THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Ambulatory Surgical Center Rule Concerning Reimbursement, Section 8.570.6.A and 8.570.6.B
Rule Number:	MSB 12-10-30-A
Division / Contact / Phone:	Rates and Analysis Division / Joe Rogers / X2715

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 12-10-30-A, Revision to the Ambulatory Surgical Center Rule Concerning Reimbursement, Section 8.570.6.A and 8.570.6.B
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) 8.570.6 A and 8.570.6 B, 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: N/A
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.570.6.A and §8.570.6.B with the new text provided. All text indicated in blue is for clarification purposes only and should not be changed. This change is effective 04/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Ambulatory Surgical Center Rule Concerning Reimbursement, Section 8.570.6.A and 8.570.6.B
Rule Number:	MSB 12-10-30-A
Division / Contact / Phone:	Rates and Analysis Division / Joe Rogers / X2715

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).

   Currently the ASC payment reimbursement rule specifies the number of ASC groupers. By removing the specified number of groupers the Department will gain the flexibility to develop more or fewer Ambulatory Surgical Center groupers

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. (2012);
   25.5-4-401, C.R.S. (2012)

Initial Review	**02/08/2013**	Final Adoption	**03/08/2013**
Proposed Effective Date	**04/30/2013**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Ambulatory Surgical Center Rule Concerning Reimbursement, Section 8.570.6.A and 8.570.6.B
Rule Number:	MSB 12-10-30-A
Division / Contact / Phone:	Rates and Analysis Division / Joe Rogers / X2715

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.

   No classes of persons will be affected by the rule other than HCPF staff who will gain more flexibility to develop ASC groupers.

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

   N/A

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.

   N/A

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

   There are no less costly or intrusive methods than the proposed rule change.

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

   No alternative methods were considered.

8.570.6 REIMBURSEMENT

8.570.6.A For payment purposes, ASC surgical procedures are grouped into categories. The Health Care Procedural Coding System (HCPCS) is used to identify surgical services.

8.570.6.B Reimbursement for approved surgical procedures shall be allowed only for the primary or most complex procedure. No reimbursement is allowed for multiple or subsequent procedures. No reimbursement shall be allowed for services not included on the Department approved list for covered services. Approved surgical procedures identified in the ASC groupers shall be reimbursed a facility fee at the lower of the following:

1. Submitted charges; or

2. Fee schedule as determined by the Department.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Dept. of Health Care Policy and Financing Cooperative Health Care Agreements Board Repeal 10 CCR 2505-1
Rule Number:	MSB 13-01-14-A
Division / Contact / Phone:	Policy and Communications Office / Barbara Prehmus / x2991

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 13-01-14-A, Dept. of Health Care Policy and Financing Cooperative Health Care Agreements Board Repeal 10 CCR 2505-1
3. This action is an adoption of: a repeal of existing rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 10 CCR 2505-1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please repeal all language indicated at 10-CCR 2505-1 and replace with the phrase"This rule was repealed, effective April 30, 2013." This change is effective 04/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Dept. of Health Care Policy and Financing Cooperative Health Care Agreements Board Repeal 10 CCR 2505-1
Rule Number:	MSB 13-01-14-A
Division / Contact / Phone:	Policy and Communications Office / Barbara Prehmus / x2991

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).

   Repeals regulatory oversight of Cooperative Health Care Agreements Board by the Department of Health Care Policy and Financing. SB 06-219 repealed Title 25.5 Article 1 Part 5 effective July 1, 2006 to conform to the statutory transfer of regulatory responsibility for Health Care Coverage Cooperatives to the Division of Insurance that was enacted under SB 04-105, effective August 4, 2004. The rule repeal is necessary to conform to statutory intent.

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:

   N/A

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   Repeal of Title 25.5 Article 1 Part 5 (2005) pursuant to Senate Bill 06-219.

Initial Review	**02/08/2013**	Final Adoption	**03/08/2013**
Proposed Effective Date	**04/30/2013**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Dept. of Health Care Policy and Financing Cooperative Health Care Agreements Board Repeal 10 CCR 2505-1
Rule Number:	MSB 13-01-14-A
Division / Contact / Phone:	Policy and Communications Office / Barbara Prehmus / x2991

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.

   No classes of persons will be affected by repeal of the rule, which is being done to conform to the repeal of Title 25.5 Article 1 Part 5 pursuant to SB 06-219, effective July 1, 2006. The repeal of the Cooperative Health Care Agreements Board was a technical statutory amendment subsequent to the statutory transfer of regulatory authority for Health Care Coverage Cooperatives to the Division of Insurance under SB 04-105, effective August 4, 2004. The Division of Insurance has confirmed there are no anticipated resulting negative consequences.

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

   Repeal of the rule to conform to statutory repeal will not result in negative quantitative or qualitative impact.

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 no probable costs to the Department resulting from the repeal.

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

   Inaction will result in the Department having rules for a Cooperative Health Care Agreements Board without any supporting statutory authority.

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

   There are no other methods for conforming to statutory intent.

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

   No alternative methods were considered.

This rule was repealed, effective April 30, 2013

~~2505 Cooperative Health Care Agreements Board~~

~~10 CCR 2505-1 REGULATIONS~~

~~I. STATEMENT OF BASIS AND PURPOSE~~

~~A. Basis. The authority for these rules is based on 25.5-1-301 through 25.5-1-303 C.R.S. as amended by S.B. 94-133; 24-32-2704(3), 24-32-2705(1)(e), 24-32-2705(2), 24-32-2708(1), 24-32-2713(1).~~

~~B. Purpose. These rules establish a framework for the review, approval, and supervision of applications for approval by the Cooperative Health Care Agreements Board ("board") that is intended to give such agreements "state action" immunity from anti-trust prosecution. The rules specify the content of applications and provide guidelines to the board for reviewing the applications by specifying what kinds of information can fulfill the standards for cooperative agreements specified in 24-32-2706(1). The legal and practical procedures of the board are stated clearly. More specifically, these rules serve the following purpose:~~

~~1. To ensure that the actions and processes of the board are fair and unbiased and to prevent conflicts of interest which would result in the approval of agreements that do not benefit the consumers of health care, but rather only the applicants to the board.~~

~~2. To ensure that the board's review of applications and supervision of cooperative agreements will be thorough enough to satisfy the "active supervision" requirement for state action immunity.~~

~~3. To establish clear procedures for both the confidentiality and the public availability of records of the board's proceedings and of certain information reviewed by the board.~~

~~4. To clearly articulate the types of information applicants must submit to the board, and the way in which the board will use that information to judge agreements under the standard of 24-32-2706(1).~~

~~5. To clarify the actions available to the board, independent of the executive director of the department.~~

~~6. To set reasonable fees to support the direct and indirect costs of operating the board.~~

~~II. DEFINITIONS~~

~~As used in the following rules and policies, the term:~~

~~A. "anti-competitive behavior" means the reduction, restriction or impediment of competition in any manner.~~

~~B. "application" means the original application submitted by the parties for board approval under CRS 24-32-2705 as well as all supporting documentation requested by the department.~~

~~C. "availability" means the financial and geographic access to health care services and/or goods.~~

~~D. "board" means the Cooperative Health Care Agreements Board created by section 24-32-2704.~~

~~E. "business" means any corporation, limited liability company, partnership, sole proprietorship, trust or foundation, or other individual or organization carrying on a business, whether or not operated for profit.~~

~~F. "competition" means the independent striving of businesses for the opportunity to provide goods and services to customers through beneficial means including, but not limited to, independently striving to reduce costs to the business of supplying goods and services, to lower prices to consumers, to supply new and higher quality goods and services, and to develop new methods of supplying goods and services.~~

~~G. "competitor" means a health care provider supplying services and/or goods similar to those provided by the applicants in any of the zip codes included in the applicants' primary or secondary service areas.~~

~~H. "conflict of interest" means an official act which may have a direct economic benefit on a business or other undertaking in which such person has a direct or substantial financial interest as described in 24-18-108.5.~~

~~I. "cooperative agreement" means any joint venture or other agreement to which one or more hospitals are a party for the purposes of sharing, allocating, consolidating, or referring:~~

~~1. patients, personnel, instructional programs, support services, and facilities;~~

~~2. medical, diagnostic, or therapeutic facilities, services, or procedures; or~~

~~3. other services traditionally offered by health care providers.~~

~~Cooperative agreements do not include mergers, consolidations, share exchanges, or other agreements that result in two or more entities consolidating into a new entity, result in two or more entities merging into one entity, result in one or more entities ceding all or substantially all control to a new or existing entity, or result in a sale, exchange, lease, or other disposition of all or substantially all the property and assets of an entity.~~

~~J. "cost" of health care means the amount of direct and indirect expenses incurred by the providers of health care services and/or goods.~~

~~K. "department" means the Department of Health Care Policy and Financing.~~

~~L. "director" means the Executive Director of the Department of Health Care Policy and Financing.~~

~~M. "DRG" means diagnostic related grouping.~~

N. “ex parte contact” means any oral or written communication between any member of the board and an interested person, or a representative of an interested person, about a specific matter related to an anticipated or pending application or ongoing oversight of an agreement within the board's jurisdiction and which does not occur in a public hearing, board meeting, or other official proceeding, and on the official record of the proceeding on the matter.

O. “financial interest” means a financial interest as defined in CRS 24-18-102(4) of the person or a member of his or her immediate family.

P. “geographic service area” means the service areas that are defined using the following method:

1. Determine a relative frequency distribution by: (1) sorting by zip code the number of discharges (or, as used throughout this section, encounters if the service is not always performed inpatient) occurring in the last twelve months for which data are available for the services included in the application (2) Rank in descending order (using the sum of discharges for each zip code) the zip codes of such patients. If an application involves multiple services, a separate analysis should be completed for each service.

2. Using the relative frequency distribution defined in (a), include in the geographic service area the zip codes that account for the highest 80% of discharges.

3. Also include in the geographic service area communities, not included based on paragraph 2 above, that have a heavy reliance on the applicants for their health care services affected by the cooperative agreement. Applicants should describe their methodology for making determinations under this paragraph 3. If the department determines that applicants have not included some communities with a heavy reliance on the applicants, then the department may ask the applicants to include those communities.

Q. “immediate family” means the board member's spouse and any parent, brother, sister, or child of the board member, and the spouse of any such parent, brother, sister, or child.

