DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 22-11-08-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 22-11-08-A, Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000.

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

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/9/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.8000. This rule is effective December 9, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 22-11-08-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

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).

   Create rules to administer the Rural Provider Access and Affordability Stimulus Grant Program established through the enactment of Senate Bill 22-200 including a methodology to determine which rural providers are qualified for grant funds, permissible uses of grant money, and reporting requirements for grant recipients.

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 enabling legislation, Senate Bill 22-200, requires that the Medical Services Board promulgate rules for the administration of the Rural Provider Access and Affordability Stimulus Grant Program on or before December 31, 2022. The legislation also created the Rural Provider Access and Affordability Advisory Committee to begin meeting in September 2022 and charged the committee with making formal recommendations to the Department on the administration of the grant program including the proposed rule. The timeline for the advisory committee's work necessitates emergency rule-making to meet the December 2022 rule deadline established by the legislation in law at Section 25.5-1-207 (5), C.R.S.

3. Federal authority for the Rule, if any:

   American Rescue Plan Act of 2021 (ARPA), Public Law 117-2

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   Section 25.5-1-207 (5), C.R.S. (2022)

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

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 22-11-08-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

REGULATORY ANALYSIS

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

   Colorado hospitals in rural communities and their associated clinics will benefit from the proposed rule by helping these providers modernize their information technology systems which tend to lag behind their urban and suburban counterparts. Residents of rural Colorado will benefit as the program will support reducing health care costs in communities, add jobs, stimulate the economy, improve access to care, and mitigate rural health disparities.

   The funding for the Rural Provider Access and Affordability Stimulus Grant Program comes from federal funds with no cost to the state or local communities.

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 Rural Provider Access and Affordability Stimulus Grant Program will drive financial sustainability for hospitals and clinics in rural areas of Colorado by investing $9.6 million in health care affordability and health care access related projects:

   - $4.8 million in health care affordability projects, such as shared analytics platforms, telehealth supports, and enabling shared care management between rural providers

   - $4.8 million in health care access projects, such as extending hours for primary and behavioral health care, telemedicine including remote monitoring supports, new or expanded access sites including surgery, chemotherapy, and advanced imaging

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 General Assembly appropriated $400,000 to the Department to administer the Rural Provider Access and Affordability Stimulus Grant Program when it enacted Senate Bill 22-200. These funds are sufficient to administer the program and no

costs to other agencies are expected. The funds for the Rural Provider Access and Affordability Stimulus Grant Program are federal funds from the American Rescue Plan Act of 2021 (ARPA) and there is no impact on state revenues.

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

   Adopting the proposed rules to administer the Rural Provider Access and Affordability Stimulus Grant Program will allow the Department to grant $9.6 million of federal funds to rural providers as directed by the General Assembly to improve health care affordability and access and stimulate the economies in rural Colorado.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no benefits to inaction.

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

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no less costly or intrusive methods for achieving the purpose of the proposed rule.

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

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no alternatives to rule making than the proposed rule. The proposed rule includes those elements necessary to administer the grant program and were developed and supported by the Rural Provider Access and Affordability Advisory Committee established by the legislation.

8.8000 Rural Provider Access and Affordability Stimulus Grant Program

8.8001 PURPOSE AND LEGAL BASIS

Pursuant to C.R.S. § 25.5-1-207, the Rural Provider Access and Affordability Stimulus Grant Program provides grants to qualified providers to improve health care affordability and access to health care services in rural communities and to drive financial sustainability for rural hospitals and clinics.

8.8002 DEFINITIONS

A. Advisory Committee means the rural provider access and affordability advisory committee as defined in section 25.5-1-207 (3), C.R.S.

B. Department means the Colorado Department of Health Care Policy and Financing.

C. Health Care Access Project means a project that expands access to health care in Rural Communities including but not limited to:

1. Extending hours for access to primary care or behavioral health services,

2. Investing in dual track emergency department management,

3. Expanding access to Telemedicine including remote monitoring support,

4. Providing new or replacement Hospital beds,

5. Expanding access to long term care and recovery care in skilled nursing facilities, and

6. Creating or expanding sites that provide surgical care, chemotherapy, imaging, and advanced imagining including computerized tomography scans.

D. Health Care Affordability Project means a project that modernizes the information technology infrastructure of Qualified Rural Providers including but not limited to:

1. Creating a shared analytics platform and care coordination platforms among Qualified Rural Providers, and

2. Enabling technologies, including telehealth and e-consult systems, that allow Qualified Rural Providers to communicate, share clinical information, and consult electronically to manage patient care.

E. Hospital means a hospital licensed or certified pursuant to section 25-1.5-103 (1)(a), C.R.S. or an affiliate owned or controlled as defined in section 25.5-4-402.8 (1)(b), C.R.S., by the hospital.

F. Qualified Rural Provider means a Hospital located in a Rural Community in Colorado that has a lower net patient revenue or fund balance compared with other Rural Hospitals~~.~~.

G. Rural Community means a county with a population of fewer than fifty thousand residents; or a municipality with a population of fewer than twenty-five thousand residents if the municipality is not contiguous to a municipality with a population of twenty-five thousand or more residents.

H. Rural Stimulus Grant means funding received from the rural provider access and affordability grant program established in section 25.5.1-207, C.R.S.

I. Telemedicine means the delivery of medical services as defined at section 12-240-104 (6), C.R.S.

8.8003 GRANT AWARD PROCEDURES

A. Rural Stimulus Grants will be awarded through an application process.

1. A request for grant application form shall be issued by the Department and posted for public access on the Department's website at https://hcpf.colorado.gov/research-data at least 30 days prior to the application due date.

2. A Qualified Rural Provider may submit applications for more than one project or may submit a joint application with another Qualified Rural Provider.

