

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Creation of the Medical Assistance Act Rule concerning the Money Follows the Person Demonstration, Section 8.555  
Rule Number: MSB 24-01-03-A  
Compliance and Innovation Division (CID) / Matt Bohanan /  
matthew.bohanan@stte.co.us /

**SECRETARY OF STATE**

**SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: Creation of the Medical Assistance Act Rule concerning the Money Follows the Person Demonstration, Section 8.555
3. This action is an adoption of: A new proposed rule set
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
None existing
5. Does this action involve any temporary or emergency rule(s)? No  
(temporary for the duration of the demonstration)  
If yes, state effective date:

**PUBLICATION INSTRUCTIONS\***

Insert the newly proposed text at 8.555 with the proposed text beginning at 8.555 through the end of 8.555.5.2. This rule is effective September 30, 2024.

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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).

Transition coordination services in the Department of Health Care Policy & Financing (the Department) was established April 30, 2018, by House Bill 18- 1326, Support for Transition from Institutional Settings. Passed with unanimous support, this enactment directed the Department to provide community transition services and supports to people who are in institutional settings, are eligible for Medicaid, and desire to transition to a home- and community-based setting. The Department implemented these services on January 1, 2019.

The purpose of this new rule is to codify State Authority to implement a Money Follows the Person (MFP) Demonstration. Implementation of the MFP Demonstration will include expansion of the Targeted Case Management - Transition Coordination (TCM-TC) benefit in addition to the creation of MFP Supplemental Services that allow for the provision of support otherwise unavailable through Medicaid.

Money Follows the Person (MFP) is a Federal Demonstration Grant that serves adult members who live in qualified institutional settings and have a desire to move to the community supported by Medicaid State Plan benefits and waiver services.

Expansion of the TCM-TC rules is addressed through MSB # 23-10-25-C where the service authorization limit was increased from 240 units to 360 units. This new rule set will represent operational guidance concerning the integration of TCM-TC into the MFP Demonstration.

MFP Supplemental Services will represent short-term resources available to members for a specified period of time and will include Environmental Adaptations, Peer Mentorship, Pre-tenancy Support, Housing Assistance, and Food Assistance.

The purpose of this new rule set is necessary to create program oversight and accountability.

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.

Initial Review **06/14/24**

Proposed Effective Date **09/30/24**

Final Adoption **08/09/24**

Emergency Adoption

**DOCUMENT #05**

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Explain: This is not an emergency rule.

3. Federal authority for the Rule, if any: Money Follows the Person Demonstration Grant; 42 USC 1396a- - State Plans for Medical Assistance.

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

Initial Review **06/14/24**  
Proposed Effective Date **09/30/24**

Final Adoption **08/09/24**  
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**DOCUMENT #05**

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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.

Medicaid members who will be affected by the proposed rule are those who have expressed interest in moving to a community-based setting utilizing transition services and supports. Eligible members are those who have resided in a nursing facility, intermediate care facility for individuals with intellectual disabilities, and regional centers for more than 60 days. Excluded are children under the age of 18 and individuals between ages 22 and 64 who are served in Institutes for Mental Disease or individuals who are inmates of correctional facilities.

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 probable quantitative and qualitative impact of the proposed rule is an increase in the number of members that may utilize transition coordination services to transition from institutional settings. The proposed rule will offer individuals with support previously unavailable to them. It will create the opportunity for members to complete modifications to their home, engage with peer mentors, and learn about the requirements of renting or leasing housing, while they are still living in the facility. It will also create the opportunity for members to receive short term food and rental assistance following the transition to the community. Availability of these resources will address previously unmet needs intended to improve the likelihood of members' ability to remain living in the setting of their choice.

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.

Implementation of the MFP Demonstration provides an Enhanced Federal Financial Participation (FFP) match for all qualified and demonstration services, resulting in a State's Savings Fund based on twenty-five percent of those direct costs. MFP Supplemental Services costs are completely funded by the Federal grant award.

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Implementation of the proposed rule set will require additional oversight from Department staff associated with this program. This will be based on increased reporting requirements of the grant, in addition to oversight for program expansion.

The proposed rule changes may also increase the utilization of community-based waiver and state plan benefits and decrease the utilization of other benefits and services related to institutional care.

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

The Department estimates that the probable quantitative and qualitative impact and benefits of the proposed rule listed above will outweigh any probable costs of increased staff time.

Implementation of the proposed rule listed above aligns with stakeholder feedback and other Department priorities. Failure to implement the proposed rule would result in a missed opportunity to expand State resources through Federal funds.

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

The State does not require additional resources to implement the proposed rule listed above. Oversight is accounted for through existing resources and those provided through the grant.

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

The proposed rule listed above is specific to a Federal grant program that does not present favorable alternatives to consider.

## **8.555 Money Follows the Person (MFP) Demonstration**

### **8.555.1 Program Overview**

#### **8.555.1.A Program Definition, Authority, and Scope**

##### 1. Program Definition

- a. Money Follows the Person is a federal grant that supports state strategies to rebalance their long-term services and supports (LTSS) systems from institutional to community-based care. MFP plays a key role in LTSS rebalancing efforts under the Medicaid program. The program provides flexible funding opportunities to help states develop and test the necessary processes, tools, and infrastructure to advance LTSS system reform and to support successful transitions from institutional to community-based settings for individuals eligible for Medicaid LTSS. The model demonstrates the likely impact of new methods of service delivery, coverage of new types of service, and new payment approaches to promote the objective of the Medicaid program.

