DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Transgender Services, Section 8.735
Rule Number: MSB 17-03-21-B
Division / Contact / Phone: Health Programs Benefits & Operations / Amanda Forsythe / 303-866-6459 / Jesse Durfee / 303-866-5519

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 17-03-21-B, Revision to the Medical Assistance Benefits Rule Concerning Transgender Services, Section 8.735
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) 8.735, 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*

Replace the current text at 8.735 with the proposed text starting at 8.735.5.D through the end of 8.735.7.A. This rule is effective August 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Transgender Services, Section 8.735
Rule Number: MSB 17-03-21-B
Division / Contact / Phone: Health Programs Benefits & Operations / Amanda Forsythe / 303-866-6459 / Jesse Durfee / 303-866-5519

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 clearly defines and codifies the amount, duration, and scope of covered gender transition-related services available to Colorado Medicaid clients. Colorado Medicaid currently covers medically necessary counseling, hormone therapy, and surgery to eligible clients. The proposed rule does not add coverage of any new services.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   92 CFR Part 92

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);

Initial Review **06/09/17** Final Adoption **07/14/17**
Proposed Effective Date **08/30/17** Emergency Adoption

DOCUMENT #01

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Transgender Services, Section 8.735
Rule Number: MSB 17-03-21-B
Division / Contact / Phone: Health Programs Benefits & Operations / Amanda Forsythe / 303-866-6459 / Jesse Durfee / 303-866-5519

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 Medicaid clients and providers will both benefit from having the amount, duration, and scope of covered transgender-related services clearly defined and codified in 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 proposed rule will have a positive impact on Colorado Medicaid clients' and providers' understanding of which services are covered, the eligibility criteria one must meet to provide or receive the covered services, as well as other requirements like documentation, potential limitations, etc.

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.

   The proposed rule does not increase the amount, duration, or scope of any covered service, nor does it add any new service to those currently covered by Colorado Medicaid.

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

   The probable cost of inaction is the continued confusion by Colorado Medicaid clients and providers as to the eligibility requirements and extent of coverage for transgender-related services. The benefit to the proposed rule is that it clearly defines, and makes enforceable, the Department's transgender related services coverage policy.

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

There are not less costly or less intrusive methods for achieving the purpose of the proposed rule, which is clarifying and codifying the amount, duration, and scope of covered transgender related services.

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, which is clarifying and codifying the amount, duration, and scope of covered transgender related services.

8.735 TRANSGENDER SERVICES

8.735.1 Definitions

Cross Sex-Hormone Therapy means a course of hormone replacement therapy intended to induce or change secondary sex characteristics.

Gender Confirmation Surgery means a surgery to change primary or secondary sex characteristics to affirm a person's gender identity. Also known as gender affirmation surgery or sex reassignment surgery.

Gender Dysphoria means either: gender dysphoria, as defined in the Diagnostic Statistical Manual of Mental Disorders, 5th Edition (DSM-5), codes 302.85 or 302.6; or gender identity disorder, as defined in the International Classification of Disease, 10th Edition (ICD-10), codes F64. 1-9, or Z87.890.

Gonadotropin-Releasing Hormone Therapy means a course of reversible pubertal or gonadal suppression therapy used to block the development of secondary sex characteristics in adolescents.

8.735.2 Client Eligibility

8.735.2.A. Clients with a clinical diagnosis of gender dysphoria are eligible for the transgender services benefit, subject to the service-specific criteria and restrictions detailed in section 8.735.5.

8.735.4 Provider Eligibility

8.735.4.A. Enrolled providers are eligible to provide transgender services if:

1. Licensed by the Colorado Department of Regulatory Agencies or the licensing agency of the state in which the provider practices;

2. Services are within the scope of the provider's practice; and

3. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

8.735.5 Covered Services

8.735.5.A. The following requirements apply to all covered transgender services:

1. Client has a clinical diagnosis of gender dysphoria;

2. Requested service is medically necessary, as defined in section 8.076.1.8.;

3. Any contraindicated medical and behavioral health conditions have been addressed and are well-controlled;

4. Client has given informed consent for the service; and

5. Subject to the exceptions in C.R.S. §13-22-103, if client is under 18 years of age, client's parent(s) or legal guardian has given informed consent for the service.

8.735.5.B. Requests for services for clients under 21 years of age are evaluated in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program criteria detailed in section 8.280.

8.735.5.C. Behavioral health services are covered in accordance with section 8.212.

8.735.5.D. Hormone Therapy

1. Covered hormone therapy services are limited to the following:

   a. Gonadotropin-Releasing Hormone (GnRH) Therapy

      i) GnRH therapy is a covered service for a client who:

         1) Meets the criteria at section 8.735.5.A.;

         2) Meets the applicable pharmacy criteria at section 8.800; and

         3) Has been referred to a licensed behavioral health provider and has a plan in place to receive behavioral health counseling concurrent with GnRH therapy.

   b. Cross-Sex Hormone Therapy

      i) Cross-sex hormone therapy is a covered service for a client who:

         1) Meets the criteria at section 8.735.5.A.; and

         2) Meets the applicable pharmacy criteria at section 8.800.

      ii) Other cross-sex hormone therapy requirements

         1) Prior to beginning cross-sex hormone therapy, a licensed behavioral health provider, with whom the client has an established and ongoing relationship, must determine that any behavioral health conditions or concerns have been addressed and are well-controlled.

         2) For the first twelve (12) months of cross-sex hormone therapy:

            a) Client must receive ongoing behavioral health counseling at a frequency determined to be clinically appropriate by the behavioral health provider; and

            b) Client must receive medical assessments at a frequency determined to be clinically appropriate by the prescribing provider.

8.735.5.E. Surgical Procedures

1. A surgical procedure listed in section 8.735.5.E.3.– 5. is a covered service for a client who:

   a. Meets the criteria section 8.735.5.A.1.–4.;
   b. Is 18 years of age or older;
   c. Has lived in the preferred gender role for twelve (12) continuous months;
   d. Has completed twelve (12) continuous months of hormone therapy, unless medically contraindicated;
   e. Has been evaluated by a licensed medical provider within the past sixty (60) days; and
   f. Has been evaluated by a licensed behavioral health provider within the past sixty (60) days.

2. Rendering surgical providers must retain the following documentation for each client:
   a. A signed statement from a licensed behavioral health provider, with whom the client has an established and ongoing relationship, demonstrating that:
      i) Criteria in section 8.735.5.E.1.a.–d. and f. have been met; and
      ii) A post-operative care plan is in place.
   b. A signed statement from a licensed medical provider, with whom the client has an established and ongoing relationship, demonstrating that:
      i) Criteria in section 8.735.5.E.1.a.–e. have been met; and
      ii) A post-operative care plan is in place.

3. Covered genital surgeries are limited to the following:

   a. Ovariectomy/oophorectomy

   b. Salpingo-oophorectomy

   c. Hysterectomy

   d. Vaginectomy

   e. Vulvectomy

   f. Metoidioplasty

   g. Phalloplasty

   h. Erectile prosthesis

   i. Scrotoplasty

   j. Testicular prostheses

   k. Urethroplasty

   l. Orchiectomy

   m. Penectomy

   n. Prostatectomy

   o. Clitoroplasty

   p. Vaginoplasty

   q. Vulvoplasty

   r. Labiaplasty

   s. Permanent hair removal to treat surgical tissue donor sites

4. Covered breast/chest surgeries are limited to the following:

   a. Mastectomy

b. Mammoplasty is covered when:

i) Client has completed twenty-four (24) continuous months of hormone therapy that has proven ineffective for breast development, unless medically contraindicated.

c. Permanent hair removal to treat surgical tissue donor sites

5. Pre- and post-operative services are covered when:

a. Related to a covered surgical procedure listed in section 8.735.5.E.; and

b. Medically necessary, as defined in section 8.076.1.8.

8.735.6 Prior Authorization

8.735.6.A. Prior authorization requests for hormone therapy services listed in section 8.735.5.D. must be submitted in accordance with the requirements in section 8.800.7.

8.735.6.B. All prior authorization requests must provide documentation demonstrating that the applicable requirements in section 8.735.5 have been met.

8.735.7 Non-Covered Services

8.735.7.A. The following services are not covered under the transgender services benefit:

1. Any items or services excluded from coverage under section 8.011.1.

2. Reversal of surgical procedures listed in section 8.735.5.E.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
Rule Number: MSB 17-04-21-A
Division / Contact / Phone: Health Programs Benefits & Operations Division / Amanda Forsythe / 303-866-6459

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 17-04-21-A, Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520

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) 8.520, 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)? <Select One>

   If yes, state effective date: 08/30/17

   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.520 with the proposed text beginning at 8.520.1 through the end of 8.520.11.B. This rule is effective August 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
Rule Number: MSB 17-04-21-A
Division / Contact / Phone: Health Programs Benefits & Operations Division / Amanda Forsythe / 303-866-6459

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 rule defines the amount, duration, and scope of covered home health services. This revision updates the home health services rule by adding provisions concerning face-to-face visits and place of service limitations, as required under recently issued federal regulations, both of which must be effective by July 1, 2017. Specifically, this revision aligns the Colorado Medicaid home health services rule with federal regulations by adding: (1) a requirement that the physician must document a face-to-face encounter with the Medicaid client for the authorization of home health services within particular timelines; and (2) language clarifying that Medicaid home health services are not limited solely to home settings.

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:

   The recently issued federal home health regulations, concerning documentation of face-to-face encounters and place of service limitations, explicitly require that the Department be in compliance with the new provisions by July 1, 2017.

3. Federal authority for the Rule, if any:

   42 CFR 440.70

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);

Initial Review — Final Adoption **07/14/17**
Proposed Effective Date **08/30/17** — Emergency Adoption

DOCUMENT #02

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
Rule Number: MSB 17-04-21-A
Division / Contact / Phone: Health Programs Benefits & Operations Division / Amanda Forsythe / 303-866-6459

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.

   The proposed rule will affect ordering providers by requiring that they must document the occurrence of a face-to-face encounter with any Colorado Medicaid client for whom they order home health services. The proposed rule will also affect home health services clients: First, it will require that the client participates in a face-to-face visit with the ordering provider to receive home health services. Second, by clarifying that home health services may be received in any setting in which normal life activities take place, it will allow many clients to receive home health services out in the community.

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 proposed rule will have a positive impact on those clients who will be able to receive necessary home health services while engaged in normal life activities in the community and not just while in the home.

   The proposed rule's face-to-face documentation requirement will likely have a moderate economic impact on the ordering providers, an analysis of which is detailed in the February 2016 Centers for Medicare & Medicaid Services Final Rule concerning Medicaid home 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 anticipated cost or effect on state revenues of 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 cost of inaction is the Department being out of compliance with federal regulations, which could result a corrective action plan, financial penalties, or other federal enforcement actions.

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 methods or less intrusive methods for achieving the purpose of the proposed rule, which is the Department's compliance with new federal regulatory requirements.

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, which is the Department's compliance with new federal regulatory requirements.

8.520 HOME HEALTH SERVICES

8.520.1. Definitions

8.520.1.A. Activities of Daily Living (ADL) means daily tasks that are required to maintain a ~~client~~~~member~~client's health, and include eating, bathing, dressing, toileting, grooming, transferring, walking, and continence. When a ~~client~~~~member~~client is unable to perform these activities independently, skilled or unskilled providers may be required for the ~~client~~~~member~~client's needs.

8.520.1.B. Acute Medical Condition means a medical condition which has a rapid onset and short duration. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

8.520.1.C. Alternative Care Facility means an assisted living residence licensed by the Colorado Department of Public Health and Environment (CDPHE), and certified by the Department of Health Cc~~c~~are Policy and Financing (Department) to provide Assisted Living Care Services and protective oversight to ~~client~~~~member~~clients.

8.520.1.D. Behavioral Intervention means techniques, therapies, and methods used to modify or minimize aggressive (verbal/physical), combative, destructive, disruptive, repetitious, resistive, self-injurious, or other inappropriate behaviors outlined on the CMS-485 Plan of Care (defined below). Behavioral interventions exclude frequent verbal redirection or additional time to transition or complete a task, which are part of the general assessment of the ~~client~~~~member~~client's needs.

8.520.1.E. Care Coordination means the deliberate organization of ~~client~~~~member~~client care activities between two or more participants (including the ~~client~~~~member~~client) for the appropriate delivery of health care and health support services, and organization of personnel and resources needed for required ~~client~~~~member~~client care activities.

8.520.1.F. Certified Nurse Aide Assignment Form means the form used by the Home Health Agency to list the duties to be performed by the Certified Nurse Aide (CNA) at each visit.

8.520.1.G. Department means the Colorado Department of Health Care Policy and Financing which is designated as the single State Medicaid agency for Colorado, or any divisions or sub-units within that agency.

8.520.1.H. Designee means the entity that has been contracted by the Department to review for the Medical Necessity and appropriateness of the requested services, including Home Health prior authorization requests (PARs). Designees may include case management entities such as Single Entry Points or Community Centered Boards who manage waiver eligibility and review.

8.520.1.I. Home Care Agency means an entity which provides Home Health or Personal Care Services. When referred to in this rule without a 'Class A' or 'Class B' designation, the term encompasses both types of agencies~~y~~.

8.520.1.J. Home Health Agency means an agency that is licensed as a Class A Home Care Agency in Colorado, and is certified to provide skilled care services to Medicare and Medicaid eligible ~~client~~~~member~~client~~s~~. Agencies shall hold active and current Medicare and Medicaid provider IDs to provide services to Medicaid ~~client~~~~member~~client~~s~~.

8.520.1.K. Home Health Services means those services listed at Section 8.520.5, Service Types.

8.520.1.L. Home Health Telehealth means the remote monitoring of clinical data transmitted through electronic information processing technologies, from the ~~client~~~~member~~client to the home health provider which meet HIPAA compliance standards.

8.520.1.M. Intermittent means visits that have a distinct start time and stop time, and are task oriented with the goal of meeting a ~~client~~~~member~~client's specific needs for that visit.

8.520.1.N. Ordering Physician means the ~~client~~~~member~~client's primary care physician, or other physician specialist. For ~~client~~~~member~~client~~s~~ in a hospital or nursing facility, the Ordering Physician is the physician responsible for writing discharge orders until such time as the ~~client~~~~member~~client is discharged. This definition may include an alternate physician authorized by the Ordering Physician to care for the ~~client~~~~member~~client in the Ordering Physician's absence.

