



COLORADO

Department of Health Care Policy & Financing

Medical Services Board

NOTICE OF PROPOSED RULES

The Medical Services Board of the Colorado Department of Health Care Policy and Financing will hold a public meeting on Friday, March 14, 2025, beginning at 9:00 a.m., at 303 E 17th Avenue, 11th Floor Conference Room, Denver, CO 80203. Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303- 866-4416 or chris.sykes@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week before the meeting.

A copy of the full text of these proposed rule changes is available for review from the Medical Services Board Office, 303 E. 17th Ave, Ste 1100, Denver, Colorado 80203, (303) 866-4416, fax (303) 866-4411. Written comments may be submitted to the Medical Services Board Office on or before the close of business on Wednesday before the meeting. Additionally, the full text of all proposed changes will be available approximately one week prior to the meeting on the Department's website at www.colorado.gov/hcpf/medical-services-board.

This notice is submitted pursuant to § 24-4-103(3)(a) and (11)(a), C.R.S.

MSB 24-10-30-B, Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Billing Clarification, Section 8.590

Medical Assistance. The proposed rule makes two clarifications to the Durable Medical Equipment (DME) rule.

First, the proposed rule clarifies contradictory language in Section 8.590.2.B, which incorrectly states that DME provided to members residing in facilities, as part of the facility's payment, must be included in the facility's per diem rate. While it is accurate that the DME must be included in the facility's payment and not billed separately, not all facilities are paid a per diem. This language excludes inpatient hospitals, which are not paid a per diem rate but rather in accordance with the APR-DRG payment methodology. DME is included in the inpatient hospital payment, and always has been, which the proposed rule clarifies by removing "per diem" and simply references "the facility's payment methodology". The proposed rule also clarifies that repairs and modification to member-owned DME purchased prior to the admission to the facility may be provided and billed separately from the facility payment. Finally, the proposed rule clarifies that prosthetics and orthotics may only be provided during an admission to a facility when they are specifically excluded from the facility payment. If they are not excluded from the facility payment, they must not be billed separately.

Second, the proposed rule removes the percentages listed in Section 8.590.7.K for the billing of manually priced DME items. Manually priced items that do not have a fee schedule rate are reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP), less a percentage listed in the DME Billing Manual for such items. Manually priced items that do not have an assigned fee schedule rate and have no MSRP are reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider, plus a percentage listed in the Billing manual for such items. The percentages are updated each year in

the State Plan Amendment for the across-the-board rate changes authorized in the Long Bill. Because these percentages are updated each year, it is cumbersome to list them in Department rule when they are already updated each year in the Billing Manual. Therefore, the proposed rule takes the percentages out of the rule and references the Billing Manual.

These clarifications reflect current Department policy, they do not change existing DME billing practices.

The authority for this rule is contained in 42 C.F.R. § 440.70(b)(3) (2024); C.R.S. § 25.5-5-102(1)(f) and Sections 25.5-1-301-303 (2024).

MSB 24-11-22-A, Revision to the Medical Assistance Act Rule concerning Out-of-State Hospital and Physician Services Rate Negotiation, Section 8.013

Medical Assistance. This rule revision aligns Department rule with current policy, and federal State Plan authority, for out-of-state services and for the negotiation of single case agreements with out-of-state hospital and out-of-state physicians. When necessary, the Department may negotiate a higher reimbursement rate with an out-of-state provider to ensure access to care for members that require services not available in Colorado. For out-of-state hospitals to be eligible for single case agreements, the required services must not be available in Colorado and they must be prior authorized. For out-of-state physician services to be eligible for single case agreements, the physician services must either be part of an out-of-state hospital single case agreement or are provided by an out-of-state physician rendering services not available in Colorado. The authority to negotiate single case agreements in such circumstances ensures access to care for members that require hospital services or physician services not available in Colorado.

The authority for this rule is contained in 42 CFR 447.201(b) (2024); Sections 25.5-5-102(1)(a-b), (d), C.R.S. and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024); Section § 25.5-6-1405(1), C.R.S. .

MSB 24-07-08-B, Revision to the Medical Assistance Eligibility Rules Concerning the Medicaid Buy-In Program for Children with Disabilities, Section 8.100.5

Medical Assistance. The proposed rule change will amend 10 CCR 2505-10 8.100.6.Q.1.f to incorporate changes to the Medicaid Buy-In Program for Children with Disabilities that would require families to enroll in medical family coverage offered through an employer-based group health plan if they are eligible and if the employer contributes at least 50% towards the plan premiums.

The proposed rule change will also amend 10 CCR 2505-10 8.100.5.H.1 and 8.100.6.Q.1.b.iv to correct and include the Medicaid Buy-In Program for Children with Disabilities under the income allocations and disregards currently applied to the Aged, Blind, and Disabled programs.

The benefit of changing the rule is to align policy with The Family Opportunity Act 1902(cc)(2)(A). The previous income disregards were not in alignment and as such resulted in an audit finding. This correction will allow appropriate income disregard calculations to be utilized, which will improve the eligibility determination process.

The Department will be updating the Colorado Benefits Management System (CBMS) to reflect these changes. A new memo explaining the disregards and employer sponsored insurance requirements changes will also be published.

The authority for this rule is contained in 42 U.S.C. 1396a(cc)(2)(A) and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024)

MSB 24-01-25-B, Revision to the Medical Assistance Act Rule concerning Rapid Reintegration Activity for Case Management Agencies, Section 8.7200

Medical Assistance. This rule revision is necessary to ensure compliance and consistency in providing individuals with information about supports and services in a timely basis. These changes would allow the opportunity for more individuals to transition to the community faster and help others avoid undesired nursing facility admissions. The rule revision will target individuals who are already determined to be at the nursing facility Level of Care and seeking admission into a skilled nursing facility.

The authority for this rule is contained in Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024).

MSB 24-11-13-A, Revision to the Medical Assistance Act Rule concerning Community Health Workers/Community Health Representative Services, Sections 8.125.3; 8.125.4; 8.126; and 8.799

Medical Assistance. Community Health Worker/Community Health Representative (CHW/CHR) services are provided as preventative health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and behavioral health and efficiency. This rule is necessary to align HCPF's rules with the state plan. Additionally, it is necessary to add these important provider types to rule.

The authority for this rule is contained in 42 CFR 440.130(c) and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024).