THIS PAGE NOT FOR PUBLICATION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 13-03-12-D, Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Ambulatory Surgery Center Benefit Coverage Standard Incorporation by Reference, Section 8.570.3.D.
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) Section 8.570.3.A, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Please add new subsection §8.570.3.D with two unnumbered paragraphs to existing text. This new text should be inserted immediately following §8.750.3.C.2 and immediately before *§ 8.570.4 NON-COVERED SERVICES*. All text indicated in blue is for clarification purposes only and should not be changed. This revision is effective 08/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Ambulatory Surgery Center Benefit Coverage Standard Incorporation by Reference, Section 8.570.3.D.
Rule Number:	MSB 13-03-12-D
Division / Contact / Phone:	Medicaid Programs & Services / Dana Batey / 303-866-3920

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Ambulatory Surgery Centers into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations.

The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers.

Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.

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:

Initial Review	**06/14/2013**	Final Adoption	**07/12/2013**
Proposed Effective Date	**08/30/2013**	Emergency Adoption	

DOCUMENT #01

42 CFR § 431.10

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2012);
24-4-103 C.R.S.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Ambulatory Surgery Center Benefit Coverage Standard Incorporation by Reference, Section 8.570.3.D.
Rule Number:	MSB 13-03-12-D
Division / Contact / Phone:	Medicaid Programs & Services / Dana Batey / 303-866-3920

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.

   This rule will impact Ambulatory Surgery Centers as defined in the Ambulatory Surgery Center Benefit Coverage Standard.

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

   By clearly defining clinical criteria in the Ambulatory Surgery Center Benefit Coverage Standard and then incorporating it by reference into rule, the Department hopes to achieve its goal to reduce inappropriate utilization and variations in care. Additionally, having clearly defined clinical criteria will allow the Department to have defensible policies when defending appeals. We hope that clearly defined and enforceable criteria will reduce the number of Department decisions overturned in appeals, and the general appeal volume.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   This rule does not have any costs to the Department or any other agency as a result of its implementation and enforcement.

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

   Enforceable policy statements will help the Department recover improper payments for inappropriate services rendered, uphold decisions based upon evidence-based criteria, and reduce the volume of appeals. By being able to enforce evidence-based criteria, this rule may generate cost-savings as inappropriate utilization and appeal volumes are reduced.

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

   Incorporation by reference is the least burdensome method for achieving the purpose of codifying the Department's benefit policy statements.

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 considered the traditional approach of defining the amount, duration, and scope of covered services within their Administrative Code. This approach involves the most detail found in the Administrative Code, requires that providers refer to rule text for information on the Department's covered services, and contributes to lengthy rules. In favor of simplicity, a more streamlined rule making process, and ease of accessibility the Department chose to employ the incorporation by reference method.

8.570.3 COVERED SERVICES

8.570.3.A. Covered services are those surgical and other medical procedures that:

1. Are ASC procedures that are grouped into categories corresponding to the CMS defined groups.

2. Are commonly performed on an inpatient basis in hospitals, but may be safely performed in an ASC.

3. Are limited to those requiring a dedicated operating room (or suite), and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room.

8.570.3.B. Covered surgical procedures are limited to those that do not generally exceed:

1. A total of 90 minutes operating time.

2. A total of 4 hours recovery or convalescent time.

8.570.3.C. If the covered surgical procedures require anesthesia, the anesthesia must be:

1. Local or regional anesthesia; or

2. General anesthesia of 90 minutes or less duration.

8.570.3.D. Benefit Coverage Standard Incorporated by Reference

All eligible Ambulatory Surgery Centers enrolled in the Colorado Medicaid program shall be in compliance with the Colorado Medicaid Ambulatory Surgery Center Benefit Coverage Standard (approved May 1, 2012) which is hereby incorporated by reference. The incorporation of the Ambulatory Surgery Center Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.570.4 NON-COVERED SERVICES

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Dialysis Treatment Center Benefit Coverage Standard Incorporation by Reference, Section 8.310
Rule Number:	MSB 13-03-12-F
Division / Contact / Phone:	Medicaid Programs & Services / Chris Acker, Dana Batey / 303-866-3920

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 13-03-12-F, Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Dialysis Treatment Center Benefit Coverage Standard Incorporation by Reference, Section 8.310
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) Section 8.310, 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). <Select One>

PUBLICATION INSTRUCTIONS*

Please insert new subsection at §8.310with new text provided. This subsection should be inserted immediately following the notice text that states "[8.300.13 – 8.375.60 Repealed effective 11/30/2009]" and immediately before "§8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM." This revision is effective 08/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Dialysis Treatment Center Benefit Coverage Standard Incorporation by Reference, Section 8.310
Rule Number:	MSB 13-03-12-F
Division / Contact / Phone:	Medicaid Programs & Services / Chris Acker, Dana Batey / 303-866-3920

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Dialysis Treatment Centers into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations.