##### 2. Legal Authority

- a. The federal authority for the MFP demonstration is section 6071 of the Deficit Reduction Act of 2005 (DRA). Section 6071 of the DRA has been amended by: section 2403 of Patient Protection and Affordable Care Act; section 2 of the Medicaid Extenders Act of 2019; section 5 of the Medicaid Services Investment and Accountability Act of 2019; section 4 of the Sustaining Excellence in Medicaid Act of 2019; section 205 of the Further Consolidated Appropriations Act, 2020 (CAA); section 3811 of the Coronavirus Aid, Relief, and Economic Security Act, 2020; section 2301 of the Continuing Appropriations Act, 2021 and Other Extensions Act; section 1107 of the Further Continuing Appropriations Act, 2021, and Other Extensions Act; and section 204 of the Consolidated Appropriations Act, 2021 (CAA).
- a. MFP is designed to complement the services offered through the Home and Community-Based Services (HCBS) waivers authorized through Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n).
- b.
- c. [The State Authority for the Rule is in C.R.S. § 25.5-6-1501\(6\).](#)

##### 3. Scope and Purpose

- a. The MFP program assists members residing in qualified institutions with exploring their community-based options for long term supports and services; facilitates the transition of members to a community setting so long as the right services and supports can be arranged in the community to ensure the health, welfare, and safety of the member; and provides enhanced services and supports through willing and qualified providers.
- b. The MFP program strengthens the transition process for members of qualified institutions and provides additional support and services for a successful transition. These additional supports and services fall into the categories of demonstration services or supplemental services.
- c. Demonstration Assurances:

- i. Services will be made available throughout the entirety of the demonstration and last for 365 calendar days, 366 days during a leap year if applicable, following discharge to a qualified residence.
- ii. Services offered under the demonstration will not duplicate any existing benefits, and adequate services definitions will create role clarity for those involved in the processes.
- iii. Outreach and training will be provided to build awareness of the services offered under the demonstration to include program goals, documentation, and quality oversight.
- iv. Successful completion of the demonstration will include authorization of HCBS services needed for continuity of care following the demonstration period.

#### **8.555.1.B Definitions**

1. Case Management means the Assessment of an individual seeking or receiving Long-Term Services and Supports' needs, the development and implementation of a Person-Centered Support Plan for such individual, Referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic Reassessment of such individual's needs and collaboration with other entities impacting the Members' HCBS, health and welfare.
2. Demonstration Services for the purposes of the MFP demonstration means Targeted Case Management - Transition Coordination (TCM-TC) where support will be available to members upon confirmation of member eligibility and for 365 calendar days following discharge from the qualified institution. Need for demonstration services will be identified by the TCM-TC Community Needs and Preference Assessment and Risk Mitigation Plan.
3. Division of Housing (DOH) is the State entity within the Department of Local Affairs (DOLA) that represents the housing authority for MFP programs through an Interagency Agreement (IA) with the Department of Health Care Policy and Financing (HCPF)
4. Qualified institution means a nursing facility; intermediate care facilities for individuals with intellectual disabilities (ICF-IID); Regional Center (RC) or institutions for mental diseases (IMD), which include Psychiatric Hospitals only to the extent medical assistance is available under the State Medicaid plan for services provided by such institutions.
5. Qualified residence means a home owned or leased by the member or the member's family member; a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside; or an apartment with an individual lease, eating, sleeping, cooking, and bathing areas, lockable access and egress, and not associated with the provision or delivery of services.
6. Qualified services mean services that are provided through an existing HCBS waiver and may continue if needed by the member and if the member continues to meet eligibility for HCBS at the end of his or her enrollment in MFP.
7. MFP Supplemental Services mean services not otherwise available under Medicaid but that directly support a member through one-time or short-term expenses. Supplemental Services are reimbursable for up to six months while the member resides in a qualified institution and for a period of up to six months following discharge to a qualified residence. Need for Supplemental Services will be identified by the TCM-TC Community Needs and Preference Assessment and Risk Mitigation Plan.

8. Targeted Case Management – Transition Coordination (TCM-TC) services means transition coordination assistance provided to a member who is transitioning from a skilled nursing facility, extended SNF LOC hospital stay, intermediate care facility for individuals with intellectual disabilities, or regional center and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition
9. Transition Assessment/Plan means an assessment of member needs completed by a transition coordinator prior to a transition and the corresponding plan developed by the coordinator to meet the needs of the member in a community-setting post-transition.
10. Transition Coordinator (TC) means a person who provides Transition Coordination Services and meets all regulatory requirements for a TC at [Section 40 CCR 2505-10-8.519.27.27.D and E.](#)
11. Transition Coordination Agency (TCA) means a public or private not-for-profit or for-profit agency that meets state and federal requirements at [Section 40 CCR 2505-10-8.519.27.27](#) and 8.763 and is certified by the Department to provide Targeted Case Management – Transition Coordination (TCM-TC) services pursuant to a provider participation agreement with the Department.
12. Transition Options Team (TOT) means a group of individuals who have a personal or professional relationship with the member who is exploring their options for community living. This group is responsible wholly or in part for the transition assessment, transition plan, determining whether the transition is recommended, completing the service plan, and brokering services.

## **8.555.2 Eligibility**

### **8.555.2.A. Eligible Persons**

1. MFP services shall be offered only to persons who meet all of the following eligibility requirements:
  - a. Members shall be aged 18 years or older.
  - b. Members shall have resided in a qualified institution for a period of 60 days or more. Days in a nursing facility for a rehabilitation stay will count towards the 60 days.
2. Members shall be Medicaid eligible
3. Members shall reside in a qualified residence post-transition.
4. MFP members admitted to a nursing facility or hospital for 30 consecutive days or longer, ~~post-shall transition~~, shall be discontinued from the MFP program but may have the option to re-enroll once they meet all eligibility requirements. The Department has the right to exempt the 30-day exclusion on a case-by-case basis where failure to do so would result in health and safety concerns, loss of housing, loss of caregivers, or loss of benefits.
  - a. MFP members entering a nursing facility for Respite Care as a qualified HCBS waiver service shall not be discontinued from the MFP program.
5. Members who reside in a residence that is not a Qualified Residence as defined in [Section 40 CCR 2505-10-8.555.1-1.B.4](#) are not eligible for MFP services.