8.520.1.O. Personal Care Worker means an employee of a licensed Home Care Agency who has completed the required training to provide Personal Care Services, or who has verified experience providing Personal Care Services for ~~client~~~~member~~client~~s~~. A Personal Care Worker shall not perform~~-~~ tasks that are considered skilled CNA services.

8.520.1.P. Place of Residence means where the ~~client~~~~member~~client lives. Includes temporary accommodations, homeless shelters or other locations for ~~client~~~~member~~client~~s~~ who are homeless or have no permanent residence.

8.520.1.Q. Plan of Care means a coordinated plan developed by the Home Health Agency, as ordered by the Ordering Physician for provision of services to a ~~client~~~~member~~client at his or her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements. This shall be written on the CMS-485 ("485") or a document that is identical in content, specific to the discipline completing the plan of care.

8.520.1.R. Pro Re Nata (PRN) means as needed.

8.520.1.S. Protective Oversight means maintaining an awareness of the general whereabouts of a ~~client~~~~member~~client. Also includes monitoring the ~~client~~~~member~~client's activity so that a caregiver has the ability to intervene and supervise the safety, nutrition, medication, and other care needs of the ~~client~~~~member~~client.

8.520.2. ~~Client~~~~Member~~Client Eligibility

8.520.2.A. Home Health Services are available to all Medicaid ~~client~~~~member~~clients and to all Old Age Pension Program ~~client~~~~member~~clients, as defined at Section 8.940, when all program and service requirements in this rule are met.

8.520.2.B. Medicaid ~~client~~~~member~~clients aged 18 and over shall meet the Level of Care Screening Guidelines for Long-Term Care Services at Section 8.401, to be eligible for Long-Term Home Health Services, as set forth at Section 8.520.4.C.2.

8.520.3. Provider Eligibility

8.520.3.A. Services must be provided by a Medicare and Medicaid-certified Home Health Agency.

8.520.3.B. All Home Health Services providers shall comply with the rules and regulations set forth by the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, the Colorado Department of Regulatory Agencies, the Centers for Medicare and Medicaid Services, and the Colorado Department of Labor and Employment.

8.520.3.C. Provider Agency Requirements

1. A Home Health Agency must:

   a. Be certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act;

   b. Be a Colorado Medicaid enrolled provider;

   c. Maintain liability insurance for the minimum amount set annually by the Department; and

   d. Be licensed by the State of Colorado as a Class A Home Care Agency in good standing.

2. Home Health Agencies which perform procedures in the ~~client~~~~member~~client's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 shall possess a certificate of waiver from the Centers for Medicare and Medicaid Services (CMS) or its Designee.

3. Home Health Agencies shall regularly review the Medicaid rules, 10 CCR 2505-10. The Home Health Agency shall make access to these rules available to all staff.

4. A Home Health Agency cannot discontinue or refuse services to a ~~client~~~~member~~client unless documented efforts have been made to resolve the situation that triggers such

discontinuation or refusal. The Home Health Agency must provide notice of at least thirty days to the ~~client~~~~member~~client, or the ~~client~~~~member~~client's legal guardian.

5. In the event a Home Health Agency is ceasing operations, or ceasing services to Medicaid ~~client~~~~member~~clients, the agency will provide notice to the Department's Home Health Policy Specialist of at least thirty days prior to the end of operations.

8.520.4. Covered Services

8.520.4.A. Home Health Services are covered under Medicaid only when all of the following are met:

1. Services are Medically Necessary as defined in Section 8.076.1.8;

2. Services are provided under a Plan of Care as defined at Section 8.520.1., Definitions;

3. Services are provided on an Intermittent basis, as defined at Section 8.520.1., Definitions;

4. The ~~Client~~~~Member~~client meets one of the following:

   a. The only alternative to Home Health Services is hospitalization or emergency room care; or

   b. ~~Client~~~~Member~~Client medical records indicate that medically necessary services should be provided in the ~~client~~~~member~~client's place of residence, instead of an outpatient setting, according to one or more of the following guidelines:

      i) The ~~client~~~~member~~client, due to illness, injury or disability, is unable to travel to an outpatient setting for the needed service;

      ii) Based on the ~~client~~~~member~~client's illness, injury, or disability, travel to an outpatient setting for the needed service would create a medical hardship for the ~~client~~~~member~~client;

      iii) Travel to an outpatient setting for the needed service is contraindicated by a documented medical diagnosis;

      iv) Travel to an outpatient setting for the needed service would interfere with the effectiveness of the service; or

      v) The ~~client~~~~member~~client's medical diagnosis requires teaching which is most effectively accomplished in the ~~client~~~~member~~client's place of residence on a short-term basis.

5. The ~~client~~~~member~~client is unable to perform the health care tasks for him or herself, and no unpaid family/caregiver is able and willing to perform the tasks; and

6. Covered service types are those listed in Service Types, Section 8.520.5.

8.520.4.B. Place of Service

1. Services shall be provided in the ~~client~~~~member~~client's place of residence or one of the following places of service:

   a. Assisted Living Facilities (ALFs);

   b. Alternative Care Facilities (ACFs);

   c. Group Residential Services and Supports (GRSS) including host homes, apartments or homes where three or fewer ~~client~~~~member~~clients reside. Services shall not duplicate those that are the contracted responsibility of the GRSS;

   d. Individual Residential Services and Supports (IRSS) including host homes, apartments or homes where three or fewer ~~client~~~~member~~clients reside Services shall not duplicate those that are the contracted responsibility of the IRSS; or

   e. Hotels, or similar temporary accommodations while traveling, will be considered the temporary place of residence for purposes of this rule.

   f. Nothing in this section should be read to prohibit a client from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

~~**2. A ClientMember's place of residence shall not include a nursing facility or hospital.**~~

8.520.4.C. Service Categories

1. Acute Home Health Services

   a. Acute Home Health Services are covered for ~~client~~~~member~~clients who experience an acute health care need that requires Home Health Services.

   b. Acute Home Health Services are provided for 60 or fewer calendar days or until the acute medical condition is resolved, whichever comes first.

   c. Acute Home Health Services are provided for the treatment of the following acute medical conditions/episodes:

      i) Infectious disease;

ii) Pneumonia;

iii) New diagnosis of a life-altering disease;

iv) Post-heart attack or stroke;

v) Care related to post-surgical recovery;

vi) Post-hospital care provided as follow-up care for medical conditions that required hospitalization, including neonatal disorders;

vii) Post-nursing home care, when the nursing home care was provided primarily for rehabilitation following hospitalization and the medical condition is likely to resolve or stabilize to the point where the ~~client~~~~member~~client will no longer need Home Health Services within 60 days following initiation of Home Health Services;

viii) Complications of pregnancy or postpartum recovery; or

iv) Individuals who experience an acute incident related to a chronic disease may be treated under the acute home health benefit. Specific information on the acute incident shall be documented in the record.

d. A ~~client~~~~member~~client may receive additional periods of acute Home Health Services when at least 10 days have elapsed since the ~~client~~~~member~~client's discharge from an acute home health episode and one of the following circumstances occurs:

i) The ~~client~~~~member~~client has a change in medical condition that necessitates acute Home Health Services;

ii) New onset of a chronic medical condition; or

iii) Treatment needed for a new acute medical condition or episode.

e. Nursing visits provided solely for the purpose of assessment or teaching are covered only during the acute period under the following guidelines:

i) An initial assessment visit ordered by a physician is covered for determination of whether ongoing nursing or CNA care is needed. Nursing visits for the sole purpose of assessing a ~~client~~~~member~~client for recertification of Home Health Services shall not be reimbursed if the ~~client~~~~member~~client receives only CNA services;

ii) The visit instructs the ~~client~~~~member~~client or client's family ~~member~~~~client~~member/caregiver in providing safe and effective care that would normally be provided by a skilled home health provider; or

iii) The visit supervises the ~~client~~~~member~~client or client's family ~~member~~~~client~~member/caregiver to verify and document that they are competent in providing the needed task.

f. Acute Home Health Services may be provided to ~~client~~~~member~~clients who receive Health Maintenance tasks through In-Home Supports and Services (IHSS) or Consumer Directed Attendant Supports and Services (CDASS).

g. GRSS group home residents may receive acute Home Health Services.

h. If the acute home health ~~client~~~~member~~client is hospitalized for planned or unplanned services for 10 or more calendar days, the Home Health Agency may close the ~~client~~~~member~~client's acute home health episode and start a new acute home health episode when the ~~client~~~~member~~client is discharged.

i. Acute Care Home Health Limitations:

i) A new period of acute Home Health Services shall not be used for continuation of treatment from a prior Acute Home Health episode. New Acute Episodes must be utilized for a new or worsening condition.

ii) A ~~client~~~~member~~client who is receiving either Long-Term Home Health Services or HCBS waiver services may receive acute Home Health Services only if the ~~client~~~~member~~client experiences an event listed in subpart c. as an acute incident, which is separate from the standard needs of the ~~client~~~~member~~client and makes acute Home Health Services necessary.

iii) If a ~~client~~~~member~~client's acute medical condition resolves prior to 60 calendar days from onset, the ~~client~~~~member~~client shall be discharged from acute home health or transitioned to the ~~client~~~~member~~client's normal Long-Term Home Health services.

2. Long-Term Home Health Services

a. Long-term Home Health Services are covered for ~~client~~~~member~~clients who have long-term chronic needs requiring ongoing Home Health Services.

b. Long-term Home Health Services may be provided to ~~client~~~~member~~clients who receive health maintenance tasks through IHSS.

c. Long-term Home Health Services may not be provided to ~~client~~~~member~~clients who receive health maintenance tasks through CDASS.

d. Long-term Home Health Services are provided:

i) Following the 60th calendar day for acute home health ~~client~~~~member~~client<u>s</u> who require additional services to meet treatment goals or to be safely discharged from Home Health Services;

ii) On the first day of Home Health Services for ~~client~~~~member~~client<u>s</u> with well documented chronic needs when the ~~client~~~~member~~client does not require an acute home health care transition period; or

iii) Continuation of ongoing long-term home health Plan of Care.

e. Long-Term Home Health Limitations:

i) ~~Client~~~~Member~~Client<u>s</u> aged 20 and younger may obtain long-term home health physical therapy, occupational therapy, and speech therapy services when Medically Necessary and when:

1) Therapy services will be more effective if provided in the home setting; or

2) Outpatient therapy would create a hardship for the ~~client~~~~member~~client.

ii) ~~Client~~~~Member~~Client<u>s</u> aged 21 and older who continue to require physical therapy, occupational therapy, and speech therapy services after the initial acute home health period may only obtain such long-term services in an outpatient setting.

iii) ~~Client~~~~Member~~Client<u>s</u> admitted to long-term Home Health Services through the HCBS waiver program shall meet level of care criteria to qualify for long-term Home Health Services.

iv) Long-term Home Health Services may be provided in GRSS group home settings, when the GRSS provider agency reimburses the Home Health Agency directly for these Home Health Services. Long-term Home Health Service provision in GRSS group homes is not reimbursable through the State Plan.

3. Long-Term with Acute Episode Home Health:

a. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

b. Long-term with acute episode home health is covered if the ~~client~~~~member~~client is receiving long-term home health services and requires treatment for an acute episode as defined in section 8.520.4.C.1.

8.520.5. Service Types

8.520.5.A. Nursing Services

1. Standard Nursing Visit

   a. Those skilled nursing services that are provided by a registered nurse under applicable state and federal laws, and professional standards;

   b. Those skilled nursing services provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws;

   c. Standard Nursing Visits include but are not limited to:

      i. 1st medication box fill (medication pre-pouring) of the week;

      ii. 1st visit of the day; the remaining visits shall utilize brief nursing units as appropriate;

      iii. Insertion or replacement of indwelling urinary catheters;

      iv. Colostomy and ~~illeostomy~~ileostomy stoma care; excluding care performed by ~~client~~~~member~~clients;

      v. Treatment of decubitus ulcers (stage 2 or greater);

      vi. Treatment of widespread, infected or draining skin disorders;

      vii. Wounds that require sterile dressing changes;

      viii. Visits for foot care;

      ix. Nasopharyngeal, tracheostomy aspiration or suctioning, ventilator care;

      x. Bolus or continuous Levin tube and gastrostomy (G-tube) feedings, when formula/feeding needs to be prepared or more than 1 can of prepared formula is needed per bolus feeding per visit, ONLY when there is not an able or willing caregiver; and

      xi. Complex Wound care requiring packing, irrigation, and application of an agent prescribed by the physician.

2. Brief Nursing Visits

   a. Brief nursing visits for established long-term home health ~~client~~~~member~~clients who require multiple visits per day for uncomplicated skilled tasks that can be completed in a shorter or brief visit (excluding the first regular nursing visit of the day)

b. Brief Nursing Visits include, but are not limited to:

i) Consecutive visits for two or more ~~client~~~~member~~client<u>s</u> who reside in the same location and are seen by the same Home Health Agency nurse, excluding the first visit of the day;

ii) Intramuscular, intradermal and subcutaneous injections (including insulin) when required multiple times daily, excluding the first visit of the day;

iii) Insulin administration: if the sole reason for a daily visit or multiple visits per day, the first visit of the week is to be treated as a standard nursing visit and all other visits of the week are to be treated as brief nursing visits.

iv) Additional visits beyond the first visit of the day where simple wound care dressings are the sole reason for the visit;

v) Additional visits beyond the first visit of the day where catheter irrigation is the sole reason for the visit;

vi) Additional visits beyond the first visit of the day where external catheterization, or catheter care is the sole purpose for the visit;

vii) Bolus Levin or G-tube feedings of one can of prepared formula excluding the first visit of the day, ONLY when there is no willing or able caregiver and it is the sole purpose of the visit;

viii) Medication box refills or changes following the first medication pre-pouring of the week;

ix) Other non-complex nursing tasks as deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate; or

x) A combination of uncomplicated tasks when deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate.

c. Ongoing assessment shall be billed as brief nursing visits unless the ~~client~~~~member~~client experiences a change in status requiring a standard visit. If a standard nursing visit is required for the assessment, the agency shall provide documentation supporting the need on the PAR form and on the Plan of Care for the Department or its Designee.

3. PRN Nursing Visits

a. May be standard nursing visits or brief nursing visits; and

b. Shall include specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.