The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers.

Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.

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:

Initial Review | Final Adoption

Proposed Effective Date | Emergency Adoption

DOCUMENT #

42 CFR § 431.10

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2012);
24-4-103 C.R.S.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Dialysis Treatment Center Benefit Coverage Standard Incorporation by Reference, Section 8.310
Rule Number:	MSB 13-03-12-F
Division / Contact / Phone:	Medicaid Programs & Services / Chris Acker, Dana Batey / 303-866-3920

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.

   This rule will impact Dialysis Treatment Centers as defined in the Dialysis Treatment Center Benefit Coverage Standard.

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

   By clearly defining clinical criteria in the Dialysis Treatment Center Benefit Coverage Standard and then incorporating it by reference into rule, the Department hopes to achieve its goal to reduce inappropriate utilization and variations in care. Additionally, having clearly defined clinical criteria will allow the Department to have defensible policies when defending appeals. We hope that clearly defined and enforceable criteria will reduce the number of Department decisions overturned in appeals, and the general appeal volume.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   This rule does not have any costs to the Department or any other agency as a result of its implementation and enforcement.

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

   Enforceable policy statements will help the Department recover improper payments for inappropriate services rendered, uphold decisions based upon evidence-based criteria, and reduce the volume of appeals. By being able to enforce evidence-based criteria, this rule may generate cost-savings as inappropriate utilization and appeal volumes are reduced.

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

   Incorporation by reference is the least burdensome method for achieving the purpose of codifying the Department's benefit policy statements.

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 considered the traditional approach of defining the amount, duration, and scope of covered services within their Administrative Code. This approach involves the most detail found in the Administrative Code, requires that providers refer to rule text for information on the Department's covered services, and contributes to lengthy rules. In favor of simplicity, a more streamlined rule making process, and ease of accessibility the Department chose to employ the incorporation by reference method.

8.310 Dialysis Treatment Centers

8.310.1 Dialysis Treatment Center Benefit Coverage Standard Incorporated by Reference

All Dialysis Treatment Centers enrolled in the Colorado Medicaid program shall be in compliance with the Colorado Medicaid Dialysis Treatment Center Benefit Coverage Standard (approved May 1, 2012) which is hereby incorporated by reference. The incorporation of the Dialysis Treatment Center Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

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 13-03-12-L, Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Bariatric Surgery Benefit Coverage Standard Incorporation by Reference, Section 8.300.3
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) Section 8.300.3, 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). <Select One>

PUBLICATION INSTRUCTIONS*

Please insert new subsection at §8.300.3.C provided immediately following current text at §8.300.3.B.3.a (no current text in the section of the rule should be deleted) and immediately before current text at §8.300.4 "Non-Covered Services." All text indicated in blue is for clarification purposes only and should not be revised. This change is effective 08/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Bariatric Surgery Benefit Coverage Standard Incorporation by Reference, Section 8.300.3
Rule Number:	MSB 13-03-12-L
Division / Contact / Phone:	Medicaid Programs & Services / Chris Acker, Dana Batey / 303-866-3920

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Bariatric Surgery into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations.

The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers.

Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.

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:

Initial Review — Final Adoption

Proposed Effective Date — Emergency Adoption

DOCUMENT #

42 CFR § 431.10

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2012);
24-4-103 C.R.S.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Bariatric Surgery Benefit Coverage Standard Incorporation by Reference, Section 8.300.3
Rule Number:	MSB 13-03-12-L
Division / Contact / Phone:	Medicaid Programs & Services / Chris Acker, Dana Batey / 303-866-3920

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.

   This rule will impact providers of Bariatric Surgery services as defined in the Bariatric Surgery Benefit Coverage Standard.

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

   By clearly defining clinical criteria in the Bariatric Surgery Benefit Coverage Standard and then incorporating it by reference into rule, the Department hopes to achieve its goal to reduce inappropriate utilization and variations in care. Additionally, having clearly defined clinical criteria will allow the Department to have defensible policies when defending appeals. We hope that clearly defined and enforceable criteria will reduce the number of Department decisions overturned in appeals, and the general appeal volume.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   This rule does not have any costs to the Department or any other agency as a result of its implementation and enforcement.

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

   Enforceable policy statements will help the Department recover improper payments for inappropriate services rendered, uphold decisions based upon evidence-based criteria, and reduce the volume of appeals. By being able to enforce evidence-based criteria, this rule may generate cost-savings as inappropriate utilization and appeal volumes are reduced.

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

   Incorporation by reference is the least burdensome method for achieving the purpose of codifying the Department's benefit policy statements.

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 considered the traditional approach of defining the amount, duration, and scope of covered services within their Administrative Code. This approach involves the most detail found in the Administrative Code, requires that providers refer to rule text for information on the Department's covered services, and contributes to lengthy rules. In favor of simplicity, a more streamlined rule making process, and ease of accessibility the Department chose to employ the incorporation by reference method.