### **8.555.2.B Financial Eligibility**



1. Members shall meet the eligibility criteria as specified in the Income Maintenance Staff Manual of the Colorado Department of Health Care Policy and Financing regulations at [Section 10-CCR 2505-10-8.100, Medical Assistance Eligibility.](#)

#### **8.555.2.C Level of Care Criteria**

1. Members shall require long-term support services at a level comparable to services typically provided in a hospital, nursing facility, or ICF-IID in accordance with the waiver to which they will enroll upon transition.

#### **8.555.2.D. Need for MFP Services**

1. Members will be eligible for the MFP program when all eligibility criteria listed in [Section 10-CCR 2505-10, 8.555.2-2.A.](#) have been met.
  - a. The desire or need for any Medicaid services other than MFP demonstration services, as listed at [Section 10-CCR 2505-10, 8.555.1](#), or qualified services offered through one of the waiver programs listed in [Section 10-CCR 2505-10, 8.555.2.A.4.a](#) shall not satisfy this eligibility requirement.
2. Eligible services include but are not limited to [Ttransition](#), [CCoordination](#), [Ppeer Mmentorship](#), [Ppre-tenancy Ssupport](#), and [Eenvironmental Aadaptations](#).
3. Once enrolled, members who have not received demonstration or qualified services for a period greater than 30 consecutive days shall be discontinued from the program.
4. MFP members will be eligible to receive all MFP Supplemental Services identified as a need during MFP enrollment

#### **8.555.2.E Exclusions**

- ~~Members who are residents of nursing facilities, other qualified institutions or hospitals are not eligible to receive qualifying MFP services in preparation for discharge unless they are enrolled in MFP.~~
- ~~MFP members admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the MFP program but may have the option to re-enroll once they meet all eligibility requirements. The Department has the right to exempt the 30-day exclusion on a case by case basis.~~
- ~~MFP members entering a nursing facility for Respite Care as a qualified HCBS waiver service shall not be discontinued from the MFP program.~~
- ~~Members who reside in a residence that is not a Qualified Residence as defined in 10-CCR 2505-10, 8.555.1.B.4, are not eligible for MFP services.~~

#### **8.555.3 MFP Demonstration Program**

##### **8.555.3.A Program Duration**

1. MFP members may be enrolled in the demonstration and receiving TCM-TC Services for a period of 365 days, 366 days during a leap year if applicable, following discharge from a qualified

institution. After discharge the member may be enrolled in the appropriate long-term care program.

2. Following discharge from a qualified institution, MFP members will be concurrently enrolled in the MFP program and one of the following waivers:

- a. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) (~~Section 40-CGR-2505-10, 8.7101.G~~);
- b. Home and Community Based Services Complementary and Integrative Health (HCBS-CIH) (~~Section 40-CGR-2505-10, 8.7101.H~~)
- c. Home and Community Based Services for People with Brain Injury (HCBS-BI) (~~Section 40-CGR-2505-10, 8.7101.E~~);
- d. Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS) (~~Section 40-CGR-2505-10, 8.7101.F~~);
- e. Home and Community Based Services for the Developmentally Disabled (HCBS-DD) (~~Section 40-CGR-2505-10, 8.7101.J~~; or
- f. Home and Community Based Services for Supported Living Services (HCBS-SLS) (~~Section 40-CGR-2505-10, 8.7101.I~~).

3. At the end of the 365-day enrollment period for the MFP program, HCBS case managers will disenroll members from the program.

- a. TCM-TC Demonstration services will terminate at the end of the 365 days of MFP enrollment period.
- b. Supplemental services will end 6 months after discharge.
- c. After MFP concludes, if members continue to meet eligibility requirements at the time of the Continued Stay Review (CSR) for one of the waivers listed in ~~Section 40-CGR-2505-10, 8.555.3.A.2~~, case managers will arrange for the continuation of qualified HCBS services through the appropriate waiver. For members that do not meet eligibility requirements for one of the waivers listed in ~~Section 40-CGR-2505-10, 8.555.4.4.D~~, case managers will provide referrals to alternate resources that may include Medicaid state plan benefits.

### **8.555.3.B MFP Demonstration Service**

1. Targeted Case Management - Transition Coordination (TCM-TC)

- a. Transition Coordination will be provided in accordance with requirements defined in Transition Coordination Services ~~Section 40-CGR-2505-10, 8.519.27.F~~.
- b. Eligibility
  - i. Members will be eligible for MFP ~~T~~ransition ~~C~~oordination services when all eligibility criteria described in Targeted Case Management - Transition Coordination (TCM-TC) ~~Section 40-CGR-2505-10, 8.519.27.27.F, 8.763.A and 8.555.2.2.A~~ are met.
- c. Inclusions

- i. Transition Coordination will ensure that members meet all eligibility requirements identified in ~~Section 10 CCR 2505-10~~, 8.555.2.2.A prior to enrollment.
- ii. Transition Coordination shall facilitate the completion of the Department approved Transition Assessment/Plan for each member with the support of the Transitions Options Team members. The need for MFP supplemental services will be determined through this assessment process.

d. Exclusions

- i. Reimbursement for mileage, travel, or transportation

e. Provider Requirements

- i. Transition Coordination Agencies will follow all policies and procedures defined in ~~Section 10 CCR 2505-10~~, 8.519.27.27 and made available through training and other guidance.

f. Provider Reimbursement

- i. TCM-TC services will be reimbursed according to requirements outlined in ~~Section 10 CCR 2505-10~~, 8.763.C and the Targeted Case Management - Transition Coordination (TCM-TC) Billing Manual.
- ii. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

2. MFP Housing Assistance

- a. MFP Supplemental service that provides funding for MFP members while long-term solutions are established. Colorado administers ~~S~~state-funded housing resources that provide members with housing vouchers. MFP Housing Assistance supports members in urgent situations while long-term ~~S~~state-funded options are pending or unavailable.