4. Nursing Service Limitations

a. Nursing assessment visits are not covered if provided solely to open or recertify the case for CNA services, physical, occupational, or speech therapy.

b. Nursing visits solely for recertifying a ~~client~~~~member~~client are not covered.

c. Nursing visits that are scheduled solely for CNA supervision are not covered.

d. Family member/caregivers, who meet the requirements to provide nursing services and are nurses credentialed by, and in active status with the Department of Regulatory Agencies, may be employed by the Home Health Agency to provide nursing services to a ~~client~~~~member~~client, but may only be reimbursed for services that exceed the usual responsibilities of the Family Member/Caregiver.

e. PRN nursing visits may be requested as standard nursing visits or brief nursing visits and shall include a physician's order with specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.

f. Nursing visits are not reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Behavioral Health Organization. Nursing visits for mentally ill ~~client~~~~member~~clients are reimbursed under Home Health Services for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

g. Medicaid does not reimburse for two nurses during one visit except when two nurses are required to perform a procedure. For this exception, the provider may bill for two visits, or for all units for both nurses. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

h. Nursing visits provided solely for the purpose of assessing or teaching are reimbursed by the Department only in the following circumstances:

i) Nursing visits solely for the purpose of assessing the ~~client~~~~member~~client or teaching the ~~client~~~~member~~client or the ~~client~~~~member~~client's unpaid family ~~member~~~~client~~member/caregiver are not reimbursed unless the care is acute home health or long-term home health with acute episode, per Section 8.520.3, or the care is for extreme instability of a chronic medical condition under long-term home health, per Section 8.520.3. Long-term home health nursing visits for the sole purpose of assessing or teaching are not covered.

ii) When an initial assessment visit is ordered by a physician and there is a reasonable expectation that ongoing nursing or CNA care may be

needed. Initial nursing assessment visits cannot be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.

iii) When a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the ~~client~~~~member~~client or the ~~client~~~~member~~client's unpaid family ~~member~~~~client~~member/caregiver how to perform the task, the visit is not considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the ~~client~~~~member~~client or unpaid family member/caregiver performing the task to verify that the task is being performed correctly is considered a visit that is solely for the purpose of assessing and teaching and is not covered.

iv) Nursing visits provided solely for the purpose of assessment or teaching cannot exceed the frequency that is justified by the ~~client~~~~member~~client's documented medical condition and symptoms. Assessment visits may continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific medical conditions or symptoms which are not stable or not resolved. Teaching visits may be as frequent as necessary, up to the maximum reimbursement limits, to teach the ~~client~~~~member~~client or the ~~client~~~~member~~client's unpaid family ~~member~~~~client~~member/caregiver, and may continue only as long as needed to demonstrate understanding or to perform care, or until it is determined that the ~~client~~~~member~~client or unpaid family ~~member~~~~client~~member/caregiver is unable to learn or to perform the skill being taught. The visit in which the nurse determines that there is no longer a need for assessment or teaching shall be reimbursed if it is the last visit provided solely for assessment or teaching.

v) Nursing visits provided solely for the purpose of assessment or teaching are not reimbursed if the ~~client~~~~member~~client is capable of self-assessment and of contacting the physician as needed, and if the ~~client~~~~member~~client's medical records do not justify a need for ~~client~~~~member~~client teaching beyond that already provided by the hospital or attending physician, as determined and documented on the initial Home Health assessment.

vi) Nursing visits provided solely for the purpose of assessment or teaching cannot be reimbursed if there is an available and willing unpaid family ~~member~~~~client~~member/caregiver who is capable of assessing the ~~client~~~~member~~client's medical condition and needs and contacting the physician as needed; and if the ~~client~~~~member~~client's medical records do not justify a need for teaching of the ~~client~~~~member~~client's unpaid family ~~member~~~~client~~member/caregiver beyond the teaching already provided by the hospital or attending physician, as determined and documented on the initial Home Health assessment.

i.) Nursing visits provided solely for the purpose of providing foot care are reimbursed by Medicaid only if the ~~client~~~~member~~client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the ~~client~~~~member~~client or unpaid family ~~member~~~~client~~member/caregiver is not able or willing to provide the foot care.

j.) Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit. The clinical record shall indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for foot care to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

i) Absent (not palpable) posterior tibial pulse;

ii) Absent (not palpable) dorsalis pedis pulse;

iii) Three of the advanced trophic changes:

1) Hair growth (decrease or absence),

2) Nail changes (thickening),

3) Pigmentary changes (discoloration),

4) Skin texture (thin, shiny), or

5) Skin color (rubor or redness);

iv) Claudication (limping, lameness);

v) Temperature changes (cold feet);

vi) Edema;

vii) Parasthesia; or

viii) Burning.

kl.) Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers are reimbursed only if:

i) The ~~client~~~~member~~client is not living in a licensed Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at C.R.S. 25-1.5-301;

ii) The ~~client~~~~member~~client is not physically or mentally capable of pre-pouring medications or has a medical history of non-compliance with taking medications if they are not pre-poured;

iii) The ~~client~~~~member~~client has no unpaid family ~~member~~~~client~~member/caregiver who is willing or able to pre-pour the medications for the ~~client~~~~member~~client; and

iv) There is documentation in the ~~client~~~~member~~client's chart that the ~~client~~~~member~~client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular ~~client~~~~member~~client.

l. The unit of reimbursement for nursing services is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~~~member~~client care or treatment.

8.520.5.B. Certified Nurse Aide Services

1. CNA services may be provided when a nurse or therapist determines that an eligible ~~client~~~~member~~client requires the skilled services of a qualified CNA, as such services are defined in this section 8.520.5.B.13

2. CNA tasks shall not duplicate waiver services or the ~~client~~~~member~~client's residential agreement (such as an ALF, IRSS, GRSS, or other Medicaid reimbursed Residence, or adult day care setting).

3. Skilled care shall only be provided by a CNA when a ~~client~~~~member~~client is unable to independently complete one or more ADLs. Skilled CNA services shall not be reimbursed for tasks or services that are the contracted responsibilities of an ALF, IRSS, GRSS or other Medicaid reimbursed Residence.

4. Before providing any services, all CNAs shall be trained and certified according to Federal Medicare regulations, and all CNA services shall be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 CFR 484.36. Title 42 of the Code of Federal Regulations, Part 484.36 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy~~

~~and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~.

5. If the ~~client~~~~member~~client receiving CNA services also requires and receives skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist shall make on-site supervisory visits to the ~~client~~~~member~~client's home no less frequently than every two weeks.

6. If the ~~client~~~~member~~client receiving CNA services does not require skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse shall make on-site supervisory visits to the ~~client~~~~member~~client's home no less frequently than every 60 days. Each supervisory visit shall occur while the CNA is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the CNA services, and cannot be billed to Medicaid as nursing visits.

7. Registered nurses and physical, occupational and speech therapists supervising CNAs shall comply with applicable state laws governing their respective professions.

8. CNA services can include personal care and homemaking tasks if such tasks are completed during the skilled care visit and are defined below:

   a. Personal care or homemaking services which are directly related to and secondary to skilled care are considered part of the skilled care task, and are not further reimbursed. For ~~client~~~~member~~clients who are also eligible for HCBS personal care and homemaker services, the units spent on personal care and homemaker services may not be billed as CNA services.

   b. Nurse aide tasks performed by a CNA pursuant to the nurse aide scope of practice defined by the State Board of Nursing, but does not include those tasks that are allowed as personal care, at Section 8.535, PEDIATRIC PERSONAL CARE.

   c. Personal care means those tasks which are allowed as personal care at Section 8.535, PEDIATRIC PERSONAL CARE, and Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE.

   d. Homemaking means those tasks allowed as homemaking tasks at Section 8.490, HOME AND COMMUNITY BASED SERVICES. - EBD, HOMEMAKER SERVICES.

~~1~~9~~0~~. CNA services solely for the purpose of behavior management are not a benefit under Medicaid Home Health, because behavior management is outside the nurse aide scope of practice.

101. The usual frequency of all tasks is as ordered by the Ordering Physician on the Plan of Care unless otherwise noted.

112. The Home Health Agency shall document the decline in medical condition or the need for all medically necessary skilled tasks.

123. Skilled Certified Nurse Aide Tasks

a. Ambulation

i) Task includes: Walking or moving from place to place with or without assistive device.

ii) Ambulation is a skilled task when:

1) ClientMemberClient is unable to assist or direct care;

2) Hands on assistance is required for safe ambulation and clientmemberclient is unable to maintain balance or to bear weight reliably; or

3) ClientMemberClient has not been deemed independent with assistive devices ordered by a qualified physician.

iii) Special Considerations: Ambulation shall not be a sole reason for a CNA visit.

b. Bathing/Showering

i) Task includes either:

1) Preparation for bath or shower, checking water temperature; assisting clientmemberclient into bath or shower; applying soap and shampoo; rinsing off, towel drying; and all transfers and ambulation related to bathing; all hair care, pericare and skin care provided in conjunction with bathing; or

2) Bed bath or sponge bath.

ii) The usual frequency of this task shall be up to one time daily.

iii) Bathing/Showering is a skilled task when either:

1) Open wound(s), stoma(s), broken skin or active chronic skin disorder(s) are present; or

2) ~~Client~~~~Member~~Client is unable to maintain balance or to bear weight due to illness, injury, disability, a history of falls, temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

iv) Special Considerations:

1) Additional baths may be warranted for treatment and shall be documented by physician order and Plan of Care.

2) A second person may be staffed when required to safely bathe the ~~client~~~~member~~client.

3) Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~~~member~~client in Activities of Daily Living when there has been a change in the ~~client~~~~member~~client's medical condition that has increased the ~~client~~~~member~~client's ability to perform this task.

c. Bladder Care

i) Task includes:

1) Assistance with toilet, commode, bedpan, urinal, or diaper;

2) Transfers, skin care, ambulation and positioning related to bladder care; and

3) Emptying and rinsing commode or bedpan after each use.

ii) Bladder Care concludes when the ~~client~~~~member~~client is returned to a pre-urination state.

iii) Bladder Care is a skilled task when either:

1) ~~Client~~~~Member~~Client is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days); or

2) ~~Client~~~~Member~~Client requires skilled skin care associated with bladder care or ~~client~~~~member~~client has been assessed as having a high and ongoing risk for skin breakdown.

d. Bowel Care

i) Task includes:

1) Changing and cleaning incontinent ~~client~~~~member~~client, or hands on assistance with toileting; and

2) Returning ~~client~~~~member~~client to pre-bowel movement status, which includes transfers, skin care, ambulation and positioning related to bowel care.

ii) Bowel care is a skilled task when ~~either :~~either:

1) ~~Client~~~~Member~~Client is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days) is present; or

2) ~~Client~~~~Member~~Client requires skilled skin care associated with bowel care or ~~client~~~~member~~client has been assessed as having a high and ongoing risk for skin breakdown.

e. Bowel Program

i) Skilled Task includes:

1) Administering bowel program as ordered by the ~~client~~~~member~~client's qualified physician, including digital stimulation, administering enemas, suppositories, and returning ~~client~~~~member~~client to pre-bowel program status; or

2) Care of a colostomy or ~~illeostomy~~ileostomy, which includes emptying the ostomy bag, changing the ostomy bag and skin care at the site of the ostomy and returning the ~~client~~~~member~~client to pre-procedure status.

ii) Special Considerations

1) To perform the task, the ~~client~~~~member~~client must have a relatively stable or predictable bowel program/condition and a qualified physician deems that the CNA is competent to provide the ~~client~~~~member~~client-specific program.

2) Use of digital stimulation and over-the-counter suppositories or over-the-counter enema (not to exceed 120ml) only when the CNA demonstrates competence in the Home Health Agency's Policies & Procedures for the task. (Agencies may choose to delegate this task to the CNA.)

f. Catheter Care

i) Task includes:

1) Care of external, Foley and Suprapubic catheters;

2) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care;

3) Emptying catheter bags; and

4) Transfers, skin care, ambulation and positioning related to the catheter care.

ii) The usual frequency of this task shall not exceed two times daily.

iii) Catheter care is a skilled task when either:

1) Emptying catheter collection bags (indwelling or external) includes a need to record and report the ~~client~~~~member~~client's urinary output to the ~~client~~~~member~~client's nurse; or

2) The indwelling catheter tubing needs to be opened for any reason and the ~~client~~~~member~~client is unable to do so independently.

iv) Special Considerations: Catheter care shall not be the sole purpose of the CNA visit.

g. Dressing

i) Task includes:

1) Dressing and undressing with ordinary clothing, including pantyhose or socks and shoes;

2) Placement and removal of braces and splints; and

3) All transfers and positioning related to dressing and undressing.

ii) The usual frequency of this task shall not exceed twice daily.

iii) Dressing is a skilled task when:

1) ~~Client~~~~Member~~Client requires assistance with the application of anti-embolic or pressure stockings and placement of braces or splints that can be obtained only with a prescription from a qualified physician; or

2) ~~Client~~~~Member~~Client is unable to assist or direct care; or

3) ~~Client~~~~Member~~Client experiences a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

iv) Special Considerations: Hand-over-hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~~~member~~client in Activities of Daily Living when there has been a change in the ~~client~~~~member~~client's

medical condition that has increased the ~~client~~~~member~~client's ability to perform this task.

h. Exercise/Range of Motion (ROM)

i) Task includes: ROM and other exercise programs prescribed by a therapist or qualified physician, and only when the ~~client~~~~member~~client is not receiving exercise/ROM from a therapist or a doctor on the same day.

ii) Exercise/Range of Motion (ROM) is a skilled task when: The exercise/ROM, including passive ROM, is prescribed by a qualified physician and the CNA has demonstrated competency.

iii) Special Considerations: The Home Health Agency shall ensure the CNA is trained in the exercise program. The Home Health Agency shall maintain the exercise program documentation in the ~~client~~~~member~~client record and it shall be evaluated/renewed by the qualified physician or therapist with each Plan of Care.

i. Feeding

i) Task includes:

1) Ensuring food is the proper temperature, cutting food into bite-size pieces, and ensuring the food is proper consistency;

2) Placing food in ~~client~~~~member~~client's mouth; and

3) Gastric tube (g-tube) formula preparation, verifying placement and patency of tube, administering tube feeding and flushing tube following feeding if the Home Health Agency and supervising nurse deem the CNA competent.

ii) The usual frequency of this task shall not exceed three times daily.

iii) Feeding is a skilled task when:

1) ~~Client~~~~Member~~Client is unable to communicate verbally, non-verbally or through other means;

2) ~~Client~~~~Member~~Client is unable to be positioned upright;

3) ~~Client~~~~Member~~Client is on a modified texture diet;

4) ~~Client~~~~Member~~Client has a physiological or neurogenic chewing or swallowing problem;

5) ~~Client~~~~Member~~Client is on mechanical ventilation;

6) ~~Client~~~~Member~~Client requires oral suctioning;

7) A structural issue (such as cleft palate) or other documented swallowing issues are present; or

8) ~~Client~~~~Member~~Client has a history of aspirating food.

iv) Special Considerations:

1) There shall be a documented decline in medical condition or an ongoing need documented in the ~~client~~~~member~~client's record.