3. The application will include:

a. Project overview.

b. Proposed budget including:

i. Total funds requested not to exceed $650,000 per project per applicant,

ii. Itemized direct expenses,

iii. Indirect expenses limited to federal Negotiated Indirect Costs Rate Agreement (NICRA) or de minimis rate of 10 percent if the applicant does not have an NICRA,

iv. If applicable, documentation of quotes or estimates for construction, equipment, or other expenditures, and

v. If applicable other sources of funding that will be utilized to complete the proposed project.

c. Project timeline to commence no earlier than July 1, 2023 and to conclude no later than December 31, 2026.

d. Description of Qualified Rural Provider's diversity, equity, and inclusion strategy and how diverse community needs are met by the project.

e. Demonstration of financial need.

i. Qualified Rural Providers in the bottom 40% of net patient revenues for the three-year average of 2016, 2017, and 2018 or the bottom 6% fund balance for 2019 as determined by the Department's review of CMS 2552-10 Medicare Cost Reports are considered to meet the financial health requirement.

ii. Other Qualified Rural Providers may submit additional financial supporting information to support their financial need.

f. For capital investment projects, facility or equipment age.

g. Impact to health care affordability or access to care.

i. Statement of need outlying underlying problem the funding will address.

ii. Description of how the project's goals and objectives will be sustained after the Rural Stimulus Grant funds have been expended.

iii. Description of how the project will increase access to specialty care, if applicable.

iv. Description of how project will improve care coordination, if applicable.

v. Description of partner engagement, if applicable.

B. The Advisory Committee will review Rural Stimulus Grant applications and recommend Rural Stimulus Grant awards to the Department's executive director based on the following criteria:

1. Budget and financial need.

2. Partner collaboration, support, or engagement.

3. Completeness of response.

4. Ability to execute and complete project.

5. Reasonableness of timeline.

6. Diversity, equity and inclusion and how diverse communities will be impacted by the project.

7. County Medicare and Medicaid caseload percentage of population.

8. Statement of need.

9. Sustainability of project.

10. Impact to health care affordability or access to care.

C. The Department's executive director or his or her designee shall make the final Rural Stimulus Grant awards to Qualified Rural Providers.

1. The total funding for Rural Stimulus Grants is limited to no more than $9.6 million with no more than $4.8 million for Health Care Access Projects and no more than $4.8 million for Health Care Affordability Projects.

2. The Department may change Rural Stimulus Grant amounts depending on the final number of Rural Stimulus Grants awarded, the availability of Rural Stimulus Grant funds, or the goals stated in the Rural Stimulus Grant application.

3. Rural Stimulus Grant applicants may request reconsideration of Rural Stimulus Grant awards within 5 business days of award notification in writing to the Department's executive director. The executive director will respond to the request for reconsideration within 10 business days of receipt.

4. The Department will execute a grant agreement with each Rural Stimulus Grant recipient.

D. The Department will disburse Rural Stimulus Grant funds no earlier than July 1, 2023 and no later than July 1, 2024. Any money not disbursed by July 1, 2024 will revert to the Economic Recovery and Relief Cash Fund created pursuant section 24-75-228 (2)(a), C.R.S.

E. Rural Stimulus Grant recipients will expend Rural Stimulus Grant funds by the timeline in their grant agreement and no later than December 31, 2026. Any Rural Stimulus Grant funds not expended by Rural Stimulus Grant recipients by December 31, 2026 will be recovered by the Department to be returned to the U.S. Department of the Treasury.

8.8004 PERMISSIBLE USES OF GRANT AWARDS

A. Rural Stimulus Grant funds must be used for Health Care Affordability Projects or Health Care Access Projects to improve health care affordability and access in Rural Communities.

B. Rural Stimulus Grant funds may not be deposited into a pension fund and may not be used to service debt, satisfy a judgment or settlement, or contribute to a "rainy day" fund.

8.8005 REPORTING REQUIREMENTS FOR GRANT RECIPIENTS

A. Recipients of Rural Stimulus Grant funds for capital expenditures must submit a written justification as set forth in 31 Code of Federal Regulations 35.6 (b)(4) to the Department.

B. For the duration of the grant agreement, Rural Stimulus Grant recipients must submit a quarterly report to the Department no later than the 10th day of the month following the end of each quarter including but not limited to a brief narrative and itemized expenditure and performance metric data.

C. Rural Stimulus Grant recipients will submit a final report to the Department within 30 calendar days following the end of the grant agreement including an overall narrative and itemization of all expenditures and performance metric data for the total Rural Stimulus Grant award.

8.8006 RECORD RETENTION AND ACCESS

A. Rural Stimulus Grant recipients must maintain records of expenditures for a minimum of five years after funds have been expended or returned to the Department, whichever is later.

~~A.~~B. Rural Stimulus Grant recipients must allow the Department and state and federal auditors access to records related to the expenditure of Rural Stimulus Grant funds.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Medicare-Only Provider Types, Section 8.125 & 8.126.
Rule Number: MSB 22-10-26-A
Division / Contact / Phone: Operations Section / Alex Lyons / 303-866-2865

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 22-10-26-A, Rule Concerning Medicare-Only Provider Types

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): 8.125, 8.126

   Pages 142-145, pg. 152, 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: 1/1/2023
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.125 with the proposed text beginning at 8.125 through the end of 8.125.15.F. Replace the current text at 8.126 with the proposed text beginning at 8.126 through the end of 8.126.7.A. This rule is effective January 1, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Medicare-Only Provider Types, Section 8.125 & 8.126.
Rule Number: MSB 22-10-26-A
Division / Contact / Phone: Operations Section / Alex Lyons / 303-866-2865

STATEMENT OF BASIS AND PURPOSE

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

   This rule clarifies that Medicare-Only Providers means a provider enrolled in the Medical Assistance Program for purposes of Medicare cost-sharing only, pursuant to 42 CFR §455.410(d).

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 rulemaking is necessary to comply with federal law, pursuant to 42 CFR §455.410(d).