b. Eligibility

- i. Members who have identified housing payments as a need during MFP enrollment will be eligible for six months of total rental payments through MFP Housing Assistance. MFP Housing Assistance recognizes rental arrears and monthly rental payments as eligible expenses where the combination of the two types of payments cannot exceed six months of total MFP Housing Assistance payments.
- ii. Will be documented by the TCA and reported to the Division of Housing (DOH) who will be responsible for authorizing the start date and amount of monthly MFP Housing Assistance payments and subsequent State-funded housing assistance.

c. Inclusions

- i. Activities reimbursable as short-term rental assistance

1) Monthly rental payments:

- 2) Will be calculated based on State-funded housing standards
- 3) Will be administered and tracked by the DOH who will be responsible for implementing State-funded housing assistance for members to avoid any interruption of payment following the member's eligibility period for MFP Housing Assistance.

ii. Rental arrears:

- 1) Rental arrears payments are eligible expenses under MFP Housing Assistance and will offset funding available for rental assistance following transition.
- 2) Rental arrears payments will not exceed six months of calculated MFP ~~Housing~~Rental Assistance.

iii. Activities reimbursable for payment prior to transitioning

1. Security Deposit ~~may include advance payments for rent as defined by the lease agreement~~

2. ~~Utility startup costs~~

~~—Activities reimbursable for securing a community-based home~~

~~—Lease application fees~~

~~—Storage fees for on-site storage for members' belongings that cannot be stored in the home~~

~~—Moving expenses~~

d. Exclusions

- i. Any MFP Housing Assistance to exceed a combination of six months of rental payments
- ii. Expenses for home furnishings or grocery items
- iii. Payment for modifications or accessibility adaptations to the home associated rental and utility fees identified during transition planning

e. Provider Requirements

- i. MFP Housing Assistance will be administered by the Division of Housing (DOH) as a State entity within the Department of Local Affairs (DOLA) through an Interagency Agreement (IA) with the Department of Health Care Policy and Financing (HCPF) and/or HCPF Department staff or contracts.

f. Provider Reimbursement

- i. MFP Housing Assistance payments will be made by the State's designated entity to landlords and/or property management groups.
- ii. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

### 3. MFP Food Assistance

a. MFP Supplemental Service that provides short-term funding for food pantry items, community meal programs, and food boxes. This service will ensure that a member has access to food while adjusting to community-living. Funding will be available for MFP Food Assistance for 30 days following transition to the community

#### b. Eligibility

- i. Members who have identified food as a need during MFP enrollment will be eligible for MFP Food Assistance for a period of 30 days following transition to the community

#### c. Inclusions:

- i. Food pantry stocking items may include:

- 1) Perishable food items
- 2) Non-perishable food items
- 3) Nutritional vitamins and other meal supplements
- 4) Nutritional items associated with dietary restrictions
- 5) Food preparation items

- ii. Community meal delivery fees for non-Medicaid resources prior to authorization of HCBS Home Delivered Meals (HDM) or other long-term alternatives. Membership fees for community programs such as Meals on Wheels or food boxes would be an example of appropriate costs under this category

#### d. Exclusions

- i. The combination of costs associated with Short-term Food Assistance will not exceed \$500 per member for the 30-day period.
- ii. HCBS Home Delivered Meals
- iii. Any costs ~~for food assistance~~ that exceeds the member's MFP Food Assistance eligibility period

#### e. Provider Requirements

- i. MFP Food Assistance providers will be subject to the standards outlined in ~~40 CCR 2505-10, Section 8.7549.06-A~~

#### f. Provider Reimbursement

- i. MFP Food Assistance must not exceed \$500 per eligible member for a period of 30 days following discharge from a qualified institution
- ii. Funding provided will not duplicate any other food expenses covered by Medicaid
- iii. The total amount will be prior authorized in the State's MMIS system and will be reimbursable upon delivery of service
- iv. Reimbursement for MFP services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.
  - 1) The statewide fee schedule for these services is reviewed annually and published in the provider billing manual.
  - 2) Reimbursement for MFP services is also conditional upon:
    - a) The member's eligibility for MFP services;
    - b) The provider's certification status; and
    - c) The submission of claims in accordance with proper billing procedures.
- v. Payments will be made by agencies designated by contract with the State to provide this service
- vi. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department

#### 4. MFP Pre-Tenancy Support

- a. MFP Supplemental Service that teaches members how to satisfy the requirements of community-based tenancy through education and direct support. The service teaches members how to successfully secure and maintain community housing and avoid unnecessary returns to higher levels of care.
- b. Eligibility:
  - i. Members who have identified housing as a need during MFP enrollment will be eligible for MFP Pre-Tenancy Support for a period up to six months prior to transitioning
- c. Inclusions
  - i. Teaching members how to satisfy the requirements of tenancy
  - ii. Teaching members their rights as tenants
  - iii. Teaching members compliance requirements for lease agreements
  - iv. Teaching members about tenancy sustaining practices
  - v. Completing lease applications and requesting rental accommodations

- vi. Coordinating required documentation
- vii. Teaching members how to make payments to landlords
- viii. Teaching members how to schedule tours for prospective units
- ix. Accessing other resources related to ~~P~~re-tenancy ~~S~~upport and household management

d. Exclusions

- i. ~~P~~re-~~t~~enancy Support shall not be available to members following transition to the community
- ii. Pre-Tenancy Support services will be limited to 52 units where 1 unit equals 15 minutes
  - 1) Reimbursement for mileage, travel, or transportation
- iii. Provider Requirements
  - 1) Providers of MFP services must:
    - a) Abide by all the terms of their provider agreement with the Department; and
    - b) Not discontinue or refuse services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services
    - c) Comply with all applicable federal and state statutes, regulations, and guidance

e. Provider Reimbursement

- i. Pre-Tenancy Support will be reimbursed up to 52 units where 1 unit equals 15 minutes
- ii. The total amount will be prior authorized in the State's MMIS system and will be reimbursable upon delivery of service
- iii. Requests for units above the authorized amount will be reviewed by designated State staff
- iv. Reimbursement for MFP services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.
  - 1) The statewide fee schedule for these services is reviewed annually and published in the provider billing manual.
  - 2) Reimbursement for MFP services is also conditional upon:
    - a) The member's eligibility for MFP services;
    - b) The provider's certification status; and