R. “interested person” means anyone or the agent of anyone who takes a position on behalf of an organization, or who has financial interest with respect to the outcome of an anticipated or pending application, or ongoing oversight of an agreement within the board's jurisdiction.

S. “majority” means the majority of board members participating in the meeting.

T. “meeting” means any kind of gathering convened to discuss public business in person, by telephone, or by other means of communication as described in CRS 24-6-402.

U. “ownership interest” means the possession of stock, equity in capital, or any interest in the profits of the entity.

V. “price” of health care means the amount actually paid by buyers for health care services and/or goods.

W. "provider of substitutes" means a health care provider that supplies services and/or goods that are substitutable for the services and/or goods provided by the applicants in any of the zip codes included in the applicant's primary or secondary service areas.

III. RULES OF CONDUCT

A. Ex Parte Contacts (C.R.S. 24-32-2704(3))

1. Ex Parte Contact Prohibited. Members of the board shall not initiate or maintain any ex parte contacts, either directly or through an agent or department staff.

2. Procedure Relevant to Ex Parte Contacts. A board member who receives an ex parte contact in violation of this section shall place on the record, prior to any further board discussions of the matter with which the communication is associated, all written communications, all written responses to the communications, and a memorandum stating the substance of all oral communications, all responses made, the identity of each person from whom the ex parte communication was received, and shall advise all parties to the ex parte communication that these matters will be placed on the record.

3. Rebuttal of Ex Parte Contact. Any person desiring to rebut the content of the ex parte contact shall be allowed to do so, upon requesting the opportunity within 10 days after notice that said communication has been placed on the record.

4. Exceptions. The following contacts are not prohibited:

a) Any communication between a staff member acting in his or her official capacity and any board member or interested person.

b) Any communication limited entirely to procedural issues, including, but not limited to, matters such as the schedule for board meetings, location, format, or date of such meetings.

c) Any communication between a member of the board and an organization with which he or she is affiliated, so long as that member has recused or intends to recuse himself or herself from all matters related to that organization. This exception does not extend to consulting or advisory arrangements initiated after a person becomes a member of the board.

5. Removal for Violation. Failure to comply with the requirements of this section may result in a board recommendation to the Governor that the violating member should be removed from the board. In addition, the board shall have authority to set aside any prior board decision involving the related matter.

B. Conflict of Interest and Breach of Fiduciary Duty (C.R.S. 24-32-2704(3))

1. Breach of Fiduciary Duty. Members of the board shall be held to the standards of conduct of CRS 24-18-101 through 24-18-113.

2. Duty to Recuse. Any member of the board who, in the discharge of his or her official duties, may be required to take an action which would be a conflict of interest shall:

a) Prepare a written statement immediately upon the board member's discovery of the potential conflict of interest, listing the amount of financial interest, if any, the purpose and duration of his or her services rendered, if any, and the compensation received for his or her services rendered, or other such information as is necessary to describe his or her interest;

b) Recuse him or herself from voting in any proceeding associated with the conflict of interest;

c) Cause copies of the written statement described in subsection (a) above to be delivered to the Secretary of State, State of Colorado Attorney General's Office, the director, and to other members of the board.

d) The Chairperson of the board shall cause such statement to be printed in the record of the proceedings at the first meeting after the statement has been filed with the Secretary of State, and shall excuse the member from votes, deliberations, and other actions and decisions on the matter on which the potential conflict exists.

3. Affirmative Defense. Recorded recusals shall constitute an affirmative defense to any civil or criminal action or any other sanction arising out of an alleged conflict of interest of a board member.

4. Status of Recused Member. A board member who has been excused from participating in any board activity relating to a matter that would violate this section may be counted for purposes of establishing a quorum. All recorded votes on such matters shall note that the board member recused himself or herself.

C. Board Meeting Attendance (C.R.S. 24-32-2704(5))

1. Pre-Excused Absence. Each board member should make every effort to attend the scheduled board meetings, however, in the event that a board member becomes aware that he or she will be unable to attend a future board meeting, such board member shall submit in writing to the department a request for board approval of such absence. The board shall decide whether to approve the absence at its next meeting. The results of the board's decision shall be entered into the minutes.

2. Request for Approval of Past Absence. In the event that a board member fails to attend a meeting without prior approval of the board, said board member shall have thirty days from the date of the absence to submit a written request for approval of the prior absence to the department, who shall ask the board to approve or disapprove the absence at its next meeting and enter the same into the minutes.

3. Removal for Unapproved Absence. Failure by any board member to attend three regular board meetings during any twelve-month period, without approval of the absences by the board, shall result in a recommendation to the Governor that such member be removed from the board in accordance with C.R.S. 24-32-2704(5).

D. Open Records/Meetings

1. Record Keeping (C.R.S. 24-32-2710). The department shall maintain on file all cooperative agreements which the board has approved and which remain in effect. All agreements submitted to the board shall be open for public review and inspection, however, such inspection is limited to materials not prohibited from disclosure under paragraph 2 of this subsection D.

2. Requirement of Confidentiality. Pursuant to C.R.S. 24-72-204(3)(a)(IV), the department and board shall deny inspection of, and keep confidential, any information or documents which would consist of trade secrets, privileged information, or confidential commercial or financial data furnished or obtained from any person or party.

3. Despite the exception of the open meeting requirement in CRS 24-6-402 for chance meetings or social gatherings, the board members shall avoid discussing matters related to an anticipated or pending application or ongoing supervision of an agreement within the board's jurisdiction under any circumstances other than at an official meeting on the record for which public notice has been given.

E. Donations and Grants (C.R.S. 24-32-2714)

1. Limitations on Acceptance. The department may accept donations and grants for any purpose connected with the work of the board, and the director has the power to direct the disposition of any such donations and grants for any purposes consistent with the terms and conditions under which given; except that no grant or donation shall be accepted if:

a) The conditions attached to such grant or donation require the expenditure thereof in a manner contrary to law; or

b) Such grant comes from a person or entity whose prior, present, or anticipated relationship with the board is such that acceptance of the donation would create, or create the appearance of, a present or potential conflict of interest.

2. Record All Donations and Grants Offered. The department must keep a record and make it available to the public upon request of all donations and grants offered, why they were offered, and whether they were accepted or rejected.

IV. APPLICATION REQUIREMENTS FOR COOPERATIVE AGREEMENTS

A. Application Procedure

All organizations, persons, or parties who wish to submit an agreement for consideration by the board must include the following information in the following format, as specified in sections IV(B) to IV(E). Applicants must submit fifteen copies of their application to the board in care of the department, except that applicants only must submit one copy of the information required by section C 2 below. If the director determines that an application is incomplete, the department may request additional information it deems necessary to make a complete application. Any incomplete application, due to unwillingness or inability of the parties involved, may render the application ineligible for consideration, at the discretion of the board.

B. Administrative Information

1. A copy of the agreement together with the names and addresses of all parties to the agreement. Parties to an agreement are assumed to be seeking antitrust immunity by the filing of the application, unless otherwise specified.

2. Names and addresses of the principal business offices of each party, if different than above.

3. Name and address of a contact person authorized to receive notices and communications with respect to the application.

4. A written statement attesting to the accuracy of all information given in the application verified and signed by a responsible officer of each party to the application.

5. A written statement by each of the governing bodies of the parties involved expressing their approval of the agreement and the filing of the application.

6. Name and addresses of all individuals and organizations that have direct or indirect ownership interests amounting to an ownership interest of 5 percent or more in the applicants.

7. A description of the agreement, including a time table, expected completion date, and the consideration passing to any party under the agreement.

8. A succinct explanation of how the agreement meets the standard set forth in CRS 24-32-2706(1).

9. A written description of community involvement, planning, oversight, control, or support for the agreement, if any, and any formal processes for such involvement, oversight, support, and control.

C. Cost Effectiveness Information

1. A statement of pricing history and anticipated pricing for services including: past, current, and projected case-mix adjusted charges, payments, and expenses for services affected by the agreement.

2. A statement of the applicants' financial condition consisting of:

a) financial statements audited by a Certified Public Accountant for the five most recent years;

b) budget "pro formas" for the next three years and a letter from a Certified Public Accountant reviewing the budget "pro formas"; and,

c) current year's report to Dun and Bradstreet from parties to the application who participate in this service.

3. A detailed description of the basis of any efficiencies that will be achieved by the agreement.

4. All other information, descriptions, and analysis necessary to show how the agreement meets the cost effectiveness review criteria of section (VI)(C).

D. Availability Information

1. A description of the geographic service area for each service affected by the agreement (by DRG or other service measure) including the methodology for determining the areas and the following:

a) current and projected geographic service area by zip code;

b) current and projected population in each zip code in the geographic service area;

c) current and projected number of patients originating from each of the zip codes;

d) current and projected percentage of total patients each zip code represents;

e) current and projected average distances and travel times from these zip codes or reasonable groupings of these zip codes to the facilities provided by the applicants; and,

f) a legible map which clearly identifies the zip codes in the current and projected geographic service area. The map should identify major highway systems, sites

of applicants, and sites of other health care facilities that provide services and/or goods similar or substitutable to those provided by the applicants.

2. All other information, descriptions, and analysis necessary to show how the agreement meets the financial, physical, and geographic availability review criteria of section (VI)(D).

E. Quality and Delivery Information

1. A description of the specific qualitative and quantitative quality goals for the proposed agreement.

2. All other information, description, and analysis necessary to show how the agreement meets the quality and delivery review criteria of section (VI)(E).

V. APPLICATION REVIEW, TERMINATION, AND IMMUNITY PROCEDURES

A. Procedures for Review of an Application

1. 90 Day Review Requirement (C.R.S. 24-32-2705(2)). Upon receipt of a complete application, as described in section IV, the board shall have 90 days to review such application and approve or disapprove the same, in whole or in part. The ninety day review requirement of CRS 24-32-2705(2) shall be tolled until such time as the department receives all information necessary for a complete application.

2. Actions Available to the Board

a) Rejection of an application. The board may reject an application if:

(1) it determines, after initial review, that an application involves a cooperative agreement beyond the statutory authority set forth in C.R.S. 24-32-2703(2) and in regulation at (II)(I); or,

(2) the applicants have failed to provide, within a reasonable time, the information and documentation requested by the department that is necessary to make a complete application that the board can review against the standard in 24-32-2706(1); or,

(3) the agreement fails to meet the standard for approval in 24-32-2706(1).

