DO NOT PUBLISH THIS PAGE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 23-06-01-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 23-06-01-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: 06/09/23
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.8000 with the proposed text beginning at 8.8000 through the end of 8.8000. This rule is effective June 9, 2023.

*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DO NOT PUBLISH THIS PAGE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 23-06-01-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. 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 must meet the requirements set in legislation 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. (2023);
   Section 25.5-1-207 (5), C.R.S. (2022)

Initial Review — Final Adoption **06/09/23**
Proposed Effective Date **07/30/23** — Emergency Adoption

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 23-06-01-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

8.8000.A PURPOSE AND LEGAL BASIS

1. 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.

8.8000.B DEFINITIONS

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

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

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

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

    b. Investing in dual track emergency department management,

    c. Expanding access to Telemedicine including remote monitoring support,

    d. Providing new or replacement Hospital beds,

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

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

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

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

    b. 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.

5. 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.

6. 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~~.~~.

7. 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.

8. 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.

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

8.8000.C GRANT AWARD PROCEDURES

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

    a. 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.

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

2. 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.

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

        b. 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.

3. 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:

a. Budget and financial need.

b. Partner collaboration, support, or engagement.

c. Completeness of response.

d. Ability to execute and complete project.

e. Reasonableness of timeline.

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

g. County Medicare and Medicaid caseload percentage of population.

h. Statement of need.

i. Sustainability of project.

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

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

a. 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.

b. 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.

c. 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.

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

5. 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.

6. 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.

8.8000.D PERMISSIBLE USES OF GRANT AWARDS

1. 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.

2. 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.

8.8000.E REPORTING REQUIREMENTS FOR GRANT RECIPIENTS

1. 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.

2. 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.

3. 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.

8.8000.F RECORD RETENTION AND ACCESS

1. 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.

~~1.~~2. 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 Act Rule concerning Cost Sharing, Section 8.754.1
Rule Number: MSB 23-04-26-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 23-04-26-A, Revision to the Medical Assistance Act Rule concerning Cost Sharing

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) 8.754.1, 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: 7/1/2023
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.754 with the proposed text beginning at 8.754.1 through the end of 8.754.1. This rule is effective July 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 Cost Sharing, Section 8.754.1
Rule Number: MSB 23-04-26-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule removes member copayments for the following services in accordance with the 2023 Colorado Long Bill (Senate Bill 23-214), effective July 1, 2023: outpatient hospital visits; physician (M.D. or D.O.) office or home visits; rural health clinic visits; brief, individual, group and partial care community mental health center visits (except services which fall under Home and Community Based Service programs); pharmacy prescription or refill; optometrist visits; podiatrist visits; psychiatric services; durable medical equipment/disposable supply services; laboratory services; and radiology 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:

   The proposed rule is imperatively necessary to align Department rule with the statutory removal of certain member copayments in the 2023 Colorado Long Bill (Senate Bill 23-214), effective July 1, 2023

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. (2023);
   Colorado Senate Bill 23-214

Initial Review — Final Adoption **08/11/23**
Proposed Effective Date **07/01/23** — Emergency Adoption **06/09/23**

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Cost Sharing, Section 8.754.1
Rule Number: MSB 23-04-26-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Members will be affected by the proposed rule.

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

   Members will not be required to provide copayments for the affected services.

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 estimates that removal of member copayments from affected services will cost $9,429,686 in total funds annually.

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 provided in question three response above. The benefit of the proposed rule is aligning Department rule with Senate Bill 23-214. The cost of inaction is misalignment between Department rule and Senate Bill 23-214. There are no benefits to inaction.

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

   There are no less costly methods or less intrusive methods for aligning Department rule with Senate Bill 23-214.

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 Senate Bill 23-214.

8.754 CLIENT CO-PAYMENT

8.754.1 CLIENT RESPONSIBILITY

Clients shall be responsible for the following co-payments:

8.754.1.A. Hospital outpatient, $~~4.00~~0.00 per visit, effective July 1, 2023.

8.754.1.B. Physician (M.D. or D.O) office or home visit, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.C. Rural health clinic, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.D. Brief, individual, group and partial care community mental health center visits except services which fall under Home and Community Based Service programs, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.E. Pharmacy, $~~3.00~~0.00 per prescription or refill, effective July 1, 2023.

8.754.1.F. Optometrist, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.G. Podiatrist, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.H. Inpatient hospital, $~~25.00~~0.00 per admission, July 1, 2023.

~~8.754.1.I. Psychiatric services, $.50 per unit of service. A unit is a 15 minute segment.~~

8.754.1.~~J~~I. Durable medical equipment/disposable supply services, $~~1.00~~0.00 per date of service, effective July 1, 2023.

8.754.1.~~JK~~. Laboratory services, $~~1.00~~0.00 per date of service, July 1, 2023.

8.754.1.~~KL~~. Radiology services, $~~1.00~~0.00 per date of service, July 1, 2023.

8.754.1.~~LM~~. Emergency services, $0.00 co-pay.

1. ~~I~~For services that continue to have a co-pay under Section 8.754.2, it is the provider's responsibility to identify emergency on the claim form so that the fiscal agent can exempt the service from co-payment.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535
Rule Number: MSB 23-04-11-A
Home and Community Based Services Division / Erin Thatcher / 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 23-04-11-A, Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers

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 and 8.535, Colorado Department of Health Care Policy and Financing, 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: 06/09/23 for 07/01/23
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.511 with the proposed text beginning at 8.511.1 through the end of 8.511.4. Replace the current text at 8.535 with the proposed text beginning at 8.535.2 through the end of 8.535.2. This rule is effective July 1, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535
Rule Number: MSB 23-04-11-A
Home and Community Based Services Division / Erin Thatcher / 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).

   An increase to the currently approved direct care worker Base Wage has been approved by the General Assembly effective July 1, 2023. The Base Wage rule will be amended to remove exact dates and rates, so that future increases can be implemented quickly without further amendments. Additionally, the rule has been simplified and reorganized. For example, the Department will remove Base Wage regulations from the Pediatric Personal Care Rule (8.535) and reference the main Base Wage rule within 8.511. Future notices of Base Wage increases will be posted on the Provider Rates and Fee Section of the website.

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 Department's Budget Request R07 was approved on May 1, 2023, when Senate Bill 23-214 was signed into law. Within SB 23-214 the General Assembly approved "an increase for home and community-based waiver services to reflect a $15.75 per hour base wage for workers statewide and $17.29 per hour in Denver." An emergency rule to amend the existing Base Wage regulations is required to implement the increase effective July 1, 2023.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Senate Bill 23-214 approved May 1, 2023;

   25.5-6-18 C.R.S. (2021) & Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023)

Initial Review		Final Adoption	**08/11/23**
Proposed Effective Date	**07/01/23**	Emergency Adoption	**06/09/23**

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535
Rule Number: MSB 23-04-11-A
Home and Community Based Services Division / Erin Thatcher / 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 continue to benefit from an increased base wage, which promotes 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. 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 received approval and funding to increase the Base Wage via Senate Bill 23-214. Providers will receive increased reimbursement rates and are responsible for ensuring Direct Care Workers' wages are compliant with the Base Wage. The Department has existing policies and mechanisms in place to monitor compliance of the Base Wage. HCBS provider agencies and Direct Care Workers will benefit from streamlined processes and simplified rules.

   The existing rule outlines that HCBS providers may incur penalties and recoupment if they do not comply with the necessary reporting requirements of this rule. This provision has not changed.

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

   The Department will utilize funding authorized through the General Assembly 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.

   If this rule is not approved, the Department will be unable to hold providers accountable for ensuring Direct Care Workers receive an increase to their Base

Wage. This will further exacerbate workforce challenges and retention of staff, impacting members receiving these critical home and community-based services.

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

   The Department is amending the rule to remove rates and dates that would require an amendment for every rate change impacting the Base Wage. This is the most effective way to ensure the Base Wage is enforced.

5. 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 less costly solutions to achieve the purpose of this proposed 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) required by the Colorado Department of Health Care Policy and Financing. ~~For the purposes of this rule, the base wage shall be $15.00 effective January 1, 2022~~ The Department shall publish current and previous Base Wage rates and related effective dates on the Provider Rates and Fee Schedule website.

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. When applicable, t~~Effective January 1, 2022, T~~the Department will increase reimbursement rates for select ~~Home and Community-Based S~~services to support the base wage. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher within the timeframe established by the Department. Services requiring Direct Care Workers to be paid at least the base wage ~~are as follows~~include:

1. Adult Day Services

2. Alternative Care Facility (ACF)

3. Community Connector

4. Consumer Directed Attendant Support Services (CDASS)

5. Foster Care Home (Children's Habilitation Residential Program)

6. Group Home Habilitation (CHRP)

7~~5~~. Group Residential Support Services (GRSS)

8~~6~~. Homemaker

9~~7~~. Homemaker Enhanced

10. Host Home~~-~~ (CHRP)

11~~8~~. In-Home Support Services (IHSS)

12~~9~~. Individual Residential Support Services (IRSS)

13~~10~~. Job Coaching

14~~1~~. Job Development

15. Mental Health Transitional Living Homes

16~~2~~. Mentorship

17~~3~~. Pediatric Personal Care

18. Personal Care

19~~4~~. Prevocational Services

20~~15~~. Respite

~~16~~21. Specialized Habilitation

~~17~~22. Supported Community Connections

~~18~~23. 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.

D. ~~Effective July 1, 2022, the Department will increase reimbursement rates for Foster Care Home, Host Home, and Group Home Habilitation service in the Home and Community Based Services-Children's Habilitation Residential Program (CHRP) waiver. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher.~~

~~1. 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 July 1, 2022 by the percent of the Department's July 1, 2022 reimbursement rate increase.~~The Department may add additional qualifying services that are applicable to this rule and not listed above.