- c) The submission of claims in accordance with proper billing procedures.
- 3) Payments will be made by agencies designated by contract with the State to provide this service
- 4) Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

## 5. MFP Peer Mentorship

- a. MFP Supplemental Service that offers support from providers with lived experience to better understand the transition process, how to navigate Colorado's Medicaid System and other community resources prior to transition. The goal of MFP Peer Mentorship is to connect members with other people who have transitioned to the community to build independence and reduce impacts of social isolation after leaving a long-term care facility.
- b. Eligibility
  - i. MFP Peer Mentorship will be available to members for a period up to six months prior to transitioning who meet the following eligibility criteria:
- c. Inclusions
  - i. MFP Peer Mentorship means support provided by peers of the member on matters of community living and may include:
    - 1) Problem-solving issues drawing from shared experience
    - 2) Goal setting, self-advocacy, community acclimation and techniques
    - 3) Assisting with interviewing potential providers, understanding complicated health and safety issues, and participating on private and public boards, advisory groups, and commissions
    - 4) Activities that promote interaction with friends and companions of choice
    - 5) Teaching and modeling of social skills, communication, group interaction, collaboration
    - 6) Developing community relationships with the intent of building social capital that results in the expansion of opportunities to explore personal interests
    - 7) Assisting the person in acquiring, retaining, and improving self-help, socialization, self-advocacy, and adaptive skills necessary for community living.
    - 8) Support for integrated and meaningful engagement and awareness of opportunities for community involvement including volunteering, self-advocacy, education options, and other opportunities identified by the individual



9) Assisting members to be aware of and engage in community resources.

ii. Exclusions

1) MFP Peer Mentorship will not be available to members following transition to the community

2) Reimbursement for mileage, travel, or transportation

iii. Provider Requirements

1) MFP Peer Mentorship providers must meet requirements at ~~10-CCR 2505-10~~Section 8.7535-06

2) Providers of MFP services must:

a) Conform to all state established standards for the specific services they provide under this program

b) Not discontinue or refuse services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services

c) Abide by all the terms of their provider agreement with the Department; and

3) Comply with all applicable federal and state statutes, regulations, and guidance

iv. Provider Reimbursement

1) MFP Peer Mentorship will be reimbursed up to 26 units where 1 unit equals 15 minutes

2) Requests for units above the authorized amount will be reviewed by designated State staff

3) The total amount will be prior authorized in the Department's MMIS system and will be reimbursable upon delivery of service

4) Reimbursement for MFP services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.

5) The statewide fee schedule for these services is reviewed annually and published in the provider billing manual.

6) Reimbursement for MFP services is also conditional upon:

a) The member's eligibility for MFP services

b) The provider's certification status

c) The submission of claims in accordance with proper billing procedures

7) Payments will be made by agencies designated by contract with the State to provide this service

8) Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

## 6. Environmental Adaptations

a. MFP Supplemental Service that allows for modifications to a member's residence to be completed prior to transitioning where the modification represents a barrier that would otherwise prevent a member from discharging safely to the community. This support is differentiated from the existing home modification waiver benefit through the ability to initiate modifications to a member's home while they reside in a skilled setting. The TCA will work directly with the member to make referrals to Environmental Adaptation providers while the member resides in the facility planning for transition. The TCA will communicate with the HCBS case manager to ensure continuity with further home modifications under the HCBS Waiver following transition as warranted.

### b. Eligibility

i. Members who have identified home accessibility as a need during MFP enrollment will be eligible for MFP Environmental Adaptations for a period up to six months prior to transitioning

### c. Inclusions

i. Inclusions for Environmental Adaptations are outlined in [Section 40-CCR-2505-10, 8.7524.03.A.](#)

### d. Exclusions

i. Exclusions for Environmental Adaptations are outlined in [Section 40-CCR-2505-10, 8.7524.04](#)

### e. Environmental Adaptations Oversight Responsibilities

i. The Environmental Adaptation (EA) Contractor shall consider alternative funding sources to complete the Environmental Adaptation. These alternatives and the reason they are not available shall be documented in the case record.

1) The EA Contractor must confirm that the member is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by the Fair Housing Act.

ii. The EA Contractor may approve Environmental Adaptation projects estimated at less than \$2,500 without Department approval, contingent on member authorization and confirmation of Environmental Adaptation fund availability.

iii. The EA Contractor shall obtain prior approval by submitting an Environmental Adaptation (EA) Request to the Department for Environmental Adaptation projects estimated at between \$2,500 and \$14,000.