In determining whether to reject an application because it is beyond its authority, the board shall consider whether the agreement is an isolated agreement or one of a series of agreements involving the same parties. Multiple agreements involving the same parties shall be considered as a single agreement for purposes of determining the authority of the board to review such agreements. In addition, once an agreement has been approved by the

board, all future agreements involving the same parties shall be considered in light of the changed competitive circumstances created by the original agreement and the combined effects of such agreements pursuant to C.R.S. 24-32-2706(2)(i).

b) Approval of an application. If the board determines that the agreement meets the standard in section 24-32-2706(1), C.R.S., the board shall approve the agreement in whole, or in part, and may place reasonable and related conditions and restrictions, specific to the agreement, on the parties. Such conditions and restrictions must be provided to the parties in writing.

3. Written Decision Requirement (C.R.S. 24-32-2705(2)). After making a determination the board shall render a written decision which shall include its specific findings and the basis therefore. Such decision shall be mailed to the applicants, the Attorney General, and any other admitted party.

B. Application and Processing Fees

1. Applicants shall submit with their application a fee of four thousand dollars ($4000).

2. In the course of reviewing an application, if the department determines that the application is of such a complex nature that the actual costs of reviewing such application will exceed the initial application fee set forth in paragraph 1 of this subsection B, then the department shall require the parties to the application to submit additional processing fees equaling the actual costs in excess of the initial application fee, up to an additional amount of fifteen thousand dollars ($15,000) for any single application. These actual costs will be itemized and provided to the applicant in writing. Failure of the applicants to submit the additional fees required by this paragraph shall cause the application to be incomplete and shall result in the application being denied.

3. After an agreement has been approved, the department shall require the parties to the agreement to submit an annual processing fee of five hundred dollars ($500) for each approved agreement.

a) If the department determines that the review of the annual report is of such a complex nature that the actual costs of review of the report will exceed the annual processing fees set forth in paragraph 3 of this subsection B, then the department shall require additional fees not to exceed the actual costs in excess of the processing fee, up to a maximum additional amount of $5000 per annual report. The actual costs will be itemized and provided to the parties to the agreement in writing.

b) Pursuant to 24-32-2707 (1) (b), failure of the applicants to submit the fees required by this paragraph 3 shall be grounds for termination of the board's approval of the agreement.

4. If the board rejects an application in accordance with section V(A)(2)(a)(i) of these regulations or if the parties choose to terminate the application process when advised of additional review expenses pursuant to paragraph 2 of this subsection B, then the department shall refund to the applicants the initial application fee, except that the amount refunded may be reduced by any actual costs, attributable to such application, which have already been incurred. The actual costs will be itemized and provided to the applicant in writing. If an application is rejected pursuant to (V)(A)(2)(a)(ii) because the parties refused to provide information necessary to constitute a completed application, then a refund shall be denied.

VI. APPLICATION REVIEW CRITERIA

A. Basis for Approval

1. General. Approval of a proposed agreement, in its entirety or in part, shall be based upon the board's determination that such agreement is likely to improve, on balance, cost effectiveness, availability, quality, or delivery of health care, and is consistent with other state statutory health care policies and programs. In evaluating whether an agreement meets this standard, the board will consider the factors in CRS 24-32-2706(2). The board recognizes that deficient marks in any specific area of analysis should not disqualify an applicant per se, but should be balanced with marks in other areas analyzed in the review of the application. The following sections are a detailed exposition of the questions the board will ask in evaluating an application against the standard of approval. While not all questions may be appropriate for all applications, the answers to all applicable questions shall serve as the basis for the board's decision.

2. Modification. If answers to the questions in sections C through E raise concerns that the entire agreement or portions of the agreement do not meet the standard in CRS 24-32-2706(1), then the board may propose modifications to the agreement that will permit its approval in whole or in part.

B. Completeness of Information. Does the application provide sufficient factual information to allow the board to determine whether or not the agreement meets the standard of CRS 24-32-2706(1)?

C. Cost Effectiveness

1. Will the agreement reduce health care prices?

a) Have the pricing structures of the applicants typically been higher or lower than their competitors and/or providers of substitutes for the goods and/or services affected by the application?

b) How will pricing structures change under the agreement?

2. Will the agreement produce efficiencies?

a) What kinds of efficiencies will be produced by the agreement?

b) How will efficiencies be measured?

c) How will the applicants achieve such efficiencies?

3. Will consumers benefit from any efficiencies?

a) How will the parties pass any efficiencies on to the consumer?

b) Do the applicants' financial statuses permit them to pass on benefits to consumers?

c) Do the applicants expect to gain financially from the implementation of the agreement (e.g. higher profits, salaries, retained earnings, or expenses)?

4. Are there alternative measures that would produce the same level of net benefits using competition, rather than regulation?

a) If there are no such alternative measures, why not?

b) If there are such alternative measures, what are their costs and benefits and why were they not pursued?

5. Is there now and will there be competition for the goods and/or services affected by this agreement?

a) What are the applicants' business histories as they pertain to anticompetitive behavior and consumer law violation? Is this past behavior an indicator of similar behavior in the future?

b) Has the agreement been submitted for business review or advisory opinion to the Department of Justice or the Federal Trade Commission? If so, what was the outcome of such review or advisory opinion? How has that review or opinion affected the applicants' decision to seek board approval for the agreement? How should the board interpret the outcome of that review or opinion?

c) Do providers of substitutes and/or competitors exist in the primary and/or secondary service areas for the goods and/or services affected by the application?

d) If providers of substitutes and/or competitors exist, what is their market share? Will these market shares change after the agreement? If so, how?

e) What are the steps an entity would need to take (e.g. regulatory approvals, capital investments, participation by a significant number of providers) to enter the relevant geographic market and effectively compete if there were no cooperative agreement?

f) Does the agreement significantly increase barriers to entry for a potential competitor or provider of a substitute?

6. What is the cost of regulating this agreement?

a) What are the costs for the department of effective regulation including, but not limited to, the costs associated with monitoring the proposed agreement and enforcing the conditions and restrictions placed on the parties to the agreement?

b) What are the costs to the applicants of observing regulation, enforcing and implementing the agreement, and submitting annual reports and reviews?

7. Will regulation be effective?

a) Do methods and measures exist that, if appropriately applied, will allow the board to determine whether an agreement continues to meet the standard for approval?

b) Is the information necessary to monitor the proposed agreement available and reliable?

8. Is there a potential for cost shifting?

a) Do the applicants currently have significant market shares in areas not covered by the agreement?

b) Could the applicants use market power to increase prices or decrease service in areas not covered by the agreement?

D. Availability

1. Does the agreement increase the affordability of goods and/or services covered by the agreement?

a) Will health care services become more affordable including, but not limited to, lower charges, or lower actual payments by third party payors and individual consumers?

b) Will the agreement enable the applicants to provide more services and/or goods to low-income, uninsured, and high-need health care users?

2. Does the agreement increase geographic and physical availability? Will the agreement result in:

a) a decrease in distance consumers are required to travel after implementation of the agreement; or,

b) a decrease in travel/access costs; or,

c) an increase in the number and type of providers of substitutes and competitors within the relevant geographic service area?

3. Will the agreement increase the utilization of necessary and appropriate services?

a) What is the expected change in patient utilization of services and/or goods covered by agreement?

b) Is the increased or decreased utilization actually appropriate to patient needs?

4. Will the agreement preserve, reduce or expand the services and/or goods provided by the applicants? Which services and/or goods will be preserved, reduced, or expanded?

5. Will the agreement result in the applicants serving a larger geographic service area?

E. Quality and Delivery

1. Are applicants currently licensed and/or certified from recognized state and national accreditation and licensing entities and will applicants obtain additional accreditation and licensure as a direct result of this agreement?

a) Has accreditation or licensure ever been requested and denied? What was the reason for such denial? What is the relationship of any denial to the explicit goals for quality improvement under the proposed agreement?

b) Are the applicants currently or planning to apply for additional accreditation or licensure? If so, is it related to the services and/or goods affected by this application? Does the cooperative agreement make this accreditation and licensure more likely?

2. Do the applicants have quality assurance and improvement programs and will these programs improve as a result of the agreement?

a) What are the specific goals of the programs particularly for services and/or goods included in the agreement?

b) What are the measurable quality variables used in the programs?

c) What processes exist for identifying and solving quality problems?

d) What is the representation of appropriate staff in the quality assurance and improvement process?

3. Do the applicants inform and educate health care consumers in the following areas: health behaviors, how the health care system works, and how patients can be more effective decision makers about personal health care needs and the use of health care resources? Will patient education efforts increase under the agreement?

4. Do applicants participate in any external clinical data collection and analysis projects (e.g. Colorado Health Data Commission, Colorado Hospital Association) and will these projects be integrated and expanded under the proposed agreement?

5. Do the applicants currently use patient satisfaction data to improve health care quality? Will the applicants use patient satisfaction data to measure satisfaction of patients with health care services and/or goods affected by the agreement?

a) What are the methods for measuring and using patient satisfaction data?

b) What are the measurable indicators of patient satisfaction, especially for targeted areas under the agreement, including factors such as convenience of services and relationships between providers, hospital and the patient?

c) What is the process for addressing consumer complaints?

d) What is the process for resolving problems between patient and hospital?

6. Do the applicants have quantitative quality goals for the agreement?

a) Will the agreement reduce mortality and morbidity?

b) Will the agreement improve the proficiency of health care delivery through increased service volume, better education and training, or other factors?

c) Will the agreement improve the appropriateness of health care services given the needs of patients?

d) Will the agreement increase patient satisfaction with the quality and delivery of health care?

e) Will the agreement improve any other variables, proposed by the applicants, that are relevant to the quality and/or delivery of health care?

7. Will the agreement improve the work environment, conditions, professional opportunities, salaries, or benefits of employees of the applicants who are responsible for the delivery of health care?