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.~~Providers shall notify Direct Care Workers annually who are affected by the base wage requirement about Direct Care Worker rights, Direct Care Employer obligations, and the minimum state and local direct care employment standards.

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~~th of each calendar year, ~~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~~ of the current calendar year~~.~~

~~d. Direct Care Workers' hourly base wage as of November 1~~ of the prior calendar year~~, 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~~ of the current calendar year~~.~~

~~d. Direct Care Workers' per diem wage as of December 1 of the prior calendar year, 2021 and per diem wage as of January 1, 2022 of the current calendar year.~~

~~3. CDASS Authorized Representatives/Employers of Record are exempt from attestation requirements.~~Providers shall submit specific information for each Direct Care Worker regarding wage rates, working hours, benefits, work location, employment status, employment type, services provided, independent contractor agreements, and any other wage related information as requested by the Department. Providers shall submit the requested information ~~to the Department~~ within the Department-specified timeframe.

~~E. For CHRP Habilitation Foster Care Home, Host Home, and Group providers, on or before 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 July 1, 2022.~~

~~d. Direct Care Workers' hourly base wage as of May 1, 2022 and current hourly base wage.~~

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

~~2. 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 July 1, 2022.~~

~~d. Direct Care Workers' per diem wage as of June 1, 2022 and per diem wage as of July 1, 2022.~~

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

~~G~~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, pay stubs with 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 applicable 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 submit Direct Care Worker information as required or 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. The Department may suspend payment of claims until requested information is received and approved by the Department.

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.~~submit the plan of correction by the date specified by the Department. 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.

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 Pediatric Personal Care providers are required to comply with all Base Wage requirements established in Section 8.511.

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.

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.

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 Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 23-06-01-B
Division / Contact / Phone: Office of Community Living / Candace Bailey / 303-866-2549

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 23-06-01-B, Novel Coronavirus Disease (COVID-19) Rules
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) 8.6000, 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: 06/09/2023

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

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.6000. This rule is effective June 9, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 23-06-01-B
Division / Contact / Phone: Office of Community Living / Candace Bailey / 303-866-2549

STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this emergency rule is to temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic

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 temporary changes to regulatory requirements in order to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic is imperatively necessary fo the preservation of public health safety, and welfare.

3. Federal authority for the Rule, if any:

   Social Security Act Section 1135, Social Security Act 1115 (Pending), and Social Security Act 1915(c), Appendix K.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2021); 25.5 Article 6, C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 23-06-01-B
Division / Contact / Phone: Office of Community Living / Candace Bailey / 303-866-2549

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.

   Individual's receiving services in community-based settings, provider-owned community-based residential settings, provider-owned facility settings, and case management will all be benefitting from an increase in available funding to respond to the COVID-19 crisis.

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

   Those rendering services in facilities, the community, or even remotely from their office or home may receive additional payment to do so during this critical time. Those receiving services are likely to continue with more likely to experience uninterrupted services as direct care workers/direct support professionals will be incentivized to continue to provide these services.

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.

   Many of the changes the Department is asking for are cost neutral. Additionally, the Department has sought, and in some cases, received approval from the Centers for Medicare and Medicaid to increase payments or rates. However, the Department also must work with its partners at the Office for State Planning and Budget as well as prioritize the many different areas of Medicaid that are impacted by COVID-19. Accordingly, the Department continues to estimate potential costs.

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

   The comparison between direct cost and cost of inaction is hard to quantify. However, it is highly likely that the cost of doing nothing could be higher costs associated with more costly forms of care, significant impact to member's quality of life, and, in some cases – the loss of life or limb.

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

   At this time, the Department is also pursuing additional alternatives to ensure health, safety, and welfare but a key component of this effort is to ensure providers, agencies, and direct support professionals have the money they need to continue to go out in a time of crisis and provide services.

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 mentioned above, the Department is also partnering with community organizations, non-profits, advocacy organizations, other executive agencies, and the governor's office to work towards prioritizing Colorado's most vulnerable citizens receiving long-term care health, safety, and welfare.

MEDICAL ASSISTANCE – SECTION 8.6000 Novel Coronavirus Disease (COVID-19) Rules

10 CCR 2505-10 8.6000

8.6000 COVID-19 EMERGENCY RULES

PURPOSE: To temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduced programmatic limitations, and alignment with existing federal guidance related to the COVID-19 pandemic.

8.6001 REGULATORY CHANGES

The following regulations require, as applicable, that funds be made available for payment, federal approval is received, and any conflicting state statutory requirements are suspended by Executive Order. Each regulation below is effective once the applicable prerequisites are satisfied and shall continue to be in effect as long as those prerequisites continue to be satisfied.

8.6001.1 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Section 8.420

Temporarily waive the requirement that payments for ICF-IID are only allowed for facilities licensed by the Colorado Department of Public Health and Environment (CDPHE) to allow for potential inclusion of existing HCBS Group Homes.

Sections 8.404.3; 8.404.1; 8.405.2.22; 8.405.2.23; 8.405.2.24; 8.405.2.25.

Temporarily allow emergency placement of eligible individuals into an ICF-IID. Individual would still need to be fully eligible in meeting placement requirements but would allow for Department to expedite process through existing layers of review.

Sections 8.443.16.A; 8.443.1.C-D.

Temporarily allow payment beyond current limitation not to exceed COVID-19 emergency supplement payments.

8.6001.2 Nursing Facilities

Sections 8.443.10.B; 8.443.10.a; 8.443.11.A

Temporarily allow Nursing Facilities to receive a supplemental payment for COVID-19 related activities, provided the Nursing Facility organization follows Departmental guidance and benchmarks for the assurance of the member's health, safety, and welfare and adherence to published guidelines for safety.

Section 8.443.12.B – Inclusion of the Following Language:

COVID-19 Mitigation Emergency Supplemental Payment

Subject to available non-provider fee funding and Upper Payment Limit restrictions, the Department shall pay an additional supplemental payment to nursing facilities increasing measures to protect residents during the COVID-19 public health emergency.

1. In order to be eligible for this payment facilities must be:

a. Compliant with all emergency related reported measures required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

b. Implementing enhanced operational guidelines required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

c. Cooperative with State or National efforts to mitigate the emergency

2. The Department will use historical Medicaid patient data to calculate and issue supplemental payments.

3. All payments issued as an emergency supplemental payment due to COVID-19 must be reported as a revenue in the cost reporting period in which it is received.

Section 8.443.1.B Addition of the Following Language

In addition to the MMIS claims reimbursement and provider fee funded supplemental payments, the Department may issue additional supplemental payments necessary to protect the health, safety and welfare of nursing facility residents when additional state or federal funding is available.

Establishment of Section 8.430.6 – Temporary Medicaid Nursing Facility Expansion

1. 8.430.6.A The Department may issue temporary enrollments for the purposes of increasing bed capacity during a public health emergency.

2. Facilities seeking temporary enrollments must submit plans to discharge residents within 60 days of the emergency end date.

3. Facilities with temporary Medicaid beds will be reimbursed statewide average rate for nursing facilities.

4. The enrollment will be effective until 60 days after the COVID-19 emergency is lifted.

5. After the 60 days has expired, the facility will receive no further reimbursement.

8.6001.3 Case Management

Sections 8.763.C; 8.761.46

Authorize providers of targeted case management services to increase, supplement, exceed, or provide additional authorization of units and correlating payments to all long-term care case management entities including transitional services for individuals needing community-placement due to COVID-19.

8.6001.4 Level of Care Assessment

Sections 8.393.2.c.5.a; 8.393.2.D.3.a; 8.393.3.A.1.c.i.3; 8.401.183.B; 8.497; 8.401; 8.491.2.B.2; 8.500.1; 8.500.90; 8.503; 8.504.1; 8.504.5.D; 8.506.3; 8.506.4.e.ii; 8.508.20; 8.515.5.B.1; 8.517.5.A.2; 8.519.1;

Remove the Professional Medical Information Page (PMIP) from the level of care determination for HCBS waivers, Long-Term Care-Home Health, PACE, NF, and ICF/IID programs to enable additional capacity and expedite enrollment.

Sections 8.390.3.A.2; 8.393.1.M.1.C; 8.393.2.C.5.; 8.393.2.D.1-3; 8.401.11 through 8.401.15; 8.485.61.B; 8.485.71.C; 8.486.201; 8.603.5.D; 8.500.18.B.3; 8.500.108.B.1; 8.503.70.3; 8.503.80.A; 8.506.3;

8.506.4.B; 8.509.14; 8.508.121; 8.503.70.A.1; 8.503.80.A.4; 8.506.4.B; 8.506.12.F; 8.508.20; 8.509.14; 8.509.31.A; 8.515.6.A.3; 8.517.7.A.3; 8.603.5.D; 8.503.30.A; 8.503.30.A.8; 8.508.121.A

Modify the requirements for initial and continued stay review assessments. For initial assessments, the level of care assessment will be limited to the Activities of Daily living which determines the functional eligibility/LOC for the member. Members pursuing a Home and Community Based Services (HCBS) waiver enrollment will be issued a start date based on the date of referral to the Case Management Agency, with the Level of Care to be completed with the member thereafter via telephonic or virtual modality. Changes to transfers from nursing facility to nursing facility by not requiring an entirely new assessment be conducted. For yearly re-assessments, the members existing eligibility will continue through the duration of 1135. Then the yearly re-assessment set to occur within six (6) months following the conclusion of the Section 1135 Waiver.

