdisciplinary or Multidisciplinary Team.

Prone Position means a client lying in a face down or front down position.

Psychiatric Residential Treatment Facility (PRTF) means a facility that is not a hospital and provides inpatient psychiatric services for individuals under age 21 under the direction of a physician, licensed pursuant to part 1 of article 36 of title 12, C.R.S.

Qualified Residential Treatment Programs (QRTP) means a facility that provides residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

Referral Agency means the Division of Youth Corrections, County Departments of Human/Social Services who have legal custody of a client, Behavioral Healthcare Organization or Community Mental Health Center that refers the client to a PRTF or RCCF for the purpose of placement through the Child Mental Health Treatment Act.

Restraint includes Drug Used as a Restraint, Mechanical Restraint and Personal Restraint.

Drug Used as a Restraint means any drug that is administered to manage a client's behavior in a way that reduces the safety risk to the client or to others; has the temporary affect of restricting the client's freedom of movement and is not a standard treatment for the client's medical or psychiatric condition.

Mechanical Restraint means any device attached or adjacent to the client's body that the client cannot easily remove that restricts freedom of movement or normal access to the client's body.

Personal Restraint means personal application of physical force without the use of any device, for the purpose of restraining the free movement of the client's body. This does not include briefly holding a client without undue force in order to calm or comfort, or holding a client's hand to safely escort the client from one area to another. This does not include the act of getting the client under control and into the required position for Restraint.

Residential Child Care Facility (RCCF) means any facility that provides out-of-home, 24-hour care, protection and supervision for children in accordance with 12 C.C.R. 2509-8, Section 7.705.91.A.

Seclusion means the involuntary confinement of a client alone in a room or an area from which the client is physically prohibited from leaving.

[SECTIONS 8.765.2-13 ARE UNAFFECTED BY THIS RULE CHANGE]

8.765.14 QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP)

8.765.14.A CLIENT ELIGIBILITY

1. Children up to age eighteen (18) years old and for those persons up to twenty-one (21) years old who consent to the placement or are placed by court order, for whom an Independent Assessment determines that the child's needs cannot be met in a less restrictive, family-based setting because of their serious emotional or behavioral disorders or disturbances.

2. Managed Care Entities must use the Independent Assessment to inform medical necessity determinations.

3. For children in the custody of a county department of human/social services or Division of ~~youth corrections~~Youth Services and for those children receiving mental health services in a Qualified Residential Treatment Program (QRTP) through the Child and Youth Mental Health Treatment Act, the Independent Assessment will determine mental health medical necessity.

8.765.14.B QRTP AND PROVIDER ELIGIBILITY

1. Beginning October 1, 2021, to be eligible for Colorado Medicaid reimbursement, a QRTP must:

   a. Be enrolled with Colorado Medicaid;

   b. Be licensed by the Colorado Department of Human Services (CDHS), Provider Services Unit (PSU), as a Child Care Facility with QRTP indicate~~d~~s as the Service Type in accordance with CDHS regulations;

   c. Be accredited by:

      i. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO),

      ii. The Commission on Accreditation of Rehabilitation Facilities (CARF),

      iii. The Council on Accreditation of Services for Families and Children, or

      iv. Any other independent, not-for-profit accrediting organization approved by the Secretary of Health and Human Services.

   d. Submit an attestation form to the Department with the facility's Colorado Medicaid enrollment application with Colorado Medicaid that attests:

      i. The facility has no more than sixteen (16) beds, including all beds at a single address or on adjoining properties regardless of program or facility type;

      ii. The facility does not share a campus with a Psychiatric Residential Treatment Facility (PRTF);

      iii. For facilities more than one (1) mile but less than ten (10) miles apart by road from another overnight facility controlled by the same ownership or governing body, the other overnight facility meets the following criteria:

         1. The facility maintains its own license;

2. The facility has dedicated staff that ensures a stable treatment environment;

3. Residents do not move between the facility and another during the episode of care

iv. For facilities less than one (1) mile apart, but not on the same campus or adjoining properties, the QRTP is in a home-like structure (cottage, house, apartment) located farther than 750 feet from another overnight facility within a community setting that includes publicly used infrastructure (roads, parks, shared spaces, etc.).