2) A Home Health Agency may ~~delegate~~ allow a CNA to perform a syringe feeding and tube feeding if the CNA is ~~to a CNA it~~ deem~~ed~~s~~d~~ competent.

j. Hygiene – Hair Care/Grooming

i) Task includes: Shampooing, conditioning, drying, and combing.

ii) Task does not include perming, hair coloring, or other extensive styling including, but not limited to, updos, placement of box braids or other elaborate braiding or placing hair extensions.

iii) Task may be completed during skilled bath/shower.

iv) The usual frequency of this task shall not exceed twice daily.

v) Hygiene – Hair Care/Grooming is a skilled task when:

1) ~~Client~~~~Member~~Client is unable to complete task independently;

2) ~~Client~~~~Member~~Client requires shampoo/conditioner that is prescribed by a qualified physician and dispensed by a pharmacy; or

3) ~~Client~~~~Member~~Client has open wound(s) or stoma(s) on the head.

vi) Special Considerations:

1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~~~member~~client in Activities of Daily Living when there has been a change in the ~~client~~~~member~~client's medical condition that has increased the ~~client~~~~member~~client's ability to perform this task.

2) Styling of hair is never considered a skilled task.

k. Hygiene – Mouth Care

i) Task includes:

1) Brushing teeth;

2) Flossing;

3) Use of mouthwash;

4) Denture care;

5) Swabbing (toothette); or

6) Oral suctioning.

ii) The usual frequency of this task is up to three times daily.

iii) Hygiene – Mouth Care is a skilled task when:

1) ~~Client~~~~Member~~Client is unconscious;

2) ~~Client~~~~Member~~Client has difficulty swallowing;

3) ~~Client~~~~Member~~Client is at risk for choking and aspiration;

4) ~~Client~~~~Member~~Client requires oral suctioning;

5) ~~Client~~~~Member~~Client has decreased oral sensitivity or hypersensitivity; or

6) ~~Client~~~~Member~~Client is on medications that increase the risk of bleeding of the mouth.

iv) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~~~member~~client in Activities of Daily Living when there has been a change in the ~~client~~~~member~~client's medical condition that has increased the ~~client~~~~member~~client's ability to perform this task.

l. Hygiene – Nail Care

i) Task includes: Soaking, filing, and nail trimming.

ii) The usual frequency of this task shall not exceed one time weekly.

iii) Hygiene – Nail Care is a skilled task when:

1) The ~~client~~~~member~~client has a medical condition that involves peripheral circulatory problems or loss of sensation;

2) The ~~client~~~~member~~client is at risk for bleeding; or

3) The ~~client~~~~member~~client is at high risk for injury secondary to the nail care.

iv) Nail Care shall only be completed by a CNA who has been deemed competent in nail care by the Home Health Agency for this population.

v) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~~~member~~client in Activities of Daily Living when there has been a change in the ~~client~~~~member~~client's medical condition that has increased the ~~client~~~~member~~client's ability to perform this task.

m. Hygiene – Shaving

i) Task includes: shaving of face, legs and underarms with manual or electric razor.

~~i~~ii) The usual frequency of this task shall not exceed once daily; task may be completed with bathing/showering.

~~i~~iii) Hygiene – Shaving is a skilled task when:

1) The ~~client~~~~member~~client has a medical condition involving peripheral circulatory problems;

2) The ~~client~~~~member~~client has a medical condition involving loss of sensation;

3) The ~~client~~~~member~~client has an illness or takes medications that are associated with a high risk for bleeding; or

4) The ~~client~~~~member~~client has broken skin at/near shaving site or a chronic active skin condition.

iv) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~~~member~~client in Activities of Daily Living when there has been a change in the ~~client~~~~member~~client's medical condition that has increased the ~~client~~~~member~~client's ability to perform this task.

n. Meal Preparation

i) Task includes:

1) Preparation of food, ensuring food is proper consistency based on the ~~client~~~~member~~client's ability to swallow food safely; or

2) Formula preparation.

ii) The usual frequency of this task shall not exceed three times daily.

iii) Meal Preparation is a skilled task when: ~~Client~~~~Member~~Client's diet requires either nurse oversight to administer correctly, or meals requiring a modified consistency.

o. Medication Reminders

i) Task includes:

1) Providing ~~client~~~~member~~client reminders that it is time to take medications;

2) Handing of pre-filled medication box to ~~client~~~~member~~client;

3) Handing of labeled medication bottle to ~~client~~~~member~~client; or

4) Opening of prefilled box or labeled medication bottle for ~~client~~~~member~~client.

ii) This task may be completed by a CNA during the course of a visit, but cannot be the sole purpose of the visit.

iii) A CNA may not perform this task, unless the CNA meets the DORA-approved CNA-MED certification, at 3 C.C.R. § 716-1 Chapter 19 Section 6. If the CNA does not meet the DORA certifications, the CNA may still ask if the ~~client~~~~member~~client has taken medications and may replace oxygen tubing and may set oxygen to ordered flow rate.

iv) Special Considerations: CNAs shall not administer medications without obtaining the CNA-MED certification from the DORA approved course. 3 C.C.R. 716-1 Chapter 19 Section 6. If the CNA has obtained this certification, the CNA may perform pre-pouring and medication administration within the scope of CNA-MED certification at 3 C.C.R. 716-1 Chapter 19 Section 3.

p. Positioning

i) Task includes:

1) Moving the ~~client~~~~member~~client from the starting position to a new position while maintaining proper body alignment and support to a ~~client~~~~member~~client's extremities, and avoiding skin breakdown; and

2) Placing any padding required to maintain proper alignment.

3) Positioning as a stand-alone task excludes positioning that is completed in conjunction with other Activities of Daily Living.

ii) Positioning is a skilled task when:

1) ~~Client~~~~Member~~Client is unable to communicate verbally, non-verbally or through other means;

2) ~~Client~~~~Member~~Client is not able to perform this task independently due to illness, injury or disability; or

3) ~~Client~~~~Member~~Client has temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

4) Positioning the ~~client~~~~member~~client requires adjusting the ~~client~~~~member~~client's alignment or posture in a bed, wheelchair, other furniture, assistive devices, or Durable Medical Equipment that has been ordered by a qualified physician.

iii) Special Considerations:

1) The Home Health Agency shall coordinate visits to ensure that effective scheduling is utilized for skilled Intermittent visits.

2) Positioning cannot be the sole reason for a visit.

q. Skin Care

i) Task includes:

1) Applying lotion or other skin care product, when it is not performed in conjunction with bathing or toileting tasks.

ii) Skin care is a skilled task when:

1) ~~Client~~~~Member~~Client requires additional skin care that is prescribed by a qualified physician or dispensed by a pharmacy;

2) ~~Client~~~~Member~~Client has broken skin; or

3) ~~Client~~~~Member~~Client has a wound(s) or active skin disorder and is unable to apply product independently due to illness, injury or disability.

iii) Special Considerations:

1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~~~member~~client in Activities of Daily Living when there has been a change in the ~~client~~~~member~~client's medical condition that has increased the ~~client~~~~member~~client's ability to perform this task.

2) This task may be included with positioning.

r. Transfers

i) Task includes:

1) Moving the ~~client~~~~member~~client from one location to another in a safe manner.

ii) It is not considered a separate task when a transfer is performed in conjunction with bathing, bladder care, bowel care or other CNA task.

iii) Transfers is a skilled task when:

1) ~~Client~~~~Member~~Client is unable to communicate verbally, non-verbally or through other means;

2) ~~Client~~~~Member~~Client is not able to perform this task independently due to fragility of illness, injury or disability;

3) ~~Client~~~~Member~~Client has a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability;

4) ~~Client~~~~Member~~Client lacks the strength and stability to stand or bear weight reliably;

5) ~~Client~~~~Member~~Client is not deemed independent in the use of assistive devices or Durable Medical Equipment that has been ordered by a qualified physician; or

6) ~~Client~~~~Member~~Client requires a mechanical lift for safe transfers. In order to transfer ~~client~~~~member~~clients via a mechanical lift, the CNA shall be deemed competent in the particular mechanical lift used by the ~~client~~~~member~~client.

iv) Special Considerations:

1) A second person may be used when required to safely transfer the ~~client~~~~member~~client.

2) Transfers may be completed with or without mechanical assistance.

3) Any unskilled task which requires a skilled transfer shall be considered a skilled task.

s. Vital Signs Monitoring

i) Task includes:

1) Taking and reporting the temperature, pulse, blood pressure and respiratory rate of the ~~client~~~~member~~client.

2) Blood glucose testing and pulse oximetry readings only when the CNA has been deemed competent in these measures.

ii) Vital sign monitoring is always a skilled task.

iii) Special Considerations:

1) Shall only be performed when delegated by the ~~client~~~~member~~client's nurse. Vital signs monitoring cannot be the sole purpose of the CNA visit.

2) Vital signs shall be taken only as ordered by the ~~client~~~~member~~client's nurse or the Plan of Care and shall be reported to the nurse in a timely manner.

3) The CNA shall not provide any intervention without the nurse's direction, and may only perform interventions that are within the CNA practice act and for which the CNA has demonstrated competency.

134. Certified Nurse Aide Limitations

a. In accordance with the Colorado Nurse Aide Practice Act, a CNA shall only provide services that have been ordered on the Home Health Plan of Care as written by the Ordering Physician.

b. CNAs assist with Activities of Daily Living and cannot perform a visit for the purpose of behavior modification. When a ~~Client~~~~Member~~c~~C~~lient's disabilities involve behavioral manifestations, the CNA shall follow all applicable behavioral plans and refrain from actions that will escalate or upset the ~~client~~~~member~~client. In such cases the guardian, case manager, behavioral professional or mental health professional shall provide clear direction to the agency for the provision of care. The CNA shall not perform Behavioral Interventions, beyond those listed in c. of this section.

c. If the ~~client~~~~member~~client has a behavior plan created by a behavior or mental health professional, the CNA shall follow this plan within their scope and training

to the same extent that a family ~~member~~client or paraprofessional in a school would be expected to follow the plan.

d. When an agency allows a CNA to perform skilled tasks that require competency or delegation, the agency shall have policies and procedures regarding its process for determining the competency of the CNA. All competency testing and documentation related to the CNA shall be retained in the CNA's personnel file.

e. CNA services can only be ordered when the task is outside of the usual responsibilities of the ~~client~~~~member~~client's family ~~member~~~~client~~member/caregiver.

f. Cuing or hand over hand assistance to complete Activities of Daily Living is not considered a skilled task, however, the agency may provide up to 90 days of care to teach a ~~client~~~~member~~client Activities of Daily Living when the ~~client~~~~member~~client is able to learn to perform the tasks independently. Cuing or hand over hand care that exceeds 90 days, or is provided when the ~~client~~~~member~~client has not had a change in ability to complete self-care techniques, is not covered. If continued cuing or hand over hand assistance is required after 90 days, this task shall be transferred to a Personal Care Worker or other competent individual who can continue the task.

g. Personal care needs or skilled CNA services that are the contracted responsibility of an ALF, GRSS or IRSS are not reimbursable as a separate Medicaid Home Health Service.

h. Family ~~member~~~~clients~~members/caregivers who meet all relevant requirements may be employed as a ~~client~~~~member~~client's CNA, but may only provide services that are identified in this benefit coverage standard as skilled CNA services and that exceed the usual responsibilities of the family ~~member~~~~client~~member/caregiver. Family ~~member~~~~client~~member/caregiver CNAs must meet all CNA requirements.

i. All CNAs who provide Home Health Services shall be subject to all requirements set forth by the policies of the Home Health Agency, and all applicable State and Federal laws.

j. When a CNA holds other licensure(s) or certification(s), but is employed as or functions as a CNA, the services are reimbursed at the CNA rate for services.

k. CNA visits cannot be approved for, nor can extended units be billed for the sole purpose of completing personal care, homemaking tasks or instrumental Activities of Daily Living.

l. Personal care needs for ~~client~~~~member~~clients ages twenty years and under, not directly related to a skilled care task, shall be addressed through Section 8.535, PEDIATRIC PERSONAL CARE.

m. Homemaker Services provided as directly related tasks secondary to skilled care during a skilled CNA visit shall be limited to the permanent living space of the ~~client~~~~member~~client. Such services are limited to tasks that benefit the

~~client~~~~member~~client and are not for the primary benefit of other persons living in the home.

n. Nursing or CNA visits, or requests for extended visits, for the sole purpose of Protective Oversight are not reimbursable by Medicaid.

o. CNA services for the sole purpose of providing personal care or homemaking services are not covered.

p. The Department does not reimburse for services provided by two CNAs to the same ~~client~~~~member~~client at the same time, except when two CNAs are required for transfers, there are no other persons available to assist, and the reason why adaptive equipment cannot be used instead is documented in the Plan of Care. For this exception, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

q. The basic unit of reimbursement for CNA services is up to one hour. A unit of time that is less than fifteen minutes cannot be reimbursed as a basic unit.

r. For CNA visits that last longer than one hour, extended units may be billed in addition to the basic unit. Extended units shall be increments of fifteen minutes up to one-half hour. Any unit of time that is less than fifteen minutes cannot be reimbursed as an extended unit.

1~~4~~5. Certified Nurse Aide (CNA) Supervision

a. CNA services shall be supervised by a registered nurse, by the physical therapist, or when appropriate, the speech therapist or occupational therapist depending on the specific Home Health Services the ~~client~~~~member~~client is receiving.

b. If the ~~client~~~~member~~client receiving CNA services is also receiving skilled nursing care or physical therapy or occupational therapy, the supervising registered nurse or therapist shall make supervisory visits to the ~~client~~~~member~~client's home no less frequently than every 14 days. The CNA does not have to be present for every supervisory visit. However, the registered nurse, or the therapist shall make on-site supervisory visits to observe the CNA in the ~~client~~~~member~~client's home at least every 60 days.

c. If the ~~client~~~~member~~client is only receiving CNA services, the supervising registered nurse or the physical therapist shall make on-site supervisory visits to observe the CNA in the ~~client~~~~member~~client's home at least every 60 days.

d. The Department does not reimburse for any visit made solely for the purpose of supervising the CNA.

e. For all ~~client~~~~member~~clients expected to require CNA services for at least a year, during supervisory visits the supervising nurse shall:

i) Obtain input from the ~~client~~~~member~~client, or the ~~client~~~~member~~client's designated representative into the Certified Nurse Aide Assignment Form, including all CNA tasks to be performed during each scheduled time period.

ii) Document details, duties, and obligations on the Certified Nurse Aide Assignment Form.

iii) Assure the Certified Nurse Aide Assignment Form contains information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information pertinent to the care to be provided by the CNA.

iv) Obtain the ~~client~~~~member~~client's, or the ~~client~~~~member~~client's authorized representative's, per section 8.520.7.E.1, signature on the form, and provide a copy to the ~~client~~~~member~~client at the beginning of services, and at least once per year thereafter. A new copy of the Written Notice of Home Care Consumer Rights form, per section 8.520.7.E.1, shall also be provided at these times.

v) Explain the rights listed in the patient's rights form whenever the Certified Nurse Aide Assignment Form is renegotiated and rewritten.

vi) For purposes of complying with this requirement, once per year means a date within one year of the prior certification.