3. Federal authority for the Rule, if any:

   42 CFR Parts 412, 413, 425, 455, and 495.

4. State Authority for the Rule:

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

Initial Review
Proposed Effective Date **01/01/23**
Final Adoption
Emergency Adoption **12/09/22**

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Medicare-Only Provider Types, Section 8.125 & 8.126.
Rule Number: MSB 22-10-26-A
Division / Contact / Phone: Operations Section / Alex Lyons / 303-866-2865

REGULATORY ANALYSIS

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

   This rule does not create any new benefit or cost. Its purpose is to clarify that "Medicare-Only Providers" means a provider enrolled in the Medical Assistance Program for purposes of Medicare cost-sharing only, pursuant to 42 CFR §455.410(d).

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

   There will be minimal quantitative or qualitative impact upon affected classes of persons because this proposed rule merely clarifies existing provider regulations and does not create or eliminate any benefit or tangible cost.

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 costs of both implementation and enforcement of the proposed rule are likely to be negligible.

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 would be the costs associated with updating our regulatory language and making affected parties aware of the change. The benefit of taking action would be complying with federal law, and the cost of inaction would be violating federal law, potentially exposing the Department to legal liability.

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

   There is likely no less-costly way to change the Department's rules to align with federal regulatory requirements other than to adopt the language that specifies the regulatory clarification required by federal statute.

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

   No alternatives were seriously considered because this rule implements federal law in the manner prescribed by 42 CFR §455.410(d) and to do otherwise would risk legal exposure for the Department.

8.125 PROVIDER SCREENING

8.125.1 DEFINITIONS.

Managed Care Entity is defined at 42 CFR § 455.101.

Ownership interest is defined at 42 CFR § 455.101.

Person with an ownership or control interest is defined at 42 CFR § 455.101.

Enrollment is defined as the process by which an individual or entity not currently enrolled as a Colorado Medicaid provider submits a provider application, undergoes any applicable screening, pays an application fee, as appropriate for the provider type, and is approved by the Department for participation in the Medicaid program. Entities that have never previously enrolled as Medicaid providers or whose enrollment was previously terminated and are not currently enrolled are required to enroll. The date of enrollment shall be considered the date that is communicated to the provider in communication from the Department or its fiscal agent verifying the provider's enrollment in Medicaid.

Revalidation is defined as the process by which an individual or entity actively enrolled as a Colorado Medicaid provider resubmits a provider application, undergoes a state-defined screening process, pays an application fee, as appropriate for the provider type, and is approved by the Department to continue participation in the Medicaid program.

Disclosing Entity and Other Disclosing Entity are defined at 42 CFR § 455.101.

8.125.2 PROVIDERS DESIGNATED AS LIMITED CATEGORICAL RISK AND NEW PROVIDER TYPES

8.125.2.A. Except as provided for in Section 8.125.2.B, provider types not designated as moderate or high categorical risk at Sections 8.125.3 or 8.125.4 shall be considered limited risk.

8.125.2.B. The risk category for each provider type designated by CMS shall be the risk category for purposes of this rule regardless of whether a provider type may be listed in Sections 8.125.3 or 8.125.4.

8.125.3 PROVIDERS DESIGNATED AS MODERATE CATEGORICAL RISK

8.125.3.A. Emergency Transportation including ambulance service suppliers

8.125.3.B. Non-Emergency Medical Transportation

8.125.3.C. Community Mental Health Center

8.125.3.D. Hospice

8.125.3.E. Independent Laboratory

8.125.3.F. Comprehensive Outpatient Rehabilitation Facility

8.125.3.G. Physical Therapists, both individuals and group practices

8.125.3.H X-Ray Facilities

8.125.3.I. Revalidating Home Health agencies

8.125.3.J. Revalidating Durable Medical equipment suppliers, including revalidating pharmacies that supply Durable Medical Equipment

8.125.3.K. Revalidating Personal Care Agencies under the state plan

8.125.3.L. Providers of the following services for HCBS waiver members:

1. Alternative Care Facility
2. Adult Day Services
3. Assistive Technology, if the provider is revalidating
4. Behavioral Programing
5. Behavioral Therapies
6. Behavioral Health Supports
7. Behavioral Services
8. Care Giver Education
9. Children's Case Management
10. Children's Habilitation Residential Program (CHRP)
11. Community Connector
12. Community Mental Health Services
13. Community Transition Services
14. Complementary and Integrative Health
15. Day Habilitation
16. Day Treatment
17. Expressive Therapy
18. Home Delivered Meals
19. Home Modifications/Adaptations/Accessibility
20. Independent Living Skills Training
21. In-Home Support Services, if the provider is revalidating
22. Intensive Case Management
23. Massage Therapy
24. Mentorship

25. Non-Medical Transportation

26. Palliative/Supportive Care Skilled

27. Peer Mentorship

28. Personal Care/Homemaker Services, if the provider is revalidating

29. Personal Emergency Response System/Medication Reminder/Electronic Monitoring

30. Prevocational Services

31. Professional Services

32. Residential Habilitation Services

33. Respite

34. Specialized Day Rehabilitation Services

35. Specialized Medical Equipment and Supplies, if the provider is revalidating

36. Substance Abuse Counseling

37. Supported Employment

38. Supported Living Program

39. Therapy and Counseling

40. Transitional Living Program

41. Youth Day Services

8.125.3.M. Medicare Only Providers

1. Independent Diagnostic Testing Facility

2. Revalidating Medicare Diabetes Prevention Program Supplier

3. Newly enrolling Opioid Treatment Program that has been fully and continuously certified by SAMHSA since October 24, 2018.

4. Revalidating Opioid Treatment Program

8.125.4 PROVIDERS DESIGNATED AS HIGH CATEGORICAL RISK

8.125.4.A. Enrolling DME Suppliers

8.125.4.B. Enrolling Home Health Agencies

8.125.4.C. Enrolling Personal Care Agencies providing services under the state plan

8.125.4.D. Enrolling providers of the following services for HCBS waiver members:

1. Assistive Technology

2. Personal Care/Homemaker Services

3 Specialized Medical Equipment and Supplies

4 In-Home Support Services

8.125.4.E. Medicare Only Providers

1. Enrolling Medicare Diabetes Prevention Program Supplier

2. Enrolling Opioid Treatment Program that has not been fully and continuously certified by SAMHSA since October 24, 2018.

