



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, April 11, 2025, beginning at 9:00 a.m., at 3885 Upham Street, Suite 100, Wheat Ridge, CO, 80033. 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 24-11-05-A, Revision to Medical Assistance Act Concerning Quality of Care Grievances Resolution Timeline, Section 8.209

Medical Assistance. the timeframe to resolve grievances is fifteen (15) working days from the day the Managed Care Organization (MCO), Prepaid Inpatient Health Plans (PIHP), or Prepaid Ambulatory Health Plans (PAHP), receives the grievance. Comprehensive investigations frequently take longer than 15 days based on the complexity of individual grievances and gaining access to relevant records and information to fully investigate, so this proposed rule will align with investigatory best practices to ensure standards of care are being met and improve safety and quality of care for members. Aligning with investigatory best practices will ensure there is adequate time to conduct and complete investigations, to ensure that managed care entities are not rushing investigations to meet current timelines. This will in turn improve member safety and quality of care. Because 42 C.F.R. § 438.408(b) allows for up to 90 calendar days for resolution of grievances, the Department is requesting that 8.209.5.D be amended to reflect the 90 calendar days resolution timeframe. As part of this rulemaking, the Department is requesting that the Medical Services Board revise 8.209.5.E. to align with this federal regulation. Furthermore, the proposed revision to 8.209.5.E requires that MCOs, PIHPs, and PAHPs provide an expedited grievance process, which will be beneficial for members with medical concerns that require more urgent attention and review. Furthermore, the proposed revision to 8.209.5.E cites the federal requirements any extensions must meet. The remaining sections are renumbered/relettered to accommodate the above changes. There are also small amendments to Section 8.209.3 to incorporate identification of acronyms and to account for a monthly report requirement for MCOs, PIHPs and PAHPs to report resolution of expedited grievances. Finally, the Department proposes an amendment to 8.209.5.I to provide a second level review by the Department should the timelines for resolving the Grievances not be followed by the MCO, PIHP or PAHP.

The authority for this rule is contained in 42 C.F.R. § 438.408(b); Section 25.5-5-406.1, C.R.S. and Sections 25.5-1-301-303 (2024).

MSB 24-06-03-A, Revision to the Medical Assistance Act Rule concerning At-Risk Diversion for Case Management Agencies, Section 8.7200

Medical Assistance. This rule revision is necessary to ensure compliance and consistency while ensuring that Medicaid Members that have been identified as At-Risk for institutionalization are connected to support, resources, and services. This is essential to ensure that these individuals have the services they may need to remain safely in the community setting of their choice. This revision will also align with rule revision 8.519.27-8.763 Transition Coordination, which will allow Medicaid members that have been identified as At-Risk for institutionalization by the Department to be eligible for transition coordination. Transition coordination can assist these individuals with housing needs to get housing support, housing navigation services to obtain a housing voucher and assistance to locate housing, and/or any additional support through major life events. This revision is intended to target Medicaid members enrolled in HCBS that will likely need nursing facility care in the near future.

The rule is being revised through 8.7200 Case Management Agency Overall Requirements; At-Risk Diversion will align with 8.7202.K Monitoring responsibilities. Under 8.7202.K, the Case Management Agency is responsible to monitor the overall provision of services and supports authorized by Case Managers to ensure the rights, health, safety and welfare of Members, quality services, and that service provision practices promote Member's ability to engage in self-determination, self-representation, and self-advocacy. Monitoring is required for all waivers in accordance with federal waiver requirements and C.R.S. §§ 25.5-6-1701 — 25.5-6-1709; §§ 25.5-6-1702(3).

Currently, there is minimal documentation and evidence within the Department's preferred system to validate that members receiving HCBS are being assessed adequately for Community-Based support and services.

Case Management Agencies will use the Department's preferred system (Care and Case Management) for documentation of all Case Management activity and At-Risk outreaches as it relates to At-Risk individuals. The Case Management Agency will be responsible for completion, and documentation, and appropriate referrals to Transition Services, Regional Accountable Agencies and/or other applicable agencies (as needed).

