THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Community Mental Health Services Program Capitation Rate Setting, § 8.215.6.C.
Rule Number:	MSB 10-10-26-A
Division / Contact / Phone:	Rates / Jed Ziegenhagen / 303-866-3200

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 10-10-26-A, Revision to the Medical Assistance Rule Community Mental Health Services Program Capitation Rate Setting, Section 8.215.6.C.
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) 8.215.6.C, 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*

Please replace current text at §8.215.6.C.2 and §8.215.6.C.3 with the new text provided. All other text is for clarification purposes only.

This change is effective 01/30/2011.

*to be completed by MSB Board Coordinator

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Title of Rule:	Revision to the Medical Assistance Rule Community Mental Health Services Program Capitation Rate Setting, § 8.215.6.C.
Rule Number:	MSB 10-10-26-A
Division / Contact / Phone:	Rates / Jed Ziegenhagen / 303-866-3200

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 provides for a change to the methodology of setting rates for the Behavioral Health Organizations, those entities which are responsible for providing services to clients under the Medicaid Community Mental Health Services Program. The Department is changing methodology for setting capitated rates for its contracted Behavioral Health Organizations by measuring the risk adjusted cost per case, and including that cost as part of the actuarially sound methodology for calculating per member per month premiums. This change in rate methodology is expected to meet the reductions in appropriations provided for in HB 10-1376, provide for fiscal sustainability for those Behavioral Health Organizations by instituting gain sharing for increased efficiencies, and does not reduce client benefits or access to 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:

3. Federal authority for the Rule, if any:

   42 CFR 438(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-5-411(4)

Initial Review — Final Adoption **12/10/2010**

Proposed Effective Date **01/30/2011** — Emergency Adoption

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Community Mental Health Services Program Capitation Rate Setting, § 8.215.6.C.
Rule Number:	MSB 10-10-26-A
Division / Contact / Phone:	Rates / Jed Ziegenhagen / 303-866-3200

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.

   Behavioral Health Organizations, which are responsible for providing services under the Medicaid Community Mental Health Services, will have reductions in their capitation payments.

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

   Under the case rate methodology provided for in this proposed rule, the anticipated decrease in Medicaid payments to Behavioral Health Organizations is anticipated to be approximately $4.4 million, annualized. Also, the rules provide for incentives for those Behavioral Health Organizations to participate in gain-sharing for increased future efficiencies in the operation of the program.

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.

   None.

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

   The rule allows the Department to implement rates that provide for a reduction to expenditures to meet legislative appropriations. In the absence of this rule, the Department would likely rely on reductions in client benefits to meet the budget target. Also, without this rule, the Behavioral Health Organizations would not have the opportunity to participate in gain sharing and also might not certify to the actuarial soundness of the rates as required at 25.5-5-404(l)(1) C.R.S. (2010)

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

   Based upon extensive consultation with the Behavioral Health Organizations and the Department's contracted actuaries, the Department has not been able to identify other less intrusive means for meeting the purpose of the proposed rule.

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

   The Department and the Behavioral Health Organizations have spent considerable time assessing possible cuts to plan administrative cost or to client services as an alternative to this proposed rule. These changes either did not generate sizeable enough savings or would provide for reductions to client benefits that would inhibit client access to care.

8.215.6 COST CONTAINMENT MECHANISMS

8.215.6.A. The Department shall establish cost-effective, capitated rates for community mental health services in a manner that includes cost containment mechanisms.

8.215.6.B. The cost containment mechanisms shall be consistent with the principles of actuarial soundness, as determined by the independent actuary.

8.215.6.C. These cost containment mechanisms shall include:

1. Limiting costs and data considered in rate setting to that reasonable based upon enrollees' need for services within the scope of services in the behavioral health organizations' contracts.

2. Establishing health status based risk adjusted case rates for a negotiated portion of the actuarially sound capitation rate. Case rates shall be calculated based upon a statewide average cost, providing BHOs an incentive for efficiency relative to peers.