8. Did the community plan, oversee, support, or influence the cooperative agreement?

a) What was the involvement of the largest employers in the geographic service area?

b) What was the involvement of health care providers in the geographic service area?

c) What was the involvement of consumer, or neighborhood organizations in the geographic service area?

d) What local, regional, and state government agencies regulate the activities of the applicants (e.g. zoning, land use, waste disposal, health care delivery) and did they plan, oversee, support, or influence the areas of the cooperative agreement related to their regulatory responsibilities?

e) What formal processes did the applicants use and do they intend to use to submit their activities to community influence, input, or control, particularly for goods and/or services in portions of the geographic service area where they will have no competition?

VII. ANNUAL REPORTING REQUIREMENTS FOR APPROVED COOPERATIVE AGREEMENTS

A. General Reporting Requirement. The parties to each approved agreement must submit an annual report by the anniversary date of the board's approval of the agreement that includes at least the information specified in sections C through F below. The parties must submit fifteen copies of their annual report to the board in care of the department, except that the parties only must submit one copy of the information required by section D 3 below. With the exception of items B 1 through B 5 below, no annual report need be made for any items that are unchanged since the time of application or the prior annual report.

B. Ongoing Supervision. After the parties to an approved agreement submit their annual report, the board shall formally approve or disapprove of the agreement remaining in effect. This approval shall be based on a determination of whether the parties are in compliance with the terms of the agreement, the board's order approving the agreement, and any conditions or restrictions placed by the board on the parties to an approved agreement. If the board does not approve of the agreement remaining in effect, it shall begin termination or modification proceedings pursuant to C.R.S. 24-32-2707.

C. Administrative Information

1. Names and addresses of all parties to the approved agreement, as well as any changes in participation by or ownership of these parties.

2. Names and addresses of the principal business offices of each party, if different than above.

3. Name and address of a contact person authorized to receive notices and communications with respect to the approved agreement.

4. A written statement attesting to the accuracy of all information given in the annual report verified and signed by a responsible officer of each party to the approved agreement.

5. A statement confirming that all parties to the agreement have complied with any and all terms of the agreement, the board's order approving the agreement, and any and all conditions or restrictions placed by the board on the parties.

6. Name and addresses of all individuals and organizations that have direct or indirect ownership interests, separately or in combination, amounting to ownership interest of 5 percent or more in the parties to the approved agreement.

7. A written description of ongoing community influence, input, planning, oversight, support or control of the cooperative agreement and formal processes for such community involvement.

8. Additional administrative information requested by the department pursuant to the board's order approving the agreement and any conditions or restrictions placed on the parties by the board.

9. A summary description of the changes undertaken by the parties as a result of the agreement.

D. Cost Effectiveness Information

1. A statement of past, current, and projected case-mix adjusted charges, payments, and expenses for services and/or goods affected by the approved agreement.

2. A detailed description of the efficiencies realized by the agreement, how they have been measured, and how they have been passed on to health care buyers.

3. A statement of the applicants' financial condition including:

a) financial statements audited by a Certified Public Accountant for the most recent five years;

b) budget “pro formas” for the next three years and a letter from a Certified Public Accountant reviewing the budget “pro formas”;and,

c) current year's report to Dun and Bradstreet from parties to the application who participate in this service.

4. A statement of the costs incurred by the parties to the agreement in the previous twelve months in complying with the order of the board approving the agreement and in completing this annual report. If this is the first annual report for an approved agreement, the statement shall include the costs incurred by the parties in making their original application to the board.

5. A statement of the market share of the competitors and providers of substitutes in the parties' geographic service area for the goods and/or services affected by the agreement.

6. Additional information related to cost effectiveness requested by the department pursuant to the board's order approving the agreement and any conditions or restrictions placed on the parties by the board.

7. A description of any differences between the actual cost effectiveness of the approved agreement and the projected cost effectiveness included in the applicants' original application to the board.

E. Availability Information

1. A description of how the agreement has met the goals stated in the original application for the provision of services and/or goods to lowincome, uninsured, and high-needs patients, for the improved affordability of health care goods and/or services, and for the improved geographic and physical availability of goods and/or services.

2. A description of the geographic service area for each service and/or good affected by the approved agreement including the following patient origin data:

a) current and projected geographic service area by zip code;

b) current and projected population in each zip code in the geographic service area;

c) current and projected number of patients originating from each of these zip codes;

d) current and projected percentage of total patients each zip code represents; and

e) current and projected average distances and travel times from these zip codes or reasonable groupings of these zip codes to the facilities provided by the applicants; and a legible map which clearly identifies the zip codes of the current and projected geographic service area. The map should identify major highway systems, sites of applicants, and sites of other health care facilities that provide services and/or goods similar to those provided by the applicants.

3. A statement of whether the utilization goals stated in the application have been achieved.

4. A description of the effect of the agreement on the preservation, reduction, or expansion of services and/or goods provided by the applicants.

5. Additional information related to availability of health care requested by the department pursuant to the board's order approving the agreement, and any conditions or restrictions placed on the parties by the board.

6. A description of any differences between the actual availability of health care under the approved agreement and estimates made by the applicants in their original application to the board.

F. Quality and Delivery Information

1. A comparison of actual progress in accreditation and licensure under the approved agreement with projected accreditation and licensure included in the original application to the board.

2. A comparison of progress of actual quality assurance and improvement programs under the approved agreement with projected programs described in the original application.

3. A comparison of progress of actual patient education programs under the approved agreement with projected programs described in the original application.

4. A comparison of the progress of actual programs to collect, analyze, and use clinical data with projected programs described in the original application.

5. A comparison of progress of actual programs to use patient satisfaction data to improve health care quality with projected programs described in the original application.

6. A comparison of improvements in the circumstances of employees with those projected under the original application.

7. A description of progress toward the quantitative quality goals included in the applicants' original application.

8. Additional information requested related to quality of health care by the department pursuant to the board's order approving the agreement, and any conditions or restrictions placed on the parties by the board.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Persons with Mental Illness HCBS-MI, Section 8.509
Rule Number:	MSB 12-08-06-B
Division / Contact / Phone:	Long Term Services & Supports Division / Sarah Hoerle / 2669

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 12-08-06-B, Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Persons with Mental Illness HCBS-MI, Section 8.509
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.509, 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 all current text from §8.509 HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH MENTAL ILNESS (HCBS-MI) through the end of §8.509.40.A with the new text provided. This change is effective 04/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

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 proposed rule revises the regulation for the Home and Community-Based Services for Persons with Mental Illness (HCBS-MI), 10 CCR 2505-10 8.509. The proposed changes are intended to improve the efficiency of the waiver program operations, to correct dated or inaccurate references to statutes and regulations, and to provide guidance and clarification on case management functions. Section 8.509.32(A) of On-Going HCBS-MI Cases changes the Single-Entry Point Requirement for quarterly face-to-face contact with clients to a bi-annual face-to-face contact. The requirement for quarterly contact with the client's has not been removed but has allowed the case manager and client to determine if this contact should be conducted over the telephone, at the client's place of residence, place of service, or other appropriate setting determined by the client's needs. This language change removes inconsistencies with the federally approved waiver application.
The proposed rule also changes the name of the waiver from Home and Community-Based Services for persons with Mental Illness (HCBS-MI) to Home and Community-Based Service for Community Mental Health Supports (HCBS-CMHS).

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:

   Social Security Act, Section 1915 (C)
   42 C.F.R. 441-300-441.310

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   25.5-6-601 through 25.6-6-607, C.R.S. (2012)

Initial Review	**02/08/2013**	Final Adoption	**03/08/2013**
Proposed Effective Date	**04/30/2013**	Emergency Adoption	

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Persons with Mental Illness HCBS-MI, Section 8.509
Rule Number:	MSB 12-08-06-B
Division / Contact / Phone:	Long Term Services & Supports Division / Sarah Hoerle / 2669

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.

   Case Management Agencies, provider agencies, current client's and their families as well as new applicants of the HCBS-MI waiver will benefit from the clarification, efficiencies, and elimination of barriers afforded by the proposed rule

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

   The implementation of this rule could create efficiencies in service planning and the service delivery processes. This could result in removing unnecessary barriers for HCBS-MI service provider participation and case management agencies.

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 no costs associated with the implementation or enforcement of this rule.

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

   There no costs associated with 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 or intrusive methods for achieving the purpose of this 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

8.509 ~~HOME AND COMMUNITY BASED SERVICES FOR PERSONS. WITH MENTAL ILLNESS (HCBS-MI)~~HOME AND COMMUNITY BASED SERVICES FOR COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS)

8.509.10 GENERAL PROVISIONS

8.509.11 LEGAL BASIS

A. The Home and Community Based Services for ~~PERSONS WITH MENTAL ILLNESS. (HCBS-MT)~~COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS) program in Colorado is authorized by a waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The ~~HCBS-MI~~HCBS-CMHS program is also authorized under state law at ~~26-4-671 through 26-4-676, C.R.S. (1999).~~25.5-6-601 through 25.5-6-607, C.R.S. (2012). The number of recipients served in the ~~HCBS-MI~~HCBS-CMHS program is limited to the number of recipients authorized in the waiver.

B. All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the. Social Security Act of 1935 and 45 CFR Part 1397 (October 1, 1991), by possession of a valid Assisted Living Residence license issued under 25-27-105, CR.S. (1999), and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains with electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, CO, 80203. Additionally, any incorporated material in these rules may be examined at any State depository library. ~~No amendments or later editions are incorporated. The staff assistant of the Community Based Long Term Care Section of the Colorado Department of Health Care Policy and Financing may be contacted at 1575 Sherman Street, Denver, Colorado 80203, for a copy of 45 CFR Part 1397; or the materials may be examined at any publications depository library.~~

8.509.12 SERVICES PROVIDED [Eff. ~~12/30/2007~~7/1/2012]

A. ~~HCBS-MI~~HCBS-CMHS services provided as an alternative to nursing facility placement include:

1. ~~Adult day services, and~~Adult Day Services

2. ~~Alternative care facility services, including homemaker and personal care services in a residential setting, and~~Alternative Care Facility Services (which includes Homemaker and Personal Care services)

3. Consumer Directed Attendant Support Services (CDASS)

4.~~3. Electronic monitoring, and~~ Electronic Monitoring

5~~4~~. ~~Home, modification, and~~Home Modification

6~~5~~. ~~Homemaker services, and~~Homemaker Services

7~~6~~. ~~Non-medical transportation, and~~Non-Medical Transportation

8~~7~~. ~~Personal care; and~~Personal Care

9. ~~8. Respite care; and~~ Respite Care

~~9. Consumer Directed Attendant Support Services; and~~

B. Case management is not a service~~,~~ of the ~~HCBS-MI~~HCBS-CMHS program, but shall be provided as an administrative activity through case management agencies.