2. Provider Qualifications.

a. The rendering provider for the following services must be an enrolled Licensed Mental Health Professional in a QRTP:

i. Individual therapy,

ii. Group therapy, and

iii. Family therapy.

8.765.14.C COVERED SERVICES

1. Medically necessary services pursuant to Section 8.076.1.8 that are not excluded in Section 8.765.14.D and are:

a. Included in the member's stabilization plan created by the QRTP in accordance Colorado Department of Human Services (CDHS) regulations.

b. Included in the member's individual child and family plan created by the QRTP in accordance with CDHS regulations.

c. Included in the member's discharge and aftercare plan created by the QRTP in accordance with CDHS regulations.

2. All EPSDT services not specified in Sections 8.765.14.C.1-3 are covered under Section 8.280.

8.765.14.D NON-COVERED SERVICES

1. The following services are not covered for members in a QRTP:

a. Room and board;

b. Educational, vocational, and job training services;

c. Recreational or social activities; and

d. Services provided to inmates of public institutions or residents of Institutions of Mental Disease (IMD).

8.765.14.E PRIOR AUTHORIZATION REQUIREMENTS

1. Prior authorization may be required for this benefit.

8.765.14.F REIMBURSEMENT.

1. QRTPs are reimbursed a per diem rate, as determined by the Department, if the following conditions are fulfilled:

   a. Rendered services are documented in the treatment record at the frequencies specified in the member's care plan(s);

   b. A care plan(s) is on record for the time period reported in the reimbursement claim; and

   c. The care meets professionally recognized standards for care in a QRTP.

2. QRTPs must enroll as a Colorado Medicaid provider to act as a billing entity for Licensed Mental Health Professionals rendering mental health services in the QRTP.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 21-12-01-A
Division / Contact / Phone:Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-12-01-A, Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300

3. This action is an adoption of: an amendment

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

   Sections(s) Sections 8.300.3 and 8.300.5, 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: December 10, 2021

   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

*to be completed by MSB Board Coordinator

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Replace the current text at 8.300 with the proposed text beginning at 8.300.3.A.6 through the end of 8.300.A.6. Insert the proposed text beginning at 8.300.4 through the end of 8.300.4. Insert the proposed text beginning at 8.300.5.F through the end of 8.300.5.F. This rule is effective December 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 21-12-01-A
Division / Contact / Phone:Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   During the Coronavirus Disease 2019 (COVID-19) public health emergency, subacute care may be administered by an enrolled hospital in its inpatient hospital or alternate care facilities. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Patients may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital. Subacute care will be paid at the rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State Plan. Adding subacute care to the covered hospital services in an inpatient hospital, or an associated alternate care facility, increases access to such services for the duration of the COVID-19 public health emergency.

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:

   Addition of subacute care to the list of the covered services for inpatient hospitals, and associated alternate care facilities, increases access to such care for the duration of the COVID-19 public health emergency and is imperatively necessary for the preservation of public health, safety, and welfare.

3. Federal authority for the Rule, if any:

   42 CFR §447, Subpart C (2020)

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   C.R.S. 25.5-5-102(1)(a) (2019)

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 21-12-01-A
Division / Contact / Phone:Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Inpatient hospitals, and associated alternate care facilities (AFC), will be affected by, and benefit from, the proposed rule with the addition of subacute care as a covered treatment modality for the duration of the COVID-19 public health emergency. Clients receiving subacute care in an inpatient hospital, or in an AFC, for the duration of the COVID-19 public health emergency will also be affected by, and benefit from, the proposed rule. The Department will bear the cost of reimbursement for subacute care services authorized under 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 qualitative impact of the proposed rule is adding the subacute care treatment modality to the inpatient hospital, and associated AFC, covered services for the duration of the COVID-19 public health emergency. The proposed rule increases access to such services during the COVID-19 public health emergency by allowing hospitals to treat clients that would normally be discharged from the hospital in order to receive a lower level of care. It may be difficult for hospitals to discharge and place such clients in a skilled nursing facility during the COVID-19 public health emergency due to COVID-19 positive or presumptive status. The proposed rule allows hospitals to treat such clients on-site and be reimbursed for such care. Because the clients are being treated at an inpatient hospital or alternate care facility for the

same care they would have otherwise received at a skilled nursing facility, the proposed rule is budget neutral.