~~2~~3. Requiring that behavioral health organizations maintain medical loss ratios in excess of 77% of total Medicaid capitations. Medical loss ratios of less than 77% shall result in a refund due the Department in the amount the medical loss is less than that threshold.

8.215.6.D. The Department may, upon consultation and feedback from the behavioral health organizations and the stakeholder community, implement other cost containment mechanisms that it finds necessary to constrain rate growth to a level that is sustainable and appropriate.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning School Health Services, Section 8.290.
Rule Number:	MSB 10-07-02-A
Division / Contact / Phone:	State Programs and Federal Financing / Kim Eisen / 3131

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 10-07-02-A, Revision to the Medical Assistance Rule Concerning School Health Services, Section 8.290.
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) 8.290.1, 8.290.3.B, 8.290.7, 8.290.8, 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*

Please add to current text at §8.290.1 DEFINITIONS two new unnumbered paragraphs provided at upar 1 and upar 10 (new 1st unnumbered paragraph beginning with *Administrative Activities means service coordination . . .***and insert new 10th unnumbered paragraph beginning with** *Medicaid Administrative Claiming means a method . .* **between the current unnumbered paragraph 8 and 9..)**

Please revised current text at § 8.290.3.B with the new text provided.

Please add the new text provided from §8.290.7 MEDICAID ADMINISTRATIVE CLAIMING, BENEFITS AND LIMITAITONS through the end of §8.290.8.E to the existing text that ends at §8.290.6.F.

All other rule text remains the same and is for clarification purposes only.

This change is effective January 30, 2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning School Health Services, Section 8.290.
Rule Number:	MSB 10-07-02-A
Division / Contact / Phone:	State Programs and Federal Financing / Kim Eisen / -3131

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).

   New citations to the School Health Services Rule are necessary to identify the activities and associated reimbursement processes for a participating school district or Board of Cooperative Education Services (BOCES) to follow in order to seek reimbursement for Medicaid Administrative Claiming (MAC). MAC is a new program component that was federally approved. The proposed citations shall provide specific and clear guidance so that participating providers can administer MAC according to federal mandates and appropriately seek reimbursement for those activities. The rules are necessary for the proper and efficient administration of MAC.

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:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-5-318, C.R.S. (2010)

Initial Review	**11/12/2010**	Final Adoption	**12/10/2010**
Proposed Effective Date	**01/30/2011**	Emergency Adoption	

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning School Health Services, Section 8.290.
Rule Number:	MSB 10-07-02-A
Division / Contact / Phone:	State Programs and Federal Financing / Kim Eisen / 3131

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.

   Public school districts and Board of Cooperative Education Services (BOCES) who choose to participate in the School Health Services Program will be impacted by the proposed rules. The proposed citations will allow a participating school district or BOCES to claim reimbursement for Medicaid administrative activities. To participate in Medicaid Administrative Claiming (MAC) a public school district or BOCES must participate in the federally mandated time study and the financial cost reporting process. Quarterly cost reporting is required to document Medicaid allowable costs for rendering administrative activities and to generate a claim for reimbursement.

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 expected aggregate increase in reimbursement to school districts and BOCES participating in MAC is between $1,000,000 and $3,000,000. It is unknown at this time how much each participating school district or BOCES may receive as reimbursement shall be individually based on the allowable cost for providing those activities. The proposed citations provide specific and clear guidance so that participating school districts and BOCES can administer the program according to federal mandates and appropriately seek reimbursement for those activities.

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.

   There are additional costs to the Department for the School Health Services (SHS) Program to administer MAC and those costs shall be paid with federal funds. The Department is allowed to retain up to 10% of the federal funds paid to participating school districts and BOCES to administer the program. The additional costs to administer and maintain the time study, the quarterly claims and additional auditing requirements shall be paid within the 10% allocation of federal funds.