8.300.3.B Covered Hospital Services – Outpatient

Outpatient Hospital Services are a Medicaid benefit when determined Medically Necessary and provided by or under the direction of a physician. Outpatient Hospital Services are limited to the scope of Outpatient Hospital Services as defined in 42 C.F.R. Section 440.20.

1. Observation Stays

Observation stays are a covered benefit as follows:

a. Clients may be admitted as Outpatients to Observation Stay status.

b. With appropriate documentation, clients may stay in observation more than 24 hours, but an Observation Stay shall not exceed forty-eight hours in length.

3. Emergency Care

a. Emergency Care Services are a Medicaid benefit, and are exempt from primary care provider referral.

b. An appropriate medical screening examination and ancillary services such as laboratory and radiology shall be available to any individual who comes to the emergency treatment facility for examination or treatment of an emergent or apparently emergent medical condition and on whose behalf the examination or treatment is requested.

8.300.3.C. Bariatric Surgery Benefit Coverage Standard Incorporated by Reference

All eligible providers of Bariatric Surgery enrolled in the Colorado Medicaid program services shall be in compliance with the Colorado Medicaid Bariatric Surgery Benefit Coverage Standard (approved August 1, 2012), which is hereby incorporated by reference. The incorporation of the Bariatric Surgery Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers Rule Language, Section 8.700
Rule Number:	MSB 13-04-22-B
Division / Contact / Phone:	HLTH PRGMS SERV &SUPP DIV / Richard Delaney / 3436

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 13-04-22-B, Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers Rule Language, Section 8.700
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) 8.700, 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 text beginning at §8.700 FEDERALLY QUALIFIED HEALTH CENTERS through the end of §8.700.7.C and replace with the new text provided that begins at §8.700 through the end of §8.700.6.D. §8.700 has been purposely omitted but § 8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS should remain as is and not be revised. This revision is effective 08/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers Rule Language, Section 8.700
Rule Number:	MSB 13-04-22-B
Division / Contact / Phone:	HLTH PRGMS SERV &SUPP DIV / Richard Delaney / 3436

3STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule change is intended to clarify existing policies, to align the current FQHC rules with current system parameters, and to remove inappropriate costs from the encounter rate. The following parts of the rule will be changed.

1) Change enrollment procedures for new FQHCs

This change allows new FQHCs to enroll in Medicaid without waiting for Medicare certification. Previously, this process took up to a year and presented significant cash flow issues for new FQHCs.

2) Add provider types that are allowed to bill an encounter

Dental hygienist and podiatrists will be explicitly allowed to bill encounters. This is currently occurring in many FQHCs and is aligned with the payment rules currently in place within the Medicaid Management Information System that looks at the types of providers eligible for encounter payments.

3) Add an "unallowable costs" section to the rules

Currently, there is an "allowable costs" section of the rule but not an "unallowable costs" section. Unallowable costs will include offsite laboratory and x-ray, costs associated with services paid by the Behavioral Health Organizations (BHOs), and costs associated with services provided by FQHCs which are not offered to Medicaid clients. Prior to this change, there was a concern that FQHCs were not offering pharmacy services to their Medicaid clients but were including this cost in the calculation of their rates. This change aligns with the State Plan Amendment language disallowing reimbursement for services not offered to Medicaid clients. Although off-site laboratory, x-ray, and BHO-paid services are not in the per-visit encounter rate for FQHCs, this rule change serves to explicitly remove such services from the encounter rate calculation.

4) Allow FQHC to bill contracted BHO on the same day as a dental and/or physical health encounter

While FQHCs have benn permitted to bill contracted BHOs on the same day as a dental or

physical health encounter in the past via provider bulletin, this practice has not been promulgated in regulation. This rule change would serve to explicitly allow FQHCs to bill BHOs for BHO-covered diagnosis and procedure codes, and would support the integration of behavioral and physical health care. This is one of five recommendations included in the Colorado Health Foundation project called Colorado PICS (Promoting Integrated Care Sustainability), and supports House Bill 12-1242, which identifies barriers to integrated care.

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 U.S.C. section 1396a(a)(30)(A), 42 U.S.C. section 1396d(1)(2)(b), Section 1905 of the Social Security Act.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   Sections 25.5-5-102, 25.5-1-301-303, C.R.S. (2012) and 10 C.C.R. 2505-10, Sectiuon 8.700.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers Rule Language, Section 8.700
Rule Number:	MSB 13-04-22-B
Division / Contact / Phone:	HLTH PRGMS SERV &SUPP DIV / Richard Delaney / 3436

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.

   There is no expected budget impact resulting from these changes, but both the Department and the FQHCs will benefit from this rule. Medicaid clients will benefit by allowing quicker approval of new FQHC providers resulting in expedited payments. By having clear approval for mental health encounters, FQHCs will be more likely to provide integrated mental health and physical health services improving the continuity of care for Medicaid clients.