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.

   Because the clients treated at an inpatient hospital or alternate care facility for the subacute care under the authority of this rule would have otherwise received such care at a skilled nursing facility, the proposed rule is budget neutral. There are no probable implementation or enforcement costs to the Department or to any other agency. There is no anticipated effect on state revenues.

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

   The probable cost of the proposed rule is reimbursement for subacute care at inpatient hospitals and associated AFCs. The probable benefit of the proposed rule is increased access to subacute care for the duration of the COVID-19 public health emergency. There are no benefits to inaction. Diminished access to subacute care, as described in question two above, for the duration of the COVID-19 public health emergency could be a cost of 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 adding subacute care to the covered services for inpatient hospitals and associated AFCs for the duration of the COVID-19 public health emergency.

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

   There are no alternative methods for adding subacute care to the covered services for inpatient hospitals and associated AFCs for the duration of the COVID-19 public health emergency.

8.300 HOSPITAL SERVICES

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

Inpatient Hospital Services are a Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. Inpatient Hospital services include:

    a. bed and board, including special dietary service, in a semi-private room to the extent available;

    b. professional services of hospital staff;

    c. laboratory services, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;

    d. emergency room services;

    e. drugs, blood products;

    f. medical supplies, equipment and appliances as related to care and treatment; and

    g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.

2. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.

3. Prior to July 1, 2020, Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

    Beginning July 1, 2020, reimbursement for a mother's hospitalization for delivery does not include reimbursement for the newborn's hospitalization. Services shall be reimbursed under the identification number of each client.

4. Psychiatric Hospital Services

    Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-network Hospital.

    a. Inpatient care in a Psychiatric Hospital is limited to forty-five (45) days per state fiscal year, unless additional services are prior-authorized as medically necessary by the Department's utilization review vendor or other Department

representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.

b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:

i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and

ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.

c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

5. Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-network DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

a. an acute medical condition for which dialysis treatments are required; or

b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or

c. placement or repair of the dialysis route (“shunt”, “cannula”).

6. Inpatient Subacute Care

Administration of subacute care by an enrolled hospital in its inpatient hospital or alternate care facilities is covered for the duration of the Coronavirus Disease 2019 (COVID-19) public health emergency. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Members may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital.

8.300.4 Non-Covered Services

The following services are not covered benefits:

1. Inpatient Hospital Services defined as experimental by the United States Food and Drug Administration.

2. Inpatient Hospital Services which are not a covered Medicare benefit.

3. Court-ordered psychiatric Inpatient care which does not meet the Medical Necessity criteria established for such care by the Department's utilization review vendor or other Department representative.

~~4. Days awaiting placement or appropriate transfer to a lower level of care are not a covered benefit unless otherwise Medically Necessary.~~

~~5~~. ~~Substance abuse rehabilitation treatment is not covered unless individuals are aged 20 and under. Services must be provided by facilities which attest to having in place rehabilitation components required by the Department. These facilities must be approved by the Department to receive reimbursement.~~

8.300.5 Payment for Inpatient Hospital Services

8.300.5.F Payment for Inpatient Subacute Care

1. Inpatient Subacute Care days shall be paid at a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved by the Centers for Medicare and Medicaid Services (CMS), for the State in which such hospital is located.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospice Room and Board
Rule Number: MSB 21-12-01-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-12-01-B, Revision to the Medical Assistance Act Rule concerning Hospice Room and Board