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

The expected aggregate increase in reimbursement to school districts and BOCES participating in MAC is between $1,000,000 and $3,000,000. It is unknown at this time how much each participating school district or BOCES may receive as reimbursement shall be individually based on the allowable cost for providing those activities. The SHS Program seeks to leverage federal funds to reimburse administrative activities necessary for the proper and efficient administration of the state Medicaid plan.

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

   The Department is unable to find less costly or less intrusive methods to operate MAC in the SHS Program as mandates set forth by CMS require a time study, quarterly claims and auditing.

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 other alternatives were explored as the new citations for the School Health Services rule are necessary for the proper and efficient administration of MAC.

8.290 SCHOOL HEALTH SERVICES

8.290.1 DEFINITIONS *[Eff. 08/30/2008]*

Administrative Activities means service coordination, outreach, referral, enrollment and administrative functions that directly support the Medicaid program and are provided by Qualified Personnel or Qualified Health Care Professionals employed by or subcontracting with a Participating District.

Board of Cooperative Education Services (BOCES) means a regional organization that is created when two or more school districts decide they have similar needs that can be met by a shared program. BOCES help school districts save money by providing opportunities to pool resources and share costs.

Care Coordination Plan means a document written by the District that describes how the District coordinates client services across multiple providers to assure effective and efficient access to service delivery and prevent duplication of services.

Case Management Services mean activities that assist the target population in gaining access to needed medical, social, educational and other services.

Disability means a physical or mental impairment that substantially limits one or more major life activities.

District means any BOCES 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 the 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.

Individualized Education Program (IEP) means a document developed pursuant to the federal Individuals with Disabilities Education Act (IDEA). The IEP guides the delivery of special education supports and services for the student with a disability.

Individualized Family Services Plan (IFSP) means a document developed pursuant to the IDEA. The IFSP guides the delivery of early intervention services provided to infants and toddlers (birth to age 3) who have disabilities, including developmental delays. The IFSP also includes family support services, nutrition services, and case management.

Local Services Plan (LSP) means a document written by the District that describes the types and the costs of services to be provided with the federal funds received as reimbursement for providing School Health Services.

Medicaid Administrative Claiming means a method for a Participating District to claim federal reimbursement for the cost of performing allowable Administrative Activities.

Medically at Risk means a client who has a diagnosable physical or mental condition having a high probability of impairing cognitive, emotional, neurological, social, or physical development.

Medically Necessary service means a benefit service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

Participating District means a District that is contracted with the Department of Health Care Policy and Financing (the Department) to provide, and receive funding for School Health Services.

Qualified Health Care Professional means an individual who is registered, certified or licensed by the Department of Regulatory Agencies as a health care professional and who acts within the profession's scope of practice. In the absence of state regulations, a qualified health care professional means an individual who is registered or certified by the relevant national professional health organization.

Qualified Personnel means an individual who meets Colorado Department of Education-recognized certification, licensing, registration, or other comparable requirements of the profession in which they practice.

School Health Service means medical or health-related assistance provided to a client, by Qualified Personnel or Qualified Health Care Professionals; which is required for the diagnosis, treatment, or care of a physical or mental disorder and is recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

Specialized Transportation means transportation service necessary to provide a client with access to Medicaid services performed in the school or at another site in the community.

8.290.3 PARTICIPATING DISTRICTS *[Eff. 08/30/2008]*

8.290.3.A. Contracts may be executed with Districts throughout Colorado that meet the following minimum criteria:

1. Approval of a Local Service Plan (LSP) by the Colorado Department of Education and the Department;

2. An assessment, documented in the LSP, of the health needs of students enrolled in the District; and

3. Evidence, documented in the LSP, of community input on the health services to be delivered to public school students.

8.290.3.B. The Participating District may employ or subcontract with Qualified Personnel or Qualified Health Care Professionals to provide School Health Services or Administrative Activities.

8.290.7 MEDICAID ADMINISTRATIVE CLAIMING, BENEFITS AND LIMITATIONS

8.290.7.A. Medicaid Administrative Claiming (MAC) services shall be performed in a school setting or at another site in the community.