- 1) The EA Contractor must submit the request and all supporting documentation according to Department prescribed processes and procedures. EA Requests submitted with improper documentation cannot be authorized.
- 2) The EA Contractor is responsible for retaining and tracking all documentation related to a member's Environmental Adaptation benefit and communicating that information to the member and EA Providers. The EA Contractor may request confirmation of a member's Environmental Adaptation history from the Department, its fiscal agent, or DOH.

iv. Environmental Adaptations estimated to cost \$2,500 or more shall be evaluated according to the following procedures:

- 1) An occupational or physical therapist (OT/PT) shall assess the member's needs and the therapeutic value of the requested Environmental Adaptation. When an OT/PT with experience in Environmental Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Environmental Adaptation would contribute to a member's ability to remain in or return to their home, and how the Environmental Adaptation would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the EA Request.
- 2) The evaluation services may be provided by a home health agency or other qualified and approved OT/PT through Medicaid Home Health consistent with Home Health rules set forth in ~~40 CCR 2505-10~~, Section 8.520, including physician orders and plans of care.
  - a) The Transition Coordinator (TC) may initiate the OT/PT evaluation process before the member has been approved for waiver services, as long as the member is Medicaid eligible.
  - b) A TC may initiate the OT/PT evaluation process before the member physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.
- 3) The EA Contractor and the OT/PT shall consider less expensive alternative methods of addressing the member's needs.
- 4) The EA Contractor shall solicit bids according to the following procedures:
  - a) The EA Contractor shall solicit bids from at least two Environmental Adaptation Providers.
    - i) The EA Contractor must verify that the provider is an enrolled Environmental Adaptation Provider.
    - ii) The bids must be submitted according to Department prescribed processes and procedures

- b) The bids shall include a breakdown of the costs of the project including:
- i) Description of the work to be completed.
  - ii) Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.
  - iii) Estimate for building permits, if needed.
  - iv) Estimated timeline for completing the project.
  - v) Name, address and telephone number of the Environmental Adaptation Provider.
  - vi) Signature, including option for digital signature, of the Environmental Adaptation Provider.
  - vii) Signature, including option for digital signature, of the member or guardian or other indication of approval.
  - viii) Signature, including option for digital signature, of the homeowner or property manager if applicable.
- c) Environmental Adaptation Providers have a maximum of ten (10) business days to submit a bid for the Environmental Adaptation project after the EA Contractor has solicited the bid.
- i) If the EA Contractor has made three attempts to obtain a written bid from an Environmental Adaptation Provider and the Environmental Adaptation Provider has not responded within ten (10) business days, the EA Contractor may request approval of one bid. Documentation of the attempts shall be maintained by the EA Contractor.
- d) The EA Contractor shall submit copies of the bid(s) and the OT/PT evaluation with the EA Request to the Department or its agent. The Department or its agent shall authorize the lowest bid that complies with the requirements of {Section 8.7524} and the recommendations of the OT/PT evaluation.
- i) If a member or homeowner requests a bid that is not the lowest of the submitted bids, the EA Contractor shall request approval by submitting a written explanation with the EA Request.
- e) A revised bid and Change Order request shall be submitted according to the procedures outlined in this section for any changes from the original EA Request according to Department prescribed processes and procedures.

v. If the member does not own a property to be modified, the EA Contractor shall obtain signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein. Signatures may be completed using a digital signature based on preference of the individual signing the form.

1) Written consent of the homeowner or property manager, as evidenced by the above-mentioned signatures, is required for all projects that involve permanent installation within the member's residence or installation or modification of any equipment in a common or exterior area.

2) If the member vacates the property, these signatures can be used as evidence that the homeowner or property manager agrees to allow the member to leave the modification in place or remove the modification as the member chooses. If the member chooses to remove the modification, the property must be left equivalent or better to its pre-modified condition. The homeowner or property manager may not hold any party responsible for removing all or part of an Environmental Adaptation project.

vi. If the EA Contractor does not comply with the process described above resulting in increased cost for an Environmental Adaptation, the Department may hold the EA Contractor financially liable for the increased cost.

vii. The Department or its agent may conduct on-site visits, or any other investigations deemed necessary prior to approving or denying the EA Request.

f. Environmental Adaptations Provider Requirements

i. An Environmental Adaptations Agency means a provider agency that has met all the standards for Home Modification and is an enrolled Medicaid provider.

ii. Provider Requirements for Environmental Adaptations are outlined in [Section 40 CCR 2505-10-8.7524.06](#)

iii. Providers of MFP services must

1) Conform to all state established standards for the specific services they provide under this program

2) Not discontinue or refuse services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services

3) Abide by all the terms of their provider agreement with the Department; and

4) Comply with all applicable federal and state statutes, regulations, and guidance

iv. Provider Reimbursement

1) Environmental Adaptations will be reimbursable up to a maximum cost of \$14,000

- 2) Payment for Environmental Adaptations is outlined in ~~40 CCR 2505-10~~, Section 8.7524.07
- 3) The total reimbursement will not exceed the total amount identified in the bid
- 4) Reimbursement for MFP services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.
  - a) The statewide fee schedule for these services is reviewed annually and published in the provider billing manual.
  - b) Reimbursement for MFP services is also conditional upon:
    - i) The member's eligibility for MFP services;
    - ii) The provider's certification status; and
    - iii) The submission of invoices in accordance with proper billing procedures.
- v. Payments will be made by agencies designated by contract with the State to provide this service
  - 1) Payment for Environmental Adaptations does not offset the funding available to members under HCBS Home Modification benefits
- vi. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department

#### **8.555.4. MFP Case Management Functions**

##### **8.555.4.A Case Management Responsibilities**

1. The case manager shall provide support in accordance with the functions outlined in ~~Section 40 CCR 2505-10~~, 8.7206

##### **8.555.4.B. Case Management Responsibilities – MFP Disenrollment**

1. The case manager shall begin preparing members for dis-enrollment from the MFP program 90 days prior to the end of the member's MFP enrollment period and arrange for the continuation of HCBS services if the member continues to meet the eligibility requirements for a waiver listed at ~~Section 40 CCR 2505-10~~, 8.7100

##### **8.555.4.C. MFP Service Plan**

1. The MFP Service Plan will be developed with input from the transition coordinator, staff from the discharging facility, the resident wanting to transition and others at the invitation of the member or guardian.
2. The transition assessment/plan, the member's level of functioning, service needs, available resources and potential funding resources will inform the development of the service plan.
3. The MFP Service Plan shall document that the member has been offered a choice:

- a. Between community-based services or institutional care;
  - b. Between the MFP Program or a traditional HCBS Waiver;
  - c. Among qualified and demonstration services; and
  - d. Among qualified providers.
4. A new MFP Service Plan will be developed each time a member is reinstitutionalized and plans to return to a community setting. The MFP Service Plan shall address the reasons for the member's reinstitutionalization.