8.6001.5 Termination from Waiver Eligibility - Adverse Action

Sections 8.393.3.A.1.a through 8.393.A.1.d; 8.485.61.A through 8.485.61.D.3.b; 8.500.16.A.1 through 8.500.16.A.4; 8.500.16.E.1 and E.2; 8.503.160.A.1 through 8.500.160.A.4; 8.503.160.E.1 through 8.503.160.E.9; 8.508.190.A.1-4; 8.508.190.E.1 and E.2 ; 8.508.190.H.1-4; 8.508.190.I.3 and I.4; 8.509.15.A.1 through 8.509.15.A.4.c.1; 8.555.5.D.2

Remove requirement to involuntarily terminate a member from their selected HCBS waiver program

8.6001.6 Preadmission Screening and Resident Review (PASRR)

Section 8.401.18.181.A

PASRR Level I Screening and Level II Evaluations will be suspended for 30 days in accordance with Section 1919(e)(7) for new admissions.

8.6001.7 Personal Care

Sections 8.485.61.D.2-3; 8.489.10.11; 8.510.4.A

Temporarily waive the restriction of personal care services provided in Hospital, Nursing Facility, or other acute-like setting.

Sections 8.510.18; 8.552.1.B

Temporarily allow legally responsible person to provide services using participant directed models (Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS)).

8.6001.8 Guidelines for Institutions for Mental Diseases (IMD's)

Section 8.401.4

Temporarily waive the IMD requirements for nursing facilities that exceed 50% of patient-census with a primary diagnosis of major mental illness.

8.6001.9 Retainer Payments

Sections 8.515.80.F; 8.500.14.B.3

Temporarily allow specified Brain Injury waiver providers to bill retainer payments for services not rendered.

MEDICAL ASSISTANCE – SECTION 8.6000 Novel Coronavirus Disease (COVID-19) Rules

10 CCR 2505-10 8.6000

8.6000 COVID-19 EMERGENCY RULES

PURPOSE: To temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduced programmatic limitations, and alignment with existing federal guidance related to the COVID-19 pandemic.

8.6001 REGULATORY CHANGES

The following regulations require, as applicable, that funds be made available for payment, federal approval is received, and any conflicting state statutory requirements are suspended by Executive Order. Each regulation below is effective once the applicable prerequisites are satisfied and shall continue to be in effect as long as those prerequisites continue to be satisfied.

8.6001.1 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Section 8.420

Temporarily waive the requirement that payments for ICF-IID are only allowed for facilities licensed by the Colorado Department of Public Health and Environment (CDPHE) to allow for potential inclusion of existing HCBS Group Homes.

Sections 8.404.3; 8.404.1; 8.405.2.22; 8.405.2.23; 8.405.2.24; 8.405.2.25.

Temporarily allow emergency placement of eligible individuals into an ICF-IID. Individual would still need to be fully eligible in meeting placement requirements but would allow for Department to expedite process through existing layers of review.

Sections 8.443.16.A; 8.443.1.C-D.

Temporarily allow payment beyond current limitation not to exceed COVID-19 emergency supplement payments.

8.6001.2 Nursing Facilities

Sections 8.443.10.B; 8.443.10.a; 8.443.11.A

Temporarily allow Nursing Facilities to receive a supplemental payment for COVID-19 related activities, provided the Nursing Facility organization follows Departmental guidance and benchmarks for the assurance of the member's health, safety, and welfare and adherence to published guidelines for safety.

Section 8.443.12.B – Inclusion of the Following Language:

COVID-19 Mitigation Emergency Supplemental Payment

Subject to available non-provider fee funding and Upper Payment Limit restrictions, the Department shall pay an additional supplemental payment to nursing facilities increasing measures to protect residents during the COVID-19 public health emergency.

4. In order to be eligible for this payment facilities must be:

d. Compliant with all emergency related reported measures required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

e. Implementing enhanced operational guidelines required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

f. Cooperative with State or National efforts to mitigate the emergency

5. The Department will use historical Medicaid patient data to calculate and issue supplemental payments.

6. All payments issued as an emergency supplemental payment due to COVID-19 must be reported as a revenue in the cost reporting period in which it is received.

Section 8.443.1.B Addition of the Following Language

In addition to the MMIS claims reimbursement and provider fee funded supplemental payments, the Department may issue additional supplemental payments necessary to protect the health, safety and welfare of nursing facility residents when additional state or federal funding is available.

Establishment of Section 8.430.6 – Temporary Medicaid Nursing Facility Expansion

6. 8.430.6.A The Department may issue temporary enrollments for the purposes of increasing bed capacity during a public health emergency.

7. Facilities seeking temporary enrollments must submit plans to discharge residents within 60 days of the emergency end date.

8. Facilities with temporary Medicaid beds will be reimbursed statewide average rate for nursing facilities.

9. The enrollment will be effective until 60 days after the COVID-19 emergency is lifted.

10. After the 60 days has expired, the facility will receive no further reimbursement.

8.6001.3 Case Management

Sections 8.763.C; 8.761.46

Authorize providers of targeted case management services to increase, supplement, exceed, or provide additional authorization of units and correlating payments to all long-term care case management entities including transitional services for individuals needing community-placement due to COVID-19.

8.6001.4 Level of Care Assessment

Sections 8.393.2.c.5.a; 8.393.2.D.3.a; 8.393.3.A.1.c.i.3; 8.401.183.B; 8.497; 8.401; 8.491.2.B.2; 8.500.1; 8.500.90; 8.503; 8.504.1; 8.504.5.D; 8.506.3; 8.506.4.e.ii; 8.508.20; 8.515.5.B.1; 8.517.5.A.2; 8.519.1;

Remove the Professional Medical Information Page (PMIP) from the level of care determination for HCBS waivers, Long-Term Care-Home Health, PACE, NF, and ICF/IID programs to enable additional capacity and expedite enrollment.

Sections 8.390.3.A.2; 8.393.1.M.1.C; 8.393.2.C.5.; 8.393.2.D.1-3; 8.401.11 through 8.401.15; 8.485.61.B; 8.485.71.C; 8.486.201; 8.603.5.D; 8.500.18.B.3; 8.500.108.B.1; 8.503.70.3; 8.503.80.A; 8.506.3;

8.506.4.B; 8.509.14; 8.508.121; 8.503.70.A.1; 8.503.80.A.4; 8.506.4.B; 8.506.12.F; 8.508.20; 8.509.14; 8.509.31.A; 8.515.6.A.3; 8.517.7.A.3; 8.603.5.D; 8.503.30.A; 8.503.30.A.8; 8.508.121.A

Modify the requirements for initial and continued stay review assessments. For initial assessments, the level of care assessment will be limited to the Activities of Daily living which determines the functional eligibility/LOC for the member. Members pursuing a Home and Community Based Services (HCBS) waiver enrollment will be issued a start date based on the date of referral to the Case Management Agency, with the Level of Care to be completed with the member thereafter via telephonic or virtual modality. Changes to transfers from nursing facility to nursing facility by not requiring an entirely new assessment be conducted. For yearly re-assessments, the members existing eligibility will continue through the duration of 1135. Then the yearly re-assessment set to occur within six (6) months following the conclusion of the Section 1135 Waiver.

8.6001.5 Termination from Waiver Eligibility - Adverse Action

Sections 8.393.3.A.1.a through 8.393.A.1.d; 8.485.61.A through 8.485.61.D.3.b; 8.500.16.A.1 through 8.500.16.A.4; 8.500.16.E.1 and E.2; 8.503.160.A.1 through 8.500.160.A.4; 8.503.160.E.1 through 8.503.160.E.9; 8.508.190.A.1-4; 8.508.190.E.1 and E.2 ; 8.508.190.H.1-4; 8.508.190.I.3 and I.4; 8.509.15.A.1 through 8.509.15.A.4.c.1; 8.555.5.D.2

Remove requirement to involuntarily terminate a member from their selected HCBS waiver program

8.6001.6 Preadmission Screening and Resident Review (PASRR)

Section 8.401.18.181.A

PASRR Level I Screening and Level II Evaluations will be suspended for 30 days in accordance with Section 1919(e)(7) for new admissions.

8.6001.7 Personal Care

Sections 8.485.61.D.2-3; 8.489.10.11; 8.510.4.A

Temporarily waive the restriction of personal care services provided in Hospital, Nursing Facility, or other acute-like setting.

Sections 8.510.18; 8.552.1.B

Temporarily allow legally responsible person to provide services using participant directed models (Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS)).

8.6001.8 Guidelines for Institutions for Mental Diseases (IMD's)

Section 8.401.4

Temporarily waive the IMD requirements for nursing facilities that exceed 50% of patient-census with a primary diagnosis of major mental illness.

8.6001.9 Retainer Payments

Sections 8.515.80.F; 8.500.14.B.3

Temporarily allow specified Brain Injury waiver providers to bill retainer payments for services not rendered.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443
Rule Number: MSB 23-06-01-C
Division / Contact / Phone: Health Program Office / Christina Winship/303-866-5578

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 23-06-01-C, Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443

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) 8.815, 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:	06/9/2023
Is rule to be made permanent? (If yes, please attach notice of hearing).	No<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.815 with the proposed text beginning at 8.815.1 through the end of 8.815.1. Replace the current text at 8.815.3 with the proposed text beginning at 8.815.3.A through the end of 8.815.3.A. Replace the current text at 8.815.4 beginning at 8.815.4.A through the end of 8.815.4.C. Replace the current text at 8.815.6 with the proposed text beginning at 8.815.6 through the end of 8.815.6. Replace the current text at 8.443 with the proposed text beginning at 8.443.7.A.5 through the end of 8.443.7.A.5. This rule is effective June 9, 2023.

*to be completed by MSB Board Coordinator

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Rule Number: MSB 23-06-01-C
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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).