8.125.4.~~E~~F. Enrolling and revalidating providers for which the Department has suspended payments during an investigation of a credible allegation of fraud, for the duration of the suspension of payments.

8.125.4.~~F~~G. Enrolling and revalidating providers which have a delinquent debt owed to the State arising out of Medicare, Colorado Medical Assistance or other programs administered by the Department, not including providers which are current under a settlement or repayment agreement with the State.

8.125.4.~~G~~H. Providers that were excluded by the HHS Office of Inspector General or had their provider agreement terminated for cause by the Department, its contractors or agents or another State's Medicaid program at any time within the previous 10 years.

8.125.4 .~~H~~I. Providers applying for enrollment within six (6) months from the time that the Department or CMS lifts a temporary enrollment moratorium on the provider's enrollment type.

8.125.5 PROVIDERS WITH MULTIPLE RISK LEVELS

8.125.5.A Providers shall be screened at the highest applicable risk level for which a provider meets the criteria. Providers shall only pay one application fee per location.

8.125.6 PROVIDERS WITH MULTIPLE LOCATIONS

8.125.6.A. Providers must enroll separately each location from which they provide services. Only claims for services provided at locations that are enrolled are eligible for reimbursement.

8.125.6.B. Each provider site will be screened separately and must pay a separate application fee. Providers shall only pay one application fee per location.

8.125.7 ENROLLMENT AND SCREENING OF PROVIDERS

8.125.7.A. All enrolling and revalidating providers must be screened in accordance with requirements appropriate to their categorical risk level.

8.125.7.B. Notwithstanding any other provision of the Colorado Code of Regulations, providers who provide services to Medicaid members as part of a managed care entity's provider network who would have to enroll in order to participate in fee-for-service Medicaid must enroll with the Department and be screened as Medicaid providers.

8.125.7.C. Nothing in Section 8.125.7.B shall require a provider who provides services to Medicaid members as part of a managed care entity's provider network to participate in fee-for-service Medicaid.

8.125.7.D. All physicians or other professionals who order, prescribe, or refer services or items for Medicaid members, whether as part of fee-for-service Medicaid or as part of a managed care entity's provider network under either the state plan, the Children's Health Insurance Program, or a waiver, must be enrolled in order for claims submitted for those ordered, referred, or prescribed services or items to be reimbursed or accepted for the calculation of managed care rates by the Department.

8.125.7.E. The Department may exempt certain providers from all or part of the screening requirements when certain providers have been screened, approved and enrolled or revalidated:

1. By Medicare within the last 5 years, or

2. By another state's Medicaid program within the last 5 years, provided the Department has determined that the state in which the provider was enrolled or revalidated has screening requirements at least as comprehensive and stringent as those for Colorado Medicaid.

8.125.7.F. The Department may deny a Provider's enrollment or terminate a Provider agreement for failure to comply with screening requirements.

8.125.7.G. The Department may terminate a Provider agreement or deny the Provider's enrollment if CMS or the Department determines that the provider has falsified any information provided on the application or cannot verify the identity of any provider applicant.

8.125.8 NATIONAL PROVIDER IDENTIFIER FOR ORDERING, PRESCRIBING, REFERRING

8.125.8.A. As a condition of reimbursement, any claim submitted for a service or item that was ordered, referred, or prescribed for a Medicaid member must contain the National Provider Identifier (NPI) of the ordering, prescribing or referring physician or other professional.

8.125.9 VERIFICATION OF PROVIDER LICENSES

8.125.9.A. If a provider is required to possess a license or certification in order to provide services or supplies in the State of Colorado, then that provider must be so licensed as a condition of enrollment as a Medicaid provider.

8.125.9.B. Required licenses must be kept current and active without any current limitations throughout the term of the agreement.

8.125.10 REVALIDATION

8.125.10.A. Actively enrolled providers must complete all requirements for revalidation at least every 5 years as established by the Department, or upon request from the Department for an off cycle review.

~~Providers actively enrolled in Medicaid must complete all requirements for revalidation at least every 5 years as established by the Department, or upon request from the Department for an off cycle review.~~

8.125.10.B. The date of revalidation shall be considered the date that the provider's application was initially approved plus 5 years, or by an off-cycle request from the Department.

8.125.10.C. If a provider fails to comply with any requirement for revalidation by the deadlines established by Sections 8.125.10.A. or 8.125.10.B., the provider agreement may be terminated. In the event that the provider agreement is terminated pursuant to this section, any claims for dates of service submitted after deadlines established by Sections 8.125.10.A. or 8.125.10.B., are not reimbursable beginning on the day after the date indicated by Section 8.125.10.B.

8.125.11 - 8.125.13 Repealed [Emergency rules eff. 07/08/2022]

8.125.14 TEMPORARY MORATORIA

8.125.14.A. In consultation with CMS and HHS, the Department may impose temporary moratoria on the enrollment of new providers or provider types, or impose numerical caps or other limits on providers that the Department and the Secretary of HHS identify as being a significant potential risk for fraud, waste, or abuse, unless the Department determines that such an action would adversely impact Medicaid members' access to medical assistance.

8.125.14.B. Before imposing any moratoria, caps, or other limits on provider enrollment, the Department shall notify the Secretary of HHS in writing and include all details of the moratoria.

8.125.14.C. The Department shall obtain the Secretary of HHS's concurrence with imposition of the moratoria, caps, or other limits on provider enrollment, before such limits shall take effect.

8.125.15 DISCLOSURES BY MEDICAID PROVIDERS, MANAGED CARE ENTITIES, MEDICARE PROVIDERS AND FISCAL AGENTS

8.125.15.A. All ~~Medicaid~~ providers, disclosing entities, fiscal agents, and managed care entities must provide the following federally required disclosures to the Department:

1. The name and address of any entity (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity having direct or indirect ownership of 5 percent or more. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.