3. This action is an adoption of: new rules

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

   Sections(s) 8.550.9.C, 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: 12/10/2021
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text beginning at 8.550.9.C through the end of 8.550.9.C.
This rule is effective December 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospice Room and Board
Rule Number: MSB 21-12-01-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule implements Colorado Senate Bill 21-214, which establishes a state-only room and board payment to qualified hospice providers that render hospice care in a licensed hospice facility to an eligible Medicaid-enrolled member who has a hospice diagnosis, is eligible for nursing facility care and, despite attempts to secure a bed, is unable to secure a Medicaid bed in a nursing facility due to COVID-19 impacts, complexity of medical care, behavioral health issues, or other issues as determined by the Department. Room and board reimbursement is available to qualified hospice providers who provided such services during the period beginning the last quarter of the 2020-21 state fiscal year through the 2021-22 state fiscal year, within existing appropriations.

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:

   This rule is imperatively necessary to comply with state law at CRS § 25.5-4-424 to implement the hospice state-only room and board payment mandated by statute.

3. Federal authority for the Rule, if any:

   Not applicable, this is a state-only payment.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   CRS § 25.5-4-424 (2021)

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

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospice Room and Board
Rule Number: MSB 21-12-01-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Eligible patients enrolled in Medicaid who are eligible for nursing facility care, have a hospice diagnosis, and, despite attempts to secure a bed, are unable to secure a Medicaid bed in a nursing facility due to COVID-19 impacts, complexity of medical care, behavioral issues, or other issues as determined by the Department are affected by this rule, as are the qualified hospice providers who provide room and board to such patients where nursing facility beds are unavailable.

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 improve access to room and board for eligible patients and, within existing appropriations, provide state-only payment to the qualified hospice providers who provide room and board to such patients.

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 will increase General Fund expenditures for the Department of Health Care Policy and Financing by $684,000 for expenditures beginning in state fiscal year 2020-21 and ending in state fiscal year 2021-22. This assumes an average of 13 patients per day will receive hospice services at an average state per diem rate of $115.38 for 456 days. For state fiscal year 2020-21, the authorizing statute includes a General Fund appropriation of $684,000 to the Department. Funds not expended prior to July 1, 2021, are further appropriated for state fiscal year 2021-22.

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

   The costs of the proposed rule are detailed in question #3. The benefit of the proposed rule is implementing the statutory mandate in CRS § 25.5-4-424 and providing state payment for room and board payment for qualified patients as

detailed in questions #1 and #2. The cost of inaction is failure to implement the statutory mandate in CRS § 25.5-4-424. There are 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 methods or less intrusive methods to implement the state-only hospice room and board payment mandated in CRS § 25.5-4-424

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

   There are no alternative methods for implementing the state-only hospice room and board payment mandated in CRS § 25.5-4-424.

8.550 HOSPICE BENEFIT

8.550.9 REIMBURSEMENT

8.550.9.C. State-Only Hospice Room and Board Reimbursement

1. As used in this section, unless context otherwise requires:

   a. "Eligible Patient" means a person who is enrolled in Colorado Medicaid at the time the service is provided and who:

      i) Is eligible under Colorado Medicaid for care in a nursing facility at the time the service is provided;

      ii) Has a hospice diagnosis; and

      iii) Despite attempts to secure a bed, is unable to secure a Medicaid bed in a nursing facility due to COVID-19 impacts, complexity of medical care, behavioral health issues, or other issues as determined by the Department.

   b. "Qualified Hospice Provider" means a hospice provider that:

      i) Has been continuously enrolled with the Department since at least January 1, 2021;

      ii) Provided hospice services to the eligible patient in a licensed hospice facility during the period beginning in the last quarter of the 2020-2021 state fiscal year through the 2021-2022 state fiscal year; and

      iii) Complies with any billing or administrative requests of the Department for purposes of determining eligibility for and administering the state payment.