   This rule revision will allow the Department to reimburse pharmacies for administration of the COVID-19 vaccine in Long-term Care Facilities through the Centers for Disease Control and Prevention's (CDC's) Pharmacy Partnership for Long-term Care Program or other partnership between an LTC and a pharmacy.

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:

   These revisions are required to facilitate administration of the forthcoming COVID-19 vaccine to nursing home facility residents.

3. Federal authority for the Rule, if any:

   Section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136

4. State Authority for the Rule:

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

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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 residing in nursing facilities and pharmacy providers licensed to administer vaccines will benefit from the flexibility provided by this rule revision. Current policy limits reimbursement to vaccines ordered by the resident's own physician and administration is either included in the facility's rate or part of a regularly scheduled home health service.

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

This revision will help expedite administration of the COVID-19 vaccine to Health First Colorado members residing in nursing facilities. The rule will also allow nursing facility providers to utilize existing partnerships with pharmacies to administer the vaccine.

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 expects this change to cost approximately $60,000 in total funds, which will be incorporated through the regular budget process.

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

   The proposed rule will facilitate the expeditious administration of the COVID-19 vaccine to this population.

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 intrusive methods to achieve the purpose of the proposed rule.

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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.

   There are no alternative methods for achieving the purpose of the proposed rule.

8.815 IMMUNIZATION SERVICES

8.815.1 Definitions

8.815.1.A. Advisory Committee on Immunization Practices (ACIP) means the group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. ACIP was established under Section 222 of the Public Health Service Act (42 U.S.C. § 2l7a).

8.815.1.B. Immunization means the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine.

8.815.1.C. School District means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado School for the Deaf and Blind, created in article 80 of title 22, C.R.S., and any public School District organized under the laws of Colorado except a junior college district.

8.815.1.D. Vaccine means a biological preparation that improves immunity to a particular disease.

8.815.1.E. Vaccine Administration Services means the provision of an injection, nasal absorption, or oral administration of a vaccine product.

8.815.1.F. Vaccines for Children (VFC) means the federally funded program administered through the Centers for Disease Control for the purchase and distribution of pediatric vaccines to program-registered providers for the Immunization of vaccine-eligible children 18 years of age and younger.

8.815.2 Client Eligibility

8.815.2.A. All Colorado Medicaid clients are eligible for Immunization and Vaccine Administration Services.

8.815.3 Provider Eligibility

8.815.3.A. Rendering Providers

1. Colorado Medicaid enrolled providers are eligible to administer Vaccines and Vaccine Administration Services as follows:

    a. If it is within the scope of the provider's practice;

    b. In accordance with the requirements at 10 CCR 2505-10, Section 8.200.2.; and

    c. If the provider is administering Vaccines and Vaccine Administration Services to a client 18 years of age or younger, the provider is using Vaccines provided free of cost by the federal government, including through the VFC program.

8.815.3.B. Prescribing Providers

1. Colorado Medicaid enrolled providers are eligible to prescribe Vaccines and Vaccine Administration Services in accordance with Section 8.815.3.A.1.a.-b.

8.815.4 Covered Services

8.815.4.A. Vaccines identified in the ACIP Vaccine Recommendations and Guidelines are updated routinely and are covered as follows:

1. For clients 18 years of age and younger, Vaccines are either provided through the VFC program or are otherwise provided without cost by the federal government.

2. For clients 19 years of age and older, Vaccines are covered by Colorado Medicaid.

8.815.4.B. Administration of Vaccines identified in the ACIP Vaccine Recommendations and Guidelines is a covered service for all clients.

8.815.4.C. Immunization and Vaccine Administration Services that are provided by home health agencies, physicians, or other non-physician practitioners to clients at nursing facilities, group homes, or residential treatment centers are covered only as follows:

1. Immunization services for clients who are residents of nursing facilities and clients receiving home health services are covered only if ordered by their physician. The skilled nursing component for Immunization administration provided at a nursing facility is included in the facility's rate or part of a regularly scheduled home health service for clients receiving home health services.

    a. Administration of the COVID-19 vaccine will be reimbursed as specified at 10 CCR 2505-10, Section 8.443.7.A.5.a.

2. Clients who are residents of an Alternative Care Facility, as defined at Section 8.495.1, may receive Immunization services from their own physician. They may also receive Immunization services as part of a home health service in accordance with Section 8.815.4.C.1.

8.815.5 Prior Authorization Requirements

8.815.5.A. Prior authorization is not required for this benefit.

8.815.6 Non-covered Services

8.815.6.A. The following services are not covered by Colorado Medicaid:

1. For clients 18 years of age and younger, Vaccines that have been obtained from a source other than the federal government;

2. Immunization and Vaccine Administration Services provided by a School District provider; and

3. Travel-related Immunization and Vaccine Administration Services.

8.443 NURSING FACILITY REIMBURSEMENT

8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION

8.443.7.A Health Care Services Defined: Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides, feeding assistants, registered dietician, MDS coordinators, nursing staff development personnel, nursing administration (not clerical) case manager, patient care coordinator, quality improvement, clinical director. These personnel shall be appropriately licensed and/or certified, although nurse aides may work in any facility for up to four months before becoming certified.

   If a facility employee or a management company/home office employee or owner has dual health care and administrative duties, the provider must keep contemporaneous time records or perform time studies to verify hours worked performing health care related duties. If no contemporaneous time records are kept or time studies performed, total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will be classified as administrative and general. Licenses are not required unless otherwise specified. Periodic time studies in lieu of contemporaneous time records may be used for the allocation. Time studies used must meet the following criteria:

   a. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

   b. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

   c. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

   d. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

   e. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

   f. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.

Health Information Managers (Medical Records Librarians): Must work directly with the maintenance and organization of medical records.

Social Workers: Includes social workers, life enhancement specialists and admissions coordinators.

Central or Medical Supply personnel: Includes duties associated with stocking and ordering medical and/or central supplies.

Activity personnel: Personnel classified as “activities” must have a direct relationship (i.e., providing entertainment, games, and social opportunities) to residents. For instance, security guards and hall monitors do not qualify as activities personnel. Costs associated with security guards and hall monitors are classified as administrative and general.

3. If the provider’s chart of accounts directly identifies payroll taxes and benefits associated with health care versus administrative and general cost centers, the amounts directly identified will be appropriately allowed as either health care or administrative and general. If these costs are comingled in the chart of accounts, payroll taxes and benefits shall be allocated to the cost centers (health care and administrative and general) based on total employee wages reported in those cost centers. The reporting method for payroll taxes and benefits by cost center is required to be consistent from year to year. When a provider wishes to change its reporting method because it believes the change will result in more appropriate and a more accurate allocation, the provider must make a written request to the Department for approval of the change ninety (90) days prior to the end of that cost reporting period. The Department has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. If the Department approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods. The approval will be for a minimum three year period. The provider cannot change methods until the three year period has expired.

4. Personnel licensed to perform patient care duties shall be reported in the administrative and general cost center if the duties performed by these personnel are administrative in nature.

5. Non-prescription drugs ordered by a physician that are included in the per diem rate, including costs associated with vaccinations.

    a. Pharmacies are eligible for reimbursement for administration of the COVID-19 vaccine

6. Consultant fees for nursing, medical records, registered dieticians, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.

7. Purchases, rental, depreciation, interest and repair expenses of health care equipment and medical supplies used for health care services such as nursing care, medical records, social services, therapies and activities. Purchases, lease expenses or fees associated with computers and software (including the associated training and upgrades) used in departments within the facility that provide direct or indirect health care services to residents. Dual purpose software that includes both a health care and administrative and general component will be considered a health care service.

8. Purchase or rental of motor vehicles and related expenses, including salary and benefits associated with the van driver(s), for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs if there is dual purpose. An example of the dual purpose vehicle is one used for both resident transport and maintenance activities.

9. Copier lease expense.

10. Salaries, fees, or other expenses related to health care duties performed by a facility owner or manager who has a medical or nursing credential. Note that costs associated with the Nursing Home Administrator are an administrative and general cost.

11. Related Party Management Fees and Home Office Costs

    Related party management fees and home office costs shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the related party which are listed in this section, may be included in the health care cost center equal to the actual costs incurred by the related party. Documentation supporting the cost and health care licenses must be maintained. Only salaries, payroll taxes and employee benefits associated with health care personnel will be considered as allowable in the health care cost center. No overhead expenses will be included. The amount allowable in the health care cost category will be calculated in one of two ways:

    a. Keeping contemporaneous time logs in 15 minute increments supporting the number of hours worked at each facility.

    b. Distributing the cost evenly across all facilities as follows: the amount allowable in each health care facility's health care costs shall be equal to the total salary, payroll taxes and benefits of the health care personnel divided by the number of facilities where the health care personnel worked during the year. For example, if a nurse's total salary, payroll taxes, and benefits total $80,000, and the nurse worked on five facilities during the year, $16,000 is allowable in each of the facility's health care costs.

    Auditable documentation supporting the number of facilities worked on during the year must be maintained. Even if a related party exception is granted in accordance with 10 CCR 2505-10 section 8.441.5.I.4, no mark-up or profit will be allowed in the health care cost center, only supported actual costs.

    Non-Related Party Management Fees

    Non-related party management fees shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the management company which are listed in this section, may be included in the health care cost center. Management contracts which specify percentages related to health care services will not be considered a direct charge from the management company.

12. Professional liability insurance, whether self-insurance or purchased, loss settlements, claims paid and insurance deductibles.

13. Medical director fees.

14. Therapies and services provided by an individual qualified to provide these services under Federal Medicare/Medicaid regulations including:

Utilization review
Dental care, when required by federal law
Audiology
Psychology and mental health services
Physical therapy
Recreational therapy
Occupational therapy
Speech therapy

15. Nursing licenses and permits, disposal costs associated with infectious material (medical or hazardous waste), background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

16. Food Costs. Food costs means the cost of raw food, and shall not include the costs of property, staff, preparation or other items related to the food program.