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

   There is no expected budget impact to the Department, FQHCs, or Medicaid clients resulting from these changes. The reimbursement to FQHCs will not change. Qualitatively, the rule will allow both the Department and the FQHCs to improve the processes on which they work together by facilitating enrollment of each FQHC location and better opportunities for integration of mental health services and physical health services..

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 is no expected budget impact to the Department, FQHCs, or Medicaid clients resulting from these changes.

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

   The implementation of this rule will potentially allow FQHCs to provide improved services to more Medicaid recipients and it will potentially improve the billing process. Inaction will result in delay of approval for new FQHC providers which may prevent them from providing services to Medicaid clients. Inaction will also restrict the provision of mental health services at FQHCs due to the inability to submit claims for a mental health encounter.

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 ways of achieving these objectives of this 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.

   There were no alternative methods considered by the Department for achieving the objective of this rule change.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

Federally Qualified Health Center (FQHC) means a hospital-based or free standing center that meets the FQHC definition found in Section 1905(1)(2)(B) of the Social Security Act. Section 1905(1)(2)(B) of the Social Security Act is incorporated by reference. This rule does not include any later amendments to or editions of the incorporated material. A copy of Section 1905(1)(2)(B) of the Social Security Act is available for public inspection for a reasonable charge at the Colorado Department of Health Care Policy and Financing, 1570 Grant St, Denver, Colorado 80203. A copy of the incorporated material is also available for a reasonable charge from the U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954. The incorporated material may also be examined at any state publications depository library: ~~*[Eff 08/30/2006]*~~

~~1. Has been certified as a Federally Qualified Health Center under Medicare. *[Eff 08/30/2006]*~~

~~2. Is located in a rural or urban area that is designated by the Secretary of Health and Human Services as either a shortage area or a medically underserved area through the Colorado Department of Public Health and Environment. *[Eff 08/30/2006]*~~

Visit means a face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker providing the services set forth in 8.700.34. *[Eff 08/30/2006]*

~~**8.700.2 REQUIREMENTS FOR PARTICIPATION**~~

~~8.700.2.A A Federally Qualified Health Center shall be certified under Medicare. *[Eff 08/30/2006]*~~

8.700.23 CLIENT CARE POLICIES

8.700.23.A The FQHCs health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the FQHC staff. *[Eff 08/30/2006]*

8.700.32.B The policies shall include: *[Eff 08/30/2006]*

1. A description of the services the FQHC furnishes directly and those furnished through agreement or arrangement. See section 8.700.34.A.3. *[Eff 08/30/2006]*

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the FQHC. *[Eff 08/30/2006]*

3. Rules for the storage, handling and administration of drugs and biologicals. *[Eff 08/30/2006]*

8.700.34 SERVICES

8.700.34.A The following services may be provided by a certified FQHC: *[Eff 08/30/2006]*

1. General services *[Eff 08/30/2006]*

   a. Outpatient primary care services that are furnished by a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse midwife visiting nurse, clinical psychologist, podiatrist or clinical social worker as defined in their respective practice acts. *[Eff 08/30/2006]*

   b. Part-time or intermittent visiting nurse care. *[Eff 08/30/2006]*

   c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.700.34.A.1.a and b. *[Eff 08/30/2006]*

2. Emergency services. FQHCs furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures. *[Eff 08/30/2006]*

3. Services provided through agreements or arrangements. The FQHC has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including inpatient hospital care; physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the FQHC. *[Eff 08/30/2006]*

8.700.45 PHYSICIAN RESPONSIBILITIES

8.700.45.A A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on patient referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians. *[Eff 08/30/2006]*

8.700.56 ALLOWABLE COST

8.700.56.A The following types and items of cost for primary care services are included in allowable costs to the extent that they are covered and reasonable: *[Eff 08/30/2006]*

1. Compensation for the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist and clinical social worker who owns, is employed by, or furnishes services under contract to an FQHC. *[Eff 08/30/2006]*

2. Compensation for the duties that a supervising physician is required to perform. *[Eff 08/30/2006]*

3. Costs of services and supplies related to the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist or clinical social worker. *[Eff 08/30/2006]*

4. Overhead cost, including clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs. *[Eff 08/30/2006]*

5. Costs of services purchased by the clinic or center. *[Eff 08/30/2006]*

8.700.5.B Unallowable costs include but are not limited to expenses that are incurred by an FQHC and that are not for the provision of covered services, according to applicable laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per visit encounter rate for Medicaid clients.