#### **8.555.5 MFP SERVICE AUTHORIZATION**

1. Determination for MFP services shall occur when all requirements defined in ~~40 CCR 2505-10,~~ 8.555.2-2 have been met. Members will be identified in the State's prescribed case management system during the MFP referral screening. Once identified in the system, all services prior authorized for the member's care will be mapped to MFP funds in the State's MMIS system.
2. Transition ~~C~~oordination services may be offered prior to the member's transition in preparation of the transition to a community setting.

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Doula Services  
Rule Number: MSB 24-05-29-A  
Division / Contact / Phone: Policy Development and Implementation / Erica Schaler / 3195

## **SECRETARY OF STATE**

### **RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

#### **SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 24-04-05-A, Revision to the Medical Assistance Act Rule concerning Doula Services
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) 8.734, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

#### **PUBLICATION INSTRUCTIONS\***

Insert the newly proposed text beginning at 8.734 through the end of 8.734.6.A.1. This rule is effective September 30, 2024.



## DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Doula Services  
Rule Number: MSB 24-05-29-A  
Division / Contact / Phone: Policy Development and Implementation / Erica Schaler / 3195

### 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 Department of Health Care Policy and Financing (Department) intends to provide coverage for doula services for Medicaid-enrolled pregnant persons effective July 1, 2024. These changes will increase access to care for all pregnant persons throughout the perinatal period to improve birth-related outcomes.

2. An emergency rule-making is imperatively necessary

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

Explain:

3. Federal authority for the Rule, if any:

42 C.F.R. 440.130(c)

4. State Authority for the Rule:

C.R.S. Section 25.5-4-506(6)

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

Initial Review  
Proposed Effective Date

**09/30/24**

Final Adoption  
Emergency Adoption

**08/09/24**

**DOCUMENT #06**

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Doula Services  
Rule Number: MSB 24-05-29-A  
Division / Contact / Phone: Policy Development and Implementation / Erica Schaler / 3195

### **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 persons who will be affected by the proposed rule are Medicaid members who are pregnant or in the postpartum period. This rule will increase access to care and improve birth outcomes by providing physical and emotional support during pregnancy, labor and delivery, and after giving birth. Doula providers will bear the cost of training to become eligible as a provider and the Department will absorb the cost of service operations. Additionally, the Department, in compliance with statute, is developing a scholarship program for Doula training to assist Doula's in becoming enrolled providers.

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 impact of the proposed rule is an increase in access to care for pregnant and postpartum persons and improve birth outcomes for these populations. These populations will receive more support during the prenatal period, labor and delivery, and postpartum period.

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.

This rule will cost the Department to implement and operate the Doula Services benefit. This rule has been reviewed by budget and is being funded through an approved 2023 budget request. This will not cost the state additional funding beyond the Colorado 2023 Long Bill. As a result of improved birth outcomes, the hope is to increase state revenue by decreasing the number of infants needing intensive medical care.

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

The benefits of the proposed rule outweigh the costs as improved birth outcomes reduce costs to the state long-term as fewer infants and postpartum persons will

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require intensive medical care and will receive increased support throughout all perinatal stages. There is no benefit 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 achieving the purpose of the proposed rule.

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

There are no alternative methods for achieving the purpose of the proposed rule as this rule is drafted to meet the requirements of a legislative mandate.

## **8.734 DOULA SERVICES**

### **8.734.1 DEFINITIONS**

8.734.1.A “Certification Pathway” means the pathway to Medicaid enrollment through which a Doula provider receives required Doula-related training by a Department-approved training program.

8.734.1.BA. “Doula” means a trained birth companion who provides personal, nonmedical support to pregnant and postpartum people and their families prior to childbirth, during labor and delivery, and during the postpartum period.

8.734.1.C “Doula Provider Attestation Form” means a Department-approved form that is required for Medicaid enrollment as a Doula provider and attests to completing the Certification Pathway or Experience Pathway, maintaining current CPR certification, and signing the Doula Code of Conduct.

8.734.1.D “Doula Code of Conduct” means a Department-approved form that outlines the conduct and standards of practice requirements for Medicaid-enrolled Doula providers to uphold a high level of ethical responsibility and personal conduct, to act with cultural humility and respect for human rights, and to maintain professional practices in relation to record-keeping, confidentiality, professional boundaries, business competence, and professional growth.

8.734.1.E “Experience Pathway” means the pathway to Medicaid enrollment that allows a Doula provider to attest to training, birth attendance, and related knowledge and competencies in place of completing training through a Department-approved training program via the Certification Pathway.

### **8.734.2 PURPOSE**

8.734.2.A. Doula services will be used to provide support for pregnant and postpartum people throughout the perinatal period, which may improve birth-related outcomes. Pursuant to 42 C.F.R. § Section 440.130(c), Doula services are provided as preventive services to promote the physical and mental health of the member during the perinatal period.

### **8.734.3 MEMBER ELIGIBILITY**

8.734.3.A. A member must be pregnant, in the postpartum period, or had a pregnancy end within the previous 12 months to be eligible for Doula services.