8.443.7.B CLASS I HEALTH CARE STATE-WIDE MAXIMUM ALLOWABLE PER DIEM REIMBURSEMENT RATES (LIMIT)

For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for direct and indirect health care services and raw food, the state department shall establish an annual maximum allowable rate (limit). In computing the health care per diem limit, each nursing facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. The health care limit will be calculated as follows:

1. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before December 31 of the preceding year.

2. The MED-13 cost report shall be deemed filed if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before December 31.

3. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of the limit, the Department may:

   a. Exclude part, or all, of a provider's MED-13.

   b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. measured from the midpoint of the reporting period to the midpoint of the payment-setting period.

4. The health care limit and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

5. The health care limit shall not exceed one hundred twenty-five percent (125%) of the median costs of direct and indirect health care services and raw food as determined by an array of all class I facility providers; except that, for state veteran nursing homes, the health care limit will be one hundred thirty percent (130%) of the median cost.

   a. In determining the median cost, the cost of direct health care shall be case-mix neutral.

b. Actual days of care shall be counted, not occupancy-imputed days of care, for purposes of calculating the health care limit.

c. Amounts contained in cost reports used to determine the health care limit shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

i). The percentage change shall be rounded at least to the fifth decimal point.

ii). The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

6. Annually, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

7. The health care limit for health care reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.7.C. CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH

For the fiscal year beginning July 1, 2009, and for each fiscal year thereafter, any increase in the direct and indirect health care services and raw food costs shall not exceed eight percent (8%) per year. The calculation of the eight percent per year limitation for rates effective on July 1, 2009, shall be based on the direct and indirect health care services and raw food costs in the as-filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the eight percent limitation for rates effective after July 1, 2009, the limitation shall be determined and indexed from the direct and indirect health care services and raw food costs as reported and audited for the rates effective July 1, 2009.

8.443.7.D. CLASS I HEALTH CARE PER DIEM REIMBURSEMENT RATES AND MEDICAID CASE MIX INDEX (CMI):

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the State Department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. This payment shall not exceed the health care limit described at 10 CCR 2505-10 section 8.443.7B. The health care per diem reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the provider's acuity adjusted actual allowable health care costs.

The state department shall adjust the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider's residents in order to adjust for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's Medicaid residents on a quarterly basis

1. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:

    a. A facility's cost report period resident acuity case mix index shall be the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period.

    b. The facility's Medicaid resident acuity case mix index shall be a two quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. The two quarter average used in the July 1 rate calculation shall be the same two quarter average used in the rate calculation for the rate effective date prior to July 1.

    c. The statewide average case mix index shall be a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1.

    d. The normalization ratio shall be determined by dividing the statewide average case mix index by the facility's cost report period case mix index.

    e. The facility Medicaid acuity ratio shall be determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.

    f. The facility overall resident acuity ratio shall be determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.

2. The annual facility specific direct health care maximum reimbursement rate shall be determined as follows:

    a. The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

    b. The statewide health care maximum allowable reimbursement rate (calculated at 10 CCR 2505-10 section 8.443.7B) shall be multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.

    c. The facility specific maximum reimbursement rate for case mix adjusted nursing costs shall be determined by multiplying the facility specific overall acuity ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.

3. The annual facility specific indirect health care maximum allowable reimbursement shall be determined as follows:

    a. The percentage of the indirect health care per diem cost to total health care cost shall be determined by dividing the indirect health care per diem cost by the sum

of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

b. The facility specific in direct health care maximum reimbursement rate shall be determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.

4. The case mix reimbursement rate component shall be determined as follows:

a. The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio.

b. This ratio shall be multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation shall the case mix reimbursement rate component.

5. The indirect health care reimbursement rate shall be the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

8.443.7.E DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM ALLOWABLE RATE (LIMIT) FOR CLASS II AND IV FACILITIES

1. For class II facilities, one hundred twenty-five percent (125%) of the median actual costs of all class II facilities;

2. For non-state administered class IV facilities, one hundred twenty-five percent (125%) of the median actual costs of all class IV facilities.

3. State-administered class IV facilities shall not be subject to the health care limit. The Med-13s of the state-administered class IV facilities shall be included in the health care limit calculation for other class IV facilities.

4. The determination of the reasonable cost of services shall be made every 12 months.

5. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed in accordance with these regulations, by each facility on or before May 2.

6. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2nd.

7. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

a. Exclude part, or all, of a provider's MED-13; or

b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report.

8. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV facilities shall be included in the maximum rate calculation for other class IV facilities.

9. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

10. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960
Rule Number: MSB 23-05-18-A
Division / Contact / Phone: Special Financing Division / Chandra Vital / 303-866-5506

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 23-05-18-A, Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960

3. This action is an adoption of: an amendment

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

   Sections(s) 25.5-1-301 through 25.5-1-303, 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: July 1, 2023
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.960 Appendix A with the proposed text beginning at 8.960 Appendix A through the end of 8.960 Appendix A. This rule is effective July 1, 2023.

*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).

   Current rule states the max program fees of the Dental Health Program for Low-Income Seniors must not fall below Medicaid dental rates. Medicaid received a 3% increase for the dental rates for FY2023-24. This made some of the program rates in Schedule A fall below the Medicaid rate. This change is necessary to stay in compliance with rule.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   Current rule states that no program max rates will be below Medicaid dental rates.

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. (2023);

Initial Review
Proposed Effective Date **07/01/23**
Final Adoption
Emergency Adoption **06/09/23**

DOCUMENT #12

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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.

   The increase in program rates will not affect any classes and there will be no incurred costs for any classes.

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 no quantitative or qualitative impact to any classes.

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 have no fiscal impact with this rule change. The funds for the Dental Health Care Program for Low-Income Seniors are appropriated, and this rule update will have no effect on the appropriation.

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

   There will be no costs to the Department. The benefits will be for the Department to be in compliance with current rule.

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

   The Department does not foresee any fiscal impact on this rule change and there are not any less costly methods that were considered.

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.

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There are no alternative methods for staying in compliance with current rule.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.A Definitions

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

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

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

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

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

6. Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2020).

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

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

9. Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior or client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans.

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

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

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

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

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

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

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

17. Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2020).

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

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

20. Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2020).

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

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

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

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

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

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

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

    a. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2020);

    b. A community-based organization or foundation;

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

    d. A local public health agency; or

e. A private dental practice.

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

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

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

31. Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2020).

8.960.B Legal Basis

8.960.B.1 The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (2020).

8.960.C Request of Grant Proposals and Grant Award Procedures

8.960.C.1. Request for Grant Proposals

8.960.C.1.a Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at https://www.colorado.gov/hcpf/research-data-and-grants at least 30 days prior to the due date.

8.960.C.2 Evaluation of Grant Proposals

8.960.C.2.a Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

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

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

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

a) Outreach to and identify Eligible Seniors;

b) Collaborate with community-based organizations; and

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

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

8.960.C.3 Grant Awards

8.960.C.3.a The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

8.960.C.4 Qualified Grantee Responsibilities

8.960.C.4.a A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

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

2) Demonstrate collaboration with community-based organizations;

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

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

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

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

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

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

8.960.C.5 Invoicing

8.960.C.5.a A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.

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

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

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

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

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

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

8.960.C.6 Annual Report

8.960.C.6.a On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

8.960.C.6.b The annual report shall be completed in a format specified by the Department and shall include:

1) The number of Eligible Seniors served;

2) The types of Covered Dental Care Services provided;

3) An itemization of administrative expenditures;

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

5) Any other information deemed relevant by the Department.

10 CCR 2505-10 § 8.960 APPENDIX A: COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS COVERED SERVICES AND PROCEDURE CODES