2. Qualified Hospice Providers who provide hospice care in a licensed hospice facility to an Eligible Patient may receive a room and board payment equal to one-half (1/2) of the statewide average per diem rate, as defined in C.R.S. § 25.5-6-201. The payment is subject to the following limitations:

   a. Payment is limited to not more than twenty-eight (28) days per Eligible Patient.

   ~~a.~~b. No payments will be made after June 30, 2022 or after appropriations are exhausted, whichever occurs first, in accordance with C.R.S. § 25.5-4-424.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Pediatric Personal Care Minimum Wage
Rule Number: MSB 21-12-02-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-12-02-A, Revision to the Medical Assistance Act Rule concerning Pediatric Personal Care Minimum Wage

3. This action is an adoption of: an amendment

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

   Sections(s) 8.535, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/10/2021
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.535 with the proposed text beginning at 8.535.2 through the end of 8.535.2.D. This rule is effective December 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Pediatric Personal Care Minimum Wage
Rule Number: MSB 21-12-02-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

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

2. An emergency rule-making is imperatively necessary

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

   Explain:

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

3. Federal authority for the Rule, if any:

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4. State Authority for the Rule:

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Pediatric Personal Care Minimum Wage
Rule Number: MSB 21-12-02-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

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

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

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

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

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

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

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

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

   There are no less costly solutions to achieve the purpose of this proposed rule.

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

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

8.535 PEDIATRIC PERSONAL CARE SERVICES

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

8.535.2 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.535.2.A DEFINITIONS

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

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

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

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

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

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

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

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

8.535.2.B QUALIFYING SERVICES

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

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

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

8.535.2.C PROVIDER RESPONSIBILITIES

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

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

    a. Provider shall utilize the Department approved letter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    a. Payroll summaries and details

    b. Timesheets

    c. Paid time off records

    d. Cancelled checks (front and back)

    e. Direct deposit confirmations

    f. Independent contractor documents or agreements

    g. Per diem wage documents

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

8.535.2.D REPORTING AND AUDITING REQUIREMENTS

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

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

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

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

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

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

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Base Wage Requirement for Direct Care Workers, Section 8.511
Rule Number: MSB 21-08-05-A
Division / Contact / Phone: Benefits & Services Management / Erin Thatcher / 303-866-5788

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-08-05-A, Revision to the Medical Assistance Act Rule concerning Base Wage Requirement for Direct Care Workers, Section 8.511

3. This action is an adoption of: an amendment

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

   Sections(s) 8.511, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 01/01/22
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.511. This rule is effective January 1, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Base Wage Requirement for Direct Care Workers, Section 8.511
Rule Number: MSB 21-08-05-A
Division / Contact / Phone: Benefits & Services Management / Erin Thatcher / 303-866-5788

STATEMENT OF BASIS AND PURPOSE

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

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

2. An emergency rule-making is imperatively necessary

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

   Explain:

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

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Base Wage Requirement for Direct Care Workers, Section 8.511
Rule Number: MSB 21-08-05-A
Division / Contact / Phone: Benefits & Services Management / Erin Thatcher / 303-866-5788

REGULATORY ANALYSIS

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

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

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

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

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

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

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

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

   There are no less costly solutions to achieve the purpose of this proposed rule.

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

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

8.511 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.511.1 DEFINITIONS

Definitions below only apply to Section 8.511.

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

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

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

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

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

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

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

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

8.511.2 QUALIFYING SERVICES

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

1. Adult Day Services

2. Alternative Care Facility (ACF)

3. Community Connector

4. Consumer Directed Attendant Support Services (CDASS)

5. Group Residential Support Services (GRSS)

6. Homemaker

7. Homemaker Enhanced

8. In-Home Support Services (IHSS)

9. Individual Residential Support Services (IRSS)

10. Job Coaching

11. Job Development

12. Mentorship

13. Personal Care

14. Prevocational Services

15. Respite

16. Specialized Habilitation

17. Supported Community Connections

18. Supported Living Program

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

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

8.511.3 PROVIDER RESPONSIBILITIES

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

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

1. Provider shall utilize the Department provided letter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Payroll summaries and details