C. ~~HCBS-MI~~HCBS-CMHS clients are eligible ~~,~~ for all other Medicaid State plan benefits.

8.509.13 DEFINITIONS OF SERVICES [Eff. 12/30/2007]

A. Adult Day Services ~~shall be as~~ is defined at Section 8.491, ADULT DAY SERVICES.

B. Alternative Care Facility ~~S~~services ~~means, services as~~ is defined at Section 8.495, ALTERNATIVE CARE FACILITY.

C. Consumer Directed Attendant Support Services (CDASS) is defined at Section 8.510, CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

C. Electronic Monitoring services ~~shall be as~~is defined at Section 8.488, ELECTRONIC MONITORING.

D. Home Modification ~~shall be as~~is defined at Section 8.493, HOME MODIFICATION.

E. Homemaker Services ~~shall be as~~is defined at Section 8.490, HOMEMAKER SERVICES.~~.~~

F. Non-Medical Transportation ~~shall be as~~is defined at Section 8.494, NON-MEDICAL TRANSPORTATION.

G. Personal Care ~~shall be as~~is defined at Section 8.489, PERSONAL CARE.

H. Respite ~~shall be as~~is defined at Section 8.492, RESPITE.

~~I. Consumer Directed Attendant Support Services shall be defined at Section 8.510.~~

8.509.14 GENERAL DEFINITIONS

A. Assessment shall be defined as a client evaluation according to requirements at Section 8.509.31, (B).

B. Case Management shall be defined as administrative functions performed by a case management agency according to requirements at Section 8.509.30.

C. Case Management Agency shall be defined as an agency that is certified and has a valid contract with the state to provide HCBS-CMHS~~MI~~ case management.

D. Case Plan shall be defined as a systematized arrangement of information which includes the client's needs; the HCBS-CMHS~~MI~~ services and all other services which will be provided, including the funding source, frequency, amount and provider of each service; and the expected outcome or purpose of such services. This case plan shall be written on a state-prescribed case plan form.

E. Categorically Eligible , shall be defined in the HCBS-CMHS~~MI~~ Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-CMHS~~MI~~ as three hundred percent eligible persons, as defined at 8.509.14(S).

F. Congregate Facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

G. ~~UNCERTIFIED CONGREGATE FACILITY~~Uncertified Congregate Facility ~~shall be~~is a facility as defined in Section 8.509.14(F) that is not certified as an Alternative Care Facility, which is defined at Section 8.495.11. ~~defined as a facility as defined above that is not certified as an alternative care facility, as defined at 8.495.11.~~

H. Continued Stay Review shall be defined as a re-assessment as defined at Section 8.402.60.

I. Cost Containment shall be defined ~~as the determination that, on an individual client basis, the daily cost of providing HCBS-MI services, plus care provided under the Home Care Allowance program, does not exceed the equivalent daily cost of nursing facility care.~~at Section 8.485.50(J)

J. Department shall be defined as the State Agency designated as the Single State Medicaid Agency for Colorado, or any division or sub-units within that agency, or another state agency operating under the authority of a memorandum of understanding with the Single State Medicaid Agency.

K~~J~~. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility services reimbursed by Medicaid, within forty-five (45) calendar days of admission to ~~HCBS-MI~~HCBS-CMHS waiver. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected ~~HCBS-MI~~the HCBS-CMHS waiver.

L. ~~K.~~ Diverted shall be define as ~~HCBS-MI~~HCBS-CMHS waiver recipients who were not deinstitutionalized, as defined ~~in this section~~ at Section 8.485.50(K).~~.~~

M.~~L.~~ ~~Home and Community Based Services for Persons with Mental Illness (HCBS-MI)~~ Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS) shall be defined as services provided in a home or community based setting to clients who are eligible for Medicaid reimbursement for long term care, who would require nursing facility care without the provision of ~~HCBS-MI~~HCBS-CMHS, and for whom ~~HCBS-MI~~HCBS-CMHS services can be provided at no more than the cost of nursing facility care.

N~~M~~. Intake/Screening/Referral shall be as defined at Section 8.390.1(J) and as the initial contact with clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long term care client assessment.

O~~N~~. Level Of Care Screen shall be described~~defined~~ as an assessment in Section 8.401.~~as described in Section 8.401.~~

PO. Non-Diversion shall be defined as a client who was certified by the Utilization Review Contractor (URC) as meeting the level of care screen and target group for the ~~HCBS-MI~~HCBS-CMHS program, but who did not receive ~~HCBS-MI~~HCBS-CMHS services for some other reason.

QP. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8393.6 and 8.487 are met.

RQ. Reassessment shall be defined as a periodic revaluation according to the requirements at Section 8.509.32. C.

~~R. Department shall be defined as the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency, or another state agency operating under the authority of a memorandum of understanding with the single state Medicaid agency.~~

S. Three ~~H~~hundred ~~P~~percent (300%) ~~E~~eligible persons shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level, and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty (30) consecutive days.

8.509.15 ELIGIBLE PERSONS

A. ~~HCBS-MI~~HCBS-CMHS services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

Clients shall meet the eligibility criteria as specified in the Income Maintenance Staff Manual of the Colorado Department of Human Services at 9 CCR 2503-1, and the Colorado Department of Health Care Policy and Finacning regulations at 10 CCR 2505-10, Section 8.100, MEDICAL ASSISTANCE ELIGIBILITY. ~~section of this manual.~~

2. Level of Care AND Target Group.

Clients who have been determined to meet the level of care AND target group criteria shall be certified by the Utilization Review Committee (URC) as functionally eligible for ~~HCBS-ML~~HCBS-CMHS. The URC shall only certify ~~HCBS-MI~~HCBS-CMHS eligibility for those clients:

a. Determined to meet the target group definition for the mentally ill as defined at Section 8.400.16; and

b. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11-15; and

c. Who are determined to be persons with mental illness as defined by State Mental Health Services and documented by the case management agency;

d. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.

3. Receiving Services

a. Only clients who receive ~~HCBS-MI~~HCBS-CMHS services, or who have agreed to accept ~~HCBS-MI~~HCBS-CMHS services as soon as all other eligibility criteria have been met, are eligible for the ~~HCBS-MI~~HCBS-CMHS program.

b. Case management is not a service and shall not be used to satisfy this requirement.

b. Desire or need for home health services or other Medicaid services that are not ~~HCBS-MI~~HCBS-CMHS services, as listed at Section 8.509.12, shall not satisfy this eligibility requirement.

c. ~~HCBS-MI~~HCBS-CMHS clients who have not received ~~no HCBS-MI~~HCBS-CMHS services for ~~one month~~thirty (30) days shall be discontinued from the program.

4. Institutional Status

a. ~~Cheats~~ Clients who are residents of nursing facilities or hospitals are not eligible for ~~HCBS-MI~~HCBS-CMHS services while residing in such institutions.

b. A client who is already an ~~HCBS-MI~~HCBS-CMHS recipient and who enters a hospital may not receive ~~HCBS-MI~~HCBS-CMHS services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the client from the ~~HCBS-MI~~HCBS-CMHS ~~-~~program.

c. A client who is already an ~~HCBS-MI~~HCBS-CMHS recipient and who enters a nursing facility may not receive ~~HCBS-MI~~HCBS-CMHS services while in the nursing facility;

1) The case manager must terminate the client from the ~~HCBS-M3~~HCBS-CMHS program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified ULTC-100.2 for the nursing facility placement, as verified by telephoning the URC.

2) A client receiving ~~HCBS-MI~~HCBS-CMHS services who enters a nursing facility for ~~respite care~~Respite Care as a service under the ~~HCBS-MI~~HCBS-CMHS program shall not be required to obtain a nursing facility ULTC-100.2, and shall be continued as an ~~HCBS-MI~~HCBS-CMHS client in order to receive the ~~HCBS-MI~~HCBS-CMHS service of ~~respite care~~Respite Care in a nursing facility.

5. Cost-effectiveness

Only clients who can be safely served within cost containment, as defined at Section 8.509.14 (I), are eligible for the ~~HCBS-MI~~HCBS-CMHS program. The equivalent cost of nursing facility care is calculated by the State, according to Section 8.509.19.

8.509.16 START DATE

The start date of eligibility for ~~HCBS-MI~~HCBS-CMHS services shall not precede the date that all of the requirements at Section 8.509.15, have been met. The first date for which ~~HCBS-MI~~HCBS-CMHS services can be reimbursed shall be the LATER of any of the following:

A. Financial The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100~~, of Staff Manual Volume 8.~~. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care This date is determined by the official URC stamp and the URC-assigned start date on the ULTC 100.2 form.

C. Receiving Services This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept ~~HCBS-MI~~HCBS-CMHS services.

D. Institutional Status ~~HCBS-MI~~HCBS-CMHS eligibility cannot precede the date of discharge from the hospital or nursing facility.

8.509.17 CLIENT PAYMENT OBLIGATION - POST ELIGIBILITY TREATMENT OF INCOME (PETI)

When a client has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, of Staff Manual Volume 8, the State may reduce Medicaid payment for Alternative Care Facility services according to the procedures at Section 8.509.31, E, of Staff Manual Volume 8.

8.509.18 STATE PRIOR AUTHORIZATION OF SERVICES

A. Upon receipt of the ~~prior authorization request~~Prior Authorization Request (PAR), as described at Section ~~8.509.31, G, of Staff Manual Volume 8,~~ 8.509.31(G), the state or its agent shall review the PAR to determine whether it is in compliance with all applicable regulations, and whether services requested are consistent with the client's documented medical condition and functional capacity, and are reasonable in amount, frequency, and duration. Within ten (10) working days the State or its agent shall:

1. Approve the PAR and forward signed copies of the prior authorization form to the case management agency, when all requirements are met;

2. Return the PAR to the case management agency, whenever the PAR is incomplete, illegible, unclear, or incorrect; or if services requested are not adequately justified;

3. Disapprove the PAR when all requirements are not met Services shall be disapproved that are duplicative of other services that the client is receiving or services for which the client is receiving funds to purchase Services shall also be disapproved if all services, regardless of funding source, total more than twenty-four hours per day care.