Capitalized terms within this appendix shall have the meaning specified in the Definitions section.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodic oral evaluation - established client	D0120	$46.00	$46.00	$0.00	Evaluation performed on a client of record to determine any changes in the client's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the client. Report additional diagnostic procedures separately. Frequency: One time per 6 month period per client.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Limited oral evaluation - problem focused	D0140	$62.00	$52.00	$10.00	This code must be used in association with a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as, endodontic or post-operative visits related to treatments including prosthesis. Specific problems may include dental emergencies, trauma, acute infections, etc. Cannot be used for adjustments made to prosthesis provided within previous 6 months. Cannot be used as an encounter fee. Frequency: Two of D0140 per year per grantee. Not reimbursable on the same date as D0120 or D0150. Dental hygienists may only provide for an established client of record.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive oral evaluation - new or established client	D0150	$81.00	$81.00	$0.00	Evaluation used by general dentist or a specialist when evaluating a client comprehensively. Applicable to new clients; established clients with significant health changes or other unusual circumstances; or established clients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the client's dental and medical history and general health assessment. A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0180.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive periodontal evaluation - new or established client	D0180	$88.00	$88.00	$0.00	Evaluation for clients presenting signs & symptoms of periodontal disease & clients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the client's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0150.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - comprehensive series of radiographic images	D0210	$125.00	$125.00	$0.00	Radiographic survey of whole mouth, intended to display the crowns & roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. Panoramic radiographic image & bitewing radiographic images taken on the same date of service shall not be billed as a D0210. Payment for additional periapical radiographs within 60 days of a full month series or a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per client. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 must be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.
Intraoral - periapical first radiographic image	D0220	$25.00	$25.00	$0.00	Six of D0220 per 12 months per client. Report additional radiographs as D0230. Working and final endodontic treatment films are not covered. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - periapical each additional radiographic image	D0230	$23.00	$23.00	$0.00	D0230 must be utilized for additional films taken beyond D0220. Working and final endodontic treatment films are included in the endo codes. Not covered if billed with D3310, D3320, or D3330. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewing - single radiographic image	D0270	$26.00	$26.00	$0.00	Frequency: 1 in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - two radiographic images	D0272	$42.00	$42.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	$52.00	$52.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - four radiographic images	D0274	$60.00	$60.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Vertical bitewings – seven to eight radiographic images	D0277	$68.32	$68.32	$0.00	Frequency: 1 time in a 12-month period. Counts as an intraoral complete series. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Panoramic radiographic image	D0330	$63.00	$63.00	$0.00	Frequency: 1 per 5 years per client. Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Prophylaxis - adult	D1110	$88.00	$88.00	$0.00	Removal of plaque, calculus and stains from the tooth structures with intent to control local irritational factors. Frequency: • 1 time per 6 calendar months; 2 week window accepted. • May be billed for routine prophylaxis. • D1110 may be billed with D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 can only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed. • May be alternated with D4910 for maintenance of periodontally-involved individuals. • D1110 cannot be billed on the same day as D4346 • Cannot be used as 1 month re-evaluation following nonsurgical periodontal therapy.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Topical application of fluoride varnish	D1206	$52.00	$52.00	$0.00	Topical fluoride application is to be used in conjunction with prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Cannot be used with D1208.
Topical application of fluoride - excluding varnish	D1208	$52.00	$52.00	$0.00	Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction with prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. Cannot be used with D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Application of caries arresting medicament – per tooth	D1354	$5.8871	$5.8871	$0.00	Two of D1354 per 12 months per patient per tooth for primary and permanent teeth. Not to exceed 4 times per tooth in a lifetime. Cannot be billed on the same day as D1355 or any D2000 series code (D2140–D2954). Must Report tooth number.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Caries preventive medicament application – per tooth	D1355	$5.6347	$5.6347	$0.00	For primary prevention or remineralization. Medicaments applied do not include topical fluorides. Medicaments that may be applied during the delivery of D1355 procedure include Silver Diamine Fluoride (SDF), Silver Nitrate (SN), thymol-CHX varnish, and topical povidone iodine (PVP-I). Cannot be billed on the same day as: D1206, D1208, D1354, D0140, D9110, or any restoration codes on the same day or within 12 months of D2140 thru D2954. Maximum of four D1355 per tooth per lifetime. Must report tooth number.
Amalgam Restorations (including polishing): Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).					
Amalgam - one surface, primary or permanent	D2140	$117.862.67	$107.862.67	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - two surfaces, primary or permanent	D2150	$147.831.20	$137.831.20	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - three surfaces, primary or permanent	D2160	$179.020.88	$169.020.88	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - four or more surfaces, primary or permanent	D2161	$214.8304.96	$204.83194.96	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-Based Composite Restorations – Direct: Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases, and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).					

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite - one surface, anterior	D2330	$115.00	$105.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - two surfaces, anterior	D2331	$146.00	$136.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	$179.00	$169.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	$212.00	$202.00	$10.00	Incisal angle to be defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	$176.00	$166.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	$218.00	$208.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces, posterior	D2394	$268.00	$258.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - porcelain/ceramic	D2740	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to high noble metal	D2750	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to noble metal	D2752	$780.00	$730.00	$50.00	Only one the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - 3/4 cast predominantly base metal	D2781	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast noble metal	D2782	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 porcelain/ceramic	D2783	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast high noble metal	D2790	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - full cast predominantly base metal	D2791	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast noble metal	D2792	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - titanium	D2794	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	$87.00	$77.00	$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	$89.00	$79.00	$10.00	Not allowed within 6 months of placement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Core buildup, including any pins when required	D2950	$225.00	$200.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. Not payable on the same tooth and same day as D2951.
Pin retention per tooth	D2951	$50.00	$40.00	$10.00	Pins placed to aid in retention of restoration. Can only be used in combination with a multi-surface amalgam.
Cast post and core in addition to crown	D2952	$332.00	$307.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Prefabricated post and core in addition to crown	D2954	$269.00	$244.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Core is built around a prefabricated post. This procedure includes the core material and refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care) Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy; pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.					

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	$566.40	$516.40	$50.00	Frequency: One D3310 per lifetime per client per tooth. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Frequency: One D3320 per lifetime per client per tooth. Teeth covered: 4, 5, 12, 13, 20, 21, 28, and 29.
Endodontic therapy, molar tooth (excluding final restoration)	D3330	$786.31	$736.31	$50.00	Frequency: One D3330 per lifetime per client per tooth. Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	$177.00	$167.00	$10.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in others.Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	$128.00	$128.00	$0.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting.. Documentation of other treatment provided at same time will be requested. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	D4346	$102.00	$92.00	$10.00	The removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures. Frequency: once in a lifetime. • Any follow-up and re-evaluation are included in the initial reimbursement. • Cannot be charged on the same date as D1110, D4341, D4342, or D4910.
Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	D4355	$98.27~~4.02~~	$88.27~~4.02~~	$10.00	One of (D4335) per 3 year(s) per patient. Prophylaxis D1110 is not reimbursable when provided on the same day of service as D4355. D4355 is not reimbursable if patient record indicates D1110 or D4910 have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as D4355.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal maintenance procedures	D4910	$136.00	$136.00	$0.00	Procedure following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. Frequency: • Up to four times per fiscal year per client. • Cannot be charged on the same date as D4346. • Cannot be charged within the first three months following active periodontal treatment.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - maxillary	D5110	$914.72~~874.52~~	$834.72~~794.52~~	$80.00	Reimbursement made upon delivery of a complete maxillary denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	$916.22~~875.94~~	$836.22~~795.94~~	$80.00	Reimbursement made upon delivery of a complete mandibular denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – maxillary	D5130	$914.72~~874.52~~	$834.72~~794.52~~	$80.00	Reimbursement made upon delivery of an immediate maxillary denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per client. Complete denture, D5110, may be considered 5 years after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – mandibular	D5140	$916.22~~875.94~~	$836.22~~795.94~~	$80.00	Reimbursement made upon delivery of an immediate mandibular denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per client. Complete dentures, D5120, may be considered 5 years after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5211	$700.00	$640.00	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5211 and D5212 are considered definitive treatments. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin maxillary per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5212	$778.00	$718.00	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5211 and D5212 are considered definitive treatment. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin mandibular per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	$884.0044.31	$824.00784.31	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can also be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	$884.0044.31	$824.00784.31	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	D5221	$635.32~~07.61~~	$575.32~~47.61~~	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5221 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	D5222	$635.32~~07.61~~	$575.32~~47.61~~	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5222 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5223	$884.0044.31	$824.00784.31	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5223 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5224	$884.0044.31	$824.00~~784.31~~	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5224 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5225	$784.34~~63.24~~	$724.34~~03.24~~	$60.00	Reimbursement made upon delivery of a partial maxillary denture to the client. D5225 and D5226 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial flexible base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial flexible base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every three years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5226	$784.3463.24	$724.3403.24	$60.00	Reimbursement made upon delivery of a partial mandibular denture to the client. D5225 and D5226 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial flexible base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial flexible base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every three years - documentation that existing prosthesis cannot be made serviceable must be maintained.
Repair broken complete denture base, mandibular	D5511	$129.453.70	$119.453.70	$10.00	Repair broken complete mandibular denture base. Frequency: two of D5511 per 12 months per client.
Repair broken complete denture base, maxillary	D5512	$129.453.70	$119.453.70	$10.00	Repair broken complete maxillary denture base. Frequency: two of D5512 per 12 months per client.
Replace missing or broken teeth - complete denture (each tooth)	D5520	$97.112.91	$87.112.91	$10.00	Replacement/repair of missing or broken teeth. Teeth 1 – 32 and must report tooth number.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Repair resin partial denture base, mandibular	D5611	$97.795.00	$87.795.00	$10.00	Repair resin partial mandibular denture base. Frequency: two D5611 per 12 months per client.
Repair resin partial denture base, maxillary	D5612	$97.795.00	$87.795.00	$10.00	Repair resin partial maxillary denture base. Frequency: two D5612 per 12 months per client.
Repair cast partial framework, mandibular	D5621	$126.931.29	$116.931.29	$10.00	Repair cast partial mandibular framework. Frequency: two D5621 per 12 months per client.
Repair cast partial framework, maxillary	D5622	$126.931.29	$116.931.29	$10.00	Repair cast partial maxillary framework. Frequency: Two D5622 per 12 months per client.
Repair or replace broken retentive/clasping materials – per tooth	D5630	$137.121.00	$127.121.00	$10.00	Repair of broken clasp on partial denture base – per tooth. Teeth 1 – 32, report tooth number(s).
Replace broken teeth-per tooth	D5640	$98.274.02	$88.274.02	$10.00	Repair/replacement of missing tooth. Teeth 1 – 32, report tooth number(s).
Add tooth to existing partial denture	D5650	$109.00	$99.00	$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Add clasp to existing partial denture	D5660	$142.4336.05	$132.4326.05	$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Rebase complete maxillary denture	D5710	$322.00	$297.00	$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Rebase complete mandibular denture	D5711	$322.00	$297.00	$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase maxillary partial denture	D5720	$304.00	$279.00	$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase mandibular partial denture	D5721	$304.00	$279.00	$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Reline complete maxillary denture (chairside)	D5730	$186.552.00	$176.552.00	$10.00	Frequency: One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (chairside)	D5731	$186.552.00	$176.552.00	$10.00	Frequency: One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (chairside)	D5740	$184.2175.82	$174.2165.82	$10.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline mandibular partial denture (chairside)	D5741	$185.9777.49	$175.9767.49	$10.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete maxillary denture (laboratory)	D5750	$248.663.00	$223.6618.00	$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (laboratory)	D5751	$249.813.00	$224.8118.00	$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory)	D5760	$246.8939.00	$221.8914.00	$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory)	D5761	$246.8939.00	$221.8914.00	$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	$116.931.78	$106.931.78	$10.00	Removal of tooth structure, minor smoothing of socket bone, and closure as necessary. Frequency: One D7140 per lifetime per client per tooth. Teeth 1 – 32.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$181.12~~72.88~~	$171.12~~62.88~~	$10.00	Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure. Frequency: One of D7210 per lifetime per client per tooth. Teeth 1 - 32
Removal of impacted tooth-soft tissue	D7220	$216.73~~07.25~~	$196.73~~87.25~~	$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32. Frequency: One of D7220 per 1 lifetime per client per tooth.
Removal of impacted tooth-partially bony	D7230	$267.45~~55.53~~	$247.45~~35.53~~	$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7230 per 1 lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	$310.37~~296.38~~	$290.37~~76.38~~	$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely boney, with unusual surgical complications	D7241	$407.88~~389.20~~	$387.88~~69.20~~	$20.00	Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Teeth 1-32. Frequency: One of D7241 per lifetime per patient per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of residual tooth roots (cutting procedure)	D7250	$191.02~~82.30~~	$181.02~~72.30~~	$10.00	Includes cutting of soft tissue and bone, removal of tooth structure, and closure. Cannot be charged for removal of broken off roots for recently extracted tooth. Teeth 1 – 32 Frequency: One D7250 per lifetime per patient per tooth.
Primary closure of a sinus perforation	D7261	$476.03~~52.46~~	$466.03~~42.46~~	$10.00	Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fisulous tract. Narrative of medical necessity may be required and if the sinus perforation was caused by a current grantee or provider of the program.
Incisional biopsy of oral tissue-soft	D7286	$381.00	$381.00	$0.00	For partial removal of an architecturally intact specimen only. D7286 is not used at the same time as codes for apicoectomy/periradicular curettage and does not entail an excision. Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	$150.00	$140.00	$10.00	D7310 is distinct (separate procedure) from extractions. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7310 or D7311 per lifetime per patient per quadrant. Reported per quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$145.97~~39.42~~	$135.97~~29.42~~	$10.00	D7311 is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7311 or D7310 per lifetime per patient per quadrant. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$210.11~~00.47~~	$200.11~~190.47~~	$10.00	No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	$210.11~~00.47~~	$200.11~~190.47~~	$10.00	No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. Reported per quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of lateral exostosis (maxilla or mandible)	D7471	$304.28~~290.11~~	$294.28~~80.11~~	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Reported per arch (LA or UA)
Removal of torus palatinus	D7472	$357.83~~41.08~~	$347.83~~31.08~~	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Must list quadrant.
Removal of torus mandibularis	D7473	$349.01~~32.69~~	$339.01~~22.69~~	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Must list quadrant.
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins. One of D7510 per lifetime per client per tooth. Report per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Palliative treatment of dental pain – per visit	D9110	$80.9278.23	$55.923.23	$25.00	Emergency treatment to alleviate pain/discomfort. This code cannot be used for filing claims or writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment.
Evaluation for moderate sedation, deep sedation or general anesthesia	D9219	$42.971.72	$42.971.72	$0.00	One of D9219 or D9310 per 12 month(s) per grantee
Deep sedation/general anesthesia-each 15 minute increment	D9223	$108.133.40	$98.133.40	$10.00	Nine of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes	D9239	$122.5109.23	$112.5199.23	$10.00	One of D9239 per 1 day per patient.
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$108.133.40	$98.133.40	$10.00	Thirteen of D9243 per 1 day per patient. Not allowed with D9223