2. For individuals: Date of birth and Social Security number

3. For business entities: Other tax identification number for any entity with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

4. Whether the entity (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the entity (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

5. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

6. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

7. The identity of any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.

8. Full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12 month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

8.125.15.B. Disclosures from any provider or disclosing entity are due at any of the following times:

1. Upon the provider or disclosing entity submitting the provider application.

2. Upon the provider or disclosing entity executing the provider agreement.

3. Upon request of the Department during revalidation.

4. Within 35 days after any change in ownership of the disclosing entity.

8.125.15.C. Disclosures from fiscal agents are due at any of the following times:

1. Upon the fiscal agent submitting its proposal in accordance with the State's procurement process.

2. Upon the fiscal agent executing a contract with the State.

3. Upon renewal or extension of the contract.

4. Within 35 days after any change in ownership of the fiscal agent.

8.125.15.D. Disclosures from managed care entities are due at any of the following times:

1. Upon the managed care entity submitting its proposal in accordance with the State's procurement process.

2. Upon the managed care entity executing a contract with the State.

3. Upon renewal or extension of the contract.

4. Within 35 days after any change in ownership of the managed care entity.

8.125.15.E. The Department will not reimburse any claim from any provider or entity or make any payment to an entity that fails to disclose ownership or control information as required by 42 CFR § 455.104. The Department will not reimburse any claim from any provider or entity or make any payment to an entity that fails to disclose information related to business transactions as required by 42 CFR § 455.105 beginning on the day following the date the information was due and ending on the day before the date on which the information was supplied. Any payment made to a provider or entity that is not reimbursable in accordance with this section shall be considered an overpayment.

8.125.15.F. The Department may terminate the agreement of any provider or entity or deny enrollment of any provider that fails to disclose information when requested or required by 42 CFR § 455.100-106.

8.126 COLORADO NPI RULE

8.126.1 Definitions

A. Billing Provider Field means the data field on a Claim that reflects the Health Care Provider to which the payer issues payment.

B. Campus means the physical area immediately adjacent to the Hospital's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the Centers of Medicare and Medicaid Services to be part of the provider's campus.

C. Claim means a request for payment for the delivery of medical care, services, or goods authorized under the Medical Assistance Program, submitted to the Department through its fiscal agent by a Health Care Provider. Claim includes the transmission of encounter information for the purpose of reporting the delivery of medical care, services, or goods.

D. Health Care Provider means any person or organization that furnishes, bills for, or is paid for medical care, services, or goods to one or more Medical Assistance Program members.

1. A Health Care Provider includes an Organization Health Care Provider, Subpart of an Organization Health Care Provider, Off Campus Location, and a Site of an Organization Health Care Provider.

2. Unless specified otherwise in Subsection 8.126.1, a Health Care Provider may include a Health Care Provider located outside the state of Colorado (out-of-state provider) that is licensed and/or certified pursuant to their state laws.

E. Hospital means an Organization Health Care Provider that is enrolled in the Medical Assistance Program under the Provider Type of "Hospital - General" as defined in this Subsection 8.126.1.

F. Medical Assistance Program means the programs authorized under Articles 4, 5, 6, 8, and 10 of Title 25.5.

G. National Provider Identifier (NPI) means the standard, unique health identifier for Health Care Providers or Organization Health Care Providers that is used by the National Plan and Provider Enumeration System (NPPES) in accordance with 45 C.F.R. pt. 162.

H. Off-Campus Location means a facility that:

1. Has operations that are directly or indirectly owned or controlled by, in whole or in part, or affiliated with, a Hospital, regardless of whether the operations are under the same governing body as the Hospital;

2. Is not on the Hospital's Campus;

3. Provides services that are organizationally and functionally integrated with the Hospital;

4. Is an outpatient facility providing preventive, diagnostic, treatment, or emergency services; and

5. Is identified on the Hospital's State License Addendum issued by the Colorado Department of Public Health and Environment or, for Hospitals licensed outside of Colorado, documentation demonstrating direct or indirect ownership or control of the Off-Campus Location.

I. Organization Health Care Provider means a Health Care Provider that is not an individual.

J. Provider Type means a classification of Health Care Provider or Organization Health Care Provider to which the payer issues payment for services provided to individuals enrolled in the Medical Assistance Program, according to the Provider Type license, accreditation, certification, and/or service provided. The Provider Types recognized by the Department are as follows:

1. Administrative Services Organization (ASO) is an entity that has entered into a valid, active contract to provide ASO services with the Colorado Department of Health Care Policy and Financing.

2. Ambulatory Surgical Center (ASC) means a health care entity that is:

a. Licensed by the Colorado Department of Public Health and Environment as an Ambulatory Surgical Center; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as an Ambulatory Surgical Center.

3. Audiologist means an individual licensed as an audiologist by the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

4. Behavioral Therapy Clinic means any group practice that has at least one affiliated Behavioral Therapy Individual. The affiliated Behavioral Therapy Individual must be enrolled in the Colorado Medical Assistance Program.

5. Behavioral Therapy Individual means an individual that:

a. Is nationally certified as a Board-Certified Behavioral Analyst (BCBA); or

b. Meets one of the following:

(1) Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology and is actively licensed by the State Board of Examiners; and has completed 400 hours of training; and/or has direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or

(2) Has a doctoral degree in one of the behavioral or health sciences; and has completed 800 hours of specific training; and/or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or

(3) Is nationally certified as a BCBA; or

(4) Has a master's degree or higher in behavioral or health sciences; and is a licensed teacher with an endorsement of school psychologist; or is a licensed teacher with an endorsement of special education or early

childhood special education; or is credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist); and has completed 1,000 hours of direct supervised training or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

6. Birthing Center means a health care entity licensed as a Birth Center by the Colorado Department of Public Health and Environment. Out-of-state providers are not eligible for enrollment.

7. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers.

8. Certified Registered Nurse Anesthetist (CRNA) means an individual who is:

   a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

   b. Included within the advanced practice registry as a CRNA.