Unallowable costs, include, but are not necessarily limited to, the following:

1. Offsite Laboratory/X-Ray;

2. Costs associated with services paid by a contracted Behavioral Health Organization (BHO) are costs for provision of covered services but not allowed in the FQHC costs; and,

3. Costs associated with clinics or cost centers which do not provide services to Medicaid clients.

8.700.~~6~~7 REIMBURSEMENT

8.700.~~6~~7.A FQHCs shall be reimbursed a per visit encounter rate based on 100% of reasonable cost. An FQHC may be reimbursed for up to three separate encounters occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: medical encounter, dental encounter, or mental health encounter. Duplicate encounters of the same service category occurring on the same

day and at the same location are prohibited unless it is a distinct mental health encounter, which is allowable only when rendered services are covered and paid by a contracted BHO.~~Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. A medical encounter and a dental encounter on the same day and at the same location shall count as two separate visits.~~

8.700.6.B A medical encounter, a dental encounter, and a mental health encounter on the same day and at the same location shall count as three separate visits.

1. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

2. Distinct mental health encounters are allowable only when rendered services are covered and paid by a contracted BHO.

8.700.~~6~~7.C~~B~~ Encounter rate calculation Effective September 1, 2009, the encounter rate shall be the average of the Prospective Payment System (PPS) rate and the alternative payment rate. Effective July 1, 2013, encounter rates will be raised by 2% with the encounter rate not to exceed the higher of the alternative payment rate or the PPS rate.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. The alternative payment rate shall be the lower of the annual rate or the base rate. The annual rate and the base rate shall be calculated as follows:

   a) Annual rates shall be the FQHCs current year's calculated inflated rate, after audit.

   b) The new base rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years. Beginning July 1, 2004 the base encounter

rate shall be inflated annually using the Medicare Economic Index to coincide with the federal reimbursement methodology for FQHCs. Base rates shall be recalculated (rebased) every three years.

3. If the PPS rate is higher than the alternative payment rate, the FQHC encounter rate shall be the PPS rate.

4. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set a reimbursement base rate for the first year. The base rate shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as a FQHC. This shall be the FQHCs base rate until the next rebasing period.

   New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

5. The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

   Freestanding FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. Freestanding FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

   The new reimbursement rate for freestanding FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement rate (if less than the new audited rate) shall remain in effect for an additional day above the 120 day limit for each day the required information is late; if the old reimbursement rate is more than the new rate, the new rate shall be effective the 120th day after the freestanding FQHCs fiscal year end.

   The new reimbursement rate for hospital-based FQHCs shall be effective January 1 of each year.

   If a hospital-based FQHC fails to provide the requested documentation, the costs associated with those activities shall be presumed to be non-primary care services and shall be settled using the Outpatient Hospital reimbursement rate.

All hospital-based FQHCs shall submit separate cost centers and settlement worksheets for primary care services and non-primary care services on the Medicare Cost Report for their facilities. Non-primary care services shall be reimbursed according to Section 8.332.

6. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual" . If a FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

8.700.~~7~~6.DC The Department shall notify the FQHC of its rate.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number:	MSB 13-04-09-C
Division / Contact / Phone:	Rates and Analysis / Luisa Sanchez de Tagle / 6277

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 13-04-09-C, Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
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) 8.300.6.A, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new text provided at §8.300.6.A.1, unnumbered paragraph #6 that begins “Effective July 1, 2013,”. This new text should be inserted immediately following unnumbered paragraph #5 that begins “Effective July 1, 2011,” and immediately before §8.300.6.A.2. All text indicated in blue is for clarification purposes only and should not be revised. This revision is effective 08/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number:	MSB 13-04-09-C
Division / Contact / Phone:	Rates and Analysis / Luisa Sanchez de Tagle / 6277

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule is being changed to comply with Senate Bill 13-230, Long Appropriations Bill, which mandates an increase of two percent for reimbursement for hospitals providing outpatient services effective July 1, 2013. Thus, the proposed rule will change the reimbursement for outpatient hospital services to 70.2% of cost which represents a payment increase of 2.0% as required by Senate Bill 13-230.

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:

   Senate Bill 13-230 Long Appropriations Bill includes a mandatory increase of 2% for outpatient hospital services effective July 1, 2013. A state plan amendment (SPA) will be submitted to CMS with a requested effective date of July 1, 2013. Reimbursement for outpatient hospital services will be made under the current rate until the SPA is approved. Once approval is received any such reimbursements made after July 1 will be adjusted to reflect the new rate contained in the rule.

3. Federal authority for the Rule, if any:

   Social Security Act, Section 1902(a)(30)(A)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   24-4-103(6), C.R.S. (2012); 25-4-402, C.R.S. (2012); Senate Bill 13-230

Initial Review — Final Adoption

Proposed Effective Date — Emergency Adoption

DOCUMENT #

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number:	MSB 13-04-09-C
Division / Contact / Phone:	Rates and Analysis / Luisa Sanchez de Tagle / 6277

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.

   Hospitals will receive increased reimbursement for outpatient hospital services provided to Medicaid clients. These costs have already been accounted for in the state budget for FY 2013-14 through Senate Bill 13-230.