15~~6~~. If a ~~client~~~~member~~client does not meet the factors that make a task skilled, as outlined in Section 8.520.5., the ~~client~~~~member~~client may be eligible to receive those services as unskilled personal care through Section 8.535, PEDIATRIC PERSONAL CARE, or Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE.

8.520.5.C. Therapy Services

1. Therapies are only covered:

a. In acute home health care; or

b. ~~Client~~~~Member~~Clients 20 years of age or younger may receive long-term home health therapy when services are medically necessary.

c. When the ~~client~~~~member~~client's Ordering Physician prescribes therapy services, and the therapist is responsible for evaluating the ~~client~~~~member~~client and creating a treatment plan with exercises in accordance with practice guidelines.

2. The therapist shall teach the ~~client~~~~member~~client, the ~~client~~~~member~~client's family ~~member~~~~client~~member/caregiver and other ~~member~~client~~s~~ of the Home Health care team to perform the exercises as necessary for an optimal outcome.

3. When the therapy Plan of Care includes devices and equipment, the therapist shall assist the ~~client~~~~member~~client in initiating or writing the request for equipment and train the ~~client~~~~member~~client on the use of the equipment.

4. Home Health Agencies shall only provide physical, occupational, or speech therapy services when:

   a. Improvement of functioning is expected or continuing;

   b. The therapy assists in overcoming developmental problems;

   c. Therapy visits are necessary to prevent deterioration;

   d. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration, and to teach CNAs or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; or

   e. Therapy visits are indicated to assess the safety or optimal functioning of the ~~client~~~~member~~client in the home, or to train in the use of equipment used in implementation of the therapy Plan of Care.

5. Physical Therapy

   a. Physical therapy includes any evaluations and treatments allowed under state law at C.R.S. 12- 41-101 through 130, which are applicable to the home setting.

   b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through 8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.

   c. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation in Medicare, at 42 CFR 484.4; and who meets all requirements under state law. Title 42 of the Code of Federal Regulations, Part 484.4 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~is hereby incorporated by reference into this rule. Such~~

~~incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~.

i) ~~i)~~ Physical therapy assistants (PTA) can render Home Health therapy but shall practice under the supervision of a registered physical therapist.

d. For ~~client~~~~member~~client~~s~~ who do not require skilled nursing care, the physical therapist may open the case and establish the Plan of Care.

e. Physical therapists are responsible for completing ~~client~~~~member~~client assessments related to various physical skills and functional abilities.

f. Physical therapy includes evaluations and treatments allowed under state law and is available to all acute home health ~~client~~~~member~~client~~s~~ and pediatric long-term Home Health ~~client~~~~member~~client~~s~~. Therapy plans and assessments shall contain the therapy services requested; the specific procedures and modalities to be used, including amount, duration, and frequency; and specific goals of therapy service provision.

g. Limitations

i) Physical therapy for ~~client~~~~member~~client~~s~~ age 21 or older is not covered for acute care needs when treatment becomes focused on maintenance, and no further functional progress is apparent or expected to occur.

ii) Physical therapy is not a benefit for adult long-term home health ~~client~~~~member~~client~~s~~. ~~Client~~~~Member~~Client~~s~~ 20 years of age or younger may receive Long-Term Home Health therapy services when services are medically necessary.

iii) ~~Client~~~~Member~~Client~~s~~ ages 21 and older who continue to require therapy after the acute home health period may obtain long-term therapy services in an outpatient setting. ~~Client~~~~Member~~Client~~s~~ shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.

iv) ~~Client~~~~Member~~Client~~s~~ 20 years of age or younger may obtain therapy services for maintenance care through acute home health and through long-term home health.

v) Physical therapy visits for the sole purpose of providing massage or ultrasound are not covered.

vi) Medicaid does not reimburse for two physical therapists during one visit.

vii) The unit of reimbursement for physical therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~~~member~~client care or treatment.

6. Occupational Therapy

a. Occupational therapy includes evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.

b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request and shall assist in training the ~~client~~~~member~~client on the use of the equipment.

c. Treatment shall be provided by or under the supervision of a registered occupational therapist who meets the qualifications prescribed by federal regulations for participation under applicable federal and state laws, including Medicare requirements at 42 CFR 484.4.

i) Occupational therapy assistants (OTA) can render Home Health therapy but shall practice under the supervision of a registered occupational therapist.

d. For ~~client~~~~member~~clients who do not require skilled nursing care, the occupational therapist may open the case and establish the Plan of Care.

e. Occupational therapy includes only evaluations and treatments that are allowed under state law for occupational therapists.

f. Occupational therapists shall create a plan and perform assessments which state the specific therapy services requested, the specific procedures and modalities to be used, the amount, duration, frequency, and the goals of the therapy service provision.

g. Limitations

i) Occupational therapy for ~~client~~~~member~~clients age 21 or older is not a benefit under acute Home Health Services when treatment becomes maintenance and no further functional progress is apparent or expected to occur.

ii) Occupational therapy is not a benefit for adult long-term home health ~~client~~~~member~~clients.

iii) ~~Client~~~~Member~~Clients ages 21 and older who continue to require therapy after the acute home health period may only obtain long-term therapy services in an outpatient setting.

iv) ~~Client~~~~Member~~Clients shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.

v) ~~Client~~~~Member~~Clients 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.

vi) Medicaid does not reimburse for two occupational therapists during one visit.

vii) The unit of reimbursement for occupational therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~~~member~~client care or treatment.

7. Speech Therapy

a. Speech therapy services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.

b. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through 8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.

c. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4.

d. For ~~client~~~~member~~clients who do not require skilled nursing care, the speech therapist may open the case and establish the Medicaid plan of care.

e. The speech/language pathologist shall state the specific therapy services requested, the specific procedures and modalities to be used, as well as the amount, duration, frequency and specific goals of therapy services on the Plan of Care.

f. Limitations

i) Speech therapy for ~~client~~~~member~~clients age 21 or older is not a benefit under acute Home Health Services when treatment becomes

maintenance and no further functional progress is apparent or expected to occur.

ii) ~~Client~~~~Member~~Clients cannot be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.

iii) Speech therapy is not a benefit for adult long-term home health ~~client~~~~member~~clients.

iv) Treatment of speech and language delays is only covered when associated with a chronic medical condition, neurological disorder, acute illness, injury, or congenital issue.

v) ~~Client~~~~Member~~Clients 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.

vi) Medicaid does not reimburse for two speech therapists during one visit.

vii) The unit of reimbursement for speech therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~~~member~~client care or treatment.

8.520.5.D. Home Health Telehealth Services

1. The Home Health Agency shall create policies and procedures for the use and maintenance of the monitoring equipment and the process of telehealth monitoring. This service shall be used to monitor the ~~client~~~~member~~client and manage the ~~client~~~~member~~client's care, and shall include all of the following elements:

a. The ~~client~~~~member~~client's designated registered nurse or licensed practical nurse, consistent with state law, shall review all data collected within 24 hours of receipt of the ordered transmission, or in cases where the data is received after business hours, on the first business day following receipt of the data;

b. The ~~client~~~~member~~client's designated nurse shall oversee all planned interventions;

c. ~~Client~~~~Member~~Client-specific parameters and protocols defined by the agency staff and the ~~client~~~~member~~client's authorizing physician or podiatrist; and

d. Documentation of the clinical data in the ~~client~~~~member~~client's chart and a summary of response activities, if needed.

i) The nurse assessing the clinical data shall sign and date all documentation; and

ii) Documentation shall include the health care data that was transmitted and the services or activities that are recommended based on the data.

2. The Home Health Agency shall provide monitoring equipment that possesses the capability to measure any changes in the monitored diagnoses, and meets all of the following requirements:

a. FDA certified or UL listed, and used according to the manufacturer's instructions;

b. Maintained in good repair and free from safety hazards; and

c. Sanitized before installation in a ~~client~~~~member~~client's home.

3. Home Health Telehealth services are covered for ~~client~~~~member~~clients receiving Home Health Services, when all of the following requirements are met:

a. ~~Client~~~~Member~~Client receives services from a home health provider for at least one of the following diagnoses:

i) Congestive Heart Failure;

ii) Chronic Obstructive Pulmonary Disease;

iii) Asthma;

iv) Diabetes;

v) Pneumonia; or

vi) Other diagnosis or medical condition deemed eligible by the Department or its Designee.

b. ~~Client~~~~Member~~Client requires ongoing and frequent monitoring, minimum of five times weekly, to manage their qualifying diagnosis as defined and ordered by a physician or podiatrist;

c. ~~Client~~~~Member~~Client has demonstrated a need for ongoing monitoring as evidenced by:

i) Having been hospitalized or admitted to an emergency room two or more times in the last twelve months for medical conditions related to the qualifying diagnosis;

ii) If the ~~client~~~~member~~client has received Home Health Services for less than six months, the ~~client~~~~member~~client was hospitalized at least once in the last three months;

iii) An acute exacerbation of a qualifying diagnosis that requires telehealth monitoring; or

iv) New onset of a qualifying disease that requires ongoing monitoring to manage the ~~client~~~~member~~client in their residence.

d. ~~Client~~~~Member~~Client or caregiver misses no more than five transmissions of the provider and agency prescribed monitoring events in a thirty-day period; and

e. ~~Client~~~~Member~~Client's home environment has the necessary connections to transmit the telehealth data to the agency and has space to set up and use the equipment as prescribed.

4. The Home Health Agency shall make at least one home health nursing visit every 14 days to a ~~client~~~~member~~client using Home Health Telehealth services.

5. The Home Health Agency shall develop agency-specific criteria for assessment of the need for Home Health Telehealth services, to include patient selection criteria, home environment compatibility, and patient competency. The agency shall complete these assessment forms prior to the submission of the enrollment application and they shall be kept on file at the agency.

6. The ~~client~~~~member~~client and/or caregiver shall comply with the telehealth monitoring as ordered by the qualifying physician.

7. Limitations:

a. ~~Client~~~~Member~~Clients who are unable to comply with the ordered telehealth monitoring shall be disenrolled from the services.

b. Services billed prior to obtaining approval to enroll a ~~client~~~~member~~client into Home Health Telehealth services by the Department or its Designee are not a covered benefit.

c. The unit of reimbursement for Home Health Telehealth is one calendar day.

i) The Home Health Agency may bill one initial installation unit ~~visit~~ per ~~client~~~~member~~client lifetime ~~each time~~ when the monitoring equipment is installed in the home.

ii) The Home Health Agency may bill the daily rate for each day the telehealth monitoring equipment is used to monitor and manage the ~~client~~~~member~~client's care.

d. Once per lifetime per ~~client~~~~member~~client, a Home Health Agency may bill for the installation of the Home Health Telehealth equipment.

8.520.6 Supplies

8.520.6.A. Reimbursement for routine supplies is included in the reimbursement for nursing, CNA, physical therapy, occupational therapy, and speech therapy services. Routine supplies are supplies that are customarily used during the course of home care visits. These are standard supplies utilized by the Home Health Agency staff, and not designated for a specific ~~client~~~~member~~client.

8.520.6.B. Non-routine supplies may be a covered benefit when approved by the Department or its Designee.

8.520.6.C. Limitations

1. A Home Health Agency cannot require a ~~client~~~~member~~client to purchase or provide supplies that are necessary to carry out the ~~client~~~~member~~client's Plan of Care.

2. A ~~client~~~~member~~client may opt to provide his or her own supplies.

8.520.7. Documentation

8.520.7.A. Home Health Agencies shall have written policies regarding nurse delegation.

8.520.7.B. Home Health Agencies shall have written policies regarding maintenance of ~~client~~~~member~~clients' durable medical equipment, and make full disclosure of these policies to all ~~client~~~~member~~clients with durable medical equipment in the home. The Home Health Agency shall provide such disclosure to the ~~client~~~~member~~client at the time of intake.

8.520.7.C. Home Health Agencies shall have written policies regarding procedures for communicating with case managers of ~~client~~~~member~~clients who are also enrolled in HCBS programs. Such policies shall include, at a minimum:

1. How agencies will inform case managers that services are being provided or are being changed; and

2. Procedures for sending copies of Plans of Care if requested by case managers. These policies shall be developed with input from case managers.

8.520.7.D. Plan of Care Requirements

1. The ~~client~~~~member~~client's Ordering Physician shall order Home Health Services in writing, as part of a written Plan of Care. The written Plan of Care shall be updated every 60 calendar days but need not be provided to the Department or its Designee unless the ~~client~~~~member~~client's status has changed significantly, a new PAR is needed, or if requested by the Department or its Designee.