B. When services are disapproved, in whole or in part the Department or its agent shall notify the case management agency. The case management agency shall notify the client of the adverse action and the appeal rights on a state-prescribed form, according to Section 8.057, et seq. ~~Staff Manual Volume 8.~~

C. Revisions received by the Department or its agent six (6) months or more after the end date shall always be disapproved.

D. Approval of the PAR by the Department or its agent shall authorize providers of services under the case plan to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the client's financial eligibility for long term care medical assistance (Medicaid) on the dates of service; and upon providers' use of correct billing procedures.

8.509.19 STATE CALCULATION OF COST-CONTAINMENT AMOUNT

A. The State shall annually compute the equivalent monthly cost of nursing facility care ~~ACCORDING TO SECTION 8.485.100.~~according to Section 8.485.100.

B. LIMITATIONS ON PAYMENT TO FAMILY

1. In no case shall any person be reimbursed to provide HCBS-CMHS~~HCBS-MI~~ services to his or her spouse.

2. Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-CMHS~~HCBS-MI~~ program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption or common law.

3. The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.

4. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

   a. The total number of Medicaid personal care units for a member of the client's family shall not exceed the equivalent of 444 personal care units per annual certification for ~~HCBS-MI~~HCBS-CMHS.

   b. The maximum shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision and all other administrative costs.

   c. The maximum number of personal care units per annual certification for ~~HCBS-MI~~HCBS-CMHS shall be 444 units. Family members must average at least 1.2164 hours of care per day (as indicated on the client's care plan) in order to receive the maximum reimbursement.

   d. If the certification period for ~~HCBS-MI~~HCBS-CMHS is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the client is receiving care by the average units per day for a full year (444/365=1.2164).

5. If two or more ~~HCBS-MI~~ HCBS-CMHS clients reside in the same household, family members may be reimbursed up to the maximum for each client if the services are not duplicative and are appropriate to meet the client's needs.

6. When ~~HCBS-MI~~HCBS-CMHS funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance cannot be used to reimburse the family.

7. Services other than personal care shall not be reimbursed with the ~~HCBS-MI~~HCBS-CMHS funds when provided by the client's family.

8. Services other than personal care shall not be reimbursed with the ~~HCBS-MI~~HCBS-CMHS funds when provided by the client's family.

C. CLIENT RIGHTS

1. The case manager shall inform clients eligible for ~~HCBS-MI~~HCBS-CMHS in writing, of their right to choose between ~~HCBS-MI~~HCBS-CMHS services and nursing facility care; and.

2. The case manager shall offer clients eligible for ~~HCBS-MI~~HCBS-CMHS, the free choice of any and all available and qualified providers of appropriate services.

8.509.20 CASE MANAGEMENT AGENCIES

A. The requirement at Section 8.390 et. seq. shall apply to the case management agencies performing the case management functions of the HCBS-CMHS program.

8.509.21 CERTIFICATION

A. Case management agencies shall be certified, monitored and periodically recertified ~~according to current Rules and Regulations For The Colorado Public Mental Health System.~~as required in Section 8.394 et. seq.

B. Case management agencies must have provider agreements with the Department that are specific to the ~~HCBS-MI~~HCBS-CMHS program.

8.509.22 REIMBURSEMENT

Case management agencies shall be reimbursed for case management activities according to ~~current procedures as approved by the State Mental Health Authority.~~Section 8.392 et. seq.

8.509.30 CASE MANAGEMENT FUNCTIONS

8.509.31 NEW ~~HCBS-MI~~HCBS-CMHS ~~CASES~~CLIENTS

A. INTAKE/SCREENING/REFERRAL

1. Case management agency staff shall complete a State-prescribed Intake form in accordance with the Single Entry Point Intake Procedures at Section 8.393.21 for each potential ~~HCBS-MI~~HCBS-CMHS applicant. The Intake form must be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the applicant for purposes of establishing a start date. Additionally, at intake, clients shall be offered an opportunity to identify a third party to receive client notices. This information shall be included on the intake form. This designee shall be sent copies of all notices sent to clients.

2. Case management agency staff shall verify the individual's current financial eligibility status, or refer the client to the county department of social services of the client's county of residence for application. This verification shall include whether the applicant is in a category of assistance that includes financial eligibility for long term care.

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform long term care client assessment (ULTC-100.2), and shall explain the reasons for the decision on the Intake form. The client shall be informed of the right to request an assessment if the client disagrees with the case manager's decision.

4. If the case management agency staff has determined that a comprehensive uniform long term care client assessment (ULTC-100.2) is needed, or if the client requests an assessment, a case manager shall be assigned to schedule the assessment

B. ASSESSMENT

1. The URC/SEP case manager shall complete the Uniform Long Term Care Client Assessment Instrument (~~ULTC 1(0.2~~ULTC 100.2) in accordance with ~~instructions provided by the State~~Section 8.393.22, ASSESSMENT.

2. The URC/SEP case manager shall begin and complete the assessment within ten (10) days of notification of client's need for assessment.

3. The URC/SEP case manager shall complete the following activities for a comprehensive client assessment:

   a. Obtain all required information from the client's medical provider including information required for target group determination;

   b. Determine the client's functional capacity during a face-to-face interview, preferably with the observation of the client in his or her residential setting;

   c. Determine the ability and appropriateness of the client's caregiver, family, and other collateral, to provide the client assistance in activities of daily living;

   d. Determine the client's service needs, including the client's need for services not provided under ~~HCBS-MI~~HCBS-CMHS~~;~~

   ~~4.~~

   e. If the client is a resident of a nursing facility, determine the feasibility of deinstitutionalization;

   f. Review service options based on the client's needs, the potential funding sources, and the availability of resources;

g. Explore the client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state rules;

h. View and document the current Assisted Living Residence license, if the client lives, or plans to live, in a congregate facility as defined at Section 8.509.14~~, Staff Manual Volume 8,~~ in order to assure compliance with the regulation at ~~8.509.11, B, Staff Manual Volume 8;~~Section 5.509.11(B).

i. Determine and document client preferences in program selection;

j. Complete documentation on the ULTC 100.2 form.

k. To de-institutionalize a client who is in a nursing facility under payment by Medicaid, and with a current ULTC 100.2 already certified by the URC/SEP agency for the nursing facility level of ULTC 100.2 completion date is older than six (6) months, the URC/SEP case manager shall complete a new ULTC 100.2 and determine if the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for ~~HCBS-MI~~HCBS-CMHS, the case manager must obtain a new ULTC 100.2 and the client shall be treated as an applicant from the community rather than as a de-institutionalized client.

l. It is the URC/SEP case manager's responsibility to assess the behaviors of the client and assure that community placement is appropriate.

C. ~~HCBS-MI~~HCBS-CMHS DENIALS AND/OR DISCONTINUATIONS

1. If a client is determined, at any point in the assessment process, to be ineligible for ~~HCBS-MI~~HCBS-CMHS according to any of the requirements at Section 8.509.15, ~~Staff Manual Volume 8,~~ the case manager shall refer the client or the client's designated representative to other appropriate services. Clients who are denied ~~HCBS-MI~~HCBS-CMHS services shall be notified of denials and appeal rights as follows:

a. Financial Eligibility

The income maintenance technician at the county department of social services shall notify the applicant of denial for reasons of financial eligibility, and shall inform the applicant of appeal rights in accordance with Sections 3.840 and 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the state.

b. Level of Care AND Target Group

The URC shall notify the applicant of denial for reasons related to determination of level of care AND target group eligibility and shall inform the applicant of

appeal rights in accordance with Section 8.0578.059.12, of Staff Manual Volume 8. The case manager shall not make judgments as to eligibility regarding level of care or target group, and shall refer all applicants who request a URC review to the URC, independently of any action that may be taken by the case manager in regard to other eligibility requirements, in accordance with the rest of this section. The case manager shall not attend the appeal hearing for a denial based on level of care or target group determination, unless subpoenaed, or unless requested by the state.

c. Receiving Services

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determine thatdetermines that the applicant does not meet the HCBS-MI HCBS-CMHS eligibility requirements at Section 8.509.15 , of Staff Manual Volume 8, and shall inform the applicant of appeal rights in accordance with Section 8.057, et. seq., of Staff Manual Volume 8. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

d. Institutional Status

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determine thatdetermines that the applicant does not meet the eligibility requirement 2 at Section 8.509.15, of Staff Manual Volume 8, and shall inform the applicant of appeal rights in accordance wit Sectionwith Section 8.057, et. seq., of Staff Manual Volume 8. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

e. Cost-effectiveness

The case manager shall notify the applicant of denial, on State-prescribed form, when the case manager determine thatdetermines that the applicant does not meet the eligibility requirement 8.509.15 , of Staff Manual Volume 8, and shall inform the applicant of appeal rights in accordance with Section 8.057, et.seq., of Staff Manual Volume 8. .The case manager shall also attend the appeal hearing to defend this denial action. If the applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the applicant, and the competency of the applicant to choose to live in an unsafe situation. If the case manager determines that the applicant will be unsafe with the amount of services available, and is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-MIHCBS-CMHS eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the client's physician attesting to the client's mental competency status, and all other available information which will support the determination that the client is unsafe and incompetent to make a decision to live in an unsafe situation; and, which will satisfy the burden

of proof required of file case manager making the denial. Denials and appeals for reasons of cost-effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the URC in regard to level of care and target group determination.

f. Waiver Cap

The case manager shall notify the applicant of denial, on a State-prescribed form, when the waiver cap limiting the number of clients who may be served under the terms of the approved waiver has been reached.

D. ~~CASE~~ SERVICE PLANNING

1. ~~Case~~ Service Planning~~planning~~ shall be defined in accordance with case planning at Section 8.393.23 and shall include, but not be limited to, the following tasks:

   a. The identification and documentation of ~~case plan~~service plan goals and client choices;

   b. The identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, finding source, and services needed but not available;

   c. Documentation of the client's choice of ~~HCBS-MI~~HCBS-CMHS services, nursing home placement, or other services, including a signed statement of choice from the client;

   d. Documentation that the client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;

   e. The formalization of the ~~case~~ service plan agreement on a State-prescribed ~~case~~ service plan form, including appropriate signatures;

   f. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision;

   g. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community;

   h. The explanation of complaint procedures to the client.