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

   Reimbursement to hospitals for outpatient services is estimated to increase by $5,210,189 for FY 2013-14 as a result of the 2.0% rate increase. The increase contained in this rule will allow participating hospitals to recuperate an additional portion of their costs of providing services to Medicaid clients. As a consequence, the availability of additional funding may affect Medicaid clients by increasing the provision of services.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   This would cost the Department approximately $5,210,189 in FY 2013-14 for the increased reimbursement to hospitals. These costs have already been accounted for in the state budget for FY 2013-14 through Senate Bill 13-230. There are no additional costs to the Department or any other agency due to the implementation and enforcement of the proposed rule.

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

   The proposed rule will allow the Department to increase reimbursement to hospitals for outpatient services provided to Medicaid clients as required in Senate Bill 13-320. Hospitals will receive a 2% rate increase, which will be funded by both state and federal dollars. Inaction would leave the Department out of compliance with state legislation, and Hospitals would continue to receive reimbursement at current levels. If this rule is not adopted by 7/1/2013, the effective date of the rate increase will need to be delayed and it will not be possible to apply the increase retroactively back to 7/1/2013.

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

Senate Bill 13-230 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2013. There are no methods for achieving the purpose of the proposed rule that are less costly or less intrusive.

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.

   Senate Bill 13-230 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2013. There are no alternative methods for achieving the purpose of the proposed rule.

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary

retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

2. Payments to Out-of-Network DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7
Rule Number:	MSB 13-04-22-A
Division / Contact / Phone:	Rates and Analysis / Greg Linster / 303-866-4370

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 13-04-22-A, Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7
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) 8.700.7, 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)? Yes
   If yes, state effective date: 7/1/2013
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace the current text in the unnumbered paragraph at §8.700.7.B that begins with "Effective September 1, 2009," with the new text provided.

Please replace the current text at §8.700.7.B.2 with the new text provided.

Please replace the current text at §8.700.7.B.3 with the new text provided.

All text indicated in blue is for clarification purposes only and should not be revised. This revision is effective 08/30/2013.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7
Rule Number:	MSB 13-04-22-A
Division / Contact / Phone:	Rates and Analysis / Greg Linster / 303-866-4370

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule is being changed to comply with Senate Bill 13-230 Long Appropriations Bill, which mandated an increase of 2% for Federally Qualified Health Centers (FQHCs) effective July 1, 2013. The rate increase is not, however, allowed to exceed the higher of the Alternative Payment Methodology (APM) rate or the PPS rate.

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:

   Senate Bill 13-230 Long Appropriations Bill includes a mandatory increase of 2% for FQHCs effective July 1, 2013.

3. Federal authority for the Rule, if any:

   Social Security Act, Section 1902(a)(30)(A)
(42 U.S.C. § 1396a(a)(30)(A))

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
24-4-103(6), C.R.S. (2012); Senate Bill 13-230

Initial Review | Final Adoption

Proposed Effective Date | Emergency Adoption

DOCUMENT #

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7
Rule Number:	MSB 13-04-22-A
Division / Contact / Phone:	Rates and Analysis / Greg Linster / 303-866-4370

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.

   Federally Qualified Health Centers (FQHCs) will receive increased reimbursements for services provided to Medicaid clients.

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

   Reimbursements to FQHCs are estimated to increase by $2,124,383 for FY 2013-14 as a result of the 2% rate increase. The rate increase contained in this rule will reduce the necessary reimbursement cuts applied in 9/1/2009. As a consequence, more funding is available to providers which will affect Medicaid clients by increasing the provision of services. If this rule is not adopted by 7/1/2013, the Department will be out of compliance with state law.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   This proposed rule would cost the Department approximately $2,124,383 in FY 2013-14 for the increased reimbursement to FQHCs. These costs have already been accounted for in the state budget for FY 2013-14 through Senate Bill 13-230. There are no additional costs to the Department or any other agency due to the implementation and enforcement of the proposed rule.

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

   As is required by Senate Bill 13-320, the proposed rule will allow the Department to increase the reimbursement rate received by FQHCs for services provided to Medicaid clients. Specifically, FQHCs will receive a 2% rate increase, which will be funded by both state and federal dollars. There would be no benefit to inaction, as it would result in the Department operating out of compliance with state legislation, and FQHCs would continue to receive reimbursement at the current rate levels.

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

Senate Bill 13-230 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2013. There are no methods for achieving the purpose of the proposed rule that are less costly or intrusive.

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.

   Senate Bill 13-230 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2013. There are no alternative methods for achieving the purpose of the proposed rule.

8.700.7 REIMBURSEMENT

8.700.7.A FQHCs shall be reimbursed a per visit encounter rate based on 100% of reasonable cost. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. A medical encounter and a dental encounter on the same day and at the same location shall count as two separate visits.