8.290.7.B. MAC services include Administrative Activities and the activities listed in this section 8.290.7.B. Additionally, MAC may include related paperwork, clerical functions or travel by employees or subcontractors which is solely related to and required to perform MAC services:

1. Medicaid Outreach

a. Medicaid Outreach shall be activities that inform Medicaid eligible or potentially eligible individuals about Medicaid and how to access the program.

b. Medicaid Outreach may only be conducted for populations served by the Participating Districts such as students and their parents or guardians.

2. Facilitating Medicaid Eligibility Determination

a. Facilitating Medicaid Eligibility Determination shall be activities that assist individuals in the Medicaid eligibility process.

b. Facilitating Medicaid Eligibility Determination may include making referrals for Medicaid eligibility determinations, explaining the eligibility process to prospective applicants, and providing assistance to individuals or families in completing or collecting documents for the Medicaid application.

3. Translation Related to Medicaid Services

a. Translation Related to Medicaid Services are translation services provided solely to assist individuals with access to Medicaid covered services, which services are not included in or paid for as part of a School Health Service. Translation services may be provided by employees of, or subcontractors with Participating Districts.

b. Translation Related to Medicaid Services may include arranging for or providing oral or signing translation services that assist individuals with accessing and understanding necessary care or treatment covered by Medicaid or developing associated translation materials.

4. Medical Program Planning, Policy Development and Interagency Coordination

a. Medical Program Planning, Policy Development and Interagency Coordination shall be activities associated with the development of strategies to improve the coordination and delivery of Medicaid covered medical, dental or mental health services to school age children.

b. Medicaid Program Planning, Policy Development and Interagency Coordination may include performing collaborative activities with other agencies or providers.

5. Medical/Medicaid Related Training and Professional Development

a. Medical/Medicaid Related Training and Professional Development shall be activities for outreach staff of Participating Districts that include coordinating, conducting or participating in training events or seminars regarding the benefits of medical or Medicaid related services.

b. Medical/Medicaid Related Training and Professional Development may include how to assist individuals or families with accessing medical or Medicaid related services and how to effectively refer students for those services.

6. Referral, Coordination and Monitoring of Medicaid Services

a. Referral, Coordination and Monitoring of Medicaid Services shall be activities that include making referrals for, coordinating or monitoring the delivery of Medicaid covered services. Activities that function as part of a School Health Service may not be included in this category.

8.290.8 MEDICAID ADMINISTRATIVE CLAIMING REIMBURSEMENT

8.290.8.A. The Participating District shall participate in a periodic CMS approved time study to determine the percentage of allowable time spent on providing Medicaid Administrative Activities.

8.290.8.B. The Participating District shall complete a cost report for MAC for each time study quarter the district participated in based on a reporting schedule established by the Department.

1. The cost report shall document the Participating District's total Medicaid allowable scope of costs for providing Medicaid Administrative Activities, based on a CMS approved cost allocation methodology.

2. If a Participating District's cost report for MAC is not submitted within the Department established reporting schedule the Participating District shall not be able to seek reimbursement for the associated period.

3. By July 30 of each fiscal year, the Participating District shall receive a notification letter from the Department identifying the MAC cost reporting schedule.

8.290.8.C. Each Participating District shall follow cost reporting procedures for MAC detailed in the Department's School Health Services Program Manual.

8.290.8.D. Payment

1. Each Participating Districts cost report for MAC shall be developed into a claim by the Department and submitted to CMS for reimbursement if appropriate.

2. Reimbursement to Participating Districts that have properly submitted valid claims for MAC shall be made on a quarterly basis.

8.290.8.E. Certification of Funds

1. Each Participating District shall complete a certification of funds statement, included in the cost report for MAC, certifying the Participating District's actual, incurred costs and expenditures for providing Medicaid Administrative Activities.

2. All cost reports and claims for MAC shall be subject to an audit by the Department or its designee.