2. Timesheets

3. Paid time off records

4. Cancelled checks (front and back)

5. Direct deposit confirmations

6. Independent contractor documents or agreements

7. Per diem wage documents

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

8.511.4 REPORTING & AUDITING REQUIREMENTS

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

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

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

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

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

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

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning the Modification of Outpatient Hospital Payment Rates through EAPG Grouper Update, Section 8.300.6
Rule Number: MSB 21-11-08-A
Division / Contact / Phone: Fee-for-Service Rates / Andrew Abalos / 2130

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-11-08-A, Revision to the Medical Assistance Act Rule concerning the Modification of Outpatient Hospital Payment Rates through EAPG Grouper Update, Section 8.300.6

3. This action is an adoption of: an amendment

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

   Sections(s) 8.300.6, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: January 1, 2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300.6.A.1 through the end of 8.300.6.A.1. This rule is effective January 1, 2022.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule modifies language in the outpatient hospital services payment Section 8.300.6, authorizing the modification of base rate and weight setting to accommodate a transition to a new version of the Enhanced Ambulatory Patient Grouping (EAPG) methodology. Currently, outpatient hospital services are reimbursed through the EAPG methodology, which is a system which is developed and maintained by 3M Health Information Systems. The Department currently reimburses using version 3.10 of EAPGs and will be transitioning to version 3.16 effective January 1, 2022. This is necessary to allow the Department to continue reimbursing hospitals using an up to date versions of the CPT/HCPCS code sets, while adjusting hospital base rates to minimize financial impacts to hospitals through the transition.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   The current version of the EAPG methodology will disallow payment to providers billing codes that are effective as of January 1, 2022. Inaction may prevent the delivery of crucial services to members of Health First Colorado. Therefore, updating rule language to accommodate and pay for such codes while adjusting hospital-specific base rates is imperatively necessary for the preservation of public health, safety and welfare.

3. Federal authority for the Rule, if any:

   42 CFR 440.10 (2021)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   Section 25.5-102(1)(a), C.R.S. (2021)

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REGULATORY ANALYSIS

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

   Health First Colorado members will benefit by maintaining access to care for outpatient hospital services. Hospitals will also be impacted as payment for such services will also change, though their hospital-specific rates will be adjusted for the purpose of maintaining revenue neutrality.

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

   Health First Colorado members will see no change through approval of the proposed rule. Hospitals will see shifts in payment for various services, though payment rates have been adjusted so that, on aggregate, hospitals should see minimal change in payment.

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

   The Department foresees no probable costs to the Department and to any other agency through the implementation and enforcement of the proposed rule. This has no anticipated effect on state revenues.

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

   A benefit of the proposed rule is allowing hospitals to continue billing using up to date standards and continue providing outpatient hospital services to Health First Colorado members. The costs of the proposed rule are possible variations in aggregate reimbursements to hospitals, though the base rate changes will minimize any signification variation. The cost of inaction is potential barriers in access to care for Health First Colorado members, as services billed using new CPT/HCPCS codes would not be reimbursed. There are no benefits of inaction.

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

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

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

   As the EAPG methodology version update is required, there are no alternative methods of achieving the purpose for the proposed rule. However, the Department examined several variations of altering payment rates for the purpose of minimizing financial impact to hospitals. Service-specific payment adjustments were rejected, as altering such rates would disproportionately benefit certain hospitals while harming others, while also undermining the integrity of the payment methodology. Different corridor hospital-specific rate adjustments were also considered, but were rejected as this change is required to be budget neutral to the state, and such corridors would create or maintain significant and disproportionate reimbursements to hospitals for outpatient services.

8.300 HOSPITAL SERVICES

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4 percent (28.4%) or billed charges less 28.4 percent (28.4%).