Case Management Agencies will receive funding for the completion of the initial At-Risk outreach. The initial At-Risk outreach shall be completed within 10 business days after the Case Manager has received notification that the individual has been identified as At-Risk. Case Managers will complete ongoing At-Risk outreach every 90 days and assess additional support and services if the member continues to be identified as At-Risk. Ongoing At-Risk outreach will align with 8.7202.K.2.C where the Case Manager shall, at a minimum, perform quarterly monitoring contacts with the member, as defined by the Members certification period start and end dates. Members have the option to accept or decline At-Risk support and services.

Case Management Agencies will receive funding for the completion of the initial At-Risk outreach through CMA contracts. System generated reports will be required to issue payments. At-Risk

Diversion will be added to the Case Management Agencies contracts on July 1, 2024. However, the Case Management Agencies will not receive the initial notification of At-Risk members until early 2025.

The Data Analysis Division at HCPF is actively working in developing a process and testing a variety of models to best identify individuals At-Risk of institutionalization. The Department conducted a robust analysis and statistical modeling process to tailor the approach to the model that will be utilized for this targeted outreach. The analysis included Stakeholder input, research on other states' implementation, review of available modeling types and published article/literature reviews, along with the alignment of available data in the Colorado Medicaid billing system. The modeling process was used to determine which of the variables were significant in leading a member to nursing facility admission. The Department will continue to review and monitor the statistical model performance and evaluate opportunities to fine-tune the model. The identification of At-Risk members will include but is not limited to: age, lack of support, previous nursing facility admission(s), multiple hospital admissions, chronic conditions, or mental/behavioral health conditions.

The Department researched and tested the model to generate a list of members with the highest risk for nursing facility admission based on their risk score and it included certain characteristics, diagnoses, and/or behavioral needs. The methodology to identify At-Risk members will be published and available on the Department's website.

The authority for this rule is contained in 42 C.F.R § 440-169 and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024).

MSB 24-12-05-A, Revision to the Medical Assistance Act Rule concerning eConsults Specialist to Specialist, Section 8.095

Medical Assistance. The Department implemented telemedicine eConsults between treating primary care providers and consulting specialty providers on February 1, 2024 after the adoption of the associated Medical Services Board rule number MSB 23-02-09-A. The Department received feedback during the rule presentations before the board that eConsult requests should not be limited to primary care providers, but also be available to specialty providers seeking consultation with other specialty providers. The Department took this into consideration and engaged stakeholders about expanding eConsults to requests between specialty providers. The proposed rule expands the authority to request an eConsult to a member's treating provider who has education, training, or qualification in a specialty field other than primary care and is a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), or physician assistant (PA). This will increase access to eConsults for members treated by specialty providers and result in more efficient and informed rendering of care.

The authority for this rule is contained in C.R.S. § 25.5-4-103 (25.7); C.R.S. § 25.5-5-321.5 and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024)

MSB 24-12-09-B, Revision to the Medical Assistance Act Rule concerning Cover All Coloradans Rule Clarifications, Sections 8.205.2.B. and 8.715.2.C

Medical Assistance. The Department brought two rules to comply with House Bill 22-1298 (Cover All Coloradans) to the Medical Services Board, which were adopted on first reading at the September 13, 2024 meeting and received final adoption at the October 11, 2024 meeting. Those rulemakings amended the Medicaid (rule number MSB 24-06-25-A) and Child Health Plan Plus (rule number CHP 24-07-18-A) eligibility rules by removing citizenship requirements and barriers to provide full coverage Medicaid and Child Health Plan Plus to non-citizens who are pregnant, and/or postpartum, and/or 18 years of age and younger, if they are eligible and enrolled, per Cover All Coloradans. The Department has since identified additional sections of rule that could exclude non-citizens otherwise covered under Cover All Coloradans in the eligibility rules for the Medicaid Statewide Managed Care System and the Breast and Cervical Cancer Program. The proposed rule provides regulatory clarification by incorporating exceptions for non-citizens covered under Cover All Coloradans in the eligibility rules for those programs and services.