2. The initial assessment or continuation of care assessments shall be completed by a registered nurse, or by a physical therapist, occupational therapist or speech therapist when no skilled nursing needs are required. The assessment shall be utilized to develop the Plan of Care with provider input and oversight. The written Plan of Care and associated documentation shall be used to complete the CMS-485 (or a document that is identical in content) and shall include:

   a. Identification of the attending physician;

   b. Physician orders;

   c. Identification of the specific diagnoses, including the primary diagnosis, for which Medicaid Home Health Services are requested.

   d. The specific circumstances, ~~client~~~~member~~client medical condition(s) or situation(s) that require services to be provided in the ~~client~~~~member~~client's residence rather than in a physician's office, clinic or other outpatient setting including the availability of natural supports and the ~~client~~~~member~~client's living situation;

   e. A complete list of supplements, and medications, both prescription and over the counter, along with the dose, the frequency, and the means by which the medication is taken;

   f. A complete list of the ~~client~~~~member~~client's allergies;

   g. A list of all non-routine durable medical equipment used by the ~~client~~~~member~~client;

   h. A list of precautions or safety measures in place for the ~~client~~~~member~~client, as well as functional limitations or activities permitted by the ~~client~~~~member~~client's qualified physician;

   i. A behavioral plan when applicable. Physical Behavioral Interventions, such as restraints, shall not be included in the home health Plan of Care;

   j. A notation regarding the ~~client~~~~member~~client's physician-ordered dietary (nutritional) requirements and restrictions, any special considerations, other restrictions or nutritional supplements;

   k. The Home Health Agency shall indicate a comprehensive list of the amount, frequency, and expected duration of provider visits for each discipline ordered by the ~~client~~~~member~~client's physician, including:

i) The specific duties, treatments and tasks to be performed during each visit;

ii) All services and treatments to be provided on the Plan of Care;

1) Treatment plans for physical therapy, occupational therapy and speech therapy may be completed on a form designed specifically for therapy Plans of Care; and

iii) Specific situations and circumstances that require a PRN visit, if applicable.

l. Current clinical summary of the ~~client~~~~member~~client's health status, including mental status, and a brief statement regarding homebound status of the ~~client~~~~member~~client;

m. The ~~client~~~~member~~client's prognosis, goals, rehabilitation potential and where applicable, the ~~client~~~~member~~client's specific discharge plan;

i) If the ~~client~~~~member~~client's illness, injury or disability is not expected to improve, or discharge is not anticipated, the agency is not required to document a discharge plan;

ii) The ~~client~~~~member~~client's medical record shall include the reason that no discharge plan is present;

n. The attending physician shall approve the Plan of Care with a dated signature. If an electronic signature is used, the agency shall document that an electronic signature was used and shall keep a copy of the physician's physical signature on file;

o. Brief statement regarding the ~~client~~~~member~~client's support network including the availability of the ~~client~~~~member~~client's family ~~member~~~~client~~member/caregiver and if applicable, information on why the ~~client~~~~member~~client's family ~~member~~~~client~~member/caregiver is unable or unwilling to provide the care the ~~client~~~~member~~client requires; and

p. Other relevant information related to the ~~client~~~~member~~client's need for Home Health care.

3. A new Plan of Care shall be completed every 60 calendar days while the ~~client~~~~member~~client is receiving Home Health Services. The Plan of Care shall include a statement of review by the physician every 60 days.

4. Home Health Agencies shall send new Plans of Care and other documentation as requested by the Department or its Designee.

8.520.7.E. Additional Required ~~Client~~~~Member~~Client Chart Documentation

1. A signed copy of the Written Notice of Home Care Consumer Rights as required by the Department and at 42 CFR 484.10. Title 42 of the Code of Federal Regulations, Part 484.10 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~;

2. Evidence of a face-to-face visit with the ~~client~~~~member~~client's referring provider, or other appropriate provider, as required at 42 CFR 4~~40~~24.~~70~~22. Title 42 of the Code of Federal Regulations, Part ~~484~~440.~~70~~22 (201~~63~~) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~;

3. A signed and dated copy of the Agency Disclosure Form as required by the Department, with requirements at 42 CFR 484.12. Title 42 of the Code of Federal Regulations, Part 484.12 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are~~

~~available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~;

4. Dates of the most recent hospitalization or nursing facility stay. If the most recent stay was within the last 90 days, reason for the stay (diagnoses), length of stay, summary of treatment, date and place discharged to shall be included in the clinical summary or update;

5. The expected health outcomes, which may include functional outcomes;

6. An emergency plan including the safety measures that will be implemented to protect against injury;

7. A specific order from the ~~client~~~~member~~client's qualified physician for all PRN visits utilized;

8. Clear documentation of skilled and non-skilled services to be provided to the ~~client~~~~member~~client with documentation that the ~~client~~~~member~~client or ~~client~~~~member~~client's family ~~member~~~~client~~member/caregiver agrees with the Plan of Care;

9. Accurate and clear clinical notes or visit summaries from each discipline for each visit that include the ~~client~~~~member~~client's response to treatments and services completed during the visit. Summaries shall be signed and dated by the person who provided the service. If an electronic signature is used, the agency shall document that an electronic signature was used and keep a copy of the physical signature on file;

10. Documented evidence of Care Coordination with the ~~client~~~~member~~client's other providers;

11. When the ~~client~~~~member~~client is receiving additional services (skilled or unskilled) evidence of Care Coordination between the other services shall be documented and include ~~-~~an explanation of how the requested Home Health Services do not overlap with these~~-~~ additional services;

12. A plan for how the agency will cover ~~client~~~~member~~client services (via family ~~member~~~~client~~member/caregiver or other agency staff) if inclement weather or other unforeseen incident prevents ~~-~~agency staff from delivering the Home Health care ordered by the qualified physician; and

13. If foot or wound care is ordered for the ~~client~~~~member~~client, the Home Health Agency shall ensure the signs and symptoms of the disease process/medical condition that requires foot or wound care by a nurse are clearly and specifically documented in the clinical

record. The Home Health Agency shall ensure the clinical record includes an assessment of the foot or feet, or wound, and physical and clinical findings consistent with the diagnosis, and the need for foot or wound care to be provided by a nurse.

8.520.8 Prior Authorization

8.520.8.A. General Requirements

1. Approval of the PAR does not guarantee payment by Medicaid.

2. The ~~client~~~~member~~client and the HHA shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations.

3. Medicaid is always the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to only bill for Medicaid approved services to Medicare or other third party insurance prior to billing Medicaid.

   a. Exceptions to this include Early Intervention Services documented on a child's Individualized Family Service Plan (IFSP) and the following services that are not a skilled Medicare benefit (CNA services only, OT services only, Med-box pre-pouring and routine lab draws).

8.520.8.B. Acute Home Health

1. Acute Home Health Services do not require prior authorization. This includes episodes of acute home health for long-term home health ~~client~~~~member~~clients.

2. If a ~~client~~~~member~~client receiving long-term Home Health Services experiences an acute care event that necessitates moving the ~~client~~~~member~~client to an acute home health episode, the agency shall notify the Department or its Designee that the ~~client~~~~member~~client is moving from long-term home health to acute Home Health Services.

3. If the ~~client~~~~member~~client's acute home health needs resolve prior to 60 calendar days, the Home Health Agency shall discharge the ~~client~~~~member~~client, or submit a PAR for long-term Home Health Services if the ~~client~~~~member~~client is eligible.

   a. If an acute home health ~~client~~~~member~~client experiences a change in status (e.g. an inpatient admission), that totals 9 calendar days or less, the Home Health Agency shall resume the ~~client~~~~member~~client's care under the current acute home health Plan of Care.

   b. If an acute home health ~~client~~~~member~~client experiences a change in status (e.g. an inpatient admission), that totals 10 calendar days or more, the Home Health

Agency may start a new Acute Home Health episode when the ~~client~~~~member~~client returns to the Home Health Agency.

c. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within 10 working days of the beginning and within 10 working days of the end of the acute care episode.

8.520.8.C~~B~~. Long-Term Home Health

1. Long-term Home Health Services require prior authorization under Section 8.017.E.

2. When an agency accepts an HCBS waiver ~~client~~~~member~~client to long-term Home Health Services, the Home Health Agency shall contact the ~~client~~~~member~~client's case management agency to inform the case manager of the ~~client~~~~member~~client's need for Home Health Services.

3. The complete formal written PAR shall include:

a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;

b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the ~~client~~~~member~~client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485, and all sections of the form shall be completed. For ~~client~~~~member~~clients 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.520.9.B. are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the ~~client~~~~member~~client is 20 years of age or younger and is receiving home health therapy services;

c. Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the ~~client~~~~member~~client's third-party insurance;

d. Any other medical information which will document the medical necessity for the Home Health Services;

e. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a CNA visit;

f. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, evidence that the ~~client~~~~member~~client's pharmacy was contacted, and advised the Home Health Agency that the pharmacy will not provide medication set-ups, shall be documented; and

g. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, documentation supporting the current need for two-person transfers, and the reason adaptive equipment cannot be used instead, shall be provided.

h. Long Term Home Health Services for ~~client~~~~member~~client s 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.

4. Authorization time frames:

a. PARs shall be submitted for, and may be approved for up to a one year period.

b. The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.

c. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the CMS-485.

5. The PAR shall not be backdated to a date prior to the 'from' date of the CMS-485.

6. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding ~~client~~~~member~~client s:

a. PAR Approval: If services requested are in compliance with Medicaid rules are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (e.g, the PAR is not consistent with the ~~client~~~~member~~client 's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician.

ii) When denied, services shall be approved for 15 additional days after the date on which the notice of denial is mailed to the ~~client~~~~member~~client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

c. Interim Services: Services provided during the period between the provider's submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment

may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.

8.520.8.DC. EPSDT Services

1. Home Health Services beyond those allowed in Section 8.520.5, for clientmemberclients ages 0 through 20, shall be reviewed for medical necessity under the EPSDT requirement, as defined at Section 8.280.1.

2. Home Health Services beyond those in Section 8.520.5, which are provided under the Home Health benefit due to medical necessity, cannot include services that are available under other Colorado Medicaid benefits for which the clientmemberclient is eligible, including, but not limited to, Private Duty Nursing, Section 8.540; HCBS Personal Care, Section 8.489; Pediatric Personal Care, Section 8.535; School Health and Related Services, Section 8.290, or Outpatient Therapies, Section 8.200.3.A.6, Section 8.200.5 and Section 8.200.3.D Exceptions may be made if EPSDT Home Health Services will be more cost-effective, provided that clientmemberclient safety is assured. Such exceptions shall, in no way, be construed as mandating the delegation of nursing tasks.

3. PARs for EPSDT home health shall be submitted and reviewed as outlined in Section 8.520.8, including all documentation outlined in Section 8.520.8, and any other medical information which will document the medical necessity for the EPSDT Home Health Services. The Plan of Care shall include the place of service for each home health visit.

8.520.8.ED. Home Health Telehealth Services

1. Home Health Telehealth services require prior authorization.

2. The Home Health Telehealth PAR shall include all of the following:

   a. A completed enrollment form;

   b. An order for telehealth monitoring signed and dated by the Ordering Physician or podiatrist;

   c. A Plan of Care, which includes nursing and therapy assessments for clientmemberclients. Telehealth monitoring shall be included on the CMS-485 form, or a form that contains identical information to the CMS-485, and all applicable forms shall be complete; and

   d. For ongoing telehealth, the agency shall include documentation on how telehealth data has been used to manage the clientmemberclient's care, if the clientmemberclient has been using Home Health Telehealth services.

8.520.9 Reimbursement

8.520.9.A. **Rates of Reimbursement:** Payment for Home Health Services is the lower of the billed charges or the maximum unit rate of reimbursement.

1. The maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed the daily maximum as designated by the Department and in alignment with the Legislative Budget.

2. The maximum daily reimbursement includes reimbursement for nursing visits, home health CNA visits, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof."

8.520.9.B. **Special Reimbursement Conditions**

1. Total reimbursement by the Department combined with third party liability and Medicare crossover claims shall not exceed Medicaid rates.

2. When Home Health Agencies provide Home Health Services in accordance with these regulations to ~~client~~~~member~~client**s** who receive Home and Community Based Services for the Developmentally Disabled (HCBS-DD), the Home Health Agency is reimbursed:

   a. Under normal procedures for home health reimbursement if the ~~client~~~~member~~client resides in an Intermediate Care Facility for the Intellectually Disabled (ICF/ID), or in IRSS host homes and settings; or

   b. By the group home provider, if the ~~client~~~~member~~client resides in a GRSS, because the provider has already received Medicaid funding for the Home Health Services and is responsible for payment to the Home Health Agency.

3. Acute Home Health Services for Medicaid HMO ~~client~~~~member~~client**s** are the responsibility of the Medicaid HMO, including ~~client~~~~member~~client**s** who are also HCBS recipients.

4. Services for a dual eligible ~~client~~~~member~~client shall be submitted first to Medicare for reimbursement. All Medicare requirements shall be met and administrative processes exhausted prior to any dual eligible ~~client~~~~member~~client's claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except for the specific services listed in Section 8.520.0.E.4.a below for ~~client~~~~member~~client**s** which meet the criteria listed in Section 8.520.9.E.4.b below.

   a. A Home Health Agency may bill only Medicaid without first billing Medicare if both of the following are true:

      i) The services below are the only services on the claim:

         1) Pre-pouring of medications;

         2) CNA services;

3) Occupational therapy services when provided as the sole skilled service; or

4) Routine laboratory draw services.

ii) The following conditions apply:

1) The ~~client~~~~member~~client is stable;

2) The ~~client~~~~member~~client is not experiencing an acute episode; and

3) The ~~client~~~~member~~client routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

b. The Home Health Agency shall maintain clear documentation in the ~~client~~~~member~~client's record of the conditions and services that are billed to Medicaid without first billing Medicare.

c. A Home Health Change of Care Notice or Advance Beneficiary Notice of Non-Coverage shall be filled out as prescribed by Medicare.

5. Services for a dually eligible long-term home health ~~client~~~~member~~client who has an acute episode shall be submitted first to Medicare for reimbursement. Medicaid may be billed if payment is denied by Medicare as a non-covered benefit and the service is a Medicaid benefit, or when the service meets the criteria listed in Section 8.520.9.E.4 above.

6. If both Medicare and Medicaid reimburse for the same visit or service provided to a ~~client~~~~member~~client in the same episode, the reimbursement is considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.

a. Home Health Agencies shall return any payment made by Medicaid for such visit or service to the Department within sixty (60) calendar days of receipt of the duplicate payment.

8.520.9.C. Reimbursement for Supplies

1. A Home Health Agency shall not ask a ~~client~~~~member~~client to provide any supplies. A request for supplies from a ~~client~~~~member~~client may constitute a violation of Section 8.012, PROVIDERS PROHIBITED FROM COLLECTING PAYMENT FROM RECIPIENTS.

2. Supplies other than those required for practice of universal precautions which are used by the Home Health Agency staff to provide Home Health Services are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the physician as a benefit to the ~~client~~~~member~~client under Section 8.590, DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLES.

3. Supplies used for the practice of universal precautions by the ~~client~~~~member~~client's family or other informal caregivers are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the physician as a benefit to the ~~client~~~~member~~client under Section 8.590, DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES.

8.520.9.D. Restrictions

1. When the ~~client~~~~member~~client has Medicare or other third-party insurance, Home Health claims to Medicaid will be reimbursed only if the ~~client~~~~member~~client's care does not meet the Home Health coverage guidelines for Medicare or other insurance.