Effective July 1, 2015, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28 percent (28%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Effective October 31, 2016, DRG Hospitals will be reimbursed for Outpatient Hospital Services based on a system of Enhanced Ambulatory Patient Grouping and a Hospital-specific Medicaid Outpatient base rate. The reimbursement for Outpatient Hospital Services shall be referred to as the EAPG Payment.

a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR 2505-10, Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific Medicaid Outpatient base rate. If the billed amount is less than the EAPG Payment, reimbursement will be the billed amount.

b. The EAPG Payment is calculated for each detail on the claim. Claim details with the same dates of service are grouped into a visit. Claims containing details describing charges for emergency room, treatment room services or patients placed under observation will have all its details grouped into a single visit.

c. Each detail on a claim is assigned an EAPG. EAPGs can have the following types:

    (1) Per Diem

    (2) Significant Procedure. Subtypes of Significant Procedures Are:

        (a) General Significant Procedures

        (b) Physical Therapy and Rehabilitation

        (c) ~~Mental~~ Behavioral Health and Counseling

(d) Dental Procedure

(e) Radiologic Procedure

(f) Diagnostic or Therapeutic Significant Procedure

(3) Medical Visit

(4) Ancillary

(5) Incidental

(6) Drug

(7) Durable Medical Equipment

(8) Unassigned

d. A detail will be subject to EAPG Consolidation when it is assigned the same Significant Procedure EAPG as a detail not already subjected to EAPG Consolidation for that visit. EAPG Consolidation will also occur for details assigned EAPGs considered to be clinically similar to another EAPG during the visit. Details subject to EAPG Consolidation will have an EAPG Payment calculated using an EAPG Weight of 0.

e. A detail will be subject to EAPG Packaging when its assigned EAPG is considered an ancillary service to a Significant Procedure EAPG or Medical Visit EAPG present on the claim for that visit. Details describing additional undifferentiated medical visits and services will be exempt from EAPG Packaging. A detail is also subject to EAPG Packaging when it is assigned a Medical Visit EAPG while a Significant Procedure EAPG is present on the claim for that visit. Details assigned Significant Procedure EAPGs that are ~~of subtypes Physical Therapy and Rehabilitation and Radiologic~~ not General Significant Procedures do not cause details with Medical Visit EAPGs to be subject to EAPG Packaging. Details subject to EAPG Packaging will be calculated using an EAPG Weight of 0.

f. A detail will qualify for Multiple Significant Procedure Discounting when a Significant Procedure of the same subtype is present on the claim for that visit. Details qualifying for Multiple Significant Procedure Discounting are ordered by their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG Weight will have its EAPG Payment calculated at 100 percent (100%) of its EAPG Weight. The qualifying detail for that visit with the next greatest EAPG Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG Weight. All other qualifying details for that visit will have its EAPG Payment calculated at 25 percent (25%) of its EAPG Weight.

g. Details assigned the same Ancillary EAPG on the same visit will qualify for Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment for all other details qualifying for Repeat Ancillary Discounting for that visit and EAPG will be calculated using 25 percent (25%) of their EAPG Weights.

h. Details describing terminated procedures will be subject to Terminated Procedure Discounting. EAPG Payment for a detail subject to Terminated Procedure Discounting is calculated using 50 percent (50%) of the EAPG Weight. Terminated procedures are not subject to other types of discounting.

i. Details describing bilateral services will have EAPG Payment calculated using 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

j. Details describing 340B Drugs will have an EAPG Payment calculated using 80 percent (80%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

k. The Hospital-specific Medicaid Outpatient base rate for ~~the year of the methodology implementation~~January 1, 2022 for each hospital is calculated using the following method.

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

(a) Pediatric Hospitals

(b) ~~Urban~~ Critical Access Hospitals

(c) ~~Rural Hospitals~~Non-~~independent Urban~~Critical Access, System Hospitals

(d) Independent Hospitals

(e) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals

(2) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals are assigned their same hospital-specific base rate as effective immediately prior to January 1, 2022.