### **8.734.4 PROVIDER REQUIREMENTS**

8.734.4.A ~~Registered~~Enrolled Medicaid providers who provide Doula services must:

1. Be at least 18 years of age;
2. Enroll as a Doula provider through either the Certification Pathway or the Experience Pathway;
  - a. The Certification Pathway requires:
    - i. Completion of a training program that is approved by the Department;
    - and,

ii. Attendance at a minimum of three (3) births within the last five (5) years. ~~Doula providers must have received training from a Department approved training program, which can be found on the Department billing site (LINK); or~~

b. The Experience Pathway requires:

i. Attendance at ten (10) births in the role of a Doula with five (5) births being within the past two (2) years;

ii. Submission of four (4) letters of recommendation that include two (2) letters from clinical members of a birth team (e.g., Nurse, Nurse Practitioner, Midwife, Obstetrician) for a previously attended birth, and two (2) letters from previous clients; and,

iii. Attesting to having knowledge and competency in specific prenatal, labor/delivery, postpartum lactation, and newborn areas of care.

8.734.4.3. Complete the Doula Provider Attestation Form;

8.734.4.4.D Submit a copy of current CPR certification; and

8.734.4.5.E Sign the Doula Code of Conduct, ~~which can be found on the Department's billing site (LINK).~~

### **8.734.5 COVERED SERVICES**

8.734.5.A Doulas will provide non-clinical services for birthing people during pregnancy, childbirth and the postpartum period. Services ~~components~~ include:

1. Perinatal support services, including pre- and postnatal care;

2. Labor support.

### **8.734.6 NON-COVERED SERVICES**

8.734.6.A The following services are not covered:

1. Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Doula Services,  
Section 8.200.2.D.a

Rule Number: MSB 24-05-29-C

Division / Contact / Phone: Policy Development and Implementation / Erica Schaler /  
3195

**SECRETARY OF STATE**

**RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

**SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 24-05-29-C, Revision to the Medical Assistance Act Rule  
concerning Physician Oversight
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) 8.200.2.D.a, Colorado Department of Health Care Policy and Financing, Staff  
Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

**PUBLICATION INSTRUCTIONS\***

Replace the current language at 8.200.2.D.1 with the proposed language beginning at  
8.200.2.D.1 through the end of 8.200.2.D.1. This rule is effective September 30, 2024.

## DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Doula Services, Section 8.200.2.D.a  
Rule Number: MSB 24-05-29-C  
Division / Contact / Phone: Policy Development and Implementation / Erica Schaler / 3195

### 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).

Pursuant to C.R.S. 25.5-4-506, provide doula benefit for Medicaid-enrolled pregnant persons effective July 1, 2024. In order to implement the doula benefit, this proposed amendment removes doulas from the rule requiring all providers who are not provided oversight by the Colorado Department of Regulatory Agencies (DORA), practice under the direct supervision of a physician. In order for doulas to be effective, they must provide community-based care. If physician oversight is required, it destroys the integrity of the community-based aspect of this important service.

2. An emergency rule-making is imperatively necessary

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

Explain:

3. Federal authority for the Rule, if any:

42 CFR 440

4. State Authority for the Rule:

C.R.S. Section 25.5-4-506;

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

Initial Review  
Proposed Effective Date

**07/01/24**

Final Adoption  
Emergency Adoption

**05/10/24**  
**DOCUMENT #14**

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Doula Services,  
Section 8.200.2.D.a

Rule Number: MSB 24-05-29-C

Division / Contact / Phone: Policy Development and Implementation / Erica Schaler /  
3195

### **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 persons who will be affected by the proposed rule are Medicaid members who are pregnant or in the postpartum period and Doula providers. This rule will increase access to care and improve birth outcomes by providing physical and emotional support during pregnancy, labor and delivery, and after giving birth. Doulas will be able to provide services within a community setting aligning with the purpose of Doula services. There are no associated costs with the proposed rule.

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

The impact of the proposed rule is an increase in access to care for pregnant persons and postpartum persons and improve birth outcomes for these populations. These populations will receive more support during the prenatal period, labor and delivery, and postpartum period. Doulas will be able to provide care within a community setting without the restriction of requiring physician oversight which would cause delays in service delivery and increase barriers to access for pregnant Medicaid members.

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.

This rule is budget neutral to implement. However, the Department anticipates an increase in state revenues by decreasing the number of infants needing intensive medical care.

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

The benefits of the proposed rule outweigh the costs. Excluding doulas from the rule that requires providers who are not regulated by DORA to practice under direct physician supervision will increase access to care for pregnant Medicaid members



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and allow for doulas to practice in community settings. There are no benefits to inaction and in fact, inaction would prevent implementation of the doula benefit.

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 achieving the purpose of the proposed rule.

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

There are no alternative methods for achieving the purpose of the proposed rule as this rule is drafted to meet the requirements of a legislative mandate.

## 8.200 PHYSICIAN SERVICES

### 8.200.2 Providers

8.200.2.D. Physician services that may be provided by a non-physician provider when supervised by an enrolled provider.

1. With the exception of the non-physician providers described in Sections 8.200.2.A. through 8.200.2.C. and 8.200.2.D.1.a., a non-physician provider may provide covered goods and services only under the Direct Supervision of an enrolled provider who has the authority to supervise those services, according to the Colorado Department of Regulatory Agencies rules. If Colorado Department of Regulatory Agencies rules do not designate who has the authority to supervise, the non-physician provider must provide services under the Direct Supervision of an enrolled physician, [with exception of doulas.](#)
  - a. Registered Nurses (RNs) are authorized to provide delegated medical services within their scope of practice as described in the Colorado Department of Regulatory Agencies rules under General Supervision.
  - b. Non-physician providers are authorized to provide Health Education Services under General Supervision of a provider who has the authority to supervise them in accordance with Colorado Department of Regulatory Agencies rules.
  - c. Physical therapy assistants, occupational therapy assistants, and speech language pathology clinical fellows are authorized to provide services within their scope of practice, and under the General Supervision of an enrolled provider who has the authority to supervise them, in accordance with Colorado Department of Regulatory Agencies rules.
  - [d.](#) Speech language pathology assistants are authorized to provide services within their scope of practice only under the Direct Supervision of a licensed speech language pathologist who has the authority to supervise them, in accordance with Colorado Department of Regulatory Agencies rules.