The authority for this rule is contained in CRS §§ 25.5-5-201(6)(a) (2024); 25.5-8-103(4)(a)(I), (b)(1) and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024).

MSB 24-07-23-A, Revision to the Medical Assistance Act Rule concerning Cost Reporting and Rate Setting for Comprehensive Community Behavioral Health Providers, Section 8.750

Medical Assistance. Comprehensive Community Behavioral Health Providers were established as a licensed provider type within Colorado House Bill 22-1278. That law directed the Department to enroll willing and qualified providers that met that licensing criteria. Under the provisions of that bill, these providers are to be paid at cost. In order to implement that statutory requirement to pay a cost-based rate, the Department must collect cost information from these providers and use that information in rate setting. This proposed rule is designed to direct these providers in the form and manner of submitting that cost data. This proposed rule also describes the processes the Department employs when using that information to set rates, including providing those providers with appeal rights to the Department's rate determination.

The authority for this rule is contained in Section 1905(a)(13)(C) of the Social Security Act; 25.5-4-403(1), C.R.S. and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024).

MSB 24-12-20-A, Revision to the Medical Services Board Act Rule Concerning Support Intensity Scale Assessment (SIS) and Interim Support Level Assessment (ISLA) Rule Revisions, Sections 8.612 & 8.7202.AA

Medical Assistance. The Department is implementing an Interim Support Level Assessment (ISLA) to evaluate the support needs of Members enrolling onto the Home and Community Based Services Supported Living Services (HCBS-SLS) waiver and the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver. The Interim Support Level Assessment (ISLA) will be used for specific services; Day Habilitation, Supported Employment, and Residential Habilitation which require a Support Level to help determine the rate paid to providers. The new Interim Support Level Assessment (ISLA) will replace the current Supports Intensity Scale (SIS) Assessment, which is a national proprietary assessment tool, and the version currently used will no longer be available to states after July 1, 2025. The Department will implement the new Interim Support Level Assessment (ISLA) in a limited approach only for newly enrolling HCBS-SLS and

HCBS-DD waiver Members who have not previously had a Supports Intensity Scale (SIS) Assessment and therefore do not have a Support Level. This means that the Department will continue to utilize the SIS Support Levels for Members where this is applicable and therefore will have both Supports Intensity Scale (SIS) Support Levels and Interim Support Level Assessment (ISLA) Support Levels for Members, but a single Member should never have both simultaneously. This will be in place until the new Colorado Single Assessment (CSA) has been fully implemented across Colorado.

Due to current Long-Term Services and Supports stabilization efforts, the Department has delayed full implementation of the Colorado Single Assessment (CSA), which will replace the Supports Intensity Scale (SIS) Assessment for people with Intellectual and Developmental Disabilities. In the interim period, the Department is taking this opportunity to “test out” those components of the Colorado Single Assessment (CSA) which map across to the Supports Intensity Scale (SIS) Support Level Algorithm in order to provide parity between Members enrolling into the HCBS-DD or HCBS-SLS waivers in the period both pre and post SIS decommission. The Department will pilot the Interim Support Level Assessment (ISLA) with newly enrolling Members while simultaneously conducting the Supports Intensity Scale (SIS) with these same Members in order to provide comparative data to the vendor who is developing the Interim Support Level Assessment (ISLA) algorithm to be used during the transitional year before implementation of the full Colorado Single Assessment (CSA).

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

MSB 25-02-12-C, Revision to the Medical Assistance Act Rule concerning Community Health Workers/Community Health Representative Services, Section 8.200.2.D

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 specifically is to exclude Community Health Workers and Community Health Representatives from supervision requirements when providing health education services. If supervision were to be required in order while providing health education services, these providers would be unable to operate at their full capacity within their scope.

The authority for this rule is contained in 42 CFR 440.130(c); C.R.S. § 25.5-5-334 and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024).