(~~2~~3) Process Medicaid outpatient hospital claims from ~~state fiscal year~~calendar year ~~2015~~2019~~, known as the Base Year,~~ through the methodology described in 8.300.6.A.1.a-j using ~~Colorado's~~ 3M's EAPG Relative Weights, scaled for budget neutrality purposes, and version 3.16 of the Enhanced Ambulatory Patient Grouping methodology. ~~For lines with incomplete data, estimations of EAPG Adjusted Weights will be used.~~ Hospital payment rates from version 3.10 of the methodology are then compared to the version 3.16 payment rates using the hospital-specific base rates immediately prior to January 1, 2022.

(~~3~~4) For Critical Access Hospitals, a weighted average base rate by outpatient hospital visit is calculated. EAPG payments for Critical Access Hospitals under version 3.10 and 3.16 are calculated using this weighted average base rate, then an inflation factor is applied to determine a revenue neutral rate for the Critical Access Hospital group. This inflation factor is then applied to all Critical Access Hospital rates effective immediately prior to January 1, 2022. For all other hospitals, with the exception of Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, a revenue neutral rate is calculated which aligns

payment under version 3.16 of EAPGs to payments calculated under version 3.10. ~~Calculate costs from hospital charge data using the computation of the ratio of costs to charges from the CMS-2552-10 Cost Report. After the application of inflation factors to account for the difference in cost and caseload from state fiscal year 2015 to the implementation period, costs and EAPG Adjusted Weights are aggregated by peer group and are used to form peer group base rates. Each hospital is assigned the peer group base rate depending on their respective peer group assigned in 8.300.6.A.1.k.(1).~~

(~~4~~5) ~~For each hospital, calculate the projected EAPG payment by multiplying its peer group base rate by its hospital-specific EAPG Adjusted Weights as calculated in 8.300.6.A.1.k.(2). If the projected payment exceeds a +/- 10% difference in payment from the prior outpatient hospital reimbursement methodology, the hospital will receive an adjustment to their base rate to cap its resulting gains or losses in projected EAPG payments to 10%~~For Critical Access Hospitals, the average and standard deviation of their rates with the inflation factor applied is calculated. All Critical Access Hospitals with a rate falling below 1 standard deviation of the average is given a rate at 1 standard deviation below the average. For Critical Access Hospitals with a rate above 2 standard deviations of the average is given a rate at 2 standard deviations above the average. For each other hospital group, except Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, the average and standard deviation of their rates are calculated. For hospitals that have a rate below 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations below the group's average rate. For hospitals that have a rate above 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations above the group's average rate.

(~~5~~6) For all hospitals, the Medicaid Outpatient base rate, as determined in 8.300.6.A.k.(1)-(4), shall be adjusted by an equal percentage, when required due to changes in the available funds appropriated by the General Assembly. The application of this change to the Medicaid Outpatient base rate shall be determined by the Department.

l. Effective June 1, 2020, by the modification of the EAPG Weights, the allowed reimbursement of outpatient hospital drugs shall be increased by 42.93% for drugs provided at Critical Access Hospitals and Medicare Dependent Hospitals, and decreased by 3.47% for drugs provided at non-independent urban hospitals.

2. Payments to Out-of-Network DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

Effective October 31, 2016, Out-of-Network DRG Hospitals will be reimbursed for Outpatient Hospital Services based the system of Enhanced Ambulatory Patient Grouping described in 10 CCR 2505-10 Section 8.300.6.A.1. Such hospitals will be

assigned to a Rural or Urban peer group depending on hospital location and will receive a base rate of 90% of the respective peer group base rate as calculated in 8.300.6.A.1.k.(3). Out-of-Network DRG Hospitals will periodically have their Medicaid Outpatient base rates adjusted as determined in 8.300.6.A.k.(5).

3. Payments for Outpatient Hospital Specialty Drugs

Effective August 11, 2018, for services meeting the criteria of an Outpatient Hospital Specialty Drug that would have otherwise been compensated through the EAPG methodology, a hospital must submit a request for authorization to the Department prior to administration of the drug. If the request is approved, then the payment will be negotiated between the Department and the hospital on a case-by-case basis.