8.700.7.B Encounter rate calculation

Effective September 1, 2009, the encounter rate shall be the average of the Prospective Payment System (PPS) rate and the alternative payment rate. Effective July 1, 2013, encounter rates will be raised by 2% with the encounter rate not to exceed the higher of the alternative payment rate or the PPS rate.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. The alternative payment rate shall be the lower of the annual rate or the base rate. The annual rate and the base rate shall be calculated as follows:

   a) Annual rates shall be the FQHCs current year's calculated inflated rate, after audit.

   b) The new base rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years. Beginning July 1, 2004 the base encounter rate shall be inflated annually using the Medicare Economic Index to coincide with the federal reimbursement methodology for FQHCs. Base rates shall be recalculated (rebased) every three years.

3. If the PPS rate is higher than the alternative payment rate, the FQHC encounter rate shall be the PPS rate.

4. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set a reimbursement base rate for the first year. The base rate shall be calculated using the audited cost report showing

actual data from the first fiscal year of operations as a FQHC. This shall be the FQHCs base rate until the next rebasing period.

New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

5. The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

   Freestanding FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. Freestanding FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

   The new reimbursement rate for freestanding FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement rate (if less than the new audited rate) shall remain in effect for an additional day above the 120 day limit for each day the required information is late; if the old reimbursement rate is more than the new rate, the new rate shall be effective the 120th day after the freestanding FQHCs fiscal year end.

   The new reimbursement rate for hospital-based FQHCs shall be effective January 1 of each year.

   If a hospital-based FQHC fails to provide the requested documentation, the costs associated with those activities shall be presumed to be non-primary care services and shall be settled using the Outpatient Hospital reimbursement rate.

   All hospital-based FQHCs shall submit separate cost centers and settlement worksheets for primary care services and non-primary care services on the Medicare Cost Report for their facilities. Non-primary care services shall be reimbursed according to Section 8.332.

6. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual" . If a FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

8.700.7.C

The Department shall notify the FQHC of its rate.

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process. This outstationing payment shall be made based upon actual cost with a reasonable cost-per-application limit to be established by the Department. The reasonable cost-per application limit shall be based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall the outstationing payment for FQHCs exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities.

8.700.8.B

1. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

2. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. Effective with the hospital cost report year 2010 and forward, the Department will make an interim payment to Denver Health Medical Center for estimated reasonable costs associated with outstationing activities based on the costs included in the as-filed Medicare cost report. This interim payment will be reconciled to actual costs after the cost report is audited. Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the interim estimated administrative costs and the final audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

8.700.8.C To receive payment, FQHCs shall submit annual logs of applicant information to the Department with their cost report. Applicant logs shall include the applicant's name, date of application, and social security number if available.

8.700.8.D Reimbursement for outstationing administrative costs shall be determined according to the following guidelines:

1. Freestanding FQHCs shall report on a supplementary schedule the administrative and general direct pass-through costs associated with outstationing activities. The Department shall allocate appropriate overhead costs (not separately identified) to calculate the total facility outstationing administrative expenses incurred. Freestanding FQHCs shall receive an annual lump sum retrospective payment based on the audited cost report.

2. Hospitals with hospital-based FQHCs shall submit the administrative and general pass through direct and indirect costs associated with outstationing activities on an extra line on the Medicaid Cost Report and submit all other source documentation to compute allowable outstationing costs. Hospitals with hospital-based FQHCs shall receive payment in accordance with 8.700.8.B. The reimbursement shall be separately identified on the Medicaid Settlement Sheet.

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 13-04-23-A, Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increases, Section 8.590.7.I
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) 8.590.7.I, 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)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please delete all current text beginning at §8.590.7.I through §8.590.7.I.3 and replace with the new text provided. All text indicated in blue is for clarification purposes only and should not be revised or deleted. This revision is effective 08/30/2013.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increases, Section 8.590.7.I
Rule Number:	MSB 13-04-23-A
Division / Contact / Phone:	Office of Clinical Services, Pharmacy Unit / Andrea Skubal / 303-866-2113

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule will increase the DME encounter rate by 2% to account for General Assembly funding appropriation.

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:

   This rule is being changed to comply with Senate Bill 13-230, Long Appropriations Bill, which mandated an increase of 2% for the Durable Medical Equipment encouter rate, effective July 1, 2013.

3. Federal authority for the Rule, if any:

   A state plan amendment (SPA) will be submitted to CMS with a requested effective date of July 1, 2013. Reimbursement for the Durable Medical Equipment encounter rate will be made under the current rate until the SPA is approved. Once approval is received, any such reimbursements made after July 1, 2013 will be adjusted to reflect the new rate contained in the rule.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   25.5-4-401, 25.5-4-416, C.R.S. (2012); and
   Senate Bill 13-230.