9. Clinic – Dental means any group practice that has at least one affiliated, licensed dentist or dental hygienist.

   a. The affiliated dentist or dental hygienist must be enrolled in the Colorado Medical Assistance Program; and

   b. A dental practice or clinic must be owned by a licensed dentist except if the dental practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.); and

   c. A dental hygiene practice or clinic must be owned by a licensed dentist or licensed dental hygienist except if the dental hygiene practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.)

10. Clinic – Practitioner means any group practice that has at least one affiliated, licensed physician, osteopath, or podiatrist. The affiliated practitioner must be enrolled in the Colorado Medical Assistance Program.

11. Community Clinic means a health care entity that is:

   a. Licensed as a Community Clinic or Freestanding Emergency Department (FSED) by the Colorado Department of Public Health and Environment;

   b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program; and

   c. Owned by a Medicare participating hospital.

12. Community Mental Health Center (CMHC) means a health care entity that:

    a. Is licensed as a Community Mental Health Center by the Colorado Department of Public Health and Environment;

    b. Has program approval to operate as a CMHC from the Colorado Department of Human Services; and

    c. If the CMHC delivers substance use disorder services, shall have Substance Use Disorder program approval from Colorado Department of Human Services.

13. Dental Hygienist means an individual who is licensed as a Dental Hygienist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

14. Dentist means an individual who is licensed as a Dentist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

15. Dialysis Treatment Clinic [Formerly Known as Dialysis Center] means a health care entity that is:

    a. Licensed as a Dialysis Treatment Clinic by the Colorado Department of Public Health and Environment; and

    b. Certified by Centers for Medicare and Medicaid Services to participate in the Medicare program as an End-Stage Renal Dialysis Facility (ESRD).

16. Federally Qualified Health Center (FQHC) means a health care entity that has been awarded a Section 330 Grant from the Health Resources and Services Administration. A health care entity that has been designated as a “look-alike” is also eligible to be enrolled as an FQHC.

17. Foreign Teaching Physician means an individual who is licensed as a distinguished foreign teaching physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

18. Home and Community Based Services (HCBS) means Health First Colorado (Colorado’s Medicaid Program)’s community-based care alternatives to institutional, Long-Term care. Providers enrolling as an HCBS provider shall meet all applicable state and federal requirements to provide HCBS by waiver and specialty type.

19. Home Health Agency means a health care entity that:

    a. Has a Class A Home Care Agency license from the Colorado Department of Public Health and Environment; and

    b. Is certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as Home Health Agency.

20. Hospice means a health care entity that is:

    a. Licensed as a Hospice by the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospice.

21. Hospital – General means a health care entity that is:

    a. Licensed as a General Hospital by the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospital.

22. Hospital – Psychiatric [Formerly Known as Hospital - Mental] means a health care entity that is:

    a. Licensed as a Psychiatric Hospital by the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Psychiatric Hospital.

23. Independent Laboratory means a laboratory that:

    a. Has a current and valid Clinical Laboratory Improvement Amendments (CLIA) certification; and

    b. Is certified through the Centers for Medicare and Medicaid Services as a laboratory.

24. Indian Health Service – Federally Qualified Health Center (FQHC) means a health care entity that:

    a. Is treated by the Centers for Medicare and Medicaid Services as a comprehensive Federally funded health center; and

    b. Includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

25. Indian Health Service – Pharmacy means a health care entity that has evidence of participation in the Indian Health Service.

26. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) [Formerly Known as Nursing Facility – ICF/IID] means a health care entity that is:

    a. Licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities through the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as an ICF/IID.

27. Licensed Behavioral Health Clinician means an individual that is licensed by the Colorado Department of Regulatory Agencies as either:

    a. A Licensed Clinical Social Worker;

b. A Licensed Professional Counselor;

c. A Licensed Marriage and Family Therapist; or

d. A Licensed Addiction Counselor.

28. Licensed Psychologist means an individual who is licensed as a psychologist by the State Board of Psychologist Examiners within the Colorado Department of Regulatory Agencies.

29. Managed Care Entity [Formerly Known as Health Maintenance Organization (HMO)] means an entity that has a valid and comprehensive or all-inclusive risk contract with the Colorado Department of Health Care Policy and Financing.

30. Medicare Only Providers means a provider enrolled in the Medical Assistance Program for purposes of Medicare cost-sharing only, pursuant to 42 CFR §455.410(d).

31. Non-Physician Practitioner Group means any group practice consisting of any of the following:

a. Licensed Nurse Practitioners;

b. Licensed Audiologists;

c. Licensed Occupational Therapists;

d. Licensed Behavioral Health Clinicians;

e. Licensed Psychologists;

f. Licensed Speech Therapists; and/or

g. Licensed Physical Therapists.

h. Beginning on the effective date of this amended rule, and for the remainder of the COVID-19 Public Health Emergency (PHE), providers that have enrolled as a Mass Immunizer Roster Biller (provider specialty type 73) with Medicare may temporarily enroll in the medical assistance program as a Non-Physician Practitioner Group for the purpose of billing for the administration of COVID-19 vaccinations for medical assistance clients.

32. Non-Physician Practitioner Individual means a registered nurse, which means an individual licensed as a Registered Nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies.

33. Nurse Midwife means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Midwife.

34. Nurse Practitioner means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Practitioner.

35. Nursing Facility means a health care entity that is:

a. Licensed as a Nursing Care Facility through the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as a Skilled Nursing Care Facility.

36. Occupational Therapist means an individual who is licensed as an Occupational Therapist by the Director of the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

37. Optical Outlet means a health care supplier that is qualified to make and supply eyeglasses and contact lenses for the correction of vision. If, in the performance of its duties, the Optical Outlet requires laboratory services, the laboratory is required to have a current and valid CLIA certification.

38. Optometrist means an individual who is licensed as an Optometrist by the State Board of Optometry within the Colorado Department of Regulatory Agencies.

39. Osteopath means an individual who holds a degree of “doctor of osteopathy,” and who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

40. Personal Care Agency means a health care entity that has a Class A or Class B Home Care Agency license from the Colorado Department of Public Health and Environment.

41. Pharmacist means an individual who is licensed as a Pharmacist by the State Board of Pharmacy within the Colorado Department of Regulatory Agencies.