2. The case manager shall meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

E. CALCULATION OF CLIENT PAYMENT (PETI)

1. The case manager shall calculate the client payment (PETI) for 300% eligible ~~HCBS-MI~~ HCBS-CMHS clients according to the following procedures:

   a. For 300% eligible ~~HCBS-MI~~ HCBS-CMHS clients who are not Alternative Care Facility clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.

   b. For 300% eligible clients who are Alternative Care Facility clients, the case manager shall complete a State-prescribed form which calculates the client payment according to the following procedures:

      1) An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the client's gross income to be used as the client maintenance allowance, from which the state-prescribed Alternative Care Facility room and board amount shall be paid: and

      2) For an individual with financial responsibility for only a spouse, an amount equal to the state Aid to the Needy ~~and~~ Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the client's gross income: or

      3) For an individual with financial responsibility for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) ~~Aid to Families with Dependent Children (AFDC)~~ grant level less any income of the spouse and/or ~~or~~ dependents (excluding income from part~~n~~-time employment earnings of a dependent child~~ren~~ who is either a full-time student of a part-time student as defined at Section 8.100.3.L.2.d.) ~~8.112.3(F) of Staff Manual Volume 8).~~ shall be deducted from the client's gross income; and

      4) Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare~~,~~, Medicaid~~,~~ or other third party shall be deducted from the client's gross income as follows:

         a) Health insurance premiums if health insurance coverage is documented in the eligibility system and the MMIS: deductible or co-insurance charges: and

         b) Necessary dental care not to exceed amounts equal to actual expenses incurred: and

         c) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred: and

         d) Medications, with the following limitations:

(1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

(2) Medications which may be purchased with the client's Medical Identification Card shall not be allowed as deductions.

(3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

(4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.

(5) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

e) Other necessary medical or remedial care shall be deducted from the client's gross income, with the following limitations:

(1) The need for such care shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.

(2) Any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.

f) Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

g) When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is

determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

5) Any remaining income-shall be applied to the cost of the Alternative Care Facility services, as defined at Section 8.495, and shall be paid by the client directly to the facility; and

6) If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the client's income, the remaining income shall be kept by the client and may be used as additional personal needs or for any other use that the client desires, ~~.~~ except that the Alternative Care Facility shall not charge more than the Medicaid rate for Alternative Care Facility services.

2. Case managers shall inform ~~HCBS-MI~~HCBS-CMHS Alternative Care Facility clients of their client payment obligation on a form prescribed by the state at the time of the first assessment visit by the end of each plan period; or within ten (10) working days whenever there is a significant change in the ~~cheat~~ client payment amount Significant change is defined as fifty dollars ~~(S50)~~($50) or more. Copies of client payment forms shall be kept in the client files at the case management agency, and shall not be mailed to the State or its agent, except as required for a prior authorization request, according to Section 8.509.31.G, ~~of Staff Manual Volume 8.~~ or if requested by the state for monitoring purposes.

F. COST CONTAINMENT

The case manager shall determine whether the person can be served at or under the cost ~~ceiling~~containment criteria of Section 8.509.14(I) for long term care services for an individual recipient by using a state-prescribed Prior Authorization Request (PAR) form ~~10~~to:

1. Determine the maximum authorized costs for all ~~HCBS-MI~~HCBS-CMHS services for the period of time covered by the case plan and compute the average cost per day by dividing by the number of days in we case plan period; and

2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:

   a. Enter (in the designated space on the PAR form) the average monthly cost of nursing facility care; and ~~as calculated by the State according to Section 8.485.100. of Staff Manual Volume 8: and~~

   b. Subtract from that amount the client's gross monthly income: and

   c. Subtract from that amount the client's Home Care Allowance grant amount, if any: and

d. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount which cannot be exceeded for the cost of HCBS services.

3. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so.

G. PRIOR AUTHORIZATION REQUESTS

1. The case manager shall submit prior authorization requests (PARs) for all ~~HCBS-MI~~HCBS-CMHS services to the state or its agent in a timely manner in accordance with the STATE PRIOR AUTHORIZATION OF SERVICES in Section 8.485.90.

2. Every PAR shall include the Long Term ~~Care~~ Service Plan form; the Prior Approval Request form; the Uniform Long Term Care Client Assessment (ULTC-100.2) form; and written documentation, from the income maintenance technician or the eligibility system, of the client's current monthly income. All units of service requested on the Prior Approval Request form must be listed on the Long Term ~~Care~~ Service Plan form. If a range of units is estimated on the Long Term ~~Care~~ Service plan, the number of units at the higher end of the range may be requested on the Prior Approval Request form. "PRN" services must be given a numerical estimate on the Long Term Care plan.

3. If a PAR is for a new admission, or a re-admission, the Intake form shall be included with the PAR.

4. If a PAR includes a request for home modification services, the PAR shall also include all documentation listed at Section 8.493, HOME MODIFICATION~~, of Staff Manual Volume 8.~~.

5. If a PAR is for an Alternative Care Facility client who is 300% eligible, the most recent state-prescribed Client Payment form shall be included in the PAR. All medical and remedial care requested as deductions on the Client Payment form must be listed on the LONG TERM Service~~Case~~ Plan form.

6. The start date on the prior authorization request form shall never precede the start date of eligibility for ~~HCBS-MI~~HCBS-CMHS services, according to Section 8.509.16, START DATE~~, of Staff Manual Volume 8~~.

7. The PAR shall not cover a period of time longer than the length of stay assigned by the URC.

8. A PAR does not have to be submitted for a non-diversion, as defined at 8.509.14~~, M.~~(O).

9. If a PAR is returned to the case management agency for corrections, the corrected PAR must be returned to the State or its agent within thirty (30) calendar days

after the case management agency receives the ~~"return to provider""~~Return to Provider" letter.

H. CASE MANAGEMENT AGENCY RESPONSIBILITY

1. The case management agency shall be financially responsible for any services which it authorized to be provided to the client, or which continue to be rendered by a provider due to the case management agency's failure to timely notify the provider that the client was no longer eligible for services, which did not receive approval by the state or its agent.

8.509.32 ONGOING ~~HCBS-MI~~HCBS-CMHS ~~CASES~~CLIENTS

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The coordination, monitoring, and evaluation of services for HCBS-CMHS clients shall be in accordance with ON-GOING CASE MANAGEMENT in Section 8.393.24. In addition, the case manager shall:~~The case manager shall monitor the services that are being provided, the appropriateness and effectiveness of services provided, the amount of care, the timeliness of service delivery, client satisfaction, the safety of the client, and shall take corrective actions as needed. Monitoring contacts must occur and be documented at least once every three months, or more frequently as determined by the client's needs.~~

   a. Contact each client quarterly, or more frequently, as determined by the client's assessed needs. Contact may be at the client's place of residence, by telephone, or other appropriate setting as determined by the client's needs.

   b. Review the ULTC.100.2 and the Service Plan with the client every six (6) months on a face-to-face basis.

~~2. The case manager shall contact each client on a face-to-face basis at least once every three months, or more frequently as determined by the client's needs.~~

2~~3~~. The case manager shall refer the client for mental health services taking into account client choice. The case manager shall coordinate case management activities for those clients who are receiving mental health services from the Behavioral Health Organizations (BHO).~~Mental Health Assessment and Service Agencies (MHASAs).~~

3~~4~~. On-going case management shall include, but not be limited to the following tasks:

   a. Review of the client's case plan and service agreements;

   b. Contact with the client concerning whether services are being delivered according to the plan; and the client's satisfaction with services provided;

   c. Contact with service providers concerning service delivery, coordination, effectiveness, and appropriateness;

   d. Contact with appropriate parties in the event any issues or complaints have been presented by the client or others;

e. Conflict resolution and/or crisis intervention, as needed;

f. Informal assessment of changes in client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;

g. Notification of appropriate enforcement agencies, as needed; and

h. Referral to community resources, and arrangement for ~~non-HCBS-MI~~non-HCBS-CMHS services, as needed.

4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or mis-utilization of any public assistance or Medicaid benefit. The case manager shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with the Colorado Department of Human Services' Staff Manual Volume 3, Section 3.810.

B. REVISIONS

1. SERVICES ADDED TO THE ~~CASE~~ SERVICE PLAN

a. Whenever a change in the ~~case~~ service plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the state or its agent.

1) The revision PAR shall include the revised Long Term Care plan form and the revised Prior Authorization Request form.

2) The revised ~~case~~ service plan form shall list the services being revised and shall state the reason for the revision. Services on the revised ~~case~~ service plan form, plus all services on the original ~~case~~ service plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement.

3) The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.

b. If a revised PAR includes a new request for home modification services, the revised PAR shall also include all documentation listed at Section 8.493~~, of Staff Manual Volume 8~~.

2. SERVICES DECREASED ON THE ~~CASE~~ SERVICE PLAN

a. A revised PAR does not need to be submitted if services on the ~~case~~ service plan are decreased or not used, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness

b. If services are decreased without the client's agreement according to Section 8.057.5, ~~of Staff Manual Volume 8,~~ the case manager shall notify the client of the adverse action and of appeal rights, according to Section 8.057, et. seq.~~, of Staff Manual Volume 8.~~

C. REASSESSMENT

1. The case manager shall complete a reassessment of each ~~HCBS-MI~~HCBS-CMHS client before the end of the length of stay assigned by the URC at the last level of care determination. The case manager shall initiate a reassessment more frequently when warranted by significant changes that may affect ~~HCBS-MI~~HCBS-CMHS eligibility.

2. The case manager shall complete the reassessment, utilizing the Uniform Long Term Care Client Assessment Instrument (ULTC 100.2).

3. Reassessment shall include, but not be limited to, the following activities:

   a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for long term care benefits;

   b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;

   c. Evaluate continuing need for the ~~HCBS-MI~~HCBS-CMHS program, and clearly document reasons for continuing HCBS; or terminate the client's eligibility according to Section 8.509.32~~(,~~ E~~), of Staff Manual Volume 8~~;

   d. Ensure that all information needed from the medical provider for the URC level of care review is included on the ULTC 100.2 form;

   e. Reassess the client's functional status, according to the procedures in Section ~~8.509.31,B,~~8.509.31(B) ~~of Staff Manual Volume 8~~;

   f. Review the case plan, including verification of whether services have been delivered according to the case plan, and write a new case plan, according to procedures at Section 8.509.31~~(,~~ D~~), of Staff Manual Volume 8~~;

   g. Refer the client to community resources as needed;

   h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31~~(,~~G~~), of Staff Manual Volume 8~~. For clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ULTC 100.2. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the client and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the URC or the ~~Division~~ Office of Administrative Courts to the client; or (c) a copy of the notice of a scheduled court date.

      Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed, and shall not be

accepted as a substitute for the approved ULTC 100.2. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

D. TRANSFER PROCEDURES

1. When clients move, cases shall be transferred according to the current statewide Mental Health Services Continuity of Care Policy.

2. INTERCOUNTY TRANSFERS shall be in accordance with Section 8.393.31.

3. INTERDISTRICT TRANSFERS shall be in accordance with Section 8.393.32.

E. TERMINATION

1. Clients shall be terminated from the ~~HCBS-MI~~HCBS-CMHS program whenever they no longer meet one or more of the eligibility requirements at Section 8.509.15~~, of Staff Manual Volume 8~~. Clients shall also be terminated from the program if they die, move out of state or voluntarily withdraw from the program.

2. Clients who are terminated from ~~HCBS-MI~~HCBS-CMHS because they no longer meet one or more of the eligibility requirements at Section 8.509.15 ~~, of Staff Manual Volume 8,~~ shall be notified of the termination and their appeal rights as follows:

   a. Financial Eligibility

      Procedures at Section 8.509.31, (C)~~, of Staff Manual Volume 8~~, shall be followed for terminations for this reason.

   b. Level of Care AND Target Group

      Procedures at Section 8.509.31, (C)~~, of Staff Manual Volume 8~~, shall be followed for terminations for this reason.

   c. Receiving Services

      Procedures at Section 8.509.31, (C)~~, of Staff Manual Volume 8~~, shall be followed for terminations for this reason

   d. Institutional Status

      Procedures at Section 8.509.31~~, (~~C)~~, of Staff Manual Volume 8~~, shall be followed for terminations for this reason. In the case of termination for extended hospitalization, the case manager shall send the termination notice on the thirtieth (30) day of hospitalization. The termination shall he effective at the end of the advance notice period. If the client returns home before the end of the advance notice period, the termination shall be rescinded.

   e. Cost-effectiveness

      Procedures at Section 8.509.31(C) ~~of Staff Manual Volume 8~~, shall be followed for terminations for this reason.

3. When clients are terminated from HCBS-MI for reasons not related to me eligibility requirements at Section 8.509.31(C) ~~of Staff Manual Volume 8~~, the case manager shall follow the procedures below:

   a. Death

      Clients who die shall be terminated from the ~~HCBS-MI~~HCBS-CMHS program, effective upon the day after the date of death.

   b. Moved out of State

      Clients who move out of Colorado shall be terminated from the ~~HCBS-MI~~HCBS-CMHS program, effective upon the day after the date of the move. The case manager shall send the client a state-prescribed Advisement Letter advising the client that the case has been closed. Clients who leave the stale on a temporary basis, with intent to return to Colorado, according to the Income Maintenance Staff Manual Section 1140.2, shall not be terminated from the ~~HCBS-MI~~HCBS-CMHS program unless one or more of the other eligibility criteria, as specified at Section 8.509.15 ~~of Staff Manual Volume 8~~ is no longer met.

   c. Voluntary Withdrawal from the Program

      Clients who voluntarily withdraw from the ~~HCBS-MI~~HCBS-CMHS program shall be terminated from the program, effective upon the day after the date on which the client either requests in writing to withdraw from the program, or the date on which the client enters a nursing facility. The case manager shall send the client a state-prescribed Advisement Letter advising the client that the case has been closed.

4. The case manager shall provide appropriate referrals to other community resources, as needed, upon termination.

5. The case manager shall immediately notify all providers on the case plan of any terminations.

6. If a case is terminated before an approved PAR has expired, the case manager shall submit, to the state or its agent, a copy of the current prior authorization request form, on which the end date is adjusted (and highlighted in some manner on the form); and the reason for termination shall be written on the form.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the income maintenance technician of any and all changes in the client's participation in ~~HCBS-MI~~HCBS-CMHS, and shall provide the technician with copies of the first page of all URC-approved ULTC-100.2 forms.

2. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current state-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

3. If the client has an open service case file at the county department of social services, the case manager shall keep the client's caseworker informed of the client's status and shall participate in mutual staffing of the client's case.

4. The case manager shall inform the client's physician of any significant changes in the client's condition or needs.

5. Within five (5) working days of receipt, from the State or it; agent, of the approved Prior Authorization Request form, the case manager shall provide copies to all the ~~HCBS-MI~~HCBS-CMHS providers in the case plan.

6. The case manager shall notify the URC, on a form prescribed by the state of the outcome of all non-diversions, as defined at Section 8.509.14~~, of Staff Manual Volume 8~~.

7. The case manager shall report to the Colorado Department of Public Health and Environment any congregate facility which is not licensed.

8. The case management agency shall notify the state of any client appeals which are initiated as a result of denials or terminations made by the case management agency.

B. CASE RECORDING/DOCUMENTATION

1. The case management agency shall maintain records on every individual for whom intake was conducted, including a copy of the intake form. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the case management agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.

2. The case record shall include:

   a. Identifying information, including the state identification (Medicaid) number, and

   b. All state-required forms; and

   c. Documentation of all case management activity required by these regulations.

3. Case management documentation shall meet all the following standards:

   a. A separate case record shall be maintained for each client receiving services in the Home and Community Based Services for ~~Persons with Mental Illness~~Community Mental Health Supports Program.

   b. Documentation shall be legible;

   c. Entries shall be written at the time of the activity or shortly thereafter,

   d. Entries shall be dated according to the date of the activity, including the year;

   e. Entries shall be made in permanent ink;

f. The client shall be identified on every page;

g. The person making each entry shall be identified;

h. Entries shall be concise, but shall include all pertinent information;

i. All information regarding a client shall be kept together for easy access and review by case managers, supervisors, program monitors and auditors;

j. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact, or is a judgment or conclusion on the part of anyone;

k. All persons and agencies referenced in the documentation shall be identified by name and by relationship to the client;

l. All forms prescribed by the State shall be filled out by the case manager to be complete, correct and accurate.

4. All records shall be kept for the period of time specified in the case management agency contract, and shall be made available to the state as specified in the contract.

8.509.40 ~~HCBS-MI~~HCBS-CMHS PROVIDERS

A. Any provider agency with a valid contract to provide HCBS-EBD services, according to Section 8.487, ~~of Staff Manual Volume 8,~~ shall be deemed certified to provide the same services to ~~HCBS-MI~~HCBS-CMHS clients.

THIS PAGE NOT FOR PUBLICATION

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 13-01-24-A, Revision to the Medical Assistance Rules Concerning the Hospital Provider Fee Collection and Disbursement, § 8.2003
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) 8.2003, 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: 4/30/2013
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.2003.A.3 with the new text provided. All text indicated in blue is for clarification purposes only and should not be revised. This change is effective 04/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rules Concerning the Hospital Provider Fee Collection and Disbursement, § 8.2003
Rule Number:	MSB 13-01-24-A
Division / Contact / Phone:	Finance Office / Matt Haynes / 6305

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).

Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers.

The proposed rule revisions increase payments to hospital providers to reduce uncompensated costs for services provided to Medicaid recipients and uninsured Coloradans, maximizing federal funds in accordance with the purpose of the Colorado Health Care Affordability Act, 25.5-4-402.3, C.R.S. (2012), and implements the Hospital Quality Incentive Payment (HQIP), as required by the act. HQIP links supplemental payments to measures of quality of care, process, and health outcomes.

The proposed rule increases the fees assessed on hospital providers to fund these payments, and to fund expansions of Medicaid and Child Health Plan Plus (CHP+) eligibility authorized under the Act.

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 Section 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   25.5-4-402.3, C.R.S. (2012)

Initial Review		Final Adoption	**03/08/2013**
Proposed Effective Date	**04/30/2013**	Emergency Adoption	

DOCUMENT #06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rules Concerning the Hospital Provider Fee Collection and Disbursement, § 8.2003
Rule Number:	MSB 13-01-24-A
Division / Contact / Phone:	Finance Office / Matt Haynes / 6305

REGULATORY ANALYSIS

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

Colorado hospitals benefit from increased Medicaid and Colorado Indigent Care Program (CICP) reimbursements made possible through provider fee funding. Low-income persons benefit from the expanded Medicaid and Child Health Plan Plus (CHP+) eligibility.

In regard to the Hospital Quality Incentive Payment, Colorado hospitals will benefit from the receipt of supplemental provider fee payments based on performance on measures related to the quality of care provided. Medicaid clients benefit to the extent that the supplemental payments, as well as quality measurement and reporting activities, lead to improved quality of care and health outcomes. Additionally, Colorado hospitals may be required to manually submit data to the Department via an electronic survey mechanism.

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

From October 2012 through September 2013, the provider fee will generate approximately $644 million in federal funds to Colorado. Hospitals will have an estimated net benefit of $158 million.

The total funds available annually for the inpatient quality incentive supplemental payment pool shall be equal to up to five percent (5%) of the sum of total inpatient and outpatient acute care expenditures from the prior State Fiscal Year as established in the Department's annual budget request. For the 2012-13 model year, the HQIP payments will be $32 million.

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.

While there are administrative costs associated with implementation of the Colorado Health Care Affordability Act, all such costs are covered by provider fees collected; no state General Fund is used.

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

   If no action is taken, the Department will not have the ability to fully fund Medicaid and CHP+ expansions.

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

The state does not currently have the resources to fund the hospital payments and coverage expansions under the hospital provider fee. The Department began collecting fees from hospitals in April 2010, after the rules were established and federal approval was obtained.

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 continues to meet regularly with stakeholders and the Hospital Provider Fee Oversight and Advisory Board and seeks their input and recommendations to maximize the benefit to the state from the Colorado Health Care Affordability Act. The first hospital provider fee expansions have been implemented and increased reimbursement has been made to hospitals. The proposed rules continue to fund the implementation of the Act to increase health care coverage and reduce uncompensated hospital costs for Medicaid and uninsured persons.

8.2003.A. Outpatient Services Fee

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.983~~865~~% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.