2. When an agency provides more than one employee to render a service, in which one employee is supervising or instructing another in that service, the Home Health Agency shall only bill and be reimbursed for one employee's visit or units.

3. Any visit made by a nurse or therapist to simultaneously serve two or more ~~client~~~~member~~clients residing in the same household shall be billed by the Home Health Agency as one visit only, unless services to each ~~client~~~~member~~client are separate and distinct. If two or more ~~client~~~~member~~clients residing in the same household receive Medicaid CNA services, the services for each ~~client~~~~member~~client shall be documented and billed separately for each ~~client~~~~member~~client.

4. No more than one Home Health Agency may be reimbursed for providing Home Health Services during a specific plan period to the same ~~client~~~~member~~client, unless the second agency is providing a Home Health Service that is not available from the first agency. The first agency shall take responsibility for the coordination of all Home Health Services. Home and Community Based Services, including personal care, are not Home Health Services.

5. Improper Billing Practices: Examples of improper billing include, but are not limited to:

   a. Billing for visits without documentation to support the claims billed. Documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the ~~client~~~~member~~client's home. Providers shall submit or produce requested documentation in accordance with rules at Section 8.076.2;

   b. Billing for unnecessary visits, or visits that are unreasonable in number, frequency or duration;

   c. Billing for CNA visits in which no skilled tasks were performed and documented;

   d. Billing for skilled tasks that were not medically necessary;

   e. Billing for Home Health Services provided at locations other than an eligible place of service, except EPSDT services provided with prior authorization; and

f. Billing of personal care or homemaker services as Home Health Services.

6. A Home Health Agency that are also certified as a personal care/homemaker provider shall ensure that neither duplicate billing nor unbundling of services occurs in billing for Home Health Services and HCBS personal care services. Examples of duplicate billing and unbundling of services include:

a.) One employee makes one visit, and the agency bills Medicaid for a CNA visit, and also bills all of the hours as HCBS personal care or homemaker.

b.) One employee makes one visit, and the agency bills for one CNA visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 1 hour plus the number of hours billed for HCBS personal care and homemaker.

c.) Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of CNA and personal care or homemaker services.

7. The Department~~A Home Health Agency~~ may take action against the offending Home Health Agency, including ~~be terminated~~ termination from participation in Colorado Medicaid in accordance with 10 C.C.R. 2505-10, Section 8.076.

8.520.10 Compliance Monitoring Reviews

8.520.10.A. General Requirements

1. Compliance monitoring of Home Health Services may be conducted by state and federal agencies, their contractors and law enforcement agencies in accordance with 10 C.C.R. 2505-10, Section 8.076.

2. Home Health Agencies shall submit or produce all requested documentation in accordance with 10 C.C.R. 2505-10, Section 8.076.

3. Physician-signed Plans of Care shall include nursing or therapy assessments, current clinical summaries and updates for the ~~client~~~~member~~client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485. All sections of the form shall be completed. All therapy services provided shall be included in the Plan of Care, which shall list the specific procedures and modalities to be used and the amount, duration and frequency.

4. Provider records shall document the nature and extent of the care actually provided.

5. Unannounced site visits may be conducted in accordance with C.R.S. Section 25.5-4-301(14)(b).

6. Home Health Services which are duplicative of any other services that the ~~client~~~~member~~client has received funded by another source or that the ~~client~~~~member~~client received funds to purchase shall not be reimbursed.

7. Services which total more than twenty-four hours per day of care, regardless of funding source shall not be reimbursed.

8. Billing for visits or contiguous units which are longer than the length of time required to perform all the tasks prescribed on the care plan shall not be reimbursed.

9. Home Health Agencies shall not bill clientmemberclients or families of clientmemberclient for any services for which Medicaid reimbursement is recovered due to administrative, civil or criminal actions by the state or federal government.

8.520.11 Denial, Termination, or Reduction in Services

8.520.11.A. When services are denied, terminated, or reduced by action of the Home Health Agency, the Home Health Agency shall notify the clientmemberclient.

8.520.11.B. Termination of sServices to ClientMemberclients sStill mMedically eEligible for Coverage of Medicaid Home Health Services:

1. When a Home Health Agency decides to terminate services to a clientmemberclient who needs and wants continued Home Health Services, and who remains eligible for coverage of services under the Medicaid Home Health rules, the Home Health Agency shall give the clientmemberclient, or the clientmemberclient's designated representative/legal guardian, written advance notice of at least 30 business days. The attending physician and the Department's Home Health Policy Specialist shall also be notified.

2. Written nNotice to the clientmemberclient, or clientmemberclient's designated representative/legal guardian shall be provided in person or by certified mail, and shall be considered given when it is documented that the recipient has received the notice. The notice shall provide the reason for the change in services

3. The agency shall make a good faith effort to assist the clientmemberclient in securing the services of another agency.

4. If there is indication that ongoing services from another source cannot be arranged by the end of the advance notice period, the terminating agency shall ensure clientmemberclient safety by making referrals to appropriate case management agencies or County Departments of Social Services; and the attending physician shall be informed.

5. Exceptions will be made to the requirement for 30 days advance notice when the provider has documented that there is immediate danger to the clientmemberclient, Home Health Agency, staff, or when the clientmemberclient has begun to receive Home Health Services through a Medicaid HMO.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Supports Intensity Scale Assessment and Support Levels, Section 8.612.3
Rule Number: MSB 16-12-19-A
Division / Contact / Phone: Division for Intellectual and Developmental Disabilities / James Ruden / 303-866-2016

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 16-12-19-A, Revision to the Medical Assistance Rule Concerning Supports Intensity Scale Assessment and Support Levels, Section 8.612.3

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) 8.601.1 and 8.603.7, 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)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.612.3 with the proposed text beginning at 8.612.3 through the end of 8.612.3. The effective date of this rule is August 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance/DIDD Rule Concerning Supports Intensity Scale Assessment and Support Levels, Section 8.612.3
Rule Number: MSB 16-12-19-A
Division / Contact / Phone: Division for Intellectual and Developmental Disabilities / James Ruden / 303-866-2016

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 Department seeks to change the rules at 10 CCR 2505-10, 8.612.3, Support Levels. Currently, there is a table in rule that reflects the algorithm used to develop the support levels. The authors of the Supports Intensity Scale (SIS), American Association for Intellectual and Developmental Disabilities (AAIDD), have re-named the instrument, re-numbered some questions, and added three new questions to the tool. The Division for Intellectual and Developmental Disabilities has worked to make certain that these changes will not affect the current levels of services for individuals receiving services. No changes to the current support levels will be necessary. The Department is simply updating the name of the instrument and including the new algorithm table in the rules.

   Additionally, the Department seeks to remove the requirement for support level review panels. Currently the regulations require the Department to convene a panel of three IDD professionals to review challenges to assigned support levels. This has resulted in determination delays for members in services while the Department finds qualified individuals to review. The Department seeks to remove this requirement and allow review by an individual. The member's due process rights are still protected through appeals to the Executive Director and the state fair hearing process. This change will simply expedite the process for members to obtain a final decision.

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 C.F.R. 441, Subpart M

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);

Initial Review	**04/14/17**	Final Adoption	**07/14/17**
Proposed Effective Date	**08/30/17**	Emergency Adoption	

DOCUMENT #03

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance/DIDD Rule Concerning Supports Intensity Scale Assessment and Support Levels, Section 8.612.3

Rule Number: MSB 16-12-19-A

Division / Contact / Phone: Division for Intellectual and Developmental Disabilities / James Ruden / 303-866-2016

25.5-10-204(2)

Initial Review	**04/14/17**	Final Adoption	**07/14/17**
Proposed Effective Date	**08/30/17**	Emergency Adoption	

DOCUMENT #03

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance/DIDD Rule Concerning Supports Intensity Scale Assessment and Support Levels, Section 8.612.3
Rule Number: MSB 16-12-19-A
Division / Contact / Phone: Division for Intellectual and Developmental Disabilities / James Ruden / 303-866-2016

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.

   All members on the HCBS-DD and HCBS-SLS Waivers will be impacted. However, the algorithm has been structured so that no support levels will be changed.

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

   This rule will have no impact upon the affected classes. The only change will be to the name of the instrument and the algorithm. However, changes to the algorithm will not change the support levels of individuals. Individuals will continue to use the current exceptions processes for SIS Reassessment and Support Level Review when there is a concern with information in his or her current SIS or level of supports.

   Through removing the requirement for a panel review, this rule will assist members in getting a faster determination when appealing their assigned support levels. Due process and appeal rights are still protected through an appeals process and the state fair hearing procedure.

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 will be no implementation and enforcement costs for this rule.

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

   It is costing the Department an additional $4,057/mo. to maintain access to the old SIS Online. Updating the rules will save this expense. If these rules are adopted it will only cost the Department $233.09 per SIS administered and not the additional maintenance costs. The per assessment cost is the same for both the old SIS and the SIS-A.

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

Title of Rule: Revision to the Medical Assistance/DIDD Rule Concerning Supports Intensity Scale Assessment and Support Levels, Section 8.612.3
Rule Number: MSB 16-12-19-A
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Not applicable. Simply updating the algorithm to reflect the current assessment.

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.

   Not applicable. To use the SIS-A the state must update the algorithm.

8.612.3 Support Levels [Eff. 2/1/12]

A. A client is assigned into one of six Support Levels according to his or her overall support needs and based upon the standardized algorithm for the HCBS-DD or HCBS-SLS waivers. The SIS-A Assessment converts subscale raw scores for each section into standard scores for each section, which are used in the algorithm for support levels. Additional information can be found on the Department's webpage or can be obtained in writing by requesting from the Department.

B. The structure of the algorithm, defined at 10 CCR 2505-10, 8.600.4 definitions, ~~-~~includes the following:

1. Algorithm factors:

a. Standard scores from Section ~~1~~2: Parts A (Home Living Activities), B (Community Living Activities), and E (Health and Safety Activities) (ABE) from the SIS assessment;

b. Total ~~S~~scores from Section ~~3A~~1A: Exceptional medial support needs score from the SIS assessment;

c Total ~~S~~scores from Section ~~3B~~1B: exceptional behavioral support needs score from the SIS assessment; and,

d. Whether the client presents as a safety risk, defined at 10 CCR 2505-10, 8.600.4 definitions, ~~-~~as follows:

1) In the HCBS-SLS waiver, Public Safety Risk-Convicted.

2) In the HCBS-DD waiver, Public Safety Risk-Convicted/Not Convicted or Extreme Safety Risk to Self.

2. The subgroups in the algorithm table under each support level reflect variations of the intensity of the client's basic support, medical support and behavioral support needs; no matter which subgroup a client falls into, he or she is eligible for that support level. The subgroups cluster individuals with similar behavioral and medical support needs within each major group. Additional information can be found on the Department's website or can be obtained in writing by requesting from the Department. ~~.~~

3. Following an assessment of the factors defined above, standard scores for each factor are applied to the algorithm.

The Support Level is determined when the scores for each factor meet all of the criteria of a support level subgroup

4. The results of the algorithm are used to assign clients to support levels one through six; with a support level one indicating a minimal need for supports and a support level six indicating a significantly higher need for supports.

5. For the HCBS-SLS Waiver, the support level determines the Service Plan Authorization Limit (SPAL), which is defined at 10 CCR 2505-10, 8.600.4 definitions. The SPALs are posted annually by the Department on the Department's webpage or available in writing by contacting the Department.

For the HCBS-DD Waiver, the support level determines the rate of reimbursement for the provider(s).

C. The formula for the algorithm is:

~~Level/Subgroup~~
~~Level 1~~
~~Subgroup 1A: ABE < 25; 3a<1 AND 3b< 2~~
~~Subgroup 1B: ABE < 25; 3a< 2 AND 3b< 5~~
~~Subgroup 1C: ABE < 25; 3a<4 and 3b< 5~~
~~Level 1 Recap~~
-
~~Level 2~~
~~Subgroup 2A: ABE 26-30; 3a<1 AND 3b<2~~
~~Subgroup 2B: ABE 26-30; 3a< 2 AND 3b< 5~~
~~Subgroup 2C: ABE 26-30; 3a<4 AND 3b< 5~~
~~Subgroup 1D: ABE < 25; 3a<6~~
~~Subgroup 1G: ABE < 25; 3b<9~~
~~Subgroup 2D: ABE 26-30; 3a<6~~
~~Subgroup 2G: ABE 26-30; 3b<9~~
~~Subgroup 3A: ABE 31-33; 3a< 1 AND 3b< 2~~
~~Subgroup 3B: ABE 31-33 3a< 2 AND 3b< 5~~
~~Level 2 Recap~~
-
~~Level 3~~
~~Subgroup 1H: ABE < 25; 3b<13~~
~~Subgroup 2H: ABE 26-30; 3b<13~~
~~Subgroup 3C: ABE 31-33; 3a<4 AND 3b< 5~~
~~Subgroup 3D: ABE 31-33; 3a<6~~
~~Subgroup 3G: ABE 31-33; 3b<9~~
~~Subgroup 4A: ABE > 34; 3a< 1 AND 3b< 2~~
~~Subgroup 4B: ABE >34 3a< 2 AND 3b< 5~~
~~Level 3 Recap~~
-
~~Level 4~~
~~Subgroup 1E: ABE < 25; 3a<8~~
~~Subgroup 1F: ABE < 25; 3a>9~~
~~Subgroup 1I: ABE < 25; 3b<15~~
~~Subgroup 1J: ABE < 25; 3b>16~~
~~Subgroup 2E: ABE 26-30; 3a<8~~

~~Subgroup 2I: ABE 26-30; 3b<15~~
~~Subgroup 2J: ABE 26-30; 3b>16~~
~~Subgroup 3E: ABE 31-33; 3a<8~~
~~Subgroup 3H: ABE 31-33; 3b<13~~
~~Subgroup 4C: ABE > 34; 3a<4 AND 3b< 5~~
~~Subgroup 4G: ABE > 34; 3b<9~~
~~**Level 4 Recap**~~
~~-~~
~~**Level 5**~~
~~Subgroup 2F: ABE 26-30; 3a>9~~
~~Subgroup 3I: ABE 31-33; 3b<15~~
~~Subgroup 3J: ABE 31-33; 3b>16~~
~~Subgroup 4D: ABE >34; 3a<6~~
~~Subgroup 4E: ABE > 34; 3a<8~~
~~Subgroup 4H: ABE > 34; 3b<13~~
~~Subgroup 4I: ABE > 34; 3b<15~~
~~Group 5A: Community Safety (either status) AND 3b<11~~
~~**Level 5 Recap**~~
~~-~~
~~**Level 6**~~
~~Subgroup 4J: ABE > 34; 3b>16~~
~~Group 6A: Community Safety (either status) AND 3b>12~~
~~Subgroup 3F: ABE 31-33; 3a>9~~
~~Subgroup 4F: ABE > 34; 3a>9~~
~~**Level 6 Recap**~~
~~-~~
~~**Level 7**~~
~~Group 7: Individuals with Tier 7 Rates~~