42. Pharmacy means a pharmacy, pharmacy outlet, or prescription drug outlet registered by the Board of Pharmacy within the Colorado Department of Regulatory Agencies.

43. Physical Therapist means an individual who is licensed as a Physical Therapist by the Physical Therapy Board within the Colorado Department of Regulatory Agencies.

44. Physician means an individual who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

45. Physician Assistant means an individual who is licensed as a physician assistant by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

46. Podiatrist means an individual licensed as a podiatrist by the Colorado Podiatry Board within the Colorado Department of Regulatory Agencies.

47. Psychiatric Residential Treatment Facility (PRTF) means a health care entity that:

a. Is licensed by the Colorado Department of Human Services as a Residential Child Care Facility and a PRTF; and

b. Is certified as a qualified residential provider by the Department of Public Health and Environment; and

c. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children; and

d. Has provided an attestation to the Department that the PRTF is in compliance with the conditions of participation as required by Colorado Department of Human Services and the Centers for Medicare and Medicaid Services.

48. Qualified Medicare Beneficiary (QMB) Benefits Only means the provider type designation used for Chiropractors who participate under the QMB Program. Chiropractor means an individual licensed as a chiropractor by the Board of Chiropractic Examiners within the Colorado Department of Regulatory Agencies. QMB Benefits Only providers must also be certified as QMB Benefits Only providers through the Centers for Medicare and Medicaid Services.

49. Regional Accountable Entity (RAE) means an entity that has entered into a valid, existing contract with the Colorado Department of Health Care Policy and Financing to be a Regional Accountable Entity.

50. Rehabilitation Agency means a group practice that requires at least one affiliated and licensed professional enrolled in the Colorado Medical Assistance Program.

51. Residential Child Care Facility (RCCF) means a health care entity that is:

a. Designated by the Colorado Department of Human Services to provide Medicaid-reimbursable mental health services as an RCCF; and

b. Licensed by Colorado Department of Human Services as an RCCF.

52. Rural Health Clinic (RHC) means a clinic that is certified by the Centers for Medicare and Medicaid Services as a Rural Health Clinic.

53. School Health Services means a school district or Board of Cooperative Educational Services that has a valid, active contract with the Colorado Department of Health Care Policy and Financing to participate in the Colorado School Health Services Program.

a. The Site at which an Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program enrolled under the Provider Type of School Health Services is a school district.

54. Speech Therapist is an individual certified as a Speech Language Pathologist by the Director of the Divisions of Professions and Occupations within the Colorado Department of Regulatory Agencies.

55. Substance Use Disorder (SUD) – Clinic means a health care entity that:

a. Is licensed as a SUD Provider by the Colorado Department of Human Services;

b. Has program approval to operate as a SUD – Clinic from Colorado Department of Human Services; and

c. Has at least one affiliated advanced practice nurse, physician/psychiatrist, physician assistant, or behavioral health clinician who is certified in addiction medicine.

56. Supply means a Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) provider that meets one or both of the following definitions:

a. Complex Rehabilitation Technology (CRT) Supplier means a health care supplier that meets all the requirements of Section 8.590.5.D, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate;

(2) Has CRT Professional Certification; and

(3) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS and CRT.

b. Durable Medical Equipment (DME) means a health care supplier that meets the requirements of Sections 8.590.5.A and B, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate; and

(2) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS.

57. Transportation means a provider that meets one or both of the following definitions:

a. Emergency Medical Transportation (EMT) [Formerly Known as Emergency Medical Transportation and Air Ambulance] means providers that:

(1) Meet all provider screening requirements in Section 8.125.

(2) Comply with commercial liability insurance requirements.

(3) Maintain the appropriate licensure for:

(a) Ground ambulance license as required by Colorado Department of Public Health and Environment; and

(b) Air ambulance license as required by Colorado Department of Public Health and Environment.

(4) License, operate, and equip ground and air ambulances in accordance with federal and state regulations.

b. Non-Emergent Medical Transportation (NEMT) means a provider that:

(1) Has a Public Utilities Commission (PUC) common carrier certificate as a taxicab; or

(2) Has a PUC Medicaid Client Transport (MCT) Permit as required by the PUC; or

(3) Has a ground ambulance license as required by Department of Public Health and Environment; or

(4) Has an Air Ambulance license as required by Colorado Department of Public Health and Environment; or

(5) Is exempt from licensure requirements in accordance with the PUC.

58. X-Ray Facility means an imaging center that:

a. Has an X-Ray Facility and Machine Registration Report certified by the Colorado Department of Public Health and Environment; and

b. Is certified by the Centers for Medicare and Medicaid Services to participate in Medicare as an X-Ray facility.

K. Service Facility Location Field means the physical location specifically where services were rendered as identified on the Claim.

L. Site means the physical location by street address, including suite number, where goods and/or services are provided. The term Site when involving a Health Care Provider that voluntarily contracts with a RAE as a Primary Care Medical Provider (PCMP) to participate in the Department's Accountable Care Collaborative (ACC) as a medical home, also includes the following requirements:

1. PCMP services must be identifiable from other goods and/or services, including services provided by specialists provided by the Health Care Provider in the same physical location through a separate and unique NPI.

2. PCMP services provided at a Campus or Off-Campus Location must be identifiable from other goods and/or services, including services provided by specialists, provided by the Health Care Provider on the same Campus or Off-Campus Location through a separate and unique NPI.

M. Subpart means a component or separate physical location of an Organization Health Care Provider that may be separately licensed or certified. This definition is intended to be consistent with the use of the term "Subpart" as defined in 45 C.F.R. pt. 162.

N. The definitions in Subsection 8.126.1 apply only to Section 8.126.

8.126.2 Enrollment of Health Care Providers

A. Health Care Providers must enroll in the Medical Assistance Program through the Department's Fiscal Agent, if they:

1. deliver medical care, services, or goods authorized under the Medical Assistance Program; and

2. are required to submit a Claim.