EXPLANATION OF RESTORATIONS		
Location	Number of Surfaces	Characteristics
Anterior - **Mesial, Distal, Incisal, Lingual, or Facial (or Labial)**	1	Placed on one of the five surface classifications. .
	2	Placed, without interruption, on two of the surface classifications.
	3	Placed, without interruption, on three of the surface classifications.
	4 or more	Placed, without interruption, on four or more of the surface classifications.
Posterior **– Mesial, Distal, Occlusal, Lingual, or Buccal**	1	Placed on one of the five surface classifications.
	2	Placed, without interruption, on two of the surface classifications.
	3	Placed, without interruption, on three of the surface classifications.
	4 or more	Placed, without interruption, on four or more of the surface classifications.

NOTE: Tooth surfaces are reported using the letters in the following table.

Surface	Code
Buccal	B
Distal	D
Facial (or Labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-03-02-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 23-03-02-A, Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443

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) 8.440 & 8.443, 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)? Emergency
   If yes, state effective date: 7/1/2023
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.440 with the proposed text beginning at 8.440.17 through the end of 8.440.39. Replace the current text at 8.443 with the proposed text beginning at 8.443 through the end of 8.443.1.B. Replace the current text at 8.443.6 with the text beginning at 8.443.6.A through the end of 8.443.6.B. Replace the current text at 8.443.10 with the proposed text beginning at 8.443.10.A through the end of 8.443.10.B. This rule is effective July 1, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-03-02-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

STATEMENT OF BASIS AND PURPOSE

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

   House Bill (H.B.) 23-1228 increases nursing home reimbursement starting in state fiscal year (SFY) 2023-24. The proposed rule increases the SFY 2023-24 statewide average nursing home per-diem reimbursement rate by 10%, compared to a limited 2% or 3% increase in previous years. The proposed rule also increases the Cognitive Performance Scale (CPS) and Preadmission Screening and Resident Review (PASRR) II supplemental payment starting in SFY 2023-24, reimbursement for providing care to residents with cognitive and/or behavioral disabilities.

   The propose rule also makes necessary changes to the case mix adjustment applied to nursing home per diem reimbursement rates due to the current Resource Utilization Group (RUG) tool no longer utilized by the Center for Medicare & Medicaid Services (CMS) after October 1, 2023.

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: H.B. 23-1228 increases SFY 2023-24 (July 1, 2023 through June 30, 2024) nursing home reimbursement. Emergency rule-making is necessary to comply with state law allowing for the change to nursing home reimbursement to be effective July 1, 2023. The proposed rule was not presented at a previous MSB meeting as H.B. 23-1228 was sent to the Governor for signature May 17, 2023.

3. Federal authority for the Rule, if any:

   42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

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

   25.5-4-402.4(4)(b), (g), C.R.S.

Initial Review — Final Adoption
Proposed Effective Date **07/01/23** — Emergency Adoption **06/09/23**

DOCUMENT #13

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-03-02-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

REGULATORY ANALYSIS

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

   Nursing homes will benefit from the proposed rule. The statewide average nursing home per-diem reimbursement rate will increase by 10% in SFY 2023-24, compared to previous years where the increase was limited to 2% or 3%. Nursing homes providing care to more residents with mental health conditions, cognitive dementia, and/or developmental disabilities will benefit as their CPS and PSRR supplemental payments will increase starting in SFY 2023-24.

   Nursing homes providing care to less residents with mental health conditions, cognitive dementia, and/or developmental disabilities will bear the costs as other nursing home supplemental payments will be reduced to offset the CPS/PASRR supplemental payment increase. There are limited provider fee funds and an increase in one supplemental payment means a decrease to the other supplemental payments. The state and federal governments will bear the costs of the proposed rule by funding the increase to per-diem reimbursement rates to nursing homes.

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

   The 10% increase in reimbursement rates equates to a $43 million reimbursement increase to nursing homes starting in SFY 2023-24. CPS and PASRR supplemental payments will increase by $5.75 million with a corresponding $5.75 million decrease to other supplemental payments.

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

   The state funding obligation is approximately $21.5 million per SFY. Additional costs include an increased administrative burden on Department staff for the implementation of these changes.

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

The benefit of the proposed rule includes additional reimbursement to nursing homes. The cost of the proposed rule is the additional administrative burden on Department staff to implement these changes. The cost of the proposed rule also includes an increased state funding obligation.

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

   There are no other methods that are less costly or intrusive that still achieve the purpose of the proposed rule.

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

   No alternative methods were seriously considered by the Department to achieve the desired goal of the proposed rule.

8.440 NURSING FACILITY BENEFITS

Special definitions relating to nursing facility reimbursement:

1. "Acquisition Cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

2. "Actual cost" or "cost" means the audited cost of providing services.

3. "Administration and General Services Costs" means costs as defined at Section 8.443.8.

4. "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the valuation system as determined by the Department.

The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities. The new appraisals shall be based upon rules promulgated by the state board.

5. "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all Medicaid-participating nursing facility providers in the state.

6. a. "Base value" means:

i. The appraised value of a capital-related asset for the fiscal year 1986-87 and every fourth year thereafter.

ii. The most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index, for each year in which an appraisal is not done pursuant to subparagraph (a) of this paragraph (1).

b. For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

c. An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.

7. "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

8. "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.

9. "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to DONs, registered nurses, licensed practical nurses, certified nurse aides and restorative nurses.

10. "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.
11. "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-mix.
12. "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of Medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's Medicaid residents as further specified in this section.
13. "Class I nursing facility provider" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of severe mental illness or dementia. Swing bed facilities are not included as Class I nursing facility providers.
14. "Core Component per diem rate" means the per diem rate for direct and indirect health care services costs, administrative and general services costs, and fair rental allowance for capital-related assets for Class 1 nursing facility providers.
15. "Direct health care services costs" means those costs subject to case-mix adjusted direct health care services costs.
16. "Direct or indirect health care services costs" means the costs incurred for patient support services as defined at Section 8.443.7.
17. "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each Case-Mix group as of a specific point in time. ~~The current system in use is the resource utilization group (RUG).~~
18. "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.
19. "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.
20. "Index" means the R. S. Means construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.
21. "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.
22. "Median per diem cost" means the daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.
23. "Medicare patient day" means all days paid for by Medicare. For instance, a Medicare patient day includes those days where Medicare pays a Managed Care Organization for the resident's care.