Initial Review | Final Adoption

Proposed Effective Date | Emergency Adoption

DOCUMENT #

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increases, Section 8.590.7.I
Rule Number:	MSB 13-04-23-A
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REGULATORY ANALYSIS

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

   DME providers will receive increased reimbursement for equipment and supplies provided.

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

   Reimbursement to DME providers is estimated to be increased by $2,100,089 for FY 2013-14.

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.

   No costs beyond the estimated expenditures due to the rate increase are anticipated.

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

   Although the rate change is expected to increase expenditures, the proposed rule revision is in response to recent years' reductions and is highly anticipated by providers. Although inaction would result in cost savings, the cost would likely be realized through decreased client services and access to benefits. Providers have expressed concern over their ability to continue supplying items that are at their incremental threshold margin.

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

   The proposed changes to increase the provider reimbursement rates were specifically targeted to those provider rates that had been the subject of rate reductions in recent years. There is not a less costly method for achieving the purpose of the proposed rule, which is to reinstate previous rates.

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 is targeting the 2% rate increase for services that were impacted by rate reductions in recent years. An alternative method for achieving a rate increase for the proposed rule was not considered.

8.590.7 REIMBURSEMENT

8.590.7.A. Invoices received from Related Owners or Related Parties shall not be accepted. Only invoices received from unrelated manufacturers or wholesale distributors shall be recognized as allowable invoices.

8.590.7.B. The provider shall not bill the Department for authorized accessory items included by the manufacturer as part of a standard package for an item.

8.590.7.C. The provider shall credit the cost of any accessory or part removed from a standard package to the Department.

8.590.7.D. Clients and providers may negotiate in good faith a trade-in amount for DME items no longer suitable for a client because of growth, development or a change in anatomical and or medical condition. Such trade-in allowances shall be used to reduce the cost incurred by the Department for a replacement item.

8.590.7.E. The refund amount due the Department on a returned Wheelchair or Facilitative Device shall be agreed upon by the dealer or manufacture; wherever the item was returned, and the Department.

8.590.7.F. Reimbursement for allowable modifications, service, and repairs on durable medical equipment is as follows:

1. Labor for modifications, service, and repairs on durable medical equipment shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

2. Parts that are listed on the Department's fee schedule, with a HCPCS code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

3. Manually priced parts are reimbursed according to the same methodology used for purchased equipment, as described in 8.590.7.I.

4. The provider shall not be reimbursed for labor or parts in excess of unit limitations.

5. Reimbursement for a modification that requires the original equipment provider to supply a part from their own inventory or stock is contingent upon the provider submitting supporting documentation that demonstrates the need and actual cost of the parts to be used in the modification.

8.590.7.G. Reimbursement for used equipment shall include:

1. A written, signed and dated agreement from the client accepting the equipment.

2. Billing the Department, the lesser of 60% of the maximum allowable reimbursement indicated in the most recent Medicaid Bulletin or 60% of the provider's usual submitted charges.

8.590.7.H. Reimbursement for purchased or rented equipment shall include, but is not limited to:

1. All elements of the manufacturer's warranties or express warranties.

2. All adjustments and modification needed by the client to make the item useful and functional.

3. Delivery, set-up and installation of equipment in the home, and if appropriate to a specific room in the home.

4. Training and instruction to the client or caregiver in the safe, sanitary, effective and appropriate use of the item and necessary servicing and maintenance to be done by the client or caregiver.

5. Training and instruction on the manufacturer's instructions, servicing manuals and operating guides.

8.590.7.I. Reimbursement rate for a purchased item shall be as follows:

1. Fee Schedule items, with a HCPC or CPT code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the ~~d~~Department fee schedule rate.

2. Manually priced items that do not have an assigned Fee Schedule rate shall be reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP) less 21.43 percent.

3. Manually priced items that do not have an MSRP or Fee Schedule rate shall be reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus 14.96 percent.

~~Manually priced items that have no maximum allowable reimbursement rate assigned, but have a Manufacture Suggested Retail Price (MSRP) shall be reimbursed the MSRP less 22.97 percent.~~

~~3. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a MSRP shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturers invoice cost, plus 12.71 percent.~~

8.590.7.J. Reimbursement for rental items shall be billed and paid in monthly increments unless otherwise indicated in the Medicaid Bulletin.

8.590.7.K. Reimbursement for clients eligible for both Medicare and Medicaid shall be made in the following manner:

1. The provider shall bill Medicare first unless otherwise authorized by the Department.

2. If Medicare makes payment, Medicaid reimbursement will be based on appropriate deductibles and co-payments.

3. If Medicare denies payment, the provider shall be responsible for billing the Department. Reimbursement is dependent upon the following conditions:

    a. A copy of the Explanation of Medicare Benefits' shall be maintained in the provider's files when billing electronically or attached to the claim if it is billed manually; or

    b. Medicaid reimbursement shall not be made if the Medicare denial is based upon provider submission error.