~~Extreme Danger to Self -This factor acts to increase the level otherwise determined by the above criteria. Level 1 ->3, Level 2 >4, Level 3 >4, Level 4 >5. No change to levels 5 or 6.~~

Support Level/Subgroup
Support Level 1
Subgroup 1A: ABE < 25; 1A<1 AND 1B< 2
Subgroup 1B: ABE < 25; 1A< 2 AND 1B< 5
Subgroup 1C: ABE < 25; 1A<4 and 1B< 5

Support Level 2
Subgroup 2A: ABE 26-30; 1A<1 AND 1B<2
Subgroup 2B: ABE 26-30; 1A< 2 AND 1B< 5
Subgroup 2C: ABE 26-30; 1A<4 AND 1B< 5
Subgroup 1D: ABE < 25; 1A<6
Subgroup 1G: ABE < 25; 1B<9
Subgroup 2D: ABE 26-30; 1A<6
Subgroup 2G: ABE 26-30; 1B<9
Subgroup 3A: ABE 31-33; 1A< 1 AND 1B< 2
Subgroup 3B: ABE 31-33 1A< 2 AND 1B< 5
Support Level 3
Subgroup 1H: ABE < 25; 1B<13
Subgroup 2H: ABE 26-30; 1B<13
Subgroup 3C: ABE 31-33; 1A<4 AND 1B< 5
Subgroup 3D: ABE 31-33; 1A<6
Subgroup 3G: ABE 31-33; 1B<9
Subgroup 4A: ABE > 34; 1A< 1 AND 1B< 2
Subgroup 4B: ABE >34 1A< 2 AND 1B< 5
Support Level 4
Subgroup 1E: ABE < 25; 1A<8
Subgroup 1F: ABE < 25; 1A>9
Subgroup 1I: ABE < 25; 1B<15
Subgroup 1J: ABE < 25; 1B>16
Subgroup 2E: ABE 26-30; 1A<8
Subgroup 2I: ABE 26-30; 1B<15
Subgroup 2J: ABE 26-30; 1B>16
Subgroup 3E: ABE 31-33; 1A<8
Subgroup 3H: ABE 31-33; 1B<13
Subgroup 4C: ABE > 34; 1A<4 AND 1B< 5
Subgroup 4G: ABE > 34; 1B<9
Support Level 5
Subgroup 2F: ABE 26-30; 1A>9
Subgroup 3I: ABE 31-33; 1B<15
Subgroup 3J: ABE 31-33; 1B>16
Subgroup 4D: ABE >34; 1A<6
Subgroup 4E: ABE > 34; 1A<8
Subgroup 4H: ABE > 34; 1B<13
Subgroup 4I: ABE > 34; 1B<15
Group 5A: Community Safety (either status) AND 1b<11
Support Level 6

Subgroup 4J: ABE > 34; 1B>16
Group 6A: Community Safety (either status) AND 1b>12
Subgroup 3F: ABE 31-33; 1A>9
Subgroup 4F: ABE > 34; 1A>9
Level 7
Group 7: Individuals with Tier 7 Rates

Extreme Safety Risk to Self (as defined at 10 CCR 2505-10, 8.600.4 definitions) -This factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 3, level 2 increases to level 4, level 3 increases to level 4, level 4 increases to level 5. No change to levels 5 or 6, as this factor is already considered in the algorithm. Public Safety Risk (as defined at 10 CCR 2505-10, 8.600.4 definitions) – this factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 5, level 2 increases to level 5, level 3 increases to level 5, and level 4 increases to level 6. No change to levels 5 or 6 as this factor is already considered in the algorithm.

D. The CMA shall make a determination whether a client meets the definition of Public Safety Risk or Extreme Safety Risk to Self through the following process:

1. The decision shall be made by a case management supervisor meeting the qualifications of a Developmental Disabilities Professional as defined in section 8.600.4. He or she shall:

   a. Document the rationale to support the decision which shall be kept in the client's record;

   b. Document that the client meets the definition in the Department required data system; and,

   c. Review the client at least annually or when significant changes occur to assure that the client continues to meet the definition.

2. At the point when a client no longer meets the definition, his or her status must be changed in the Department-required data system and his or her Support Level must be re-calculated.

E. The CMA shall inform each client, his or her legal guardian, authorized representative, or family member, as appropriate, of his or her Support Level at the time of the Service Plan development or when the Support Level changes for any reason.

F. Notification of a Support Level change shall occur within ten (10) business days of the date after the Service Plan development or Support Level change.

G. Each Support Level corresponds with the standardized reimbursement rates for individual waiver services and the Service Plan Authorization Limits (SPAL) in HCBS-SLS.

H. In HCBS-DD, the Department may assign a reimbursement rate for day habilitation services and residential habilitation services provided to a client with exceptional overall needs in accordance with the Support Level Review Process.

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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 **Error! Reference source not found.**, **Error! Reference source not found.**
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)?	Yes
If yes, state effective date:	7/1/2017
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700 with the proposed text starting at 8.700.1 through the end of 8.700.8.D. This rule is effective August 30, 2017.

*to be completed by MSB Board Coordinator

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Title of Rule: **Error! Reference source not found.**
Rule Number: MSB **Error! Reference source not found.**
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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 clarify the Department's payment methodology for services outside of the Federally Qualified Health Center (FQHC) encounter rate. Currently, the rules state that FQHCs are reimbursed a 100% cost-based encounter rate for a one-on-one, face-to-face visit between a client and an eligible provider. This Rule revision is necessary to allow for payments to FQHCs separate from the encounter rate for Long Acting Reversible Contraceptives (LARCs), dentures and partial dentures, services provided at an inpatient hospital setting by the FQHC, dental services provided at an outpatient hospital setting by the FQHC, the Nurse Home Visitor Program, and the Prenatal+ Program. Services provided by a FQHC at an inpatient hospital setting are not FQHC services and therefore should not be reimbursed at the encounter rate. The provision of LARCs, dentures, and partial dentures is costly for FQHCs and therefore an additional payment separate from the encounter rate is necessary to incentivize access and the provision of LARCs. The Prenatal+ Program and Nurse Home Visitor Program currently have payment methodologies that are separate from the encounter rate and are clarified elsewhere in the Rules.

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 revision fulfills the necessary requirements to be an Emergency Rule. The purpose of this rule revision is to clarify the Department's payment methodology for Federally Qualified Health Centers (FQHCs), specifically regarding payments separate from the encounter. Currently, our State Plan and rules for FQHCs state that the Department pays the encounter rate for one-on-one, face-to-face visits between a client and eligible provider. However, it is common practice for FQHCs to bill the Department at the Fee Schedule rate for other types of services – such as inpatient hospital services, the cost of LARC devices, dentures, partial dentures, dental services provided at an outpatient hospital location by the FQHC, the Prenatal+ Program, and the Nurse Home Visitor Program. These services should not be reimbursed at the encounter rate and instead should be reimbursed the Fee Schedule

rate. However, since our current rules and State Plan do not reference this type of payment there is a large amount of confusion and concern among Department staff and FQHC staff about how to reimburse FQHCs. The Department must revise its rules to reflect payment for these services outside of the encounter rate. If we stop paying for these services outside of the encounter rate they will no longer be provided.

3. Federal authority for the Rule, if any:

   Section 1902(bb) of the Social Security Act states that State Medicaid Agencies may create an alternative payment methodology for FQHCs as long as the FQHC receives at least their Prospective Payment System (PPS) rate.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   Section 25.5-4-401 (1)(a), C.R.S.

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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.

   This rule will affect the 420,513 Medicaid members that receive medical services at Federally Qualified Health Centers.

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

   Total expenditures for services received at FQHCs during the last fiscal year was $173,425,927.05 or approximately $412.41 per member. This rule change could cause reimbursement to increase for some services delivered at certain FQHCs and to decrease for other services delivered at FQHCs. Many FQHCs are already billing in this manner, and it would have zero budget impact on those FQHCs.

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.

   It is anticipated that the proposed rule will be budget neutral to the Department. This is a change in policy that primarily codifies already existing practices. For those FQHCs that are not billing in line with the proposed rule, there could be a decrease in payment for services that will be determined unallowable under the proposed rule. There could also be an increase in payment for certain services as it clarifies when encounters and fee-for-service claims can be billed in conjunction with each other. The Department assumes that these two impacts will offset each other, resulting in a net budget neutral change.

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

   Since many FQHCs are already billing the Department for these services, and other services, outside of the encounter rate, the costs should be minimal. This rule will eliminate improper billing of services and will give the Department the authority to pay for certain services as fee-for-service claims. Inaction could lead to a

disallowance from CMS since these payments were not authorized before they began.

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

   It could potentially be less costly to disallow all payments outside of the encounter rate. However, this would lead to less access to important services such as LARCs, dentures, and partial dentures, or result in an increase in utilization of the services from other provider types.

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 seriously considered disallowing all payments for services outside the encounter rate. However, this idea was rejected as it would be too restrictive to FQHCs and decrease access to imperative health services.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule:

Visit means a one-on-one, 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 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

8.700.2 CLIENT CARE POLICIES

8.700.2.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.

8.700.2.B The policies shall include:

1. A description of the services the FQHC furnishes directly and those furnished through agreement or arrangement. See section 8.700.3.A.3.

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.

3. Rules for the storage, handling and administration of drugs and biologicals.

8.700.3 SERVICES

8.700.3.A The following services may be provided by a certified FQHC:

1. General services

   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.

   b. Part-time or intermittent visiting nurse care.

   c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.700.3.A.1.a and b.

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.

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.

8.700.3.B A certified FQHC may also provide any service authorized for payment outside the per visit encounter rate by 8.700.6.B.

8.700.4 PHYSICIAN RESPONSIBILITIES

8.700.4.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.

8.700.5 ALLOWABLE COST

8.700.5.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:

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.

2. Compensation for the duties that a supervising physician is required to perform.

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.

4. Overhead cost, including clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs.

5. Costs of services purchased by the clinic or center.

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;

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

4. Costs of services reimbursed separately from the FQHC encounter rate as described in Section 8.700.6.B.

8.700.6 REIMBURSEMENT

8.700.6.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 with the same client 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.

8.700.6.B The following services are reimbursed separately from the FQHC encounter rate. These services shall be reimbursed in accordance with the following:

1. Long-Acting Reversible Contraception (LARC) devices shall be reimbursed separately from the FQHC encounter rate. In addition to payment of the encounter rate for the insertion of the device(s), the LARC device(s) must be billed in accordance with Section 8.730 and shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department.

2. Services provided in an inpatient hospital setting shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department.

3. The provision of complete dentures and partial dentures must be billed in accordance with Section 8.201. and Section 8.202. and shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department. The fee schedule payment includes denture alignments, adjustments, and repairs within the first 6 months after placement of the denture. If the fee schedule amount is less than what would have been reimbursed under the per visit PPS rate, the Department will ensure that full payment has been received by the FQHCs.

4. Dental services provided in an outpatient hospital setting shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department.

5. The Prenatal Plus Program shall be billed and reimbursed in accordance with Section 8.748.

6. The Nurse Home Visitor Program shall be billed and reimbursed in accordance with Section 8.749.

7. A FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number in accordance with Section 8.800.

8.700.6.CB 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.DC Encounter rate calculation

a) Effective July 1, 2014, the encounter rate shall be the higher of the Prospective Payment System (PPS) rate or the alternative payment 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, Dec. 21, 2000. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for a reasonable charge and 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. a) 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:

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

   2. 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. a) 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.

b) 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.

4. a) 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.

b) 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.

c) 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.

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

e) 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.

f) 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 8.300.6.

5. a) If a FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.

b) A FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC. The documented change in the scope of service of the FQHC must meet all of the following conditions:

1. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as

described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

2. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5.

3. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

4. The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.

5. The change in scope of service must have existed for at least a full six (6) months.

c) A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.700.6.C.5.b and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.

1. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;

2. The addition or deletion of a covered Medicaid service under the State Plan;

3. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

4. Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;

5. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;

6. Changes resulting from a change in the provider mix, including, but not limited to:

i. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;

ii. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a

corresponding change in the services provided by the FQHC (e.g. delivery services);

iii. Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and/or residents; or,

iv. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

d) The following items do not prompt a scope-of-service rate adjustment:

1. An increase or decrease in the cost of supplies or existing services;

2 An increase or decrease in the number of encounters;

3. Changes in office hours or location not directly related to a change in scope of service;

4. Changes in equipment or supplies not directly related to a change in scope of service;

5. Expansion or remodel not directly related to a change in scope of service;

6. The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;

7. The addition or removal of administrative staff;

8. The addition or removal of staff members to or from an existing service;

9. Changes in salaries and benefits not directly related to a change in scope of service;

10. Change in patient type and volume without changes in type, duration, or intensity of services;

11. Capital expenditures for losses covered by insurance; or,

12. A change in ownership.

e) A FQHC must apply to the Department by written notice within ninety (90) days of the end of the FQHCs fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

f) Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.C.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. A FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

g) The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:

1. The Department's application form for a scope-of-service rate adjustment, which includes:

   i. The provider number(s) that is/are affected by the change(s) in scope of service;

   ii. A date on which the change(s) in scope of service was/were implemented;

   iii. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;

   iv. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

   v. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC;

2. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

h) The reimbursement rate for a scope-of-service change applied for January 30, 2017 or afterwards will be calculated as follows:

1. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also calculate the Adjustment Factor (AF = covered health care costs/total cost of FQHC services) associated with the change in scope of service of the FQHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the FQHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the FQHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

2. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.

3. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The “current PPS rate” means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.

4. The Department will check that the adjusted PPS rate meets the 3% threshold described above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.

5. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.

i) The Department will review the submitted documentation and will notify the FQHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC’s fiscal year end.

j) Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified by the Department through an audit or review process.

1. If the Department identifies a change in scope of services, the Department may request the documentation as described in Section 8.700.6.C.5.g from the FQHC. The FQHC must submit the documentation within ninety (90) days from the date of the request.

2. The rate adjustment methodology will be the same as described in Section 8.700.6.C.5.h.

3. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

4. The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.

k) A FQHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, a FQHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

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.

8.700.6.E~~D~~ 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.