8.126.3 Health Care Provider Requirements to Obtain and Use an NPI

A. A Health Care Provider that is required or eligible to obtain an NPI pursuant to 45 C.F.R. § 162.410 must:

1. Enroll with a unique NPI that identifies the Health Care Provider that delivers medical care, services, or goods authorized under the Medical Assistance Program; and

2. Utilize the Health Care Provider's unique NPI for all Claims.

a. A Health Care Provider that is not enrolled as of January 1, 2020, must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2020.

b. All Off Campus Locations must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2020.

c. All Health Care Providers must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2021.

d. On every Claim, including Coordination of Benefits Agreement (COBA) automatic crossover Claims, the Organization Health Care Provider shall use the Service Facility Location Field to represent the most specific Site with an NPI where the services are rendered unless the Billing Provider Field represents the most specific Site with an NPI where the services are rendered.

8.126.4 Organization Health Care Provider Requirements to Obtain and Use an NPI

A. Each Organization Health Care Provider and each Subpart of an Organization Health Care Provider that is required or eligible to obtain an NPI pursuant to 45 C.F.R. § 162.410 must enroll using a unique NPI.

1. Each Organization Health Care Provider must enroll using its unique NPI for each Site at which the Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program.

a. A Hospital must enroll in the Medical Assistance Program with a unique NPI for:

(1) Its Campus; and

(2) Each Off-Campus Location.

2. Each Organization Health Care Provider must enroll in the Medical Assistance Program using a unique NPI for each Provider Type at each Site from which the Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program.

a. A Hospital must enroll with a unique NPI for each Provider Type at each Site at its Campus and at each Off-Campus Location at which it delivers medical care, services, or goods authorized under the Medical Assistance Program.

3. An Organization Health Care Provider that is a School Health Services provider type must enroll once per School District and not each individual Site.

8.126.5 Health Care Provider Requirements Not Eligible to Receive an NPI

A. A Health Care Provider that is not eligible pursuant to 45 C.F.R. § 162.410 to receive an NPI shall:

1. Enroll without submitting an NPI. The Health Care Provider must obtain a unique identification number assigned by the Department through its Fiscal Agent, that identifies

both the unique Provider Type at each Site at which the Health Care Provider delivers medical care, services or goods authorized under the Medical Assistance Program; and

2. Use the unique identification number assigned by the Department through its Fiscal Agent on every Claim.

    a. A Health Care Provider that is not eligible to obtain an NPI that is not enrolled as of January 1, 2020, must submit every Claim using the unique identification number used for enrollment that identifies both the Provider Type and Site, effective January 1, 2020.

    b. All Health Care Providers that are not eligible to obtain an NPI must submit every Claim using the unique identification number used for enrollment that identifies both the Provider Type and Site, effective January 1, 2021.

8.126.6 New Providers as of January 1, 2020

A. A Health Care Provider that is not enrolled as of January 1, 2020, shall not apply to be enrolled to deliver medical care, services, or goods authorized under the Medical Assistance Program unless the Health Care Provider complies with Section 8.126.

8.126.7 Existing Providers as of January 1, 2021

A. A Health Care Provider that is enrolled as of January 1, 2021, shall not apply to have their enrollment revalidated to deliver medical care, services, or goods authorized under the Medical Assistance Program, as required under 42 C.F.R. § 455.414, unless the Health Care Provider complies with Section 8.126.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule Concerning Inpatient Payment Rates for Opioid Antagonist, Section 8.300.5.D.
Rule Number: MSB 22-11-17-A
Division / Contact / Phone: Fee for Service Rates / Andrew Abalos / 2130

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 22-11-17-A, Revision to the Medical Assistance Act Rule Concerning Inpatient Payment Rates for Opioid Antagonist, Section 8.300.5.D.

3. This action is an adoption of: an amendment

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

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

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 1/1/2023
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300.5.D with the proposed text beginning at 8.300.5.D through the end of 8.300.5.D.2. This rule is effective January 1, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule Concerning Inpatient Payment Rates for Opioid Antagonist, Section 8.300.5.D.
Rule Number: MSB 22-11-17-A
Division / Contact / Phone: Fee for Service Rates / Andrew Abalos / 2130

STATEMENT OF BASIS AND PURPOSE

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

   House Bill 22-1326 appropriates funding allowing the Department of Health Care Policy and Financing to reimburse opioid antagonist drugs outside of its current reimbursement methodology. Currently, there is not distinct reimbursement for the opioid antagonist drug Naloxone in the payment bundles used for outpatient hospital payment calculation. This rule change will allow the Department to make payment outside of the payment bundles, creating greater incentive to inpatient hospitals to provide take-home Naloxone to patients at-risk for opioid overdoses.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   House Bill 22-1326 appropriates funding allowing the Department of Health Care Policy and Financing to reimburse opioid antagonist drugs outside of its current reimbursement methodology and assumes implementation within the 2023 state fiscal year.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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

Initial Review — Final Adoption
Proposed Effective Date **01/01/23** — Emergency Adoption **12/09/22**

DOCUMENT #05

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule Concerning Inpatient Payment Rates for Opioid Antagonist, Section 8.300.5.D.
Rule Number: MSB 22-11-17-A
Division / Contact / Phone: Fee for Service Rates / Andrew Abalos / 2130

REGULATORY ANALYSIS

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

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

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

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

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

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

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

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

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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 or intrusive methods for achieving the purpose of the proposed rule.

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

   The Department considered modification of its DRG payment bundles in order to better accommodate the cost

8.300 HOSPITAL SERVICES

8.300.5 Payment for Inpatient Hospital Services

8.300.5.D ~~Long-Acting Reversible Contraceptives~~APR-DRG Payment Methodology Exclusions

1. Long-acting reversible contraceptives (LARC) devices, inserted following a delivery, are excluded from the DRG Relative Weight calculation and are paid according to the Department's fee schedule.

2. Pursuant to § 25.5-5-509, C.R.S. opiate antagonists identified by the Department shall be paid according to the Department's fee schedule when dispensed to a medical assistance recipient upon discharge.