24. "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the Medicare and Medicaid programs.
25. "MMIS per diem reimbursement rate" means the per diem rate used for Medicaid Management Information Systems (MMIS) claims-based reimbursement.
26. "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.
27. "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.
28. "Nursing facility provider" means a facility provider that meets the state nursing facility licensing standards established pursuant to C.R.S. §25-1.5-103, and is maintained primarily for the care and treatment of inpatients under the direction of a physician.
29. "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse's aides.
30. "Nursing weights" means numeric scores assigned to each category of the Case-Mix groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents. ~~The current system in use is the resource utilization group (RUG).~~
31. "Occupancy-imputed days" means the use of a predetermined number for patient days rather than actual patient days in computing per diem cost.
32. "Per diem cost" means the daily cost of care and services per patient for a nursing facility provider.
33. "Per diem fee" means the dollar amount of provider fee that the Department shall charge a nursing facility provider per non-Medicare day.
34. "Provider fee" means a licensing fee, assessment, or other mandatory payment as specified under 42 C.F.R. § 433.55.
35. "Raw food" means the food products and substances, including but not limited to nutritional supplements, that are consumed by residents.
36. "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.
~~37. "Resource utilization group" (RUG) means the system for grouping a nursing facility's residents according to their clinical and functional status identified from data supplied by the facility's minimum data set as published by the United States Department of Health and Human Services.~~
~~38~~37. "Statewide average per diem rate" means the average per diem rate for all Medicaid-participating nursing facility providers in the state.

~~39~~38. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under 42 C.F.R § 483.12 Freedom from abuse, neglect, and exploitation, 42 C.F.R. § 483.24 Quality of life, or 42 C.F.R. § 483.25, Quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

~~40~~39. "Supplemental Payment" means a lump sum payment that is made in addition to a nursing facility provider's MMIS per diem reimbursement rate. A supplemental Medicaid payment is calculated on an annual basis using historical data and paid as a fixed monthly amount with no retroactive adjustment.

8.443 NURSING FACILITY PROVIDER REIMBURSEMENT

8.443.1.B CLASS 1 NURSING FACILITY PROVIDER REIMBURSEMENT

i. ~~2.~~ For state fiscal year (SFY) 2019-20, if the MMIS per diem reimbursement rate is less than ninety-five percent (95%) of the SFY 2018-19 MMIS per diem reimbursement rate, the SFY 2019-20 MMIS per diem reimbursement rate shall be the lesser of 95% of the SFY 2018-19 MMIS per diem reimbursement rate or the SFY 2019-20 Core Component per diem rate.

b. For SFY 2020-21 and SFY 2021-22, the percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by a two percent (2.00%) statutory limit.

c. For SFY 2023-24, the percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by a ten percent (10.00%) statutory limit.

~~3. In the event that MMIS per diem reimbursement rate is greater than the Core Component per diem rate, the Department shall reduce the rate to no greater than the Core Component per diem rate.~~

The Core Component per diem rate shall be the sum of the following per diem rates:

a. ~~1.~~ Medicaid utilization supplemental payment described in Section 8.443.10.C,

b. ~~2.~~ Acuity Adjusted Core Component supplemental payment described in Section 8.443.11.B,

c. ~~3.~~ Pay-For-Performance supplemental payment described in Section 8.443.12,

d. ~~4.~~ Cognitive Performance Scale supplemental payment described in Section 8.443.10.A,

e. ~~5.~~ Preadmission Screening and Resident Review II Resident supplemental payment described in Section 8.443.10.B,

f. ~~6.~~ Preadmission Screening and Resident Review II Facility supplemental payment described in Section 8.443.10.B, and

g. ~~7.~~ Core Component supplemental payment described in Section 8.443.11.A.

8.443.6 CASE MIX ADJUSTMENTS

8.443.6.A. ~~The resource utilization group–III (RUG-III) 34 category, index maximizer model, version 5.12b, as published by the Centers for Medicare and Medicaid Services (CMS), the resource utilization group–III (RUG-III) 34 category, index maximizer model, version 5.12b is hereby incorporated by reference. The incorporation of RUG-III 34 category, index maximizer model, version 5.12b excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.~~A resident's case mix index shall be determined using a case mix classification system. The case mix classification system shall be maintained through public postings on the Department's website. The ~~Department may update the~~ case mix classification system~~methodology~~ may be updated to reflect advances in resident assessment or classification subject to federal requirements.

8.443.6.B. A resident's case mix index shall be determined on a Quarterly basis.

1. The Department shall distribute facility listings identifying current assessments for residents in the nursing facility on the 1st day of the first month of each quarter as reflected in the Department's MDS assessment database.

   a. ~~1.~~ The listings shall identify resident social security numbers, names, assessment reference date, the calculated ~~RUG-III category~~ case mix index, and the payor source as reflected on the prior full assessment and/or current claims data.

2. Resident listings shall be reviewed by the nursing facility for completeness and accuracy.

3. If data reported on the resident listings is in error or if there is missing data, facilities shall have until the last day of the second month of each quarter to correct data submissions, or until a later date if approved by the Department pursuant to 10 CCR 2505-10 section 8.442.2.

   a. Errors or missing data on the resident listings due to untimely submissions to the CMS database maintained by CDPHE shall be corrected by the nursing facility transmitting the appropriate assessments or tracking documents to CDPHE.

   b. Errors in key field items shall be corrected by following the CMS key field specifications through CDPHE

   c. Errors on the current payor source shall be noted on the resident listings prior to signing and returning to the Department.

4. Each nursing facility shall sign and return its resident listing to the Department no later than 15 calendar days after it was mailed by the Department.

5. Residents shall be assigned a ~~RUG-III~~ case mix index ~~group calculated~~ based on their most current non-delinquent assessment available on the 1st day of the first month of each quarter as amended during the correction period.

a. The RUG-III group shall be translated to the appropriate case mix index or weight.

b. Two average case mix indices for each Medicaid nursing facility shall be determined from the individual case mix weights for the applicable quarter:

   i. The facility average case mix index shall be a simple average, carried to four decimal places, of all resident case mix indices.

   ii. The Medicaid average case mix index shall be a simple average, carried to four decimal places, of all residents where Medicaid is the per diem payor source anytime during the 30 days prior to their current assessment.

c. Any incomplete assessments and current assessment in the database older than 122 days shall be included in the calculation of the averages using the case mix index established in these rules.

8.443.10 COGNITIVE PERFORMANCE SCALE, PREADMISSION SCREENING AND RESIDENT REVIEW II, AND MEDICAID UTILIZATION SUPPLEMENTAL PAYMENTS

8.443.10.A COGNITIVE PERFORMANCE SCALE SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers who have residents with moderate to very severe mental health conditions, cognitive dementia, or acquired brain injury, based upon the resident's score on the Cognitive Performance Scale (CPS).

1. Annually, the Department shall calculate the payment by multiplying a CPS per diem rate by CPS Medicaid days.

2. The CPS per diem rate is calculated based on the number of standard deviations a nursing facility provider's CPS percentage is above the statewide average CPS percentage. The CPS per diem rate shall be determined in accordance with the following table:

Standard Deviation Above Statewide Average	CPS Per Diem
Greater Than or Equal to Statewide Average + 1 Standard Deviation	1x
Greater Than or Equal to Statewide Average + 2 Standard Deviation	2x
Greater Than or Equal to Statewide Average + 3 Standard Deviation	3x

The CPS per diem rate multiplier (x) shall equal an amount such that the total statewide CPS supplemental payment divided by total statewide CPS Medicaid days equal ~~one~~ two percent of the statewide average ~~MMIS~~ July 1 Core Component per diem ~~reimbursement~~ rate.

3. The CPS percentage is the sum of Medicaid residents with a CPS score of 4, 5, or 6 divided by the sum of Medicaid residents.

   a. Medicaid residents with a CPS score of 4, 5, or 6 are determined using the Department utilized case mix ~~RUG-III~~ classification system and reported on the MDS form.

   b. The determination of Medicaid residents with a CPS score of 4, 5, or 6 shall be made using the April MDS roster.

4. CPS Medicaid patient days shall equal the count of Medicaid residents with a CPS score of 4, 5, 6, or equivalent, multiplied by the days in the year.

5. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.10.B PREADMISSION SCREENING AND RESIDENT REVIEW II SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers who have residents with severe mental health conditions or developmental disabilities that are classified at Level II by the Medicaid program's preadmission screening and resident review assessment tool (PASRR II).

1. Annually, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.

2. Medicaid PASRR II days shall equal the count of PASRR II residents on May 1, multiplied by the days in the year.

3. The PASRR II per diem rate shall equal ~~two~~ four percent of the statewide July 1~~MMIS~~ Core Component per diem ~~reimbursement~~ rate ~~as described Section 8.443.1.B~~.

4. The Department shall pay an additional PA~~S~~SRR II supplemental payment to facilities that offer specialized behavioral services to residents who have severe behavioral health needs. These services shall include enhanced staffing, training, and programs designed to increase the resident's skills for successful community reintegration.

5. The additional PASRR II supplemental payment for nursing facility providers that have an approved specialized behavioral services program shall be calculated using the methodology described in Section 8.443.10.B.1 through Section 8.443.10.B